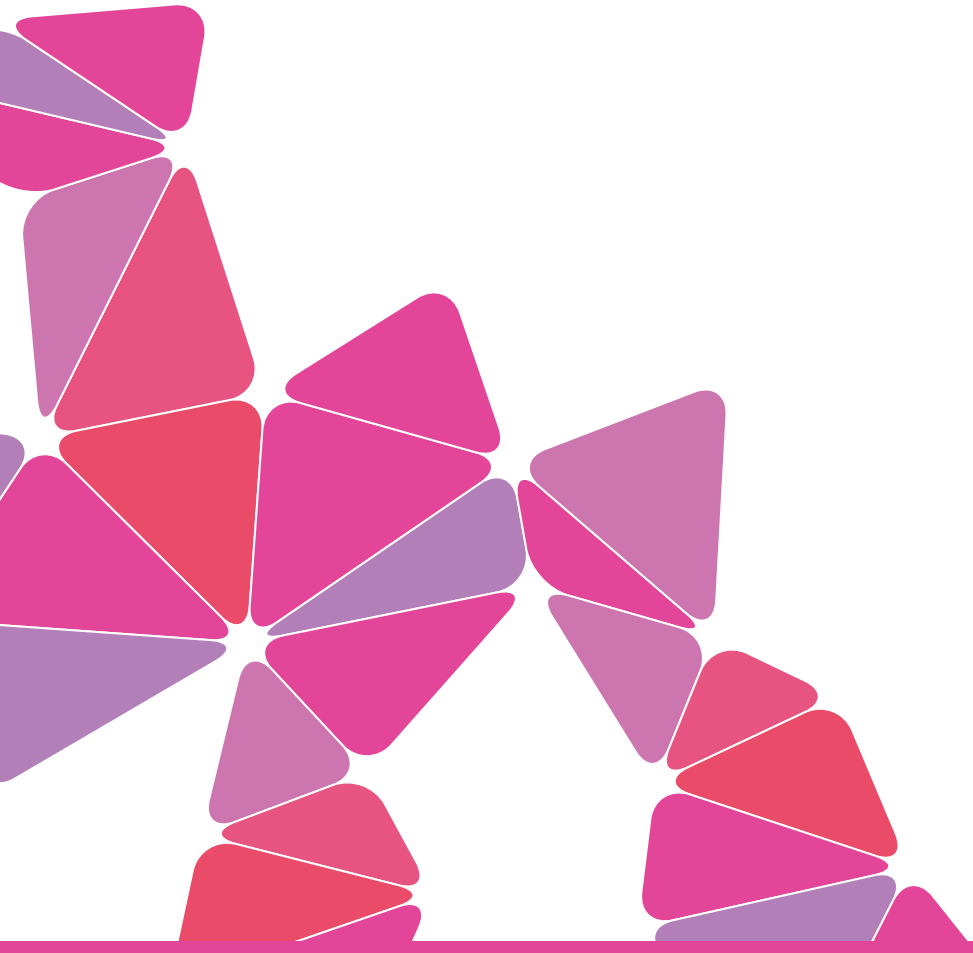
Out of your mind

Improving provision of drug & alcohol treatment for lesbian, gay, bisexual & trans people



Monty Moncrieff
London Friend

friend LONDON

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Introduction

This scoping study has been completed thanks to a grant from the Department of Health's Innovation, Excellence and Service Development (IESD) Fund.

This scoping study set out to examine how drug and alcohol treatment services could better meet the needs of lesbian, gay, bisexual & trans (LGBT) people. It sought to explore models of provision, and mechanisms for improved strategic inclusion of LGBT people when planning and delivering drug and alcohol support services.

Higher levels of both drug and alcohol use have been reported within LGBT populations, although these groups report being less likely to engage in traditional substance misuse services, citing lack of understanding of the substance use and cultural needs amongst the barriers. This scoping study set out to investigate ways in which this imbalance might be addressed, ensuring that LGBT people have access to high quality, responsive, and inclusive treatment and support services.

Our research has found very poor representation of LGBT treatment need in local needs assessment. It feels like LGBT issues are literally out of people's minds when they plan and deliver drug and alcohol services. We hope this report will encourage better consideration of the different treatment and support needs LGBT people have.

The report is aimed at anyone Involved in the planning and delivery of drug and alcohol services, including commissioners, service providers, drug and alcohol practitioners, policy makers and researchers. It includes recommendations for these different audiences as well as practical toolkits to assess LGBT competence and develop personalised Improvement plans at a local authority, organisational or personal level.

Approach

This review has been conducted via discussion with substance misuse commissioners and other key staff in several London local authorities, and through supporting them developing various approaches to local needs assessment and service improvements. We also engaged LGBT people with experience of drug and alcohol problems, and who had accessed services, via focus groups and questionnaires. Additionally we examined several different delivery structures via the provision of our own services, including in partnership with NHS substance misuse services and GUM clinics.

We spoke to a broader range of stakeholders through conferences, training, roundtable discussions, service visits, and individual conversations. These included local substance misuse service providers, LGBT organisations, sexual health service providers, Public Health England, Department of Health, Home Office, and NHS managers.

Scope

This study focusses on community-based provision of treatment services, including information and advice services, and services providing psycho-social interventions combined with community-based medical interventions where targeting of resources or specialisation of service provision for LGBT people is both practical and achievable. It recognises that here are areas where the targeting of provision is less practical, e.g. in-patient services, residential rehabilitation, prison services etc. However generic services should take steps to become more inclusive, even if they do not provide LGBT-specific services. Suggestions for making generic service more LGBT inclusive are given in the audit tool for providers in Appendix B.

Whilst this study examines experiences in London the recommendations extend nationally to improve the strategic inclusion of LGBT need in the planning and delivery of local services; managing performance based on outcomes for LGBT service users; and improving LGBT competence within generic services. Likewise whilst this study focusses on substance misuse treatment services we believe many recommendations can be applied to help improve health and care services more broadly.



Monty Moncrieff
Chief Executive

May 2014

About London Friend

London Friend is a charity working to promote the health and wellbeing of lesbian, gay, bisexual and transgender (LGBT) people. It is the oldest LGBT charity in the UK, operating since 1972. Its services include one-to-one and group support for people coming out or exploring their sexual orientation or gender identity; a helpline; a counselling service; HIV prevention and sexual health. Since 2011 it has managed Antidote a targeted LGBT drug and alcohol service providing information, advice, and structured psycho-social treatment interventions. (The Antidote service was established in 2002 and was previously managed and provided by Turning Point from their Hungerford Drug Project, now the South Westminster Drug and Alcohol Service.)

Through Antidote London Friend works in partnership with several NHS services: the CNWL Club Drug Clinic and two GUM clinics – 56 Dean Street and the Mortimer Market Centre.

London Friend is a member of The National LGB&T Partnership, a group of LGBT organisations collectively working as a member of the Department of Health's Health and Care Voluntary Sector Strategic Partners Programme.

About the author

Monty Moncrieff is the Chief Executive of London Friend joining the service in 2011. He has been working in LGBT services for almost 20 years. Previously he worked with Turning Point managing several drug treatment teams including setting up the Antidote service in 2002. Prior to working at London Friend he worked with the Department of Health managing a national programme of LGBT equality. He was a volunteer with the London Lesbian and Gay Switchboard for 10 years.

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Abbreviations

BCS:	British Crime Survey
CCG:	Clinical Commissioning Group
CNWL:	Central and North West London NHS Foundation Trust
CSEW;	Crime Survey for England & Wales
GUM:	Genito-Urinary Medicine
HIV:	Human Immunodeficiency Virus
JHWS:	Joint Health and Well-being Strategy
JSNA:	Joint Strategic Needs Assessment
LGB:	Lesbian, gay and bisexual
LGBT:	Lesbian, gay, bisexual and transgender
MSM:	Men who have sex with men
NDTMS:	National Drug Treatment Monitoring System
NHS:	National Health Service
NPS;	Novel Psychoactive Substances
PEP:	Post-exposure prophylaxis
PHE:	Public Health England
PLHPP:	Pan-London HIV Prevention Programme
PTB;	Pooled Treatment Budget
STI:	Sexually-transmitted infection
UKDPC:	UK Drug Policy Commission
VCO:	Voluntary and community organisation
VCS:	Voluntary and community sector

Executive Summary

This scoping study set out to examine how drug and alcohol treatment services could better meet the needs of lesbian, gay, bisexual & trans (LGBT) people. It sought to explore models of provision, and mechanisms for improved strategic inclusion of LGBT people when planning and delivering drug and alcohol support services.

Higher levels of both drug and alcohol use have been reported within LGBT populations, although these groups report being less likely to engage in traditional substance misuse services, citing lack of understanding of the substance use and cultural needs amongst the barriers. This scoping study set out to investigate ways in which this imbalance might be addressed, ensuring that LGBT people have access to high quality, responsive, and inclusive treatment and support services.

The full report can be downloaded from www.londonfriend.org.uk/outofyourmind

Changing needs

Antidote at London Friend is the UK's only service specifically targeting LGBT drug and alcohol users. Analysis of our own treatment data over a decade indicates a sharp change in the substances service users present seeking support around. Most noticeably this has been the emergence of drugs associated with 'chemsex', the sexualised use of drugs by gay, bisexual, and other men who have sex with men (MSM).

The three main presenting drugs are now mephedrone, crystal methamphetamine and GHB/GBL. Increasingly MSM users seeking support reporting injecting and use of these drugs in sexualised contexts with multiple partners. Concern has also been raised at the role use of these drugs may play in HIV transmission, with the number of new infections amongst MSM rising.

Use of these drugs by MSM has been the main focus of work at Antidote in the past 5 years. However, a focus on meeting MSM needs would not ensure broader LGBT need is met. The full report outlines issues for lesbian and bisexual women, bisexual people generally, and trans people reporting a drug or alcohol treatment need.

Needs assessment

Our analysis found poor representation of LGBT health needs generally within published Joint Strategic Needs Assessments on London Local Authority websites, with very poor inclusion of LGBT needs in relation to drugs and alcohol. Without explicit inclusion there is a risk that LGBT needs continue to go unmet in the procurement and delivery of services.

Planning tools for local commissioners do not currently prompt for LGBT inclusion, and treatment data supplied by Public Health England is not currently disaggregated or analysed by sexual orientation or gender identity. The report recommends mandated collection of sexual orientation across all regions, along with steps to sensitively implement collection of gender identity data.

LGBT service user views

Extensive consultation was carried out with LGBT drug and alcohol service users through questionnaires and focus groups. A strong desire was expressed for access to specialist LGBT services, which were felt to offer an emotionally and physically safer environment, and which were felt to better understand the differing support needs related to service users sexual orientation or gender identity. Many who had used generic services felt they had been unable to fully disclose or explore their issues; sensitive topics such as sexualised using were felt difficult to disclose, particularly in group settings.

Some users reported generic services being inexperienced in working with the drugs they were using. Others reported feeling their choice of provider was restricted by local authority connections, particularly if they moved away from an area with a more inclusive local service.

Commissioning inclusive services

Commissioners we engaged with were sympathetic to need, but differed in how best to address it. Some backed joint arrangements with neighbouring authorities whilst others preferred to develop LGBT competence in local services. Commissioners can improve inclusion by requesting providers to address LGBT need

through service specifications and monitoring outcomes for LGBT service users.

In London, localism in commissioning creates some barriers for developing specialist services, in terms of economies of scale. LGBT populations are a community of interest, rather than geographical, although some areas have much higher levels of LGBT populations than others. There is a case for commissioning some level of specialist provision over a larger geographical urban area such as London, although this needs further consideration of how such a mechanism would work. The model for pan-London HIV prevention could provide a template.

LGBT audit tools

Antidote has developed a set of audit tools for commissioners, providers and practitioners to assess their own LGBT competence and inclusion. These are included in the full report along with detailed guidance notes. Audits can identify areas where practice is already inclusive, and areas requiring further development, which can then form the basis of individual or organisational action plans.

Recommendations

Detailed recommendations are given in the full report for Public Health England; for commissioners and local public health; for substance misuse provider organisations; for practitioners; and for researchers.

General recommendations

- Ensure that the separate and distinct needs of L, G, B and T people are considered.
- Engage LGBT people in development work at the planning stage and throughout.
- Assess the impact of policy, planning, commissioning and delivery decisions on LGBT people.
- Counselling and psychotherapy treatments should not use 'anti-LGBT reparative' therapies.

For Public Health England

- Monitoring of sexual orientation data should be mandated.
- Monitoring of gender identity should be considered.
- Analysis of NDTMS data to inform local needs assessment and planning.
- JSNA planning and guidance documents should prompt for assessment of LGBT needs.
- Consideration of joint funding arrangements for specialist substance misuse services.
- National resources and campaigns should be LGBT inclusive.

For commissioners and local public health

- Commissioners should carry out an LGBT audit.
- Access to targeted LGBT services should be provided.
- Service specifications should address LGBT need.
- Monitoring of sexual orientation data should be mandated.
- Monitoring of gender identity should be considered.
- Procurement processes should encourage and facilitate the participation of smaller, specialist providers in the tendering process.
- Commissioners should include outcomes for LGBT people in performance management.
- Consideration of joint funding arrangements for specialist substance misuse services.
- Consideration of joint funding arrangements for integrated substance misuse and sexual health services.

For providers

- Providers should carry out an LGBT audit and develop an LGBT-inclusion plan.
- Training should be provided as part of a LGBT strategic development plan.
- Providers should identify LGBT Champions.

For practitioners

- Practitioners should carry out an LGBT audit.
- Practitioners should consider becoming an LGBT Champion for their services.
- LGBT specific diversity training should be provided to all staff.

For researchers

- Researchers can undertake work to reduce the gaps in evidence relating to LGBT substance use.
- Researchers can include monitoring of sexual orientation and gender identity in wider health research.
- Researchers can further explore monitoring of trans identity.

1. Establishing a baseline population estimate

Accurate assessment of the extent of drug and alcohol use – and problematic use – within LGBT populations is complex, not least because of the lack of robust data about LGBT populations as a whole. Collecting information about sexual orientation or gender identity can be sensitive, with safety risks to LGBT people when choosing to disclose. Such data are not collected in the UK Census, one of the main sources of population level data. Additional issues arise in the nature of what is being asked; e.g. asking a person's sexual identity may derive different responses from asking about their sexual behaviour. Under the Equality Act the two relevant Protected Characteristics relating to LGBT people are 'sexual orientation' and 'gender reassignment'.

A Government estimate of the size of the UK's LGB population for the purposes of assessing the impact of Civil Partnerships in 2003 suggested 5-7%[1]. More recently a question on sexual identity was included in the Integrated Household Survey which put the number at 1.5%[2]. The GP Survey[3] in England is one of the few datasets including sexual orientation that can be disaggregated to local level (by Clinical Commissioning Group area). In 2013 this showed an England LGB level at 2%, rising to an average of 4% in London. In some London local areas this rises to a high of almost 9% (NHS Lambeth).

Estimates of the trans population level are more difficult. For many trans people the preference is simply to identity as a man or a woman following transition, and many may fear disclosure of a previous gender identity may lead to discrimination or ridicule, or leave them vulnerable to harassment or attack. Some trans people may not wish to identify within the binary male/female conventions. The protected characteristic relating to trans people is gender reassignment, and a person is said to enjoy protection on these grounds if they are undergoing, have undergone, or are proposing to undergo gender reassignment. Legal recognition of gender change does not require any medical intervention, a social change of gender role is sufficient.

Good practice should consider the needs of those trans people who may not fit under the description of gender reassignment. Research by the Gender Identity Research and Education Society (GIRES) indicates a level of gender variance in the population at around 1%[4].

Monitoring sexual orientation & gender identity

Research about LGBT people and their health needs remains relatively poor as a direct result of not recording these characteristics as standard practice. Outcomes cannot be disaggregated by these characteristics without routine monitoring of this data, which compounds the cyclical problem. LGBT organisations regular cite monitoring as one of the highest priorities to improve knowledge and outcomes for these groups[5].

Monitoring is vital if providers, commissioners and policy makers wish to analyse trends and outcomes for LGBT people. For service users it is also an indicator that the service has considered LGBT needs and that workers are aware needs may differ if related to a service user's sexual orientation or gender identity. For frontline staff asking the question offers the opportunity to explore the relevance of a service user's sexual orientation or gender identity to their support needs, and offer an appropriate and inclusive response in care planning.

Monitoring service users' sexual orientation can be a sensitive issue, but need not be problematic. Concerns can always be addressed through simple training (and performance management if required).

Commissioners can set targets for completion and be pro-active in managing this with their

[1] DTI 2003

[2] http://www.ons.gov.uk/ons/rel/integrated-household-survey/integrated-household-survey/april-2011-to-march-2012/stb-integrated-household-survey-april-2011-to-march-2012.html

[3] http://results.gp-patient.co.uk/report/6/rt3_result.aspx

[4] http://www.gires.org.uk/assets/Research-Assets/Prevalence2011.pdf

[5] http://nationallgbtpartnershipdotorg.files.wordpress.com/2012/07/national-lgbt-partnership-manifesto3.pdf

providers. The Lesbian & Gay Foundation has produced a guide, commissioned by NHS North West, which provides further information on monitoring sexual orientation in health settings[6].

Monitoring gender identity requires some different considerations to monitoring sexual orientation. Care should be taken not to conflate the two. Many trans people who have undergone gender reassignment do not wish to be detected and will not be happy to disclose their trans history. Many may have experienced harassment or violence and be afraid to disclose if they do not know how safe it will be. However, not monitoring compounds the lack of information related to trans health needs and increases the invisibility of those trans people who wish to identify as such. It is essential that monitoring is carried out with sensitivity, but again this is something which can be addressed through training. The charity GIRES has developed a quick-start guide which provides an introduction to some of the issues[7]. Providers wishing to develop work on gender identity monitoring should engage with trans individuals and organisations (or trans-inclusive LGBT organisations) for further support.

[6] http://www.lgf.org.uk/som

[7] http://www.gires.org.uk/assets/Workplace/Monitoring.pdf

2. Drug & alcohol use by LGBT people

Prevalence

Official statistics on LGB drug use were collected in the 2007/8 and 2008/9 British Crime Survey (BCS). They show much higher levels of use of drugs by LGB people than respondents who identified as heterosexual. Compared with heterosexual adults LGB adults were more likely to have taken any drug (10.0% and 32.8% respectively) or any Class A drug (3.6% and 11.1% respectively) in the last year[8].

This higher prevalence of last year drug use among lesbian, gay or bisexual adults was found across most drug types: powder cocaine, ecstasy, hallucinogens, amphetamines, cannabis, tranquilisers, ketamine and amyl nitrite.

Comparing gay/bisexual men with heterosexual men, use of any drug in the last year is around three times higher (38.2% and 13.3% respectively). This reflected higher levels of use of the majority of individual drugs asked about: powder cocaine, ecstasy, hallucinogens, amphetamines, cannabis, tranquillisers, ketamine and amyl nitrite. The greatest difference was detected in the use of amyl nitrite in the last year by gay/bisexual and heterosexual men (23.7% and 1.8% respectively).

Last year use of any drug among lesbian/bisexual women was around four times higher than for heterosexual women (26.9% and 6.8% respectively). Among individual drugs, last year prevalence of powder cocaine, ecstasy, hallucinogens, amphetamines, cannabis and amyl nitrite was higher among gay/bisexual females than heterosexual females.

Whilst the highest levels of use, and greater disproportionality between LGB and heterosexual use, are found with club drugs, it should be noted that the reported use of heroin and crack cocaine are also higher amongst LGB people in the BCS.

The BCS (now the Crime Survey for England and Wales) has not published disaggregated drug use by sexual orientation more recently. There are no official statistics for drug use by trans people.

Several other key recent reports illustrate the extent of drug use by LGBT populations in the UK. Part of The Picture is a five-year research project undertaken by the Lesbian & Gay Foundation[9]. It looks at self-reported alcohol and drug use by LGB people, with data collected through online surveys and at events such as LGBT Pride festivals. Headline figures indicate LGB people are up to 7 times more likely to have used drugs in the past year than the wider population. Use was higher than the general population across all drugs and across all age ranges. Binge drinking is roughly twice as common for LGB people than in men and women in general.

In 2010 the UK Drug Policy Commission (UKDPC) undertook a literature review of available research on drug use[10]. Amongst their findings they reported consistently higher levels of prevalence of drug use by LGBT populations across the research than seen in the population in general. The review highlighted the difficulty of separating out issues for different groups within the LGBT spectrum; much of the evidence could not separate out the issues for lesbians, bisexual people or trans people and some focussed only on MSM.

The Chemsex Study 2014 commissioned by the London Boroughs of Lambeth, Southwark and Lewisham examines drug use in sexual contexts amongst gay and bisexual men through qualitative research[11]. It also includes some quantitative research drawn from the European MSM Internet Survey[12].

All the available research should be treated as indicative rather than robust data. The numbers in the BCS are relatively small and other research tends to be from a self-selecting sample.

8 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/116325/hosb13101-annex2.pdf

9 http://www.lgf.org.uk/potp

10 http://www.ukdpc.org.uk/publication/the-impact-drugs-different-minority-groups-lgbt-groups/

11 http://www.sigmaresearch.org.uk/projects/project59/

12 http://www.emis-project.eu/

2.1 Separating out L, G, B & T

The UKDPC research warns that much of the available evidence is skewed towards the needs of men. Within this it is dominated by gay men, with many sources unable to distinguish the issues for bisexual men. There is less evidence available relating to lesbian or bisexual women, to bisexuals of both sexes, and to trans people.

In our engagement for this study the needs of gay and bisexual men were of greatest concern for local providers, especially where this related to sexual health. Our own client base is largely gay and bisexual men, and it is this group where we have seen the most noticeable trends in recent years, and where we have seen the most significant harms.

There is a risk that in attempting to address LGBT needs more focus is given to MSM health needs and both commissioners and providers may not adequately address the needs of all LGBT groups, although may think they are doing so. Likewise MSM may not all identify as gay or bisexual.

2.2 Lesbian & bisexual women

The UK Drug Policy Commission's 2010 report identified a lack of information relating to lesbian and bisexual women. At Antidote we have seen relatively few women, just 34 (4.5%) of our service users in 2013/14. With so few women accessing the service it is difficult to highlight particular drug or alcohol issues for lesbian and bisexual women, although the most prominent presenting issues were alcohol (7); powder cocaine (5); mephedrone (4); and cannabis (3). Two women had issues around crystal meth, one presented with GHB/GBL. Other drug use included prescription drugs; several women presented drug and alcohol free for relapse prevention support.

Table 1: **Drug(s) cited as a treatment need by female clients in 2013/14**

Substance	No. clients
Mephedrone	4
Crystal meth	2
GHB/GBL	1
Ketamine	1
Cocaine	5
Alcohol	7
Ecstasy/MDMA	0
Heroin	0
Cannabis	3
Crack cocaine	0

The Part of the Picture study had more responses from women (2274, 55%) than men (1868, 45%). In this women were far more likely than men to identify as bisexual; of the respondents who identified as bisexual 583 of these (74%) were women.

When breaking down drug use female respondents were less likely to have used most drugs in the past month compared to males:

> "While females were equally as likely to have used cannabis in the last month (20% for each), males were four times more likely to have used poppers (29% compared to 7%), three and a half times more likely to use ketamine (7% compared to 2%), nearly twice as likely to use cocaine powder (10% compared to 6%), ecstasy (9% compared to 5%) and amphetamines (5% compared to 3%) and one a half times more likely to have used non-prescribed

> benzodiazepines (3% compared to 2%). GHB was almost exclusively used by males."

Levels of alcohol use were high (89% in the survey as a whole) with levels consistent between men and women. 29% of lesbian women reported binge drinking at least once or twice a week in the past month; for bisexual women this was similar at 27%. Part of the Picture compared this with data from the ONS General Lifestyle Survey 2010 which shows that in the wider population, 15% of females drank more than 6 units on their heaviest drinking day in the last week[13].

Stonewall's Prescription for Change[14] found that 41% of lesbian and bisexual women drank three or more times in the previous week, compared to 26% of women in general. They also found lesbian and Bisexual women were 5 times more likely to use drugs than women in general, with more than one in ten having used cocaine, compared to just 3% of women in general.

Stonewall's qualitative research indicated that lesbian and bisexual women felt they were more at risk than women in general due to having fewer places to meet where alcohol was not available, and to being invisible in health promotion messaging:

> "I believe many lesbians (the ones who pub and club) are at higher risk of life-style illness than straight women, smoking, drinking etc because there are fewer alternatives outside these sort of environments where lesbians can be together (other than once you are established in a social network) yet there is no targeted health promotion that features lesbians."

Over half of lesbian and bisexual women had reported negative experiences when accessing healthcare services. Common experiences included feeling misunderstood or being asked inappropriate questions. Some felt this would lead to them not accessing services, and believed they had unequal access:

> "I don't believe I have equal access to appropriate healthcare services as my heterosexual counterparts – partly due to the continued lack of understanding of specific lesbian health needs and at times of illness not always feeling emotionally confident or sufficiently resilient to frequently have to cope with outing myself each visit, facing a barrage of heterosexist and inappropriate questioning from GP's and other health workers. Most of which results in me not bothering to seek medical intervention or preventive healthcare advice until it's virtually not a choice. I will self help and self treat as far as possible. The healthcare sector is alienating, unsafe and does not meet my needs."

Reluctance to access healthcare services is echoed in Part of the Picture with very few LGB people who had sought help around their drug or alcohol use reporting having accessed drug or alcohol services; just 5.5% had accessed drug treatment and 6.6% treatment for alcohol, although 29.8% had accessed support through their GP. Most reported similar self-help approaches, accessing information on the internet (71.4%) or support through family and friends (49.5%).

At Antidote we provide a targeted monthly service for lesbian, bisexual and trans women with targeted promotion but still attract very few women to the service. More research is needed to understand and address the barriers experienced by lesbian and bisexual women in accessing drug and alcohol treatment. The data also tells us little about the contexts in which lesbian and bisexual women use alcohol and drugs.

Although there are significant information gaps relating to the drug and alcohol needs of lesbian and bisexual women, Part of the Picture makes a salient point in relation to providing service for these groups:

> "Although use amongst gay and bisexual males may present the most cause for concern in terms of the pressing need for drugs misuse information and interventions, drug use in the last month for lesbian and bisexual females is still far more common than that of the wider population and may also require targeted information and interventions."

[13] http://www.ons.gov.uk/ons/rel/ghs/general-lifestyle-survey/2010/index.html
[14] http://www.healthylives.stonewall.org.uk/lgb-health/lesbian-and-bisexual-women/default.aspx

2.3 Gay & bisexual men

Most of the research reviewed by the UKDPC focused on gay, bisexual and other MSM. This review found consistently higher levels of drug and alcohol use by these groups than in the population as a whole. Part of the Picture also found higher levels of use by LGB people, with use greater amongst men than women.

Alcohol is a significant concern. Stonewall's Gay and Bisexual Men's Health Survey[15] found that half of gay and bisexual men had used drugs in the past year compared to just 1 in 8 men in general, but also found high levels of alcohol use; 78% of gay and bisexual men drank in the last week compared to 68% of men in general. This is echoed by Part of the Picture where 89% of LGB people drank alcohol within the past month. The 2014 Chemsex Study[16] of MSM in the London Boroughs of Lambeth, Southwark and Lewisham reported 93.2% of MSM had used alcohol within the past 4 weeks, with half (50.9%) of them drinking in the previous 24 hours. Alcohol was highlighted as the substance MSM were most concerned about.

As in Stonewall's research on lesbian and bisexual women, men viewed the nature of the way they meet and socialise with other gay and bisexual men as increasing the potential for harm, with a focus on socialising in licensed premises such as bars and clubs.;

> "Gay men's culture seems to revolve around getting pissed as often as possible which often then seems to lead to increased drug and tobacco use as well as increased risk of sexually transmitted infections and violence."

Gay and bisexual men account for by far the largest proportion of Antidote service users totalling 94% of those who specified their gender. Men accounted for 657 of 758 clients in 2013/14 (57 preferred not to specify a gender). Gay and bisexual men present with the greatest harms associated with their using, and the vast majority presented with a primary substance issue other than alcohol. 50 men presented with a primary alcohol issue.

Compared to the findings of the Chemsex Study where alcohol was the greatest reported concern this may suggest that few men are seeking support for alcohol, despite high levels of use and health worry.

The main drugs used by gay and bisexual men have changed enormously in the past decade. In 2004/05 the biggest presentation to Antidote was alcohol (reported by 130 of 174 service users). The most common drug was powder cocaine (46), ecstasy (37) and ketamine (23). Only 3 users reported use of GHB/GBL. No users reported crystal meth, despite widespread media concern that this drug would be the next problematic drug in the UK. By 2013/14 the main three problematic drugs, and those most closely linked to the emerging concerns associated with 'chemsex', were mephedrone, crystal meth, and GHB/GBL.

In 2006/07 Antidote saw its first presentation for crystal meth (7 of 249 service users), and from then began to see an increase in use, initially reported by men who had lived in the USA or Australia and for who this drug was one of several they had been using. Use increased slowly until a very sharp increase in 2010/11 with 265 of 553 service users reporting use. In 2013/14 use was reported by 373 users, 51.3% of all clients using drugs. In 2011 the HIV organisation NAM collated the then-available evidence on crystal use by gay men in London[17].

Use of GHB/GBL remained low until around 2008/09 when 53 of 311 service users reported this. Prior to this use had mainly been reported as a secondary issue rather than the main substance of concern. The increase in use coincided with the first reports of services users taking GBL (10) rather than GHB (43). By 2010/11 reported use increased sharply to 317 of 553 clients, with use exclusively reported as GBL. In 2013/14 334 service users reported use, 46% of all clients using drugs. Use is more likely to be reported as a secondary (152) or tertiary (114) drug issue, with fewer (68) reporting primary use.

Mephedrone was not recorded as a separate drug in records up to 2010/11, although there were emerging anecdotal reports of its use. By 2013/14 this had become the most prevalent

[15] http://www.healthylives.stonewall.org.uk/lgb-health/gay-and-bisexual-men/default.aspx

[16] http://www.sigmaresearch.org.uk/projects/project59/

[17] http://www.aidsmap.com/Crystal-meth-and-London-gay-men-examining-the-evidence/page/2568846/

drug used by Antidote clients with 461 people reporting use, 64% of all drug using clients.

The use of drugs more typically seen as problematic within drug services remains low. In 2013/14 only 2 clients reported use of heroin and 6 or crack cocaine. This was a decline within the decade (20114/05 = 5 heroin, 14 crack cocaine) although this may be explained by Antidote having been previously a service hosted within a mainstream drug service working mainly with homeless drug and alcohol users. Presentations seeking treatment for cannabis remained low, and fell in proportionate terms.

Table 2 indicates the shift in drug use within the past 10 years within people accessing Antidote.

The Part of the Picture data (table 3) indicates that use of GHB/GBL and crystal were still very low between 2009 – 2011 amongst LGB people. No data was captured for mephedrone.

The Chemsex Study's review of data in the European MSM Internet Survey (EMIS) reported higher levels of the three main chemsex drugs than Part of the Picture, but still lower recent and lifetime use than drugs such as cocaine, ecstasy and cannabis. Lower levels of use, with higher levels of reported use within treatment, indicate the harms associated with these drugs are much greater, and lead users to seek support more readily.

There is also some evidence that the chemsex trend is, for now, more prevalent in London. The analysis of EMIS data in the Chemsex Study found higher levels of use of all drugs by MSM in London compared to the rest of England with the exception of speed. Within London use is disparate across areas; in the three London Boroughs where the Chemsex Study focused use was higher again, with particular increases in the chemsex drugs, cocaine and ketamine. Table 4 shows the EMIS data reported in the Chemsex Study and compares it with use reported in the past year in the official drug use statistics from the Crime Survey for England and Wales (CSEW) 2012/13.

The data tells us much more about the context of problematic drug use for gay and bisexual men than we know about use by lesbian and bisexual women. Almost all of the male service users accessing Antidote who use drugs now tell us they used in sexualised situations. In the Chemsex Study many participants reported

Table 2: **Comparison of drug(s) cited as treatment need by clients (2004/5 & 2013/14)**

Substance	2004/05 174 clients	2013/14 758 clients
Alcohol	130	79
Ecstasy/MDMA	37	9
Powder cocaine	46	86
Ketamine	23	44
Crystal meth	0	373
GHB/GBL	3	334
Mephedrone	0	461
Cannabis	24	28
Heroin	5	2
Crack	14	6

Table 3: **Drugs used in the past month by LGB people, 2009 -2011 (Part of the Picture)**

Substance	Number	%
Cannabis	798	20
Poppers	686	18
Cocaine powder	300	8
Ecstasy	268	7
Ketamine	158	4
Amphetamines	152	4
Benzodiazepines (non-prescribed)	101	3
GHB	62	2
LSD	38	1
Crystal meth	34	1%
Crack cocaine	30	1%
Steroids	27	1%
Heroin	27	1%
Other	181	5%

Table 4: **Comparison of data on drug use by MSM and all adult populations in England and Wales**

Substance	% MSM use (EMIS)			% adult use CSEW
	Lambeth, Southwark & Lewisham	Rest of London	Rest of England	
Crystal meth	4.9	2.9	0.7	0.1
Mephedrone	10.2	5.2	2.9	0.5
GHB/GBL	10.5	5.5	1.6	n/a
Powder cocaine	18	11	4.8	1.9
Ketamine	9.6	5.9	3.8	0.4
Alcohol	93.2	90.6	87.6	n/a

having progressed to the main chemsex drugs having previously used other drugs on the clubbing or dance scene.

Injecting crystal meth and mephedrone has become more common; a decade ago no clients reported injecting club drugs but in 2013/14 this was reported by 49% of service users (239 of 490 records where this information was available). Some MSM still shun this route of administration and the Chemsex Study reported many still felt injecting to be a 'taboo' or crossing a boundary, even where they had injected themselves. This route of administration was felt by some to be linked to using moving out of clubs and venues and into private parties. Some cited increased venue security as a factor for this.

Service users reported frequent use of sexual networking apps and internet sites to find sexual partners. Both anecdotal evidence from Antidote service users and the Chemsex Study indicate apps are often used to arrange sex parties, and to source drugs, with some evidence of transactional sex in exchange for drugs, particularly amongst younger men. There was a link between use of some drugs, particularly crystal meth, and men who were already HIV positive, with a quarter making an intentional choice to have unprotected anal intercourse with other men they knew or believed to be HIV positive. The Chemsex Study found around a third of men had taken unintended sexual risks, a concern with almost 1 in 5 MSM living with HIV being unaware they are positive. However the Study also reported that all men the interviewed took their responsibilities for HIV very seriously, not wishing to be the source of onward transmission. A quarter had maintained strict boundaries about condom use whilst having chemsex.

In treatment sufficient gay and bisexual men have accessed support with Antidote to be able to indicate recurrent themes, which are also found in the Chemsex Study. A large number of men report issues of self-esteem related to their sexual identity as a gay or bisexual man and their self-confidence in negotiating sex and the gay scene. Many discuss how the scene was a place to explore their identity or where they would look to meet people to form friendships, but how they felt this incredibly difficult to do, partially due to the heavily sexualised nature of some social settings and media messaging. Many spoke of their use of sexual networking apps as making the facilitation of sex easier, including the acquisition of drugs to use for sex, but that this also felt limiting and made making non-sexual friendships more difficult. Many report dissatisfaction with chemsex and the reliance on drugs for sex, with the prevalence making it difficult to avoid, and the desire for intimacy and relationships being a very common theme.

As for lesbian and bisexual women, gay and bisexual men see barriers in access to treatment. Stonewall's research indicates a third of gay and bisexual men reported a negative experience in accessing healthcare. A common theme from this research and our own focus groups is that people didn't feel public health messages or healthcare services targeted them:

> "There was no visible commitment to equality. I saw lots of posters about services for disabled people and the elderly, but nothing for lesbian, gay and bisexual people."

In contrast the numbers of gay and bisexual men accessing Antidote as a targeted LGBT service, and also accessing the CNWL Club Drug Clinic as a generic service that had partnered with Antidote to improve LGBT competence indicates that where interventions are targeted there are fewer barriers in accessing them.

The change in the patterns of drug use reported by gay and bisexual men has been sharp, and whilst use of the three chemsex drugs is still lower overall that alcohol, cannabis or cocaine they account for the majority of presentations to treatment by gay and bisexual men in London. From working with services outside of the capital we have heard increasing anecdotal evidence of these drugs, particularly mephedrone and GHB/GBL, becoming more widely used and within sexual contexts, so services outside of London should be preparing to monitor trends and raise staff confidence in working with them.

Gay and bisexual men still experience barriers in accessing healthcare services and report the importance of feeling interventions are targeted at them. The Chemsex Study indicates a high level of satisfaction with targeted services that are experienced in working with

gay and bisexual men, and valued pragmatic, non-judgemental advice about managing their drug use and related harms. Men generally felt comfortable accessing drug information and harm reduction advice in sexual health settings (both clinical and community-based) or would prefer to do so in future.

2.4 Bisexual issues

Most of the research available looks at drug and alcohol issues for lesbian, gay and bisexual people together, and does not disaggregate findings specific to bisexual people. Part of the Picture included a significant number of bisexual respondents, and found that bisexual men were marginally more likely to have taken drugs in the past month that gay and bisexual men as a whole, and bisexual women were much more likely to have taken drugs in the past month that lesbian and bisexual women together. However their report notes the difficulties in analysing information for this group:

> "Because lesbians and gay people are groups of one gender and the bisexual group is made of both genders, it is problematic to make comparisons between the three groups. Comparing lesbians with bisexual females, or comparing gay males with bisexual males is a better way of identifying the specific experiences of bisexual people, but small sample sizes (for example, once the sample is broken down by drug used) have often made this impractical."

Other research indicates that bisexual people often face different issues to both heterosexual people and lesbian and gay people, and report greater health inequalities with related health issues. The Bisexuality Report found that bisexual people have significantly higher levels of distress and mental health difficulties than equivalent heterosexual or lesbian/gay populations. Bisexual issues can be invisible, through amalgamation with LGBT issues more broadly, which in practice can lead to only lesbian and gay issues, or even more commonly issues for only gay men, being considered.

The Bisexuality Report[18] found that bisexual men and women are usually less at ease with their sexual orientation and are less likely to be out. This is echoed in Stonewall's Bisexuality health briefing[19] which found 6 in 10 bisexual men and two thirds of bisexual women are not out to their GP compared to 3 in 10 gay men, and 49% of lesbians.

Stonewall's briefing also reported that bisexual people are more likely to experience health inequalities, including poorer mental health. Regarding sexual health, levels of sexually transmitted infections were higher in bisexual women, and bisexual men were less likely to have tested for HIV, with 49% untested compared to 25% of gay men.

Of the 724 Antidote service users in 2013/14 27 (3.5%) identified as bisexual. With a small sample it is difficult to draw trends. Most of these were men, with one woman, 4 identified as transwomen and two preferred not to state a gender. With a mostly male sample it is not surprising that drug use amongst bisexual service users largely reflected the same trends as for gay men. The table below shows how many bisexual people indicated use of each substance as a treatment need.

Table 5: **Drug(s) cited as a treatment need by bisexual clients in 2013/14**

Substance	Number of clients
Mephedrone	11
Crystal meth	10
GHB/GBL	10
Ketamine	2
Cocaine	4
Alcohol	5
Ecstasy/MDMA	2
Heroin	1
Cannabis	2
Poppers	1

[18] http://www.open.ac.uk/ccig/news/the-bisexuality-report-is-now-available

[19] http://www.stonewall.org.uk/documents/bisexuality.pdf

There is a need for more information about the pattern and context of drug and alcohol use amongst bisexual people. However there is evidence of greater inequality and exclusion, and poorer visibility of bisexual people within services. With sexual identity a common theme in of the underlying issues presented by service users it is essential that providers and staff become more aware of the distinct issues that may affect bisexual people, and that bisexual identity is acknowledged and reflected within services and health promotion messaging and interventions.

2.5 Trans issues

The UK Drug Policy Commission's 2010 report identified that research on drug and alcohol use by trans people was particularly ignored within the literature it reviewed. Gender identity is rarely monitored in health data sets making it impossible to disaggregate most health research by the protected equality characteristic for gender reassignment. NDTMS does not record gender identity or gender reassignment so we have no official data on trans people accessing drug and alcohol treatment.

The Trans Mental Health Study 2012[20] contains brief findings on drugs and alcohol. 24% (of 577 respondents) had used drugs in the past year. 2% of these had injected. 23% believed their drug use was, or sometimes was, a problem for them.

Participants were screened for alcohol dependency using the Audit C screening tool[21]. This asks about frequency of alcohol consumption, how many units are typically consumed and how frequent binge drinking occurs. A score is given between 0 and 12 with a score of 5 or above indicating increasing or higher risk drinking. The study reported 47% scored 4 – 12, suggesting high and potentially problematic levels of use.

In 2013/14 ten Antidote service users identified as being outside the male-female binary, nine as trans and one as another gender identity (1.4% of all clients). Of these nine, five identified as trans men and four as trans women. In total 24 service users (3.4%) indicated their gender identity was different to that typically associated with the sex they were assigned at birth. The table below shows how many trans people, and people who identified as having a different gender identity indicated use of each substance as a treatment need.

Table 6: **Drug(s) cited as a treatment need by trans clients in 2013/14**

Substance	Number of clients
Mephedrone	11
Crystal meth	7
GHB/GBL	7
Ketamine	1
Cocaine	0
Alcohol	6
Ecstasy/MDMA	2
Heroin	1
Cannabis	2
Crack cocaine	3

Despite the lack of research specific on drugs and alcohol, other trans health research cites significant health inequalities and barriers when accessing services. The Trans Mental Health Study found extremely high levels of experience of depression (88%), stress (80%) and anxiety (75%), along with over 90% experiencing harassment. 81% of respondents stated they avoided certain situations because of fear.

The Engendered Penalties report found that almost a third (29%) of trans people felt that being trans adversely affected they way they were treated by healthcare professionals. A common theme was to focus inappropriately on their trans identity as the primary support need, even where this was unconnected:

> "Cleary some healthcare professionals do not know how to deal with trans people appropriately. Indeed, the evidence suggests that some healthcare professionals have a tendency to see trans people as transsexual first – regardless of the

[20] http://www.scottishtrans.org/wp-content/uploads/2013/03/trans_mh_study.pdf

[21] http://www.alcohollearningcentre.org.uk/Topics/Browse/BriefAdvice/?parent=4444&child=4898

non-trans healthcare needs that they may present with."

Encouragingly the Trans Mental Health Study found that most (70%) respondents were more satisfied with their lives after transitioning, and only 2% were less satisfied. Dissatisfaction centred on poor surgical outcomes, loss of employment, and loss of family, friends and social support as a result of ongoing transphobia.

In addressing joint sexual health and substance needs commissioners and providers should be aware that trans people may require different and targeted sexual health advice. This may be related to their anatomy, which may not match their outward gender presentation, or to sexual health following genital surgery. Sexual risk amongst some trans people and their partners may be commensurate with risk for MSM, although sexual health messages and interventions targeted at MSM may not be inclusive of trans issues. Sexual health guides for transmen and trans women are available from the Terrence Higgins Trust[22].

With identity and self-esteem such a prominent underlying reason for presentations to drug and alcohol treatment it is essential that trans people are able to feel welcome, visible and acknowledged within services. This includes the right to privacy about their trans status or previous gender history where they have disclosed this. The Trans Mental Health Study found 29% of people felt services did not view their gender identity as genuine, which risks compounding negative feelings of self-worth.

Although trans people may experience similar discrimination and prejudice as LGB people the issues affecting them are different to those around sexual orientation. Care should be taken to not confuse or conflate the two. In our audit guidance for commissioners, providers and practitioners we have indicated that assessment of LGBT competence should be separated into LGB and trans areas. Needs assessment and planning should view the issues separately and ensure that work which addresses LGB issues is not mistakenly assumed to also be adequate for trans issues.

Services should consider how they target trans populations and how they build trans competence. Antidote has partnered with NHS and VCS providers in cliniQ, a specialist trans sexual health and well-being service[23]. This has been achieved through these services allotting existing resource to deliver services targeting trans people at a specific clinic each week, bringing together GUM and sexual health services with drug and alcohol support, counselling, housing advice, advocacy and support around hate crime and domestic abuse. Partner agencies receive no specific funding for this, instead considering this a best-practice approach in making our own services more accessible to trans people. Resources such as Galop's Shining The Light[24] provide a toolkit for services to improve trans competence.

2.6 Summary

There is evidence of significantly higher levels of drug and alcohol use amongst LGBT people, although much of this evidence concentrates on information relating to gay men. Whilst changing patterns of problematic use can be clearly seen by gay and bisexual men there is less data available to identify trends for lesbian and bisexual women or for trans people. There is evidence that use of some substances is more common in London than the rest of the country.

The drugs most commonly seen in most drug treatment services, heroin and crack cocaine, are far less likely to be used by LGBT people. Across all sub groups within the LGBT population barriers in accessing services are cited, with the perception that information and interventions do not target these groups.

Within treatment, inconsistent levels of recording sexual orientation and not official recording of different gender identities is a barrier to analysing data including drug prevalence, trends, and outcomes for these populations. Additionally the large number of LGBT people who are seeking support from places other than drug and alcohol treatment services may be masking the scale of problematic use.

[22] http://www.tht.org.uk/sexual-health/Sex-and-relationships/Sexuality-_and_-gender/Trans

[23] http://www.cliniq.org.uk/

[24] http://www.galop.org.uk/wp-content/uploads/2011/05/final-shine-report-low-res.pdf

3. Treatment data

Data for LGBT people accessing treatment service is patchy: sexual orientation is captured by NDTMS, although recording of this field is mandated differently across the country, with regional variation from 30% completion in East Midlands to 89% in London, where it is mandated. The national average for completion of this field is 67%.

Data is not routinely analysed by sexual orientation although in October 2013 Public Health England commissioned a review of NDTMS data relating to MSM as part of their own approach to addressing concerns around MSM sexual health and drug use. There is indication of higher levels of the use of drugs, particularly those associated with chemsex, by MSM compared to amongst heterosexual men. This data will be included in forthcoming guidance from PHE on commissioning substance misuse services for MSM.

NDTMS does not provide an option for recording trans identity, or the protected characteristic of gender reassignment so treatment data cannot be disaggregated for this group. There are additional sensitivities, including legal and privacy considerations around monitoring of gender identity but without the ability to capture this data can never be disaggregated for this population.

Antidote's own data is not currently submitted to NDTMS meaning there are a number of LGBT people opting to access drug and alcohol treatment support in a specialist LGBT setting that are not currently being captured in official treatment statistics. Antidote's work is currently funded by the Big Lottery Fund and reports outcomes to them which does not require submission to NDTMS, although we identified this data gap in the application to conduct this scoping study. During this study we worked to implement a database that would capture the same information required by NDTMS and sought consent from service users to submit this data to Public Health England. We opted to build a database rather than purchase a commercially available package that is NDTMS compliant, primarily as we wished to customise it to record additional information relevant to LGBT use, and to extend use into London Friend's other areas of work, including recording counselling clients, support and social group attendance, and a volunteer management system.

In hindsight the decision to build our own database complicated our data collection and sharing capacity. The design and build was a lengthier process than anticipated, resulting in earlier data not being able to be captured and us not having the capacity to fully backdate this from paper files. As a very small service we also lacked sufficient staff capacity to submit to NDTMS. We do now have a full year data for 2013/14 and we continue to discuss with NDTMS colleagues how best to share this going forward.

The learning on data management from this project highlights the importance of ensuring smaller and specialist providers plan sufficient capacity for data requirements under local authority contracts.

4. The London picture & the localism challenge

London is home to the highest density of LGBT people in the UK with the exception of Brighton and Hove[25]. Population levels vary by local authority but the nature of the city means the LGBT population does not divide on geographic local authority boundaries. Some areas have a higher density of LGBT social venues or support services which may attract larger numbers of LGBT people to particular areas. LGBT people may live in one area, work in another and socialise in several. Non-cohabiting couples may live in different boroughs.

The need to ensure confidence and safety in a service often leads LGBT people to seek specialist support, or to seek services they feel they can trust. This may not always be a service local to where they live. Where health services are not provided within local authority boundaries there is evidence that many LGBT people favour services which are marketed towards them. For example, sexual health clinics such as the 56 Dean Service have done much to attract a high number of LGBT clients through its central location in the heart of Soho, well known for many LGBT bars, cafes, nightclubs, shops and other services. It has also marketed clinics to specific groups, e.g. the MSM Code Clinic and the trans service cliniQ, as well as advertised heavily in LGBT media.

This transient nature presents some public health challenges, particularly relating to HIV and sexual health where LGBT people may access sex-on-premises venues such as saunas and sex clubs. A number of these operate around the capital, mainly targeting MSM and the trans sex scene. Patrons may travel across London boroughs, from out of town, or from outside the UK to access these venues. The Chemsex Study identified that MSM often are engaged in dense sexual networks meaning that threats to heath can spread rapidly, requiring a joined-up public health response not limited to local residency.

Many LGBT organisations in London are also organised on a pan-London level; community norms often anticipate specialist services provided on this basis, e.g. the specialist LGBT housing service Stonewall Housing, or the LGBT policing and hate crime support organisation Galop. Some organisations providing services to LGBT people do limit their work to local areas and residents of specific local authorities where funding is from local sources, although this can mean services offering a 'two-tier' approach, e.g. a counselling service offering subsidised places to residents of some borough but not to others. Fewer services are targeted towards lesbian and bisexual women, bisexual people generally, and trans people.

Demand by LGBT people resident in outer London boroughs for services local to where they live may be reduced by the extent to which the focus of their activities is towards central London. The gravitational pull of central London raises the target population above a critical mass such that there may be sufficient demand to make niche services aimed at specific population groups viable. It may therefore be reasonable for a London borough to look at commissioning out-of-borough provision as being useful outreach to the target population i.e. working with people where you find them and not requiring them to look for you.

Investment in the wider LGBT voluntary sector is low. Centred (formerly Kairos in Soho) has published an analysis of the London LGBT voluntary sector capacity in their LGBT Almanac[26]. LGBT VCS income in London in Centred 2012 survey was £5,579,319, which accounts for just 0.038% of the total VCS income in London. The focus of this investment relates to health and care services. Centred reports:

> "83% of expenditure pertains to what might be deemed 'social service' organisations, i.e. those with a focus on housing, health, domestic violence or 'public services' more generally."

[25] http://results.gp-patient.co.uk/report/6/rt3_result.aspx

[26] http://www.centred.org.uk/sites/centred/files/almanac%202012%20for%20web.pdf

Expenditure on LGBT individuals is much lower compared to the population as a whole. Here Centred reports:

> "The level of expenditure amongst London LGBT VCOs is equivalent to £9 per head spent on the LGBT population compared with £1796 per head spent by VCOs on the whole population of London."

Centred found the sources of funding for the LGBT VCS to differ significantly from the VCS as a whole, potentially impacting the medium to long-term sustainability of some specialist health and care provision. LGBT organisations are overly reliant on the public sector for funding; 61% of investment in LGBT organisations comes from the public sector compared to just 31% of income for VCS as a whole. With existing and planned cuts in public sector spending this potentially exposes the LGBT VCS at a disproportionate level of risk. At the same time the LGBT VCS is able to rely less on individual giving, accounting for just 21% of income in London compared to 42% in the VCS as a whole.

Participants in focus groups run as part of this scoping study (see section 9) discussed some of the challenges they had experienced in accessing drug and alcohol treatment services locally, including having to transfer from one service to another if they moved or were re-housed in specialist LGBT supported housing schemes. They reported varying levels of LGBT competence but felt restricted by the local nature of provision, and unable to choose to go to a service they felt to be more LGBT-inclusive.

Mechanisms for funding drug and alcohol treatment on a pan-London level are not simple; current arrangements see most decisions, and all monies, devolved to local level. The current Government has pursued a policy of reducing central Government direction in favour of localism, with decisions made on local needs. Whilst this approach offers local commissioners greater flexibility to target inequalities e.g. within specific wards that experience higher levels of social deprivation or poor health outcomes, for non-geographic communities of association like the LGBT population this approach can create additional barriers and inequalities.

A local authority with smaller, or less visible, LGBT population may be reluctant or unable to identify much or any resource for targeting specialist services towards these groups. Local commissioners have the opportunity to work in partnership with neighbouring boroughs, which we have seen during this project, although no formal mechanism exists for commissioning substance misuse services at pan-London level.

London-wide health structures

A number of high-level structures exist with aims to improve the health and well-being of Londoners, and to support integration of health services. As with the newer health structures created under the Health and Social Care Act many of these have only been in place a short time, but there are opportunities for these to provide leadership on improving the health of minority populations through their duties to tackle health equalities and inequalities.

In 2011 the Greater London Authority planned to set up the London Health Improvement Board, to look at certain health areas which could benefit from a city-wide approach. Initial priorities included alcohol. A proposed model of top-slicing between 3% and 6% of local budgets was discussed. However the Board failed to obtain statutory status and ceased to exist in March 2013[27]. It was replaced by the London Health Board with a role to "provide leadership on health issues of pan-London significance, where this adds value to decisions, agreements and action at local level".[28] The Board is chaired by the Mayor with partners from Local Government, NHS England, Public Health England and the London Clinical Commissioning Council.

A pan-London mechanism for commissioning HIV prevention interventions exists and was reviewed in 2013, offering a potential model for commissioning targeted substance misuse interventions on a London-wide scale, particularly relating to the chemsex needs of MSM. This model is discussed in further detail in section 10.

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27 http://www.londoncouncils.gov.uk/policylobbying/healthadultservices/lhib/

28 http://www.londonhealthboard.org.uk/default.htm

5. Targeted approaches: Demographic or substance based?

An unexpected aspect of discussion for this study was whether LGBT need could best be met through services targeting the group as a demographic, or through services targeting the drugs LGBT people are more likely to be using. The UKDPC 2010 review highlighted some of the barriers LGBT people faced, including the focus on drugs less commonly used by LGBT people. It also noted the lack of understanding of LGBT specific needs as an additional barrier.

Between applying to conduct this study and commencing it Antidote began a partnership with the CNWL Club Drug Clinic[29], a specialist service that targeted users of club drugs. One of the prompts for that service had been a high level of MSM seen in sexual health services who reported use of crystal meth and other recreational drugs. This in turn had prompted the partnership with Antidote as a specialist LGBT service. The partnership gave us the additional opportunity to examine this model of service.

Antidote had previously worked to highlight the issues and trends being seen within its own service by focusing on the LGBT demographic. This was met with limited engagement outside of the LGBT sector and media. The focus on club drugs as the primary issue, which then talked about issues for LGBT people within this, attracted more engagement from Government agencies, commissioners and providers. This may have coincided with greater media attention to 'legal highs' and other novel psychoactive substances, and their increased availability in new online markets.

Although the Club Drug Clinic is open to all users of club drugs it attracted a much higher than anticipated number of LGBT clients (80% in the first two years). The majority of these were MSM. Given the low levels of LGBT access highlighted by the UKDPC and others this suggests service users perceived higher levels of LGBT competence and were happier to engage.

We were not able to assess whether this was due to the partnership with Antidote being responsible for a higher level of referrals into the service or whether the focus on club drugs made the clinic more attractive anyway. However the clinic benefitted from staff and volunteer input which was LGBT specific, improving ability to meet LGBT need throughout the service, and increasing the perception of the clinic as LGBT-competent through close association with a specialist LGBT organisation.

Some of the commissioners and providers we worked with elected to consider LGBT needs as part of a broader club drugs approach. Some areas completed a club drugs needs assessment which outlined issues specific to LGBT communities. Westminster's report is available online[30]. Some commissioners asked providers to develop a local club drug response and use this to focus on LGBT clients. Antidote developed and provided training on club drugs for local providers as part of our own offer, and in partnership with the Club Drug Clinic.

The focus on improving service awareness and competence in supporting club drug users does offer encouragement for LGBT users of club drugs. However, commissioners and providers considering this model should be cautious that building competence around a wider range of substances does not necessarily equate to competence in LGBT specific cultural issues. It should also not overlook the needs of a smaller group of LGBT people using more traditional drugs, or the needs of LGBT alcohol users. Likewise a targeted offer within a generic service should consider whether this would reduce some of the cited barriers in perception by locating the service within the same premises or at the same times as it is accessed by more traditional users.

Any plan for developing a targeted club drug approach should complement a plan for developing LGBT inclusion, although both should address broader issues where they intersect.

[29] http://clubdrugclinic.cnwl.nhs.uk/

[30] http://transact.westminster.gov.uk/committee/index.cfm?c_docs=Policy_and_Scrutiny_Committees/Current_P_and_S_Committees/Adults,%20Health%20and%20Community%20Protection/2013%20-%202014/5%20-%2025%20February%202014/09.%20Party%20Drugs%20and%20High%20Risk%20Behaviour%20in%20Westminster

6. Current commissioning arrangements

Substance misuse services form a key part of a local authority's health provision and public health responsibilities. Local commissioners are tasked with assessing need and procuring services which respond to this. A range of services should be provided, including advice and information; community based services; psycho-social interventions; medical interventions (e.g. prescribing, assisted detoxification); in-patient services; and access to residential rehabilitation services.

Services are usually commissioned to be delivered within the local authority area, and to residents of that local authority (residential services are typically provided out of area, purchased as an advance block or spot-purchased upon need). Residents can not usually request to attend a service outside of their local authority area.

Some local authorities have formed 'cluster' arrangements to procure a range of council services (e.g. the 'Tri-Borough' approach operated by Westminster, Hammersmith& Fulham, and Kensington & Chelsea in London). For substance misuse this has consolidated 'back office' functions across the three areas under one commissioner, and allows for consideration of spend for services accessible to residents from all three areas. Most services, however, are currently still provided in a single-area model, maintaining geographical boundaries, although there is an expectation of cooperation across the three areas. Other services, such as the Club Drug Clinic provided by the CNWL NHS Foundation Trust, are commissioned across the three authorities.

Until March 2013 provision of treatment was overseen by the National Treatment Agency, a specialist health authority of the NHS, and an arms-length body of the Department of Health, with national and regional outposts. Since the restructuring of the health and care system in the Health and Social Care Act this function has transferred to a team within Public Health England, retaining some regional structures. This move to public health creates some possibilities for improved strategies for prevention and increased synergies between e.g. sexual health. Drugscope has published a briefing on the public health reforms and their impact on drug and alcohol services[31].

Needs assessment

Commissioners are required to assess need in their local area. This detailed assessment should inform the local authority's Joint Strategic Needs Assessment (JSNA), which in turn will inform both the local Joint Health and Wellbeing Strategy (JHWS) and commissioning intentions. The JSNA is examined in more detail in section 7.

Move to public health

Prior to April 2013 a variety of local arrangements applied for local commissioning. Funds were allocated by the Department of Health based on local need under the Pooled Treatment Budget (PTB). Additional monies were provided by other Government departments e.g. the Home Office for criminal justice functions. From April 2013 the commissioning function transferred to local authority public health teams working under the local Health and Wellbeing Board. As outlined above this offers opportunities for synergies in commissioning with other public health functions e.g. sexual health, HIV prevention.

Although initially ring-fenced substance misuse funding will become part of the general public health envelope from April 2016 with concerns that allocation may be at risk from competing demands within local public health teams.

The changes to the health and care system, including to substance misuse commissioning, were announced during the first year of this study, and came into force in the final year. The changes impacted on the availability of access we had to commissioners' time as inevitably people wanted to see how changes would be implemented and their impact before committing to a programme of engagement.

31 http://www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/Policy/PublicHealthReform.pdf

Payment by results information

In April 2012 the Government began a three year pilot of a Payment by Results approach to funding drug and alcohol treatment[32]. Eight areas were selected to trial the approach which implements a mechanism whereby providers are paid only part up front with the remainder of the contract value being paid dependent on achieving a set of recovery focussed outcomes for service users. Outcomes are grouped under three domains: freedom from drug(s) of dependence; reduction in offending; improvement in health and wellbeing. The pilot schemes are being independently evaluated. Early analysis published by the Department of Health showed a mixed picture, with improvements in abstinence for drug users, but with a reduction in successful completions of treatment[33].

In April 2014 the National Council for Voluntary Organisations (NCVO) published a review of the impact of payment by results contracts on the voluntary sector. It acknowledged support for the principles of paying for impact and commissioning for outcomes, but warned of the concern of the financial risk to charities that need to ensure they can operate with payments in arrears, and that such contracts favour larger providers. It also highlighted the concern that payment by result contracts do not encourage innovation. These are concerns to delivering to LGBT clients as all specialist LGBT organisations are smaller, and working with this population requires considering new and different approaches[34].

The LGBT perspective

Although the 2010 Drugs Strategy explicitly references the need to consider differing approaches to meet the needs of LGBT people, there is still little evidence of commissioned services targeting this population directly. Where specific provision exists this is generally due to providers allocating a portion of their generic funding to resource a targeted group, or encouraging a member of staff who happens to be openly LGBT to act as a lead.

There is anecdotal evidence from our focus groups (see section 9) that the localism approach is failing LGBT clients, and that is does not offer efficiencies which could be achieved through collaborative provision over a larger geographical area.

The move to an integrated public health system does offer opportunities to address some LGBT need, particularly those related to MSM engaged in chemsex through joint arrangements with sexual health and HIV prevention.

Our own analysis of published JSNA information shows little inclusion of LGBT need both generally and in relation to drugs and alcohol. Omission risks exclusion in the JHWS and in commissioning plans.

Payment by Results also pains a mixed picture in relation to LGBT clients and the outcome domains. The typical demographic of LGBT club drug users is a group with higher recovery capital that generally found amongst opiate and crack users, for example, with the potential for quicker journeys towards abstinence. The UKDPC 2010 LGBT review also found lower levels of offending amongst LGBT people. However, the Equality Analysis published with the policy for Payment by Results pilots[35] (which was signed off by the Department of Health four months *after* the pilots had commenced) highlights a "possible negative impact" relating to the protected characteristics of sexual orientation and gender reassignment.

The rationale for this assessment was that the higher levels of drug and alcohol misuse experienced by LGBT people, combined with stigma and discrimination in access to treatment could reduce the likelihood of these groups achieving positive outcomes. The analysis does not, however, highlight any

32 http://webarchive.nationalarchives.gov.uk/20130802095348/http://recoverypbr.dh.gov.uk/2012/03/08/go-live/

33 https://www.gov.uk/government/publications/performance-of-payment-by-results-pilot-areas-april-2012-to-february-2013

34 http://www.ncvo.org.uk/images/documents/about_us/media-centre/payment-by-results-and-the-voluntary-sector-april-2014.pdf

35 http://webarchive.nationalarchives.gov.uk/20130802095348/http://recoverypbr.dh.gov.uk/2012/08/16/eia/

actions to mitigate this risk. Any consideration of extension of this policy following the pilots must carefully consider this risk and take actions to address it.

A further concern relates to the size of contracts; in Drugscope's State of the Sector 2013 report the Chief Executive of a leading substance misuse provider says:

"We're increasingly seeing contracts bundled into larger financial packages, which raises questions for smaller organisations." (Simon Antrobus, Chief Executive, Addaction)

Specialist LGBT organisations who could potentially become providers are all very small, which can leave them unable to tender for service provision, particularly where larger contracts are standard and no resource is given to smaller contract offers. Here there are opportunities for LGBT organisations to partner with larger providers for an integrated offer (a model we explore in section 8
); however commissioners can influence this through requiring providers to demonstrate their approach to meeting LGBT needs, and though performance management by requiring reporting of outcomes for LGBT people.

7. Local needs assessment

Needs assessment forms an integral part of the planning, commission, delivery and evaluation of all health and care services. The statutory mechanism for this is through the Joint Strategic Needs Assessment (JSNA) which in turn should inform the local Joint Health and Well-Being Strategy (JHWS). The NHS Confederation's guidance states[36]:

> "A joint strategic needs assessment (JSNA) analyses health needs of populations to inform and guide commissioning of health, well-being and social care services within a local authority area."

Under the Health and Social Care Act 2012 responsibility for preparing the local JSNA and JHWS is handed to a range of new and existing local health structures working together under the Health and Well-Being Board. The Department of Health's guidance states[37]:

> "Local authorities and clinical commissioning groups (CCGs) have equal and joint duties to prepare JSNAs and JHWSs, through the health and wellbeing board."

There is no mandated format for a JSNA or JHWS, allowing these to be responsive to local needs, although there is a Core Data Set, which includes some information on alcohol related hospital admissions; local modelled alcohol use; and numbers of clients receiving substance misuse treatment. Those compiling the assessment and strategy are, however, required to engage with a range of stakeholders.

The Act places duties on local authorities to carefully consider integration of services, potentially by pooling budgets or resources. This offers some opportunity for economies of scale relating to meeting LGBT need though consideration of jointly commissioned services such as substance misuse and sexual health interventions. Where local authorities also consider integration with neighbouring authorities the potential for further efficiencies may be realised.

The JSNA may be supported by additional focussed needs assessments which analyse issues pertaining to a particular health issue or population group; our work with commissioners on this project included supporting the development of an LGBT Needs Assessment[38], and an MSM Needs Assessment[39], as well as a local authority needs assessment of Club Drugs[40].

JSNAs are supported by the provision of data directly by Public Health England, and through information and research available through web online libraries such as the Knowledge Hub[41], and the NHS Health and Social Care information Centre[42].

The increased importance of the JSNA and JHWS under the Health and Social Care Act 2012 is clear. However, this raises some concerns for LGBT people as LGBT needs are not well-addressed within existing published JSNAs in any meaningful way, in part due to the lack of routine monitoring of and subsequent disaggregation by sexual orientation and gender identity in research. A briefing published by the Lesbian and Gay Foundation states[43]:

> "LGB&T issues within health and social care remain a relatively low priority for policy makers, clinicians and commissioners, due to a relative lack of local evidence relating to LGB&T people's needs, outcomes and

36

http://www.nhsconfed.org/Publications/Documents/Briefing_221_JSNAs.PDF

37 https://s3-eu-west-1.amazonaws.com/media.dh.gov.uk/network/18/files/2013/03/Statutory-Guidance-on-Joint-Strategic-Needs-Assessments-and-Joint-Health-and-Wellbeing-Strategies-March-20131.pdf

38

http://www.haringey.gov.uk/lgbt_community_and_substance_misuse_final_2013.pdf

39 http://www.hpac.lslsis.nhs.uk/HPAC/ClickCounter?action=d&resourceId=12589&url=%27uploads/hplambethlewisham/pdf/A072611.pdf%27

40 http://transact.westminster.gov.uk/committee/index.cfm?c_docs=Policy_and_Scrutiny_Committees/Current_P_and_S_Committees/Adults,%20Health%20and%20Community%20Protection/2013%20-%202014/5%20-%2025%20February%202014/09.%20Party%20Drugs%20and%20High%20Risk%20Behaviour%20in%20Westminster

41 https://knowledgehub.local.gov.uk/

42 http://www.hscic.gov.uk/

43 http://www.lgf.org.uk/policy-research/JSNA/

> experiences of health and social care services. This is despite the fact that policy and decision makers must now take account of LGB&T people when designing and delivering publicly funded services, under the Public Sector Equality Duty, part of the Equality Act 2010. This relative lack of LGB&T specific evidence reinforces LGB&T needs and experiences as being a low priority, which in turn further re-enforces the lack of LGB&T specific evidence."

Drugs & alcohol in the JSNA

Information relating to drugs and alcohol should form an integral part of the JSNA, including where this impacts on related health areas such as mental or sexual health, housing, criminal justice and so on. Guidance on compiling the drug and alcohol content of the JSNA is available from Public Health England[44]. Guidance is supported by data sets provided to each local authority by Pubic Health England. These data are restricted ahead of publication of national data by PHE. Example templates are provided, currently still hosted on the former National Treatment Agency's website.

The data set for alcohol[45] includes: alcohol related hospital admissions; alcohol and crime; mortality rates; safeguarding; employment; additional substances; and data on waiting times, treatment and treatment outcomes.

The data set for drugs[46] additionally includes information on blood borne viruses and club drug use.

A separate guidance document[47] and data set template[48] are available to support the planning of services for young people.

The adult guidance document[49] includes some prompts for commissioners that may benefit assessment of need and provision for LGBT clients, although does not explicitly prompt consideration of the needs of these populations. The guidance suggests opportunities, particularly related to prevention, that readily relate to LGBT needs, such as 'multi-component prevention programmes that address [...] sexual health". They remind of the importance of making every contact with a drug user count, including providing brief interventions at contact points such as sexual health, which supports our experience of providing interventions in GUM clinics at a much earlier contact point than when uses typically present to treatment services.

The guidance includes prompts for commissioners and providers to ensure that support for club drugs, legal highs and other novel psychoactive substances is available, which will increase competence of providers in treating for the drugs more commonly used by LGBT people.

Consideration of provision for targeted groups is also prompted, including for women, young people, families, etc. although no prompt is given for similar targeting of resource for LGBT people, or MSM.

This guidance and supplied data from Public Health England offers an opportunity to include both prompts and data analysis relating to LGBT need, and should be explored further by PHE.

PHE can also consider promoting awareness of LGBT resources. The LGBT Companion to the Public Health Outcomes Framework[50] has been supported by Duncan Selbie, PHE's Chief Executive, and distributed to local authorities. Additional LGBT information resources such as the Lesbian & Gay Foundation's LGBT Evidence Exchange,[51] Stonewall's health research into LGB people[52], and the reviews of research

[44] http://www.nta.nhs.uk/healthcare-JSNA.aspx
[45] http://www.nta.nhs.uk/uploads/jsnasupportpack-alcohol2012-13dummytemplate.pdf
[46] http://www.nta.nhs.uk/uploads/jsnasupportpack-adult2012-13dummytemplate.pdf
[47] http://www.nta.nhs.uk/uploads/goodpracticeinplanningyoungpeoplesspecialistsubstancemisuseinterventions[0].pdf
[48] http://www.nta.nhs.uk/uploads/jsnasupportpack-yp2012-13dummytemplate.pdf

[49] http://www.nta.nhs.uk/uploads/goodpracticeinplanningforalcoholanddrugspreventiontreatmentandrecovery[0].pdf
[50] http://www.lgf.org.uk/phof
[51] http://www.lgf.org.uk/evidence-exchange/
[52] http://www.healthylives.stonewall.org.uk/lgb-health/default.aspx

relating to sexual orientation[53] and trans[54] people by the Equality and Human Rights Commission can be of use. Awareness should also be raised that the available research does not routinely include local level data due to non-collection of monitoring data on these two relevant protected characteristics.

JSNA analysis

As part of this scoping study we conducted our own analysis of published JSNA information on local authority websites in London. The results confirmed the concerns highlighted in the Lesbian & Gay Foundation's JSNA briefing, and their LGBT Strategy report Breaking The Cycle[55].

Our analysis indicates that nearly three-quarters of London local authorities have not included LGBT communities in their JSNAs. Those authorities mentioning LGBT communities in their JSNAs are:

- Hackney
- Haringey
- Harrow
- Hounslow
- Islington
- Kingston upon Thames
- Lambeth
- Lewisham
- Merton
- Newham
- Sutton

The JSNAs differ enormously in format, structure, style, breadth of issues and commissioning actions/recommendations. In those surveys which make mention of their LGBT populations, the coverage, recognition and needs of these populations vary widely. Most local authorities include an analysis of their population demographics. This analysis covers principally age, gender (male/female) and ethnicity. Religion, language and disability are included in some of the surveys. Where LGBT communities are recognised in JSNAs, all note there are no definitive or comprehensive statistics either locally or nationally. Sexual orientation is not collected in the standard UK data sources such as the census. This absence of data is seen as the primary obstacle in determining services for LGBT needs.

For example, Newham note a Department of Trade and Industry (DTI) report published in 2005 estimated the UK LGBT population to comprise 6% of the total population, allowing the council to calculate that this would equate to 16,800 people in the borough. Richmond-upon-Thames apply the DTI's Final Regulatory Impact Assessment: Civil Partnership report in 2004 to calculate that it has a LGB population of between around 7,600 and 10,650. But it recognises that there is evidence showing higher LGB population in London than in other UK regions and therefore, the estimate for Richmond may be even higher. Hackney and City point to the results of the 2012/13 GP Patient Survey in which 4.7% of the boroughs' residents identify as lesbian, gay or bisexual. However, Hackney and City recognise that current data for LGB residents is likely to be significantly under-reported. Lewisham note that the Greater London Authority based its Sexual Orientation Equality Scheme on an estimate that the lesbian and gay population comprises roughly 10% of the total population which would indicate that the borough contains roughly 20,000 lesbian and gay residents. However, it records its uncertainty whether this figure includes bisexual or transgender individuals.

Very few boroughs have conducted local LGBT population surveys or included LGBT communities in other local demographic surveys. For example, Newham's Liveability survey sampled 3,620 residents, of which 9.7% identified themselves as bisexual (9.4%) or gay/lesbian (0.3%).

A number of JSNAs recognise that no data exists concerning the size of the national transgender population. Hackney and City notes that it is estimated that around 1% of the national population is 'gender variant' to some degree, with the numbers seeking medical treatment rising. Kingston-upon-Thames use the estimate that there are between 300,00

53 http://www.equalityhumanrights.com/uploaded_files/sexual_orientation_research_review.pdf

54 http://www.equalityhumanrights.com/key-projects/trans-inequalities-reviewed/

55 http://www.lgf.org.uk/Your-rights/LGBT-Strategy/

and 500,000 transgender people living in the UK, and on this figure estimate that there are between 960 and 1,600 transgender people living in Kingston. The overwhelming majority of JSNAs do not cover trans need.

This lack of information about sexuality and gender identity makes it difficult to assess accessibility of services and local requirements. Hackney and City acknowledges that they know little about the drug treatment needs of LGBT communities living and working in the borough. Again local or general inferences are made from national sources. Hackney and City understand from national research that people from LGBT communities are more likely to have problematic drugs and alcohol use. But provide no figures for this assessment. In addition, LBG and transgender populations are believed to be disproportionately affected by poor mental health, sexually transmitted inflections and smoking. Islington cite their 'Revealing LGBT Islington' survey (2007) to indicate the LGBT population in that borough has a higher incidence of a number of risk factors such as smoking and drug misuse

In terms of JSNA commissioning actions, some local authorities recognise and record the need for further work in the area of LGBT communities. Some assessments action that better interface with the wider community is required to enhance recovery options and to increase partnership working for a more integrated approach to tackling drug and alcohol use. This 'wider community' includes LGBT populations, as well as other minority groups. Hounslow lists as one of its JSNA key challenges "local data on population in Hounslow who have significant and complex health needs (such as LGBT and single homeless people) should be collected, in order to meet their health and well-being needs through targeted and appropriate services". Newham states "More local research is needed in this area [LGBT populations]". Both Merton and Sutton state that "understanding how sexual orientation [but not gender identity] can affect access to services and how life style choices of LGBT people can impact on long term health is important in order to reduce inequalities". Both boroughs have as one of their key commissioning implications the recommendation that formal training and educational events for providers and commissioners on the issues/prejudices facing LGBT people is needed to reduce inequalities".

In terms of JSNA assessments of drug and alcohol needs within boroughs, there is no specific reference to LGBT communities. For example, LGBT communities are not included in the key groups identified with alcohol and substance misuse issues. For example, in the Newham JSNA, LGBT communities are only covered specifically in the sections on 'suicide and undetermined injury' and 'sexual health and HIV'. Where LGBT (and MSM) communities are mentioned, it is usually under the needs relating to sexual health or provision of youth services. In addition, there is little know about substance misuse among lesbian and bisexual women.

It is also worth noting that LGBT populations are grouped together as a whole community, rather than their needs assessed and addressed individually.

Haringey is the only London local authority specifically addressing provision of drugs and alcohol support/treatment for LGBT people in their JSNA. In conjunction with London Friend, Haringey commissioned a separate internal local needs assessment on LGBT population in 2013. This document is available on the council's website[56].

Summary

The JSNA and other local planning is increasingly a significant tool to ensure need is identified and can then be met. LGBT issues are very poorly covered in current JSNAs, and this coverage is poorer still when specifically related to drug and alcohol issue, despite evidence of much higher levels of use and changing harms relating to LGBT substance misuse. Even where more detailed local work had been carried out relating to LGBT or MSM need this was not always reflected in the published JSNA, or remained as internal local authority documents.

This compounds the perception that LGBT need is not addressed in any meaningful way, and gives no confidence that LGBT need will be included in JHWSs or be met through commissioning intentions. Local authorities need to consider this inclusion as a mark of visibility; as a sign that needs have been

56 http://www.haringey.gov.uk/lgbt_community_and_substance_misuse_final_2013.pdf

considered; and as a means for LGBT people and organisations to hold public bodies to account in meeting their Public Sector Equality Duties. Senior staff involved with the compiling of the JSNA and JHWS may consider acting as LGBT Champions to ensure that LGBT need and any work undertaken is publicly recognised.

8. Exploring delivery models

As part of this study London Friend drew on its own experience of delivering services in different settings and models, as well as looking at differing approaches by local commissioners and providers to address LGBT inclusion. We examined the benefits and challenges of differing models, and asked service users, providers and commissioners for their opinions on differing approaches. We also examine other potential models which could be commissioned.

The models include:

- Regional centres of specialism (based on targeting the LGBT demographic, or on type of drug use);
- Earlier intervention within GUM clinics;
- Local services addressing LGBT competence;
- Local services addressing club drug competence;
- Targeted MSM interventions;
- LGBT specialist partnerships with generic services.

Pan-London LGBT service

This is the model which currently forms the main Antidote offer. Clients can access walk-in support unrestricted by local authority area from multiple delivery locations (currently Kings Cross and Soho). The service provides assessment, care planning, structured psycho-social interventions, complementary therapies, and peer support. Through drop-in services clients are also able to access ongoing relapse prevention and other recovery support.

The service is staffed by two paid staff and supported by a team of volunteers, all of whom identify as LGBT. Our own delivery is currently funded by Big Lottery Fund, which allows the pan-London aspect.

Client engagement and feedback is positive: clients appreciate the targeted nature of the service feeling understood and safe, addressing some of the concerns identified in the UKDPC 2010 review regarding perception of how well a service may meet their needs. Having access to a pan-London service has also allowed for the development of a positive reputation, meaning potential clients can assess the quality of the service before attending.

An unexpected consequence of a pan-London targeted service has been the ability to highlight trends quickly within LGBT populations, which may not have been spotted if the density of clients attending a single service had been dispersed over several local services and is unlikely to have been picked up in analysis of NDTMS data. It has taken 3-4 years before, for example, the 'chemsex' trend amongst MSM has reached 'critical mass' to be noticeable in some local services.

The challenges facing such a service relate mainly to the existing funding mechanisms. Although there is potential for very significant efficiency savings in a pan-London mechanism where commissioners contribute relatively small amounts into a central pot to enable an LGBT specific pathway, the work to establish such a mechanism and manage up to 32 different commissioner relationships is vast. The alternate is to establish individual contracts with commissioners, although this is equally time consuming relative to the contract size and monitoring requirements. Failure to establish contracts with all local commissioners would result in potential inequality of access to the service by LGBT people based on where they reside, or in a selection of commissioners 'propping up' the service for non-residents.

London Council's recent work to review and maintain a pan-London commissioning mechanism for HIV prevention services may offer an opportunity for similar commissioning arrangements.

Antidote's experience of providing this kind of service has been limited to psycho-social interventions. Where a client has required medical interventions we have used pathways through our partnership with the Club Drug Clinic, or referred the client back to local services, continuing to provide pyscho-social interventions and/or aftercare. Options under this model could remain limited to funding targeted psycho-social support with medical interventions provided locally, or could be expanded so a targeted LGBT service is sufficiently resourced to employ a multi-

disciplinary team under a VCS or NHS provider, or as a partnership.

Pan-London service targeting club drugs

This is the model we have explored in partnership with the CNWL NHS Foundation Trust's Club Drug Clinic (CDC). The clinic was established in 2011 in response to the growing number of MSM presenting to GUM services citing crystal meth use, and also to pilot the provision of a service to non-traditional drug service clients. This aimed to remove the barriers of association non opiate/crack clients have reported in accessing services mainly supporting this group. It was also viewed as a positive option for LGBT clients due to the almost exclusively club drug using profile of clients.

Antidote and CDC partnered to establish a specialist pathway for club drug users, which addressed the growing need for GHB/GBL detoxifications, and brought LGBT expertise into a clinic aiming to address needs of a large MSM client group. The NHS side of the partnership was initially funded by a two-year grant from the CNWL Innovation Fund to evaluate the need for such a service and such a delivery model. The Antidote side was resourced by targeting part of the service funded by the Big Lottery Fund to work in this way. Antidote does *not* currently receive any funding from the NHS side of CDC to deliver this work.

The service operates self-referral and provides a full range of community treatment exclusively for club drug using clients, including psycho-social, medical and pharmacological interventions. Although not specifically LGBT 80% of its clients have been LGBT in the first two years, the vast majority of which are gay men. During its pilot stage the clinic operated an open access policy not restricted to local residency and attracted interest from outside London and internationally.

The service also conducts clinical research: it leads Project Neptune which is developing protocols for the acute management of club drug users presenting to services such as A&E, and is currently undertaking a trial of Baclofen for GHB/GBL detoxification.

The benefits of this model are similar to the LGBT targeted model: clients report feeling understood, their drug needs addressed, and comfortable in a targeted environment that does not carry the associations of traditional drug services. Joint working has benefitted both services, creating accessible pathways that are not dependent on local competence, and the service can act as a centre of excellence, monitoring trends and evaluating approaches such as the Baclofen study. As such it has an intelligence as well as treatment role for public health staff.

This model similarly experiences the same challenges in funding mechanisms as an LGBT centre of specialism, with the localism agenda providing no current opportunity to facilitate efficient commissioning, despite the possibility for significant efficiency savings. Likewise London Council's pan-London HIV Prevention mechanism may offer a model for substance misuse.

Earlier intervention in GUM clinics

This model is based on taking substance misuse support out of traditional services and into services where LGBT people may otherwise present. Clients, especially MSM, were increasingly reporting using drugs in highly sexualised contexts. We heard many incidents of people acquiring HIV or other sexually transmitted infections, or reporting an HIV exposure risk and requiring emergency PEP (post-exposure prophylaxis) treatment to reduce the risk of becoming HIV positive. We therefore decided to partner with the Chelsea and Westminster NHS Foundation Trust's 56 Dean Street GUM clinic, establishing Code, a targeted clinic session for MSM using drugs for sex.

Initially Code targeted MSM into the harder ('fetish') sex scene, as we anticipated this to be synonymous with club drug use. Early evaluation showed that men into this scene were often highly informed about their activities; fetish practices, particularly those linked to the BDSM (bondage, dominance and sadomasochism) scene can carry risks of injury and many men who engaged in them had taken time to understand these risks and reduce them. This extended into drug use, where this was engaged in. The clinic was therefore 're-branded' to target a wider group of MSM using drugs in a sexualised context,

where we found use to be sometimes less informed, leading to greater sexual risk behaviour.

This model was initially piloted with Antidote directing existing resource to staffing this clinic, in order to reach out to potential clients. The NHS side of the partnership generates funds through the sexual health tariff for screening, treatment and vaccinations. Antidote's work here is now resourced from HIV prevention money through the national HIV Prevention England programme.

Code offers substance misuse assessment, brief interventions, short-term structured behavioural change interventions (to address substance and sexual risk jointly), and referral into structured substance misuse treatment for those clients requiring this. The same model has been extended into the Mortimer Market Centre, another GUM clinic in central London with a large MSM client base.

The benefits of this model have been to gain access to MSM at risk of contracting or onwardly transmitting HIV connected to their drug use. This access is at a significantly earlier stage than when they might present to a treatment service, if they ever would at all. The trigger for accessing the service is the urgent sexual health need treatment for a sexually-transmitted infection (STI) or PEP (post-exposure prophylaxis) following exposure to HIV, as opposed to the crisis point typically required to access drug treatment. MSM are, generally, more comfortable accessing GUM healthcare which has assisted the creation of a safe environment within the clinic.

Interventions used in this setting are based on Motivational Interviewing to address behavioural change. The purpose of intervention is to prevent both primary and onward HIV infection as well as prevent drug use becoming problematic. This fits with a broader public health agenda currently concerned with rising HIV infections amongst MSM and offers synergies for commissioners.

The model, as explored so far, is limited to brief or short-term interventions and our own delivery did not provide structured treatment onsite, nor access to medical interventions for substance misuse. However the model does offer the opportunity for a larger service within GUM clinics, or as an outreach approach, as well as significant potential to prevent problematic drug use.

This model has great potential but wider success rests with the competence to screen for drug use within GUM settings and by sexual health staff for referral to a substance misuse worker. Increasingly this part of the health and care workforce is the 'frontline' of provision, with earlier access to clients. Through training with GUM staff in other services we have identified a reluctance to ask about drug or alcohol use at initial triage stage. This is largely due to lack of confidence and competence as opposed to unwillingness, but it highlights the need for GUM staff to have access to thorough training and updates on substance misuse, and to know when and how to refer.

The potential for public health intelligence data to be gathered via this route is high, although further work is needed to establish an effective assessment tool and dataset to capture this.

GUM model for lesbian or bisexual women and trans clients

Caution is required here though as this model best serves MSM clients, and should not be considered as a sole approach to address broader LGBT needs. Antidote has explored similar models for lesbian and bisexual women and for trans people with less efficacy. We partnered with 56 Dean Street's Orange Clinic for lesbian and bisexual women, but the service was under attended and ceased by the NHS provider. This may be reflective of the differing sexual health needs and risks of lesbian and bisexual women to MSM; of the differing contexts of drug and alcohol use by these groups; or of the lower engagement of lesbian and bisexual women across the service.

The cliniQ service is a sexual health and wellbeing service for trans people, aiming to reduce the barriers trans people may experience accessing sexual health support where sensitivities about their anatomy, or the need for advice specific for post-operative genitalia, may lead to not accessing services. Here clinical sexual health services are also provided by 56 Dean Street with a partnership of LGBT and sexual health VCS organisations providing 'wrap-around' services such as counselling, advocacy, drugs and alcohol, and housing advice as a 'one-stop shop' model for trans wellbeing. The premise of the clinic is

that existing services pool some resource to ensure their services are accessible by trans people (and that they have paid trans people 'due regard' under the Equality Act's Public Sector Equality Duty); the service is not specifically funded. Here the Antidote experience has been a greater demand for our counselling service than for drug and alcohol treatment.

If commissioners or providers are considering the GUM model they should acknowledge that this will largely meet the needs only of some gay and bisexual men, and should not be considered an LGBT approach.

LGBT Specialism within generic services

This model involves a generic service operating in a way as to develop some LGBT specialism. Although this model was not trialled under Antidote's current delivery structures this is how the service was provided when part of the Turning Point Hungerford Drug Project from 2002-2010. During some of that time the service was funded by a grant from the Association of London Government (now London Councils) which funded a team leader and a project worker for three and a half years.

After the end of the grant the host agency continued support for the project by agreeing to devote some of its generic support towards targeting LGBT clients and maintained the provision of one specialist member of staff. A pan-London offer was able to continue as the host agency was funded by more than one local authority. When the host agency became funded by just one local authority it became untenable to sustain a pan-London offer and Antidote moved to London Friend.

The model operated a weekly drop-in (still maintained by London Friend today), specialist keyworking and counselling. Clients could also access some of the host agency's generic support such as complementary therapies. Clients requiring medical interventions had to be referred back to their local authority area's pathways but could enjoy joint support arrangements. The service also offered a training package to build LGBT capacity. As now the service depended upon the support of volunteers who supported all aspects of the service. From 2007 it benefitted from the support of a volunteer working virtually full time. Without volunteer support it would not have been able to meet capacity.

The benefits of working in this way included significant efficiencies by being part of a larger host agency, streamlining back office costs. The host agency, itself a branch of a national organisation, benefitted from centralised head office and governance arrangements. Clients too benefitted from having access to a wider range of services from the host agency's generic offer.

The challenges of this model are mainly in economies of scale. Our experience and client feedback favour a centralised service, but current funding mechanisms and localism require further consideration. A local service may decide to devote some time to target local LGBT clients (e.g. a weekly drop-in, special clinic etc.) although this would be limited due to the geographical limitations on the generic service. Hosting an LGBT service within a generic service also requires consideration of how LGBT client need can be best met, including the location and timings of the service, bearing in mind the evidence that many LGBT people feel disconnected from generic services. Work at service level to improve the external perception of the service may be needed.

A provider, and a commissioner, could agree to a specialist LGBT role within a local provider. This would need to be carefully planned but could meet the requirements for a general occupational requirements under employment law, permitting a provider to recruit an LGBT-identified applicant to work specifically with LGBT clients, providing this was the focus of the post[57]. A provider would need to exercise caution not to just expect any member of staff who happens to be openly LGBT to occupy such a role; LGBT staff members in non-specialist roles must be afforded the same level of privacy and confidentiality over whether they choose to disclose LGBT status to other staff and service users, including the right to be out in some circumstances and not in others.

Antidote recommends any LGBT targeted role should not be the sole option for LGBT clients,

[57] http://www.equalityhumanrights.com/advice-and-guidance/your-rights/sexual-orientation/when-is-sexual-orientation-discrimination-lawful/genuine-occupational-circumstances/

who may opt to work with a non-LGBT keyworker. An LGBT specialist role can include duties to 'champion' LGBT issues through the service and to enable the agency, staff and other stakeholders to improve their own LGBT competence and capacity, e.g. through provision of training or supporting non-LGBT staff to work more effectively with LGBT service users.

Larger providers with services spanning more than one local authority area (e.g. with services commissioned in several London boroughs) may wish to investigated a pooling of resources to provide an LGBT service open to clients from across these areas. Commissioner support should be obtained, particularly if there is concern that monies might be 'diverted' out of area. This option could benefit from back-office efficiencies and be cost effective as a stand-alone or feed-in service. Consideration would need to be made on how the service was advertised and arrangements for exclusion of any service users based on local residency.

Personal Health Budgets

Personal health budgets[58] have been piloted in substance misuse services since 2009 with an evaluation report published in November 2013[59]. They allow a service user to have more input into their care, and exercise choice over aspects of their treatment, e.g. choosing a provider for some or all of their care, or opting to spend an allocated amount to facilitate a successful outcome of treatment, such as buying the services of a carer or spending the money on transport which allowed them to attend treatment.

The pilot focussed largely around the choice of in-patient detoxification and residential rehabilitation, although also included examples where service users had bought counselling with their budget. This could offer choice to LGBT service users who may choose to spend their treatment budget with a specialist provider.

The evaluation of the trial indicated that patients reported improved relationships with healthcare professionals and had a positive impact on service quality. This was echoed by professionals who believed that improved choice and person-centred planning had a positive impact on outcomes for service users.

Personal budget holders however reported a lack of available aftercare services, and a lack of information on possible use of personal health budgets. Aftercare, relapse prevention and ongoing support are services which could easily be provided by many local LGBT organisations, including those which do not specialise in substance misuse but provide e.g. counselling and a range of other social support services.

Work would inevitably be needed locally for commissioners to satisfy themselves with the quality and competence of a local LGBT organisation to provide support and become an option for service users to spend their personal health budgets on, but this could offer a small-scale option to provide access to LGBT specific support, particularly as part of a shared care arrangement. However both commissioners and LGBT providers should be mindful that the infrequent and 'spot-purchased' nature of such an arrangement would not be a sustainable option for the LGBT provider.

Spot purchasing LGBT specific support

Spot purchasing arrangements for LGBT specific treatment can be viewed similarly to the use of Personal Health Budgets. Packages of care could be purchased on an individual basis from individual commissioners. This would ensure that any service user wishing to access specialist care could do so. Care packages could easily be tailored to meet individual needs (e.g. keyworking, then counselling and aftercare).

This model does however carry significant risk. For commissioners this potentially incurs additional costs which may vary depending on need. For providers the uncertain nature of income may not be a viable operating model to ensure sustainability. Commissioners from areas with higher numbers of LGBT residents may achieve better value by block purchasing a number of care pathways. This would also ensure better security for providers who could ensure continuity of core services which could

58 http://www.personalhealthbudgets.england.nhs.uk/

59 https://www.phbe.org.uk/documents/substance-misuse-final-report.pdf

operate as referral or open-access for residents from funded areas, allowing additional care to be purchased ad-hoc by commissioners from areas with lower levels of need.

9. Focus groups of LGBT people with experience of drug & alcohol treatment

As part of this study we held a number of focus groups with LGBT people who had experienced problematic drug and alcohol use and had accessed treatment. The focus groups aimed to establish people's experiences of accessing services; their preferences for how services should be structured; how important or not specialist LGBT services were; and whether they felt information about risk had been accessible to them.

We asked whether accessing specialist LGBT support was important to participants and if so why.

Views on this varied. Some participants told us it was just important to access *any* drug treatment at a point of crisis. For others it was more important, telling us they felt the targeted nature of an LGBT service was more welcoming and appropriate to meeting their needs:

> "I felt more comfortable around LGBT people."

> "I've been using mainstream services but I don't feel they're relevant for me. I like to access something more specific."

A common concern was safety, with participants feeling that they could be themselves more within specialist services:

> "It was very important for me, I felt intimidated in mainstream services. I couldn't express who I am. I never disclosed my sexuality. You can feel more relaxed in LGBT services."

> "I felt it uncomfortable going through detox, the other men were quite macho and I couldn't discuss who I was."

Safety is an issue that was also highlighted through our annual service user satisfaction surveys. We ask clients why they chose to access a specialist LGBT service. The most common responses included feeling safe to fully disclose issues relating to their sexual or gender identity, or to talk about potentially embarrassing behaviour they may have engaged in whilst using drugs or alcohol, particularly where this behaviour was sexual.

We asked whether people felt that their needs had been understood by mainstream services.

Here participants strongly indicated that they didn't feel LGBT issues were well understood, although it was acknowledged that this varied from service to service, or even worker to worker. There was a strong feeling however that this was not necessarily due to prejudice, but rather lack of awareness or experience, although the impact of this was felt and created a barrier for LGBT clients:

> "Some workers in mainstream service just don't have a clue. They don't mean to be ignorant but they just don't understand. It feels intimidating to go there."

The nature of how people used drugs and alcohol and the behaviours it led to was a factor which made some people feel shame or guilt, particularly where this was related to sexual activity. Clients in treatment regularly tell us they feel unable to disclose some of their behaviour to staff in mainstream services, or have the perception that staff will find it difficult or impossible to understand. One participant summed it up:

> "I just couldn't talk to services about what I was doing, you know, shagging my way round the sauna. They just didn't have the understanding to be able to deal with that."

Previous negative experiences when accessing other health or support services played a big role in people's confidence in accessing support in other services. Participants said that they had experienced discrimination or had been treated less favourably, often for reasons they felt to be quite trivial. One participant told us about the reaction of a service to their same-sex partner:

> "In an in-patient unit I was told that hugging my partner when they came to visit was making other patients feel uncomfortable."

Sometimes it was the behaviours or attitudes of other service users that were discriminatory,

not those of staff or the service. However even when staff were felt to be supportive it still posed difficulties:

> "I experienced homophobia from other clients, not from the service itself. The staff were supportive, but I didn't really feel I could fully discuss it."

Participants described situations where they felt health professionals had judged them on moral grounds:

> "My GP told me that prescribing cross-sex hormones was against nature, so I had to change GP."

In this instance the participant went on to explain that although they felt justified to pursue a complaint they didn't feel resilient enough to do so:

> "I wanted to complain but I had so much else to deal with it was just easier to change. I just didn't have the capacity to do it."

Such experiences sometimes led to people disengaging from support altogether, feeling the additional pressure was adding to their anxieties:

> "You just don't want to have to deal with homophobia on top of feeling vulnerable and at your lowest ebb."

Where issues were not considered to be well understood, or people felt unsafe or uncertain about a service's LGBT competence there was a tendency to not fully disclose information which may have been relevant to ensuring need was met. This risks the relevance of a person's identity and connected issues not being explored or addressed. One trans participant told us:

> "I've had contact with psychiatric services and my gender identity just seemed to confuse them, so I stopped talking about it."

Some participants indicated the need to work more holistically on the emotional or underlying issues connected to how their sexual orientation or gender identity impacts on their drinking or drug use, and felt that this was not something more traditional drug services were able to offer, with support there focussing more on the practical aspects of treatment:

> "Mainstream services don't tend to look too much at why you're taking drugs, it's more about how much and when. Here at Antidote I can explore some of the underlying issues much more."

Where services had taken steps to address LGBT inclusion participants appreciated this. One client who had accessed the Club Drug Clinic described their surprise at feeling included:

> "I was actually very impressed by the Club Drug Clinic. I was surprised by the positive response I got, they didn't make any assumptions about my sexuality or my gender."

This response is indicative of the barriers that are created by the *perception* of a service's LGBT inclusivity and competence. The UKDPC research indicated that many LGBT people felt services would not understand their circumstances, but here the service exceeded the service user's expectation. It is important to note that although services may undertake work to improve their LGBT competence this also needs to be conveyed to potential service users whose previous experiences of accessing health support may make them wary of accessing service again.

We asked what issues participants felt needed to be addressed in meeting LGBT need.

Here participants indicated strongly that they felt services did not have experience dealing with the drugs they were more likely to be using. Data on the prevalence of drugs clearly shows the changing trends and the increase of, in particular, GHB/GBL, crystal and mephedrone. Participants felt this contributed to their needs not being met:

> "There's not enough awareness of the drugs that are more prevalent in the LGBT community, things like G [GHB/GBL], workers just don't know enough about it."

> "Workers were like "What are you talking about?" They just didn't know the risks [of GHB/GBL]. One of my friends died from it."

Participants also felt that mainstream services did not always have insight into the sometimes

different reasons that LGBT people cited as related to their drug or alcohol use, and felt that those contributed to the perception their needs would not be met:

> "The reasons LGBT people take drugs can be different from other people. It's about dealing with your sexuality, loneliness."

Through our experience of providing training on club drugs and LGBT awareness this is a need that has been regularly highlighted. Drugs workers with experience of working with opiate and crack users often felt they did not know enough about the emerging drugs, or had never had the opportunity to consider LGBT issues professionally. Awareness has increased, though, and discussion with drug workers throughout this project has indicated improved awareness of, e.g. the risk of GHB/GBL dependency and protocols for detoxification. Professional development to raise LGBT competence can also help generic staff to better understand the common issues LGBT may bring to services.

Participants went on to discuss the reasons they thought their drug or alcohol use had become problematic.

Much of this discussion centred on feeling uncomfortable trying to find an identity within the LGBT 'community'. Many pursued this through the commercial bar and club scene, often the first place they went to try to meet other LGBT people. Common themes in these discussions included feeling that they did not 'fit in' with what they perceived to be the norms of LGBT culture leading them to feel as if they did not live up to the expectations of others. One gay male participant summed up the pressures he felt were on men:

> "Unless you're this guy with the perfect body, looking like a porn star, nobody's going to be around you. If you're slightly overweight, or you don't have the image people want you to have you just feel invisible."

The issue of finding or exploring identity was a very common thread of these discussions. Women felt they had access to far fewer venues in which to meet other women. One trans participant struggled just to understand that there could be other people like him:

> "I didn't even know there were female-to-male trans people, even though I knew that's what I was!"

Participants discussed some of the pressures they felt, describing the scene as feeling very fuelled by drugs and alcohol. They felt there was a high level of sexualisation, which was reinforced by some of the scene media such as the free magazines distributed in venues. They complained that this created expectations of behaviour which made it difficult to meet people as friends and get to know them well. Questions were consistently raised about whether people accessing scene venues actually wanted this kind of environment or whether they adapted to the perceived norms of the environment because they wanted to fit it and feel as though this was somewhere they belonged. One male participant said:

> "It's so difficult just to talk to people, it feel like it's all about drugs and sex. Or at least that's how people think they have to be and everybody's too scared to challenge that."

Participants told us that although they sometimes were aware that going to LGBT bars and clubs was not helpful for them, and contributing to their increasing alcohol or drug use, many felt they did not know where else to socialise, or did not see any alternative ways of feeling part of a broader group of LGBT people:

> "I just couldn't cope with the scene at all, but it's so difficult to go out and meet [other LGBT] people."

Some felt that even if they did not want to use drugs when they were out socialising they felt an amount of peer pressure to do so:

> "I've felt pressured into using stuff when I didn't want to."

There was a strong desire to have access to alternative social venues and activities:

> "We need activity spaces, places to do things with other people, not just rely on going out on the scene."

There are in fact many alternatives to the bar and club scene available, including LGBT organisations offering support and social groups and activities; LGBT sports, leisure, and special interest groups; volunteering opportunities and so on, but feedback here suggests clients are not always aware of non-

scene alternatives.

Participants felt increased pressure where they were becoming older, and some described anxieties of trying to engage with people in scene venues as an older person. Some described the added pressures that could be felt by those coming out later in life or re-entering the scene following a relationship breakdown:

> "Age is an issue. Anyone who comes out late or has a relationship breakup just doesn't know how to manage the scene."

This resonated with some experiences of our wider client group, some of whom felt that they had developed difficulties with the newer drugs they had taken, which had not been prevalent when they went out earlier in life:

> "There's different drugs. It's easier to be off your face for much longer for just a few quid."

> "It's all these 'designer drugs' now, it's all changed."

We explored this and asked participants whether they felt informed about the newer drugs that have become more prevalent. It was clear that participants did not feel adequately informed:

> "No. I was using all different legal highs and just couldn't stop. I didn't know what I was taking."

It was common for information about drugs to have come from peers who the person was using with, but there was an acknowledgement that this may not have always been accurate, or well-informed:

> "I had information but only from what my friends had told me. They could have been wrong."

Tallying with what many of our services users tell us one participant described how he had become dependent on one of the newer drugs without being aware that this was a risk:

> "I never knew that G could be addictive, then one day I didn't have it, I had the shakes. It would have helped if I'd had more information about it, to realise earlier what was happening."

Sometimes it was reaching a crisis point that was the first realisation drug use had become unmanageable, along with a lack of recognition that use could become problematic. One participant had not anticipated that their use could lead to poor mental health:

> "I would just use, use, use like there was no tomorrow until I had my first psychotic episode and I really shit myself! I learned the hard way. I had always felt it wouldn't happen to me, I was too strong."

Recognising problematic use

Acknowledging that alcohol or drug use had reached problematic levels was difficult. Although this is generally a difficulty for anyone who has developed problems with substance use there was agreement that the normalisation of use within the scene culture, and the notion of the most commonly used drugs being more 'recreational' added to the difficulty of admitting to problematic use:

> "There's a feeling of it not being a problem, it's just a party thing."

Participants reported typical feeling of shame, guilt or embarrassment at both realising and acknowledging use had become a problem, although there was acknowledgement that talking to a health care professional was useful:

> "You don't want to tell anybody that you've lost control."

> "I was embarrassed about my drug taking, lying to myself, and downplaying my use. It's helpful to have people you can speak to objectively and not feel judged."

We asked participants what might have helped avoid their drinking or using becoming problematic, and where information should be available. There was less consensus over this, with participants feeling that each of their individual sets of circumstances may have required different approaches. Suggestions included information provided by LGBT organisations and in the bathrooms of LGBT venues, although there was no agreement what form this information should take. Many wanted information based on harm reduction and cited HIV awareness and sexual health campaigns as an example:

> "You need information on how to do it

> more safely, a bit like the safer sex campaigns."

People wanted the information prior to starting to go out to LGBT social venues so people could make more informed choices or be aware of the substances being commonly used, and also of the risks of alcohol:

> "You need the information before you go on the scene."

The most commonly supported source for where information should be provided was online. People backed factual information together with some real life examples of the kind of problems other LGBT people had experienced and how they addressed these. One participant discussed how reading about other people's experiences had helped them to realise that their own use was becoming problematic, which prompted them to seek support:

> "I was researching other people's experiences on the internet and read some real horror stories. I realised I wasn't far off it myself."

One of the recurrent themes was a desire to see a changed perspective towards drugs and alcohol within the LGBT population, especially on the scene. There was no consensus on how this could be achieved, however, although it was felt that challenging the community narrative on norms of behaviour was important, seeking greater discussion within LGBT sector media and community events. Ownership within the LGBT community was felt to be important:

> "It's a community problem, it needs to be addressed within the community. We need to talk about it more, but it's not made a health priority."

In an ideal world...

We asked participants what kind of drug and alcohol services they would like to access. A strong desire for ease of access was expressed, with services offering walk-in access. The themes of safety, confidentiality and LGBT competence featured prominently in these discussions, although it was clear that people wanted different options available, ranging from a single specialist LGBT service for the whole of London, to a desire to improve mainstream services for LGBT people. People expressed a desire for choice: specialist LGBT provision was felt to be essential but it was also clear that this should not be the only option available, and that mainstream services should be able to meet LGBT needs effectively. There was caution, however, as to whether some mainstream services prioritised addressing LGBT need:

> "It would be nice if mainstream services could meet the need of LGBT people but it's not at the top of their agenda."

For others having access to LGBT specific support was the most important factor:

> "I don't think I could use a drop-in service if it wasn't LGBT."

Again access to online information was felt important:

> "It's important to be able to access services online. I wouldn't have been able to pick up the phone."

Some felt that there could be an LGBT single point of contact, acting as a hub for initial contact and referral to relevant services:

> "A referral centre, where everybody who's LGBT can go and they know where to send you."

Some suggested better partnerships between mainstream and specialist services was the way forward, and that such partnerships could offer a mark of quality and confidence to encourage LGBT clients:

> "It would be interesting if there was more of a partnership with other drug services and [specialist services such as] Antidote, so people could know they would get a good service."

One idea that people felt might bridge the gap between specialist and mainstream services was some kind of LGBT specific advocacy, or support engaging with generic providers:

> "It's helpful to have support from an LGBT service when I have to go to mainstream services, someone to come with me."

Participants also felt that peer-led groups should offer LGBT meetings. This currently happens with some 12-step groups, and a new London based Crystal Meth Anonymous meeting has attracted a large number of gay

and bisexual men. One participant suggested this also extend to Smart Recovery Groups, where a male participant told us about some of the barriers he faced being able to talk openly about his behaviour:

> "I go to Smart groups but you can't always talk about gay stuff in open groups, people are like "You did what?" if you say you went to a sauna. If we had more gay groups that would make it much easier."

Participants were in agreement that recovery support requires not just drug or alcohol treatment, but additional support that would allow them to build confidence in their identities as LGBT people. These included support to gain skills in 'surviving' the scene, as well as learn how to form relationships based on trust:

> "It would be good to have groups that help you engage in the scene, not just discussion groups."

> "You don't have to be just on the scene, it's important to have other activities. Lots of LGBT people have trust issues, it would be good to have places where you could learn to understand people better."

Where would service users like to go?

We discussed the current commissioning arrangements with participants, checking their understanding of how services were planned and delivered locally and asking their opinions of this. There were strong views that access criteria based on local residency or connection limited clients' options, particularly where there was little choice about where people could live. Having to move between services was felt to be disruptive:

> "We're too transient in services, I couldn't keep going to the same service just because I moved a few streets."

> "The lack of continuity means you just have to start again, you've got no choice where you go."

> "Where you live is restricted to where you can afford, which dictates where you can go."

> "If you're in social housing you have to take what you're given."

Local residency or connection can be an issue for any client where they move or are rehoused but this was felt to carry additional restrictions where LGBT competence varied between services, or where that rehousing was dictated by the location of the very small amount of specialist LGBT supported housing schemes. In situations where participants had been required to transfer their care some found their new services less welcoming or less understanding.

> "I went to a local service because I got housed by an LGBT housing organisation in that area and experienced a lot of homophobia there, it was really bad."

Some participants did not feel LGBT issues were given sufficient consideration when planning or commissioning services. Concerns was expressed about how much money there might be left for specialist services once generic services had been accounted for, although this was in relation to any specialist LGBT support, not drug and alcohol treatment:

> "It doesn't feel there's much money left for LGBT services within boroughs."

There was also scepticism about local political influence, and whether the needs of minority groups would be acknowledged:

> "It depends on the local politics as well as to whether they'll commission LGBT services."

Some participants gave their views on how they saw the commissioning process working in practice, feeling that both delivery and commissioning could improve by better understanding different needs. One thought the process too tied to the provider seeking continuing funding:

> "There's a culture of services chasing the money's that's available, rather than demanding services that are needed by the community."

Another felt delivery was shaped around what commissioners felt best, rather than on client need:

> "Providers are responsive to the funders, not to the client group. It's about what the commissioners want to provide, not always about what's needed."

Participants saw benefit in closer engagement between funders of services and LGBT organisations to better understand need:

> "LGBT organisations need to be talking to commissioners and charitable trusts to tell them what's needed."

Summary of Focus Groups

Although some LGBT people felt happy to access local, mainstream services, for many this was not the preferred option. This fits with our own service user satisfaction survey feedback where 53% of service users told us they would not feel comfortable accessing mainstream services, with a further 35% unsure. Only 12% reported they would have felt comfortable accessing mainstream treatment. The strong desire to feel safe, comfortable and understood influenced decisions on where to seek treatment. Previous negative experiences, including feeling misunderstood, in other health and care services plays a big factor in deciding whether a service feels 'safe' or not.

The need to be able to disclose sensitive, and potentially embarrassing behaviour leads many people to prefer working with other LGBT-identified workers, although there was recognition that improved staff awareness and sensitivity could go towards addressing this. This should include awareness of both LGBT cultural issues, such as the pressures people can feel finding their identity as an LGBT person and the different drugs being more commonly used by this population.

Information about risk and identifying potential problems needs to be improved, and targeted to resonate with this client group. The LGBT communities themselves have a role to play with this, in challenging cultural norms.

Service provision needs to balance improving general competence around LGBT issues with access to specialist LGBT support to ensure that those requiring targeted treatment options can access these. This need not be the entirety of treatment, but may be one aspect of a joint care approach. This could be achieved by partnerships between mainstream and specialist organisations. Specialist provision should extend to user-led initiatives such as 12-step and SMART groups.

The unintended negative impacts of local boundaries should be addressed so that service users have a choice to attend services where they feel safe and understood, and where they can access specialist support if required. Factors such as the limited availability of specialist LGBT housing support should be considered in decisions about where people may be housed and where treatment may be accessed.

Both commissioners and providers can ensure they make robust cases for the provision and improvement of services for LGBT people to mitigate any adverse local political influence. Both can facilitate better engagement with LGBT groups and organisations; this should be in a sustainable way, with regard to the resource of those groups.

10. Commissioner views

As part of the study we worked with commissioners from several London boroughs. Part of this work included a series of discussions throughout the project to understand their views relating to meeting LGBT needs. The discussions included substance misuse commissioners, sexual health commissioners, and their colleagues.

We asked about commissioning specific services for LGBT people. Opinion was mixed; there was wide acknowledgement of differing needs but a range of views on how services should be provided. All agreed that as a minimum their generic providers should take steps to be LGBT inclusive. Many people recognised the positive impact that specialist provision could have for some clients, but there was less agreement over how this could be provided. One commissioner told us that although they found commissioning in 'silos' generally unhelpful they saw the need to account for smaller groups too, saying:

> "The main brief is generic, but you have to remember subsets who require something tailored."

There was wide desire to understand more about the populations they were commissioning for. Many spoke about the need for LGBT inclusion in local needs assessment. This contrasted with the level of published LGBT needs assessment we found in JSNAs, although some commissioners told us that LGBT need was addressed in their own internal needs assessments, often as a consideration linked to meeting needs around club drugs and novel psychoactive substances (NPS). Several areas had begun to develop specialist services for club drugs, and this seemed to be preferred by commissioners as a specialist route rather than looking at services based on demographic groups. There was though acknowledgement that whilst this could make services more accessible, cultural competence around addressing LGBT need was important:

> "You need to protect the LGBT environment for those people who otherwise wouldn't access the service."

Commissioners were quick to acknowledge their own responsibilities in adapting to changing need. All of the commissioners we spoke to were willing to engage on this agenda and to learn how they could facilitate improvements within their local areas. All had arranged training at local authority level for their providers to improve knowledge both of club drugs and of LGBT awareness feeling this was vital to allay fears in front-line staff. One identified that front-line providers could "panic with difference, whether it's drugs or behaviour" and they had a responsibility in addressing this.

Cost was a significant issue. Many commissioners were concerned about the demands on their budgets, particularly with substance misuse no longer having a ring-fenced budget within the broader public health allocations. Given this, they felt there was less resource available for specialist services, whoever they may target. One said:

> "Your money goes a fair way in generic services, but not so far in specialist ones."

One commissioner questioned whether their role could include helping smaller organisations enter their local provider chain through accessing funding or grants that were unavailable to statutory services.

Joint commissioning arrangements were highly favoured, particularly linking to sexual health in the local area. Many commissioners were also amendable to the possibilities of commissioning with neighbouring local authorities, and some already had structures in place to do this. These varied from full integrated working arrangements between two or more local authorities to arrangements between individual commissioners on smaller projects.

The impact of localism was a recurring theme. Some commissioners preferred developing their existing treatment providers rather than paying for clients to go to services out of area. Others were more open to challenging local boundaries, suggesting that in London for example local could mean London-wide. Where substance misuse linked to areas such as HIV prevention some felt localism was overridden by wider public health concerns, but this did not yet translate into thinking about substance misuse treatment.

Most were supportive of some specialist provision being available over a larger level, e.g. pan-London. Generally it was felt that psycho-social interventions worked best at this level, with medical interventions provided locally as part of existing arrangements. There was though concern over how this could be achieved. Several had been involved in joint commissioning projects before and felt there were significant challenges in managing these.

> "Who is the lead? How do we pay in, and how much? What's the process? And what do we get for it? We need to have these structures in place for it to work. It needs to be identified through needs assessment."

Collaborative approaches

The role of the Mayor's office in coordinating some pan-London provision was repeatedly discussed and some felt very strongly that the Mayor should be leading on more areas of health that were a London-wide issue. Some commissioners felt that specialist services serving a larger geographical area could become regional, national, or international 'centres of excellence', with a role to play in developing clinical standards and good practice. This was, though, felt impractical with only local funding solutions, and some were considerably less enthusiastic about contributing to a centralised resource than others, with fears cited about the impact of any reduction in resources locally. One commissioner told us:

> "With the Mayor leading on a centralised pot we could do something really effective, but it needs to be a separate pot that doesn't destabilise local grants."

Another concern was that the burden of these costs would not be fairly met, and could create additional demands on local services if others didn't buy-in to the process:

> "Our council members are against an influx of people from neighbouring boroughs. We'd be very happy to sit around the table for proposals with other boroughs but it can't be at a cost to our own local authority."

Link with sexual health

The link with sexual health was felt to be vital to address. Many commissioners saw the synergies for linking substance misuse support with sexual health and GUM services. Many had already seen a rise in the number of people, particularly MSM, presenting to these services and identifying drug use and for some this was both the first time they had identified these presentations locally and the main route of referral for this group. One commissioner told us they would like to see:

> "Truly joint commissioning, with sexual health and substance misuse the joint responsibility of both, whether we bring drugs into sexual health services or sexual health into drugs services."

The challenge of this was acknowledged though, not least due to the differing way both services are structured with sexual heath and GUM being open access and substance misuse provided locally. One commissioner was honest saying that they would not want to provide substance misuse services to anyone not from their area who used their local GUM clinic. This presents significant challenges on how to resource a joint approach, with many LGBT people, particularly MSM, choosing to access GUM services that have worked to target them, rather than using services locally that they may perceive to be more generic.

The changing landscape

We discussed the changes to the commissioning landscape and any opportunities or challenges commissioners envisaged. Many spoke of the adjustments that had to be made to working under a local authority where they had not done so before, with different levels of scrutiny and differing agendas. Different arrangements existed within different local authorities as to where the commissioning teams sat in relation to local public health structures, and some felt this impacted both positively and negatively on their ability to influence other colleagues or develop innovative joint proposals. Most felt that the changes were still taking some time to bed-in. Some spoke of their concern that elected councillors may have their own priorities based on election commitments. Many of the responses spoke more generally of

concerns with cuts to budgets and the risks they saw to public health money in the longer term with lifting of ring-fenced budgets.

Some commissioners lamented a loss of skills, telling us they felt some experienced commissioning colleagues had moved on during the transition of the health and care sectors. Some felt this would reduce the appetite for developmental commissioning, with pressures to concentrate on core provision. This is a particular concern for this population as the lack of evidence on LGBT need, the use of newer drugs, and poor monitoring of outcomes for LGBT service users often necessitates a pilot or investigative approach.

There was, though, some optimism at the opportunities that could be created, particularly around joint commissioning with commissioners telling us they could see synergies across public health, and welcoming a broader approach that had the potential to improve prevention work as well as treatment. Some already saw greater connection with a push for saving through integration.

Current commissioning

We asked what was currently provided locally for LGBT clients. Nobody specifically commissioned targeted LGBT interventions, although some commissioners supported local initiatives. Some had providers where LGBT staff had themselves developed initiatives such as a weekly LGBT session. Although individual commissioners had not initiated these services they supported them in a number of ways, including helping to promote them more widely, and opening them up to residents of neighbouring areas to ensure they had sufficient clients accessing them. Some had allowed generic resource to be diverted to support these, for example adding clinical staff such as nurses to work alongside keyworkers to expand the range of services that could be delivered during these sessions. Some areas had completed or were considering targeted needs assessment for LGBT populations or for MSM.

We discussed some options for improving LGBT inclusion with commissioners, such as redefining their service specification to require providers to demonstrate how they meet LGBT need, reporting on outcomes for LGBT clients, and facilitating joint working arrangements with larger generic providers and smaller specialist organisations. Few currently considered these but most were amenable to developing this aspect of their work.

Some commissioners felt there were actions they could build into their local specifications, including supporting monitoring of outcomes by sexual orientation. Nobody had yet seriously advanced on monitoring of gender identity. Some felt that there were opportunities in the renegotiation of NHS contracts to improve LGBT representation.

Many commissioners were most engaged by the idea of specialist providers becoming partners in larger tenders with generic providers. This was also felt easier for commissioners than issuing a number of smaller contracts. One commissioner told us they felt:

> "The trend is for bigger but fewer contracts, as we have less resource to manage them."

There was an acknowledgement by many that they had done less work on LGBT issues than on issues affecting groups with other protected equality characteristics, e.g. services for women or for people from BME backgrounds.

Summary of Commissioner Engagement

We found a willingness to engage by commissioners but less evidence of specific actions taken so far beyond training. Where local development had been supported this was often building on the initiative of LGBT staff in providers who had begun this work themselves. This is typical of work on LGBT issues, which is often driven by the will of individuals; it is important that LGBT development is considered as part of a strategic approach by commissioners and providers.

Some actions taken had been helpful; commissioners had facilitated the provision of training at a local authority wide level ensuring all staff had access to this. Most commissioners had considered their response to increasing need of club drug users, and this had improved access by LGBT people. However this had not always been accompanied by targeting any

LGBT specific resource, and therefore risks continuing to exclude the high number of LGBT people who say they would only access a specialist service and those who are offered greater confidence by having the option to choose specialist provision.

Some commissioners supported at least some level of LGBT specialist work, although none currently specifically commissioned any. All however expected their services to improve their LGBT competence. With a high level of LGBT people expressing a desire to access specialist provision commissioners and providers should take care to ensure that efforts to improve inclusion do not only focus on developing generic services but also address the needs to those LGBT people who wish to access specialist support.

Where commissioners supported specialist provision there was acknowledgment that some of this could be done more cost-effectively on a larger scale with neighbouring local authorities or regionally e.g. pan-London. All however expressed concern over how this would happen in practical terms. Such mechanisms could offer cost savings and improve quality, e.g. a 'centre of excellence' approach. More work needs to be done to facilitate this.

There was universal agreement that access could be improved through better integration if sexual health and substance misuse services, echoing the strong desire seen in the Chemsex Study by MSM to access drug and alcohol support through sexual health and GUM services. Commissioners should explore opportunities for this, although should be mindful that whilst this can address MSM needs additional consideration should be given to how the needs of lesbian and bisexual women and trans people can be met through this approach.

A set of actions for commissioners is provided in our recommendations section and more detailed suggestions for action are provided in the guidance notes and audit tools in Appendix A.

11. MSM HIV Prevention in London: A template for LGBT specialism in drugs & alcohol?

A pan-London mechanism exists for the commissioning of some HIV prevention interventions. This offers opportunities for commissioning synergies and efficiencies with drug and alcohol interventions for MSM. The mechanism could also offer a template for extending the scope of drug and alcohol interventions to cover LGBT need.

The Pan London HIV Prevention Programme (PLHPP) was commissioned until March 2013. It commissioned a range of interventions for all communities at risk of HIV, including testing, media, outreach, and behavioural change interventions such as counselling and small group work at a pan-London level. The programme was intended to complement local spend on HIV prevention, delivering a range of services considered better to be delivered over a larger geographical area. London Primary Care Trusts contributed in proportion to the levels of HIV prevalence and at risk communities in their local areas.

Prior to the transfer of responsibility for commissioning HIV prevention services to local authorities under the Health and Social Care Act 2012 a review of the PLHPP was instigated. Local authorities were inheriting a range of varying HIV prevention activities along with the PLHPP. An immediate commissioning decision was required about the future of the pan-London programme, which had attracted questions of efficacy and value for money, both significant concerns under the transfer to local authorities which had experienced considerable budget cuts over recent years.

An interim decision was made by all 33 London boroughs to roll over 5 of the 18 contracts under the PLHPP for 2012/14 and conduct a thorough needs assessment to inform the future commissioning of HIV prevention across London. The assessment concluded that whilst the majority of provision should be commissioned at local level there was evidence that some prevention initiatives should continue to be funded on a pan-London level, particularly for some of the most 'at risk' populations.

Responsibility at local level was welcomed, allowing consideration of specific local needs:

> "Each local authority is now responsible for securing appropriate HIV prevention services to meet the needs of their communities. This enables boroughs to consider the best way of tailoring services to meet the specific needs of their 'at risk' populations and to link HIV prevention into other local services and programmes. As in the past, the expectation is that the majority of HIV prevention services will continue to be locally commissioned."

The balance between local and pan-London level was examined with the needs assessment concluding that joint commissioning could offer value for money as well as improvements in both quality and outcomes:

> "There may be some circumstances, however, when collaborative commissioning arrangements between some or all London boroughs offer benefits over and above individual borough-based commissioning. For example, such collaborative arrangements may offer economies of scale, improvements in quality and outcomes owing to the ability to deliver services at a critical scale, or reflect the epidemiology of HIV in London."

The assessment found that the transient and city-wide nature of MSM and the services and venues they are more likely to access offered different opportunities to reach these groups with health promotion interventions than just offering these locally:

> "For example, some 'at risk' groups are highly mobile and there may be a case for targeting interventions at places where people socialise, rather than where they live."

The assessment also considered the use of communication campaigns, and varying media, concluding that consistency of messaging across London targeting specific populations could have a greater impact:

> "Other interventions, such as communications and campaigns

> delivered through a variety of channels, including web-based interventions, could be commissioned at sufficient scale at London level, deliver consistent and visible messages to the target populations and audiences, and tailored to suit local circumstances and need as appropriate."

The mechanism for coordinating such an approach was considered:

> "As each borough undertakes its own HIV prevention commissioning, stakeholders have suggested there is a case for this local work to be supported by an individual, with an overview and coordination role across London, who can provide support to boroughs and ensure HIV prevention provision is not fragmented, but fits within an overall framework. This framework could sit within and join up to the emerging arrangements for sexual health across London."

The needs assessment considered some of the new and emerging evidence of the link between drug use and HIV in MSM. It concluded that HIV prevention interventions should be integrated with substance misuse interventions to target those MSM at risk from the dual combination of factors:

> "There is considerable concern about increasing sexual risk taking behaviours in MSM associated with recreational drug use. This new trend needs to be addressed through broader interventions targeting sexual and other health-related risk-taking behaviours, and indicates the need for a more integrated approach between substance misuse and sexual health services."

It also highlighted the emerging risks associated with the injecting of club drugs amongst MSM, and supported a harm reduction approach including access to needle exchange schemes for those MSM who are increasingly reporting this practice. It added that needle exchange services ought to meet the differing needs of MSM as opposed to their more traditional opiate and crack cocaine injectors:

> "The evidence of on-going transmission of HIV amongst MSM suggests that the priority for primary prevention should focus on reducing risky sexual behaviour in MSM. Prevention activity should take account of emerging evidence of increased recreational drug use, including injecting, amongst MSM. Measures to reduce the harm from injecting will need to meet the needs of MSM."

The needs assessment made several recommendations which related to substance misuse, firstly highlighting the opportunities the new public health arrangements offered for integration:

> "The significant opportunities afforded by local authority commissioning of HIV prevention services should be maximised. As well as integrating HIV prevention into wider sexual health services and programmes, there are potential opportunities to address HIV and sexual health risks alongside other risk behaviours, for example, alcohol and substance misuse. There are also opportunities to use Councils' leverage and sphere of influence in relation to the wider determinants of health to reach and support populations at increased risk of HIV."

For drug and alcohol services the recommendation was to preserve harm reduction and improve local public heath knowledge of the issues affecting MSM:

> "Drug treatment services should maintain their focus on harm reduction approaches (particularly needle exchange schemes) and work collaboratively with public health commissioners and sexual health service providers to understand and address the emerging issue of HIV spread associated with recreational drug use in MSM."

In looking to coordinate prevention activities the needs assessment recommended that some centralised resource over and above existing responsibilities could assist with this, as well as the creation of supporting resources and drive improvements in quality and outcomes:

> Whilst [Directors of Public Health] in London should provide strategic leadership and coordination for HIV prevention efforts across

the capital, there would be benefit to resourcing some coordination capacity between the various commissioners and stakeholders across the capital, to support integration between borough, London and national programmes, to develop a range of commissioning support tools, such as specifications, standards and outcome frameworks, as well as supporting evaluation and sharing of best practice.

Finally the assessment recommended improved use of new media and digital technologies to deliver health promotion messaging and interventions:

> "Digital media and technologies offer scope for reaching target audiences at scale as well as the potential to target people via the digital means and channels through which they now socialise. These new approaches should be explored, developed and evaluated."

Such digital channels can be assumed to include the range of websites and smartphone social networking apps MSM commonly report using to facilitate sourcing sexual partners and chemsex.

Future Pan-London Commissioning

Following publication of the needs assessment the project steering group was tasked to plan the detail of a pan-London programme for 2014/15 until 2017. This is currently in the early procurement stages with Directors of Public Health to establish specifications for HIV Prevention contracts

Links to substance misuse

The needs assessment for HIV prevention also provides opportunities to consider targeted substance misuse interventions for MSM at risk through chemsex behaviours. The findings support our own assessment that some provision over a pan-London area, or through collaborative arrangements between selected local authorities, would offer cost savings and provide access to a 'centre of excellence' with a high level of experience working with the dual nature of sexual and substance risk. Where this is combined with commissioning HIV prevention or broader sexual health interventions further efficiencies can be realised, along with improved integration and increased awareness of issues and needs.

The recommendation to further develop online and other digital communications and interventions was also reflected in our focus groups with drug and alcohol users, who reported they would like to see better use of new technologies. This also offers the opportunity for engagement with the providers of social networks used to facilitate chem sex through corporate social responsibility initiatives.

The scale of developing a mechanism for commissioning on a larger scale however should not be underestimated. The pan-London accord was achieved through resourcing this needs assessment and the subsequent senior level appointment to coordinate pan-London provision reflects the responsibilities of managing such an approach. A similar agreement to resource any pan-London substance misuse support would require a similar 'buy-in' by local authorities. If this decision is supported by Directors of Public Health this approach offers a template that could be extended to include substance misuse, or develop joint chemsex interventions for MSM at a pan-London level. For local provision commissioners can use the recommendations to integrate local approaches.

As throughout this scoping study caution is advised that linking substance misuse interventions with HIV prevention targets mainly the needs of gay and bisexual men and other MSM. Any such provision would not adequately address the needs of lesbian or bisexual women or address the needs of all trans people. The mechanism of centralised funding based on contributions from all London boroughs does however offer an opportunity to expand this approach towards meeting broader LGBT (or other minority) needs through specialist services on a city-wide basis.

12. Other related publications

Several connected pieces of work have been recently published or are due to be published soon after this report. We recommend they are also considered in conjunction with this study.

Part of the Picture

The latest phase of findings from this study being carried out by the Lesbian and Gay Foundation will be published in May 2014[60].

NAT briefing on HIV and injecting drug use

This briefing includes updates on injecting use by MSM and recommendations for service and strategic improvements[61].

LGBT Companion to the Public Health Outcomes Framework

This publication examines LGBT evidence in relation to each outcome indicator in the Public Health Outcomes Framework, including where gaps in evidence exist, and makes recommendations for policy and practice[62]

London Councils review of pan-London HIV Prevention

This review considered the provision of some HIV prevention interventions on a pan-London level and established the mechanism to achieve this[63].

Public Health England guidance on MSM needs in drug & alcohol services

This guidance will be published in 2014 and will contain a set of recommendations for providers and commissioners in meeting the needs to MSM service users.

Public Health England Strategic Framework to promote the health and wellbeing of gay, bisexual and other men who have sex with men

This strategy will be published in June 2014. It will set out PHE's vision for improving MSM health and well-being. At time of publication a draft is available for consultation[64].

NHS England review of access to healthcare by trans patients

This review will be published in 2014. It has examined access to health and care services by trans people, including specialist gender care and general healthcare. Additional work is being advanced through a Clinical Reference Group regarding access to specialist Gender Identity Services[65].

Project Neptune (Novel Psychoactive Treatment UK Network)

This project led by the Central and North West London NHS Foundation Trust is developing guidance for the management of acute and chronic harms of club drugs and novel psychoactive substances. This guidance will be published in summer 2014.

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[60] https://www.lgf.org.uk/potp

[61] http://www.nat.org.uk/media/Files/Policy/2013/HIV_and_Injecting_Drug_Use_Report_2013.pdf

[62] http://www.lgf.org.uk/phof

[63] http://www.londoncouncils.gov.uk/policylobbying/healthadultservices/hivprevention/

[64] https://www.gov.uk/government/consultations/strategic-framework-to-improve-the-health-and-wellbeing-of-gay-bisexual-and-other-men-who-have-sex-with-men

[65] http://www.england.nhs.uk/ourwork/commissioning/spec-services/npc-crg/group-c/c05/

13. Recommendations

The scoping study identified the following recommendations. They are given here in relation to Public Health England, local public health and commissioners; providers; and front-line staff. Given the lack of evidence and research, particularly associated with some groups, recommendations are also identified for researchers. Some overarching general recommendations are provided at the start. More detailed check-lists of good practice are given in the appendices.

General recommendations:

Ensure that the separate and distinct needs of L, G, B and T people are considered:

- Approaches to meeting this needs of these populations often focus on gay men. Work to improve the inclusion of LGBT people should take care to ensure the full range of LGBT need is addressed. Plans to address the needs of MSM should not be considered as addressing all needs for LGB or trans people, for example.

Engage LGBT people in development work at the planning stage and throughout:

- Good practice includes consultation with affected groups early and at all stages. Engagement should be undertaken responsibly with consideration of adequate remuneration or resourcing to permit individuals and LGBT organisations to have the capacity to engage.

Assess the impact of policy, planning, commissioning and delivery decisions on LGBT people:

- A robust equality analysis should assess how any planned work could impact LGBT people, including an assessment of any potential negative impacts. Where these are highlighted action to mitigate risk should be identified before being implemented (e.g. the equality analysis of payment by results indicates potentially negative impacts for LGBT people, which should be addressed before the being extended).

Counselling and psychotherapy treatments should not use 'anti-LGBT reparative' therapies:

- LGBT people should not be offered counselling which utilises 'reparative' therapies which aim to 'change' sexual orientation or gender identity. Such practices have been denounced and are considered potentially damaging by professional bodies for counselling & psychotherapy.

For Public Health England

Monitoring of sexual orientation data should be mandated:

- This would provide consistency across England to allow full disaggregation of data by this protected characteristic.

Monitoring of gender identity should be considered:

- This would provide data relating to trans people in treatment for the first time. Due to the additional considerations of sensitivity and privacy further work is needed to introduce this, including agreement of gender identity monitoring questions, guidance for providers, and an amendment of NDTMS to permit central recording.

Analysis of NDTMS data to inform local needs assessment and planning:

- NDTMS data should be analysed and disaggregated by sexual orientation (and gender identity where available). This should include analysis of outcomes for LGB and trans people in treatment. This date should be made available to local public health teams and commissioners to assist needs assessment and planning.

JSNA planning and guidance documents should prompt for assessment of LGBT needs:

- PHE should analyse data relating to LGBT people in treatment and provide this to local public health officials to assist with needs assessment and local planning. Action should be outlined to improve data relating to trans people in treatment.

Consideration of joint funding arrangements for specialist substance misuse services:

- PHE nationally and regionally, together with local Directors of Public Health and commissioners, should examine the opportunities for efficient and effective treatment provision for LGBT people in larger urban areas on a regional basis or in partnership with neighbouring local authorities. In London this could follow the example of the new Pan-London HIV Prevention work programme, and could utilise opportunities through other London health bodies such as the London Health Board, the Clinical Commissioning Council, London Councils.

National resources and campaigns should be LGBT inclusive:

- LGBT specific content should be developed in resources such as Frank, and LGBT audiences should be considered in the development of awareness campaigns, including targeted messaging 'sub-campaigns' where appropriate.

For Local Public Health & Commissioners

Commissioners should carry out an LGBT audit:

- Our audit tools are provided in Appendix A. These give a snapshot of current practice in relation to meeting the needs of LGBT people and indicate where good practice is already in place as well as areas requiring further development.

Access to targeted LGBT services should be provided:

- Our analysis indicates that having access to targeted LGBT support is extremely important to many LGBT people, some of whom say they would not access generic services. Local commissioners should consider how they can best meet this need, including commissioning in partnership with neighbouring local authorities in larger urban areas. Commissioners may wish to consider buying into services which are provided outside of their local authority area due to the nature of how many LGBT people access targeted LGBT support.

Service specifications should address LGBT need:

- Commissioners should ensure service specifications request actions to address LGBT need and that potential providers outline how they propose to meet these needs through targeted and generic services. LGBT people should be involved in the design of these specifications.

Monitoring of sexual orientation data should be mandated:

- Commissioners should require their providers to monitor sexual orientation and report on outcomes for LGBT clients.

Monitoring of gender identity should be considered:

- Commissioners should consider how to sensitively introduce this with providers. Due to the additional considerations of sensitivity and privacy further work is needed to introduce this, including agreement of gender identity monitoring questions, and guidance for providers.

Procurement processes should encourage and facilitate the participation of smaller, specialist providers in the tendering process:

- Commissioners can ensure that specialist providers have an opportunity to enter local supplier markets. This may be through the availability of smaller contracts or by facilitating the opportunity for specialist providers to engage with generic providers to partner in consortia tenders. This can permit smaller, specialist organisations to participate in the tendering process as a subcontracted provider. This could apply similarly to other small providers working with specific groups.

Commissioners should include outcomes for LGBT people in performance management:

- A requirement on providers to demonstrate their outcomes disaggregated by sexual orientation (and in time by gender identity) will ensure that LGBT inclusion is not permitted to be 'optional'. Any concerns about achieving outcomes for LGBT can be identified and addressed.

Consideration of joint funding arrangements for specialist substance misuse services:

- Local Directors of Public Health and commissioners, together with PHE nationally and regionally, should examine the opportunities for efficient and effective treatment provision for LGBT people in larger urban areas on a regional basis or in partnership with neighbouring local authorities. In London this could follow the example of the new Pan-London HIV Prevention work programme, and could utilise opportunities through other London health bodies such as the London Health Board, the Clinical Commissioning Council, London Councils.

Consideration of joint funding arrangements for integrated substance misuse and sexual health services:

- Integration can offer efficiencies in joint commissioning, and MSM have indicated a desire to access substance misuse support through sexual health services. Any services should consider how the needs of lesbian and bisexual women, bisexual people generally, and trans people can be met through joint provision with sexual health.

For NHS, VCS and other Providers

Providers should carry out an LGBT audit and develop an LGBT-inclusion plan:

- Our audit tools are provided in Appendix A. These give a snapshot of current practice in relation to meeting the needs of LGBT people and indicate where good practice is already in place as well as areas requiring further development.

Training should be provided as part of a LGBT strategic development plan:

- Training addresses professional development needs but can be more effective when provided as part of an organisational-wide strategic plan to improve LGBT access and outcomes with actions to develop policy and practice. Training should be supported and implemented at senior management level.

Providers should identify LGBT Champions:

- Providers should support the development of LGBT Champions at all levels, including senior management. LGBT Champions should lead on LGBT development and capacity building.

For Practitioners

Practitioners should carry out an LGBT audit:

- Our audit tools are provided in Appendix A. These give a snapshot of current practice in relation to meeting the needs of LGBT people and indicate where good practice is already in place as well as areas requiring further development. A personal professional development can then then be identified e.g. for discussion in supervision or annual appraisals.

Practitioners should consider becoming an LGBT Champion for their services:

- Practitioners can offer to lead on their service's response to improving LGBT capacity and competence. LGBT Champions need not be LGBT themselves. A range of actions are suggested in the LGBT Audit tools in Appendix A. Front-line Champions should be accompanied and supported by Champions at senior management level.

LGBT specific diversity training should be provided to all staff:

- Training should allow staff to consider how LGBT people's experiences may contribute to their drug or alcohol issues, and allow them to understand the different contexts in which drugs and alcohol may be used. Bear in mind that generic diversity training may not address specific LGBT issues related to substance use.

For researchers

Researchers can undertake work to reduce the gaps in evidence relating to LGBT substance use:

- Gaps are highlighted in the UK Drug Policy Commission's 2010 report and also in the LGBT Companion to the Public Health Outcomes Framework, and include: use by lesbian and bisexual women; use by bisexual people generally; use by trans people.

Researchers can include monitoring of sexual orientation and gender identity in wider health research:

- Routine inclusion of sexual orientation and gender identity in health research would provide access to more information which could be disaggregated in relation to LGBT people.

Researchers can further explore monitoring of trans identity:

- There is not a current consensus on how trans identity can be sensitively and appropriately monitored as a demographic or protected characteristic. More research could be undertaken on this.

Appendix A: Audit tool & guidance for commissioners

LGB&T Audit for Substance Misuse Commissioners

This audit tool allows you to assess your performance across a range of indicators in commissioning services that are inclusive of lesbian, gay, bisexual and trans service users. It also allows you to identify actions that can be taken to improve the overall competence of your providers and staff in working effectively with people from these groups, and demonstrating successful outcomes for them.

The audit tool is a checklist; it is not expected to be the only action you will need to take. It will assist in identifying areas which require a change of policy or practice, or that need to be incorporated into your service's business or operational planning or into personal objectives for teams or staff members. You may also need to work with your own commissioned providers and specialist LGB & T providers. A similar tool has been produced for providers to evaluate their own LGB & T inclusiveness.

A guidance document has been produced to accompany this audit, giving further detail on the rationale for some questions and tips for improving service provision. It should be read in conjunction with this audit tool.
Antidote @ London Friend is happy to provide further support, and this work forms part of a developing package of LGB & T support interventions. Antidote is the specialist substance misuse service run by London Friend, the UK's oldest charity working to improve LGB & T health and well-being.

Web: www.londonfriend.org.uk/antidote
Email: antidote@londonfriend.org.uk

1. Your own employment policies

Question	Yes	No	In Progress	Comments/Action	By whom; by when
Do your employment policies include explicit reference to equality for LGB people?	☐	☐	☐		
Do your employment policies include explicit reference to equality for trans people?	☐	☐	☐		
Do you monitor sexual orientation in employees?	☐	☐	☐		
Do you monitor sexual orientation at application?	☐	☐	☐		
Do you monitor gender identity/reassignment in employees?	☐	☐	☐		
Do you monitor gender identity/reassignment at application?	☐	☐	☐		
Do you monitor staff attitudes to sexual orientation?	☐	☐	☐		
Do you monitor staff attitude to gender identity?	☐	☐	☐		
Do any staff partner benefits apply to same-sex partners?	☐	☐	☐		
Do you have a workplace policy relating to staff who undergo gender reassignment at work?	☐	☐	☐		
Does your sickness policy include time of work for staff who undergo gender reassignment?	☐	☐	☐		
Do you participate in any workplace benchmarking related to LGB equality? (E.g. Stonewall Workplace Equality Index, Diversity Champions etc.)	☐	☐	☐		
Do you undertake any workplace benchmarking related to trans equality?	☐	☐	☐		
Do you facilitate a staff network for LGB & T employees?	☐	☐	☐		
Do you actively personally champion LGB & T issues at strategic level?	☐	☐	☐		

2. Needs assessment

Question	Yes	No	In Progress	Comments/Action	By whom; by when
Does your local authority's JSNA include analysis of LGB need?	☐	☐	☐		
Does your local authority's JSNA include analysis of trans need?	☐	☐	☐		
Does the substance misuse contribution to your local JSNA include analysis of LGB need?	☐	☐	☐		
Does the substance misuse contribution to your local JSNA include analysis of trans need?	☐	☐	☐		
Is LGB need specifically highlighted in your local Health & Well-being Strategy?	☐	☐	☐		
Does this include specific LGB substance misuse need?	☐	☐	☐		
Is trans need specifically highlighted in your local Health & Well-being Strategy?	☐	☐	☐		
Does this include specific trans substance misuse need?	☐	☐	☐		
Have you engaged with LGB people and organisations in assessing local need?	☐	☐	☐		
Have you engaged with trans people and organisations in assessing local need?	☐	☐	☐		

3. Commissioning intentions

Question	Yes	No	In Progress	Comments/Action	By whom; by when
Do you currently commission any targeted work for LGB people?	☐	☐	☐		
Do you currently commission any targeted work for trans people?	☐	☐	☐		
Do your service specifications include providing for LGB service users?	☐	☐	☐		
Do your service specifications include providing for trans service users?	☐	☐	☐		
Do you require prospective providers to demonstrate how they would meet the needs of LGB people during the tendering process?	☐	☐	☐		
Do you require prospective providers to demonstrate how they would meet the needs of trans people during the tendering process?	☐	☐	☐		
Have you explored opportunities for commissioning synergies for targeted LGB & T work across health areas? (E.g. links with sexual health, mental health)	☐	☐	☐		
Have you explored opportunities for commissioning synergies for targeted LGB & T work across local geographical boundaries? (E.g. joint commissioning with neighbouring DAATs/PCTs/CCGs)	☐	☐	☐		
Do you actively encourage your providers to pursue joint tenders with specialist LGB & T organisations?	☐	☐	☐		
Do you enable your providers to sub-contract work to specialist LGB & T organisations to assist delivery?	☐	☐	☐		

4. Outcome monitoring

Question	Yes	No	In Progress	Comments/Action	By whom; by when
Do you require your providers to monitor sexual orientation of service users? (if yes, what is your local completion rate for this field and local breakdown?)	☐	☐	☐		
Do you require your providers to monitor gender identity of service users? (if yes, what is your local completion rate for this field and local breakdown?)	☐	☐	☐		
Do you require providers to report on outcomes disaggregated by sexual orientation?	☐	☐	☐		
Do you require providers to report on outcomes disaggregated by gender identity?	☐	☐	☐		
Do you publish outcomes disaggregated by sexual orientation?	☐	☐	☐		
Do you publish outcomes disaggregated by gender identity?	☐	☐	☐		

5. Staff development

Question	Yes	No	In Progress	Comments/Action	By whom; by when
Do you provide training on equality and diversity for your own staff?	☐	☐	☐		
Do you provide training for your own staff on LGB issues?	☐	☐	☐		
Do you provide training for your own staff on trans issues?	☐	☐	☐		
Is any of this mandatory?	☐	☐	☐		
Do you facilitate access to training on equality and diversity issues for your providers, or require them to provide this?	☐	☐	☐		
Do you facilitate access to training on LGB issues for your providers or require them to provide this?	☐	☐	☐		
Do you facilitate access to training on trans issues for your providers or require them to provide this?	☐	☐	☐		
Do you provide refresher training on a regular basis?	☐	☐	☐		
Is any of this mandatory?	☐	☐	☐		
Do you provide training on new trends in drug use for your own staff?	☐	☐	☐		
Do you facilitate training on new trends in drug use for your providers?	☐	☐	☐		

6. Compliance with Public Sector Equality Duties

Question	Yes	No	In Progress	Comments/Action	By whom; by when
Are you already aware of the Public Sector Equality Duties?	☐	☐	N/A		
Can you evidence paying 'due regard' in the exercise of your function as a public body in relation to sexual orientation as required by the Equality Act 2010?	☐	☐	☐		
Can you evidence paying 'due regard' in the exercise of your function as a public body in relation to gender reassignment as required by the Equality Act 2010?	☐	☐	☐		
Do your local authority's equality objectives include specific commitments to LGB equality?	☐	☐	☐		
Do your local authority's equality objectives include specific commitments to trans equality?	☐	☐	☐		
Do your own team's business plans and objectives include specific commitments to LGB equality?	☐	☐	☐		
Do your own team's business plans and objectives include specific commitments to trans equality?	☐	☐	☐		
Do you carry out an equality analysis (or equality impact assessment) of your policies, practice and planning?	☐	☐	☐		
Do you utilise any external benchmarking tools to assist with your analysis of performance in relation to equality & diversity? (E.g. NHS Equality Delivery System)	☐	☐	☐		

LGB & T Audit for Substance Misuse Commissioners: Guidance Notes

These notes accompany our audit tool for commissioners of substance misuse services. They give further detail on the rationale for some questions and tips for improving service provision. They should be read in conjunction with the audit tool.

Introduction

The Drugs Strategy 2010 acknowledges the need for services to be responsive to the needs of certain groups such as lesbian, gay, bisexual and transgender (LGB & T) users[66]. Evidence indicates that these populations are more likely to use alcohol and other substances, and to be using different drugs in different contexts to those typically seen in many drug services, with more emphasis on 'party' or 'recreational' drug use[6768]. Services providing targeted interventions to LGB & T people are reporting an increase in drugs such as methamphetamine and dependent use of GBL requiring supervised detoxification[69]. Service users are also indicating a preference to access interventions targeted at LGB & T people for reasons of safety, and due to a perception these services will better understand their circumstances[70].

Practitioners working with LGB & T users will not generally be required to use different interventions, except where indicated by different drugs used, but successful outcomes are more likely where the practitioner can demonstrate robust understanding of the user's circumstances and experience as an LGB or T person. It is essential to create an environment which gains trust and allows the service user to be open and frank about their substance use and other risk behaviours such as unsafe sexual practices. Partnerships with e.g. sexual health services can help with an integrated approach to care. Training to improve knowledge and awareness of the issues commonly faced by LGB & T people can help with this; LGB & T-specific sessions offer more scope than generic diversity training for adequate consideration of such issues, which most staff will never have had the opportunity to discuss in a professional setting.

Commissioners can help to improve the treatment experience through service specifications which require providers to demonstrate measures for LGB & T inclusion; through monitoring sexual orientation and gender identity; and via performance management indicators which

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66 http://www.homeoffice.gov.uk/drugs/drug-strategy-2010/
67 http://85.13.242.12/publication/drugs-diversity-lgbt-groups-policy-briefing/
68 http://www.lgf.org.uk/potp
69 Antidote saw an increase from 0% of service users reporting crystal meth use in 2004/5 to 49% in 2013/4; 1.7% reporting G use in 2004/5 to 44% in 2013/4.
70 http://85.13.242.12/publication/drugs-diversity-lgbt-groups-policy-briefing/

measure outcomes for LGB & T service users. Such measures will also assist to evidence compliance with the Public Sector Equality Duty under the Equality Act[71].

About this guidance

We have separated many questions into effectively two halves, asking the same question in relation to sexual orientation (LGB) and gender identity (T). This is to ensure attention is given to both LGB and T people equally. The needs of each group have some overlap but can be quite distinct, with people mistakenly believing trans issues are covered where in effect only issues relating to sexual orientation are.

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Some trans people fall outside of this description, because their gender identity does not fit a pattern of changing one binary gender role (male or female) to another; considering gender identity ensures that good practice is managed for all gender non-conforming people.
For most questions we have provided a yes, no, and in progress response, the later denoting where some consideration has been made but work is still yet to do on this issue. In general you should be aiming to moving from no to yes responses over a period of assessment and ensuing improvement actions.

1. Your own employment policies

Ensuring that the commissioning body, as an employer, has robust policies in place relating to LGB & T issues is an essential first step. We ask about monitoring sexual orientation and gender identity of both current employees and applicants. Monitoring at application stage allows analysis of recruitment policies but also provides a statement to prospective employees that your organisation has considered equality issues as an employer and that you see monitoring as an important way of being able to analyse your staff data. Public bodies who are subject to the specific public sector equality duties of the Equality Act 2010 are also required to publish equalities data about their staff. Care should be taken to ensure confidentiality at all stages, especially where low numbers may identify individuals. You should also note that information received in an official capacity about an individual's previous gender identity is classified as protected Information under section 22 of the Gender Recognition Act[72]; human resources

[71] http://www.homeoffice.gov.uk/equalities/equality-act/equality-duty/
[72] http://www.equalityhumanrights.com/advice-and-guidance/your-rights/transgender/transsexual-people-your-rights-relating-to-privacy/

departments should ensure processes for protecting such information are in place. Guidance on monitoring as a public sector employer is available from the Equality & Human Rights Commission[73].

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For more thorough evaluation of your staff policies special benchmarking schemes are in operation such as Stonewall's Workplace Equality Index and Diversity Champions programmes, which allow you to assess a very broad range of workplace conditions in relation to LGB employees[74]. Stonewalls work in England relates only to sexual orientation and as yet no parallel scheme exists for trans employees, but you could adapt the basic principles of equality benchmarking for your own internal assessments.

Finally this section asks about your personal commitment to championing LGB & T issues professionally. The backing of senior managers can provide a significant boost for the LGB & T voice at strategic level. You can demonstrate your commitment to these issues by ensuring LGB & T diversity is acknowledged and included at levels such as your local JSNA and commissioning plans. With improved knowledge of the issues you will be better equipped to challenge exclusion, and can play a vital role in promoting equality for these groups.

2. Needs assessment

This section evaluates how well LGB & T issues are embedded in your local Joint Strategic Needs Assessment, joint health and well-being strategies that will inform commissioning. It asks about inclusion at a general level as well as specifically from a substance misuse focus.

Good practice here will include analysis of available research on levels of drug use within LGB & T people and local population estimates. Antidote has produced information sheets on where to find some of this information. It should be noted that poor monitoring of sexual orientation, and

[73] http://www.equalityhumanrights.com/advice-and-guidance/public-sector-equality-duty/
[74] http://www.stonewall.org.uk/at_work/

especially of gender identity, means that information about these two groups is not always readily available, particularly not broken down to local population level. Neither characteristic was included in the Census data, from which a large amount of local demographic data is derived. As such, best available data should be used, especially where two or more sources indicate trends. Consideration should be made of all relevant data sources.

Templates that do not yet include questions on LGB & T need should not be allowed to be a barrier to collating and analysing this data. Consideration of these groups is still at an early stage, and you will be effectively 'ahead of the game' in doing so. Consideration should also be given to identifying actions that seek to reduce gaps in data where that are found; it should not be acceptable to highlight a lack of evidence in a subsequent cycle of needs assessment where an action has not been taken to attempt to remedy this. You may find it useful to work with colleagues in neighbouring geographical areas, or related health fields, to share any information.

The importance of engagement with local LGB & T people individuals and organisations is stressed here. This is an essential part of good local needs assessment, and helps demonstrate that you have have paid 'due regard' in the exercise of your public sector equality duty. Consideration should be made of the capacity of individuals and organisations to engage; many LGB & T organisations are very small and employ a very small number of staff, if any. Responsible engagement may include remuneration for time.

3. Commissioning intentions

This section asks about your current and future commissioning. It ascertains whether you currently commission any specialist work with LGB or T people, and also looks at whether you incorporate requirements to demonstrate work with LGB & T people in your commissioning practice.

Good practice here starts from drawing up service specifications when opening up tenders to prospective providers. By building the requirement to demonstrate how providers will target and achieve outcomes for LGB & T people into your specifications you are indicating that reaching diverse communities is of importance to you, and also providing further evidence that you are meeting you public sector equality duties in considering the needs of protected groups.

This section also checks whether you have considered alternate delivery models, such as looking at the synergies which could exist with joint commissioning of sexual or mental health services. (Increasingly service users of Antidote are presenting first in sexual health settings; we have been successful in forming delivery partnerships with GUM clinics to meet need in a one-stop setting.) You may also find it cost effective to look at joint commissioning with neighbouring local authorities; a relatively small amount of money from each commissioner over London's boroughs, for example, could contribute to a pan-London specialist referral pathway for all LGB & T Londoners.

Finally this section looks at how you can facilitate joint bids with mainstream providers and specialist LGB & T organisations, and also enable your providers to sub-contract work with these organisations.

4. Outcome monitoring

This section looks at the essential issue of monitoring sexual orientation and gender identity. Specifically it looks at how you can use your role as a commissioner to improve monitoring and drive reporting of outcomes for your LGB & T service users. Research about LGB & T people remains relatively poor as a direct result of not recording these characteristics as standard practice. Outcomes cannot be disaggregated by these characteristics without routine monitoring of this data, which compounds the cyclical problem. LGB & T organisations regular cite monitoring as one of the highest priorities to improve knowledge and outcomes for these groups[75].

Monitoring service users' sexual orientation can be a sensitive issue, but need not be problematic. Concerns can always be addressed through simple training (and performance management if required). The NTA currently requests this information in some regions but completion rates are typically poor, with fields left blank, or staff assuming heterosexuality. As a commissioner you can set targets for completion and be pro-active in managing this with your providers. The Lesbian & Gay Foundation has produced a guide, commissioned by NHS North West, which provides further information on monitoring sexual orientation in health settings[76].

Monitoring gender identity requires some different considerations to monitoring sexual orientation. Care should be taken not to conflate the two. Many trans people who have undergone gender reassignment do not wish to be detected and will not be happy to disclose their trans history. Many may have experienced harassment or violence and be afraid to disclose if they do not know how safe it will be. However, not monitoring compounds the lack of information related to trans health needs and increases the invisibility of those trans people who wish to identify as such. It is essential that monitoring is carried out with sensitivity, but again this is something which can be easily addressed through training. The charity GIRES (Gender Identity Research and Education Society) has developed a quick-start guide which provides an introduction to some of the issues[77].

This section finishes by checking whether you request your providers to report on outcomes disaggregated by these two characteristics. Reporting this provides you with performance indicators on how well your LGB & T service users are provided for, whether they are achieving drug-free outcomes and satisfaction with the service. Routine monitoring allows disaggregation across your full range of performance indicators.

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[75] http://nationallgbtpartnershipdotorg.files.wordpress.com/2012/07/national-lgbt-partnership-manifesto3.pdf
[76] http://www.lgf.org.uk/Our-services/Campaigns/sexual-orientation-monitoring-guide/
[77] http://www.gires.org.uk/assets/Workplace/Monitoring.pdf

5. Staff development

This section looks at the role of the commissioner in ensuring your own staff and those working in your services are equipped with adequate knowledge and experience to meet the needs of your LGB & T populations. It looks at whether you provide or facilitate access to equality and diversity training, and whether this also includes specific training on LGB & T issues. If you do not provide this at local authority level, it questions whether you require your providers to ensure access to such training. Diversity training is typically a minimum requirement, but often overlooks the specific issues related to sexual orientation, and particularly gender identity. As stated above staff have often never had the opportunity to consider these issues, and how their practice may impact on service users, in a professional setting.

This section also looks at providing training around new drug trends. The UKDPC research highlights that LGB & T people may be 'early adopters' of new drugs[78]. This has also been the experience of Antidote in relation to crystal meth and G.

6. Compliance with Public Sector Equality Duties

This section aims to support you in evidencing how you meet your Public Sector Equality Duties under the Equality Act 2010. The Act places general and specific duties on Public Bodies to demonstrate compliance[79]. Public Bodies include NHS Trusts, PCTs and local authorities.

Although monitoring is not explicitly required by the Duty it has many other benefits in demonstrating outcomes for service users and commitment to diversity issues for service users and staff. The Duty does require you to be able to demonstrate how you have considered issues for the protected groups in the planning and delivery of your services, what the Act calls having "due regard". Any specific work you have done can help evidence your compliance, such as engagement, needs assessment, targeted commissioning, facilitating training etc.

The Duty applies at senior level, such as the requirement to publish equality information and objectives, but good practice also includes inclusion at your own team level, so incorporating objectives into your own team or local business planning is an example of how equality is embedded throughout the organisation. You may wish to set a general objective and consider the outcomes from an LGB & T perspectives, or set specific objectives relating to developing work with these groups.

The Act does not require the completion of a formal Equality Impact Assessment, but these tools, or similar equality analysis of your policies, practice, and planning are still extremely useful to complete as they provide assurance that consideration has not been overlooked, and will help evidence compliance with the Duty.

[78] http://85.13.242.12/publication/drugs-diversity-lgbt-groups-policy-briefing/
[79] http://www.homeoffice.gov.uk/equalities/equality-act/equality-duty/

Finally this section asks about the use of any benchmarking tools you may use to help assess performance on equality, such as the NHS Equality Delivery System.

Next steps

Once you have completed the audit you will have a clearer idea of where you are already performing well, and where more attention is needed. You can use it to begin action planning, and think about how you embed some of the issues and needs into the ongoing operation of your service. For example, you may wish to check that LGB & T need around substance misuse is represented and analysed in your local JSNA, or task your providers with ensuring sexual orientation and gender identity is robustly monitored.

Achieving successful outcomes for all your diverse populations need not be difficult, but will require some additional thought. Antidote is available for support and offers a wide range of professional services to help ensure your practice is LGB & T aware and competent.

Appendix B: Audit tool & guidance for providers

LGB&T Audit for Substance Misuse Providers

This audit tool allows you to assess your organisation's performance across a range of indicators in providing services that are inclusive of lesbian, gay, bisexual and trans service users. It also allows you to identify actions that can be taken to improve the overall competence of your service and staff in working effectively with people from these groups, and demonstrating successful outcomes for them.

The audit tool is a checklist; it is not expected to be the only action you will need to take. It will assist in identifying areas which require a change of policy or practice, or that need to be incorporated into your service's business or operational planning or into personal objectives for teams or staff members. You may also need to work with your commissioners and specialist LGB & T providers. A similar tool has been produced for commissioners to evaluate their own LGB & T inclusiveness.

A guidance document has been produced to accompany this audit, giving further detail on the rationale for some questions and tips for improving service provision. It should be read in conjunction with this audit tool.

Antidote @ London Friend is happy to provide further support, and this work forms part of a developing package of LGB & T support interventions. Antidote is the specialist substance misuse service run by London Friend, the UK's oldest charity working to improve LGB & T health and well-being.

Web: www.londonfriend.org.uk/antidote
Email: antidote@londonfriend.org.uk

1. Your own employment policies

Question	Yes	No	In Progress	Comments/Action	By whom; by when
Do your employment policies include explicit reference to equality for LGB people?	☐	☐	☐		
Do you monitor sexual orientation in employees?	☐	☐	☐		
Do you monitor sexual orientation at application?	☐	☐	☐		
Do you monitor gender identity/reassignment in employees?	☐	☐	☐		
Do you monitor gender identity/reassignment at application?	☐	☐	☐		
Do you monitor staff attitudes to sexual orientation?	☐	☐	☐		
Do you monitor staff attitude to gender identity?	☐	☐	☐		
Do any staff partner benefits apply to same-sex partners?	☐	☐	☐		
Do you have a workplace policy relating to staff who undergo gender reassignment at work?	☐	☐	☐		
Does your sickness policy include time of work for staff who undergo gender reassignment?	☐	☐	☐		
Do you participate in any workplace benchmarking related to LGB equality? (E.g. Stonewall Workplace Equality Index, Diversity Champions etc.)	☐	☐	☐		
Do you undertake any workplace benchmarking related to trans equality?	☐	☐	☐		
Do you facilitate a staff network for LGB&T employees?	☐	☐	☐		

2. Creating an LGB&T welcoming environment

Question	Yes	No	In Progress	Comments/Action	By whom; by when
Do your reception areas have an LGB inclusive diversity statement on display?	☐	☐	☐		
Do your reception areas have a trans inclusive diversity statement on display?	☐	☐	☐		
Do you display posters for LGB & T services?	☐	☐	☐		
Do you have leaflets for LGB & T services?	☐	☐	☐		
Do you have any other LGB & T media on display?	☐	☐	☐		
If you provide information sheets with contact details of other organisations does this include LGB & T organisations?	☐	☐	☐		
Do you provide sexual health literature that is relevant to same-sex behaviour?	☐	☐	☐		
Do you provide sexual health literature that is relevant to trans people and their bodies?	☐	☐	☐		
Do you promote your services in a way which reaches LGB & T people?	☐	☐	☐		
Is your website inclusive of LGB people and their needs?	☐	☐	☐		
Is your website inclusive of trans people and their needs?	☐	☐	☐		

3. Interventions and referral pathways

Question	Yes	No	In Progress	Comments/Action	By whom; by when
Do you currently receive any funding to provide LGB specific interventions?	☐	☐	☐		
Do you currently receive any funding to provide trans specific interventions?	☐	☐	☐		
Do you use any of your general capacity to target interventions to LGB & T service users?	☐	☐	☐		
Do you 'sub-contract' any expertise or delivery support from an LGB & T specialist organisation?	☐	☐	☐		
Do your assessments explore the role a service user's sexual orientation or gender identity play in their treatment and support needs?	☐	☐	☐		
Do your staff have information about where to refer a service user looking for a community LGB & T-specific substance misuse service?	☐	☐	☐		
Do your staff have information about where to refer a service user looking for a residential LGB & T-friendly substance misuse service?	☐	☐	☐		
Do you staff have information about other LGB & T specific support services?	☐	☐	☐		
Do your staff have knowledge and experience of working with users of club drugs such as crystal meth, G and mephedrone?	☐	☐	☐		
Do you detox referral pathways include services experienced in providing G detoxification?	☐	☐	☐		

4. Outcome monitoring

Question	Yes	No	In Progress	Comments/Action	By whom; by when
Do you monitor sexual orientation of service users? (if yes, what is your local completion rate for this field and local breakdown?)	☐	☐	☐		
Do you monitor gender identity of service users? (if yes, what is your local completion rate for this field and local breakdown?)	☐	☐	☐		
Are you required by your commissioners to report on outcomes disaggregated by sexual orientation?	☐	☐	☐		
Are you required by your commissioners to report on outcomes disaggregated by gender identity?	☐	☐	☐		
Do you report outcomes disaggregated by sexual orientation?	☐	☐	☐		
Do you report outcomes disaggregated by gender identity?	☐	☐	☐		

5. Staff development

Question	Yes	No	In Progress	Comments/Action	By whom; by when
Do you provide training for your staff on equality and diversity issues?	☐	☐	☐		
Do you provide training for your staff on LGB issues?	☐	☐	☐		
Do you provide training for your staff on trans issues?	☐	☐	☐		
Is any of this mandatory?	☐	☐	☐		
Do you provide refresher training for your staff on LGB & T issues?	☐	☐	☐		
Do you provide training on new trends in drug use for your staff?	☐	☐	☐		
Are your clinical leads sufficiently equipped to provide supervision and guidance on working with LGB & T issues?	☐	☐	☐		
Do you require your staff to set professional development objectives that include diversity issues?	☐	☐	☐		
Are these inclusive of LGB issues?	☐	☐	☐		
Are these inclusive of trans issues?	☐	☐	☐		
Have you ever invited a local LGB & T organisation to speak to your staff about their services?	☐	☐	☐		
Do you provide your staff with information about local LGB & T services?	☐	☐	☐		

6. Compliance with Public Sector Equality Duties

Question	Yes	No	In Progress	Comments/Action	By whom; by when
Are you already aware of the Public Sector Equality Duties?	☐	☐	N/A		
Can you evidence paying 'due regard' in the exercise of your function as a public body in relation to sexual orientation as required by the Equality Act 2010?	☐	☐	☐		
Can you evidence paying 'due regard' in the exercise of your function as a public body in relation to gender reassignment as required by the Equality Act 2010?	☐	☐	☐		
Do your organisation's equality objectives include specific commitments to LGB equality?	☐	☐	☐		
Do your organisation's equality objectives include specific commitments to trans equality?	☐	☐	☐		
Do your own team's business plans and objectives include specific commitments to LGB equality?	☐	☐	☐		
Do your own team's business plans and objectives include specific commitments to trans equality?	☐	☐	☐		
Do you utilise any external benchmarking tools to assist with your analysis of performance in relation to equality & diversity? *E.g. NHS Equality Delivery System)	☐	☐	☐		

LGB&T Audit for Substance Misuse Providers: Guidance Notes

These notes accompany our audit tool for providers of substance misuse services. They give further detail on the rationale for some questions and tips for improving service provision. They should be read in conjunction with the audit tool.

Introduction

The Drugs Strategy 2010 acknowledges the need for services to be responsive to the needs of certain groups such as lesbian, gay, bisexual and transgender (LGB & T) users[80]. Evidence indicates that these populations are more likely to use alcohol and other substances, and to be using different drugs in different contexts to those typically seen in many drug services, with more emphasis on 'party' or 'recreational' drug use[8182]. Services providing targeted interventions to LGB & T people are reporting an increase in drugs such as methamphetamine and dependent use of GBL requiring supervised detoxification[83]. Service users are also indicating a preference to access interventions targeted at LGB & T people for reasons of safety, and due to a perception these services will better understand their circumstances[84].

Practitioners working with LGB & T users will not generally be required to use different interventions, except where indicated by different drugs used, but successful outcomes are more likely where the practitioner can demonstrate robust understanding of the user's circumstances and experience as an LGB or T person. It is essential to create an environment which gains trust and allows the service user to be open and frank about their substance use and other risk behaviours such as unsafe sexual practices. Partnerships with e.g. sexual health services can help with an integrated approach to care. Training to improve knowledge and awareness of the issues commonly faced by LGB & T people can help with this; LGB & T-specific sessions offer more scope than generic diversity training for adequate consideration of such issues, which most staff will never have had the opportunity to discuss in a professional setting.

Commissioners can help to improve the treatment experience through service specifications which require providers to demonstrate measures for LGB & T inclusion; through monitoring sexual orientation and gender identity; and via performance management indicators which measure outcomes for LGB & T service users. Such measures will also assist to evidence compliance with the Public Sector Equality Duty under the Equality Act[85].

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[80] http://www.homeoffice.gov.uk/drugs/drug-strategy-2010/
[81] http://85.13.242.12/publication/drugs-diversity-lgbt-groups-policy-briefing/
[82] http://www.lgf.org.uk/potp
[83] Antidote saw an increase from 0% of service users reporting crystal meth use in 2004/5 to 49% in 2013/4; 1.7% reporting G use in 2004/5 to 44% in 2013/4.
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1. Your own employment policies

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[86] http://www.equalityhumanrights.com/advice-and-guidance/your-rights/transgender/transsexual-people-your-rights-relating-to-privacy/
[87] http://www.equalityhumanrights.com/advice-and-guidance/public-sector-equality-duty/

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2. Creating an LGB & T welcoming environment

This section is about how you can create an environment which allows LGB & T service users to feel confident that your service is a place where they can feel safe and be open about their issues. Past experience of discrimination in services can mean LGB & T service users are cautious about disclosure for fear of harassment of less favourable treatment by staff or other service users.

We all know how much first impressions count. LGB & T people will often look for visual clues as to how 'friendly' your service is. Displaying equality and diversity statements, that explicitly include LGB & T people, can provide reassurance, although statements alone are only part of the solution; they need to be backed up by competent service delivery. Other visual signs of inclusion include displaying posters for LGB &T-specific service, or carrying their leaflets, or including LGB & T lifestyle magazines if you carry a range of other publications.

A common complaint of LGB & T people is that sexual health information and advice focusses on pregnancy and contraception; whilst this may be of relevance to some LGB & T people, when heterosexuality is assumed it can feel excluding, or the information be of no relevance. Sexual identity and behaviour (which may not always match identity) should be explored where relevant to the person's issues, and appropriate sexual health advice provided. Antidote has

[88] http://www.stonewall.org.uk/at_work/

seen a sharp increase in the correlation between using certain drugs and sexual activity, with many people feeling guilt or shame when reflecting on their behaviour afterwards. It is vital that issues of sexual behaviour and identity are handled sensitively and with understanding. Sexual health information for trans people is available from THT[89][90].

Finally this section asks about the way you publicise your services and whether this is accessible to LG & T people. Good practice here may include ensuring local LGB & T services carry your literature, and whether this has indicators of relevance to LGB & T people. It also may include ensuring local LGB & T services, or services with higher levels of LGB & T attendance such as sexual health, are aware of how to refer, and that you offer an LGB & T competent service.

3. Interventions and referral pathways

This section looks at the services you provide and how you provide them. Firstly it asks whether you are funded to provide any specific interventions for LGB & T people. Even if you are not, you have a duty to consider the needs of LGB & T people in planning and delivering your programmes. To achieve this, one option may be to consider allocating a portion of your resources – one evening a week, for example – to providing a specialist group or drop-in service.

You may wish to consider a partnership with a local LGB & T service to deliver a satellite session. Additionally you might consider sub-contracting, or buying in time and expertise from a specialist LGB & T service to help you provide targeted interventions. These options also help evidence that you have complied with the Public Sector Equality Duties under the Equality Act 2010.

Assessments are the point at which the relationship between somebody's sexual orientation and/or gender identity and their substance use can be explored. There may be no correlation, but equally a person's use may be linked, e.g. as a coping mechanism for dealing with homophobic or transphobic harassment, or as an intrinsic link to their lifestyle. (Gay bars, clubs and other social outlets are often the place people will first explore their identity, so alcohol and drug use is often closely linked wit this.) Monitoring can also act as the trigger for further discussion of the relevance to their presenting issue. Over the years we have heard anecdotal evidence of people never disclosing their sexual orientation, even though their substance use was so closely linked, purely because they were never asked the question.

This section also looks at the information resources you have available for staff about LGB & T specific support services, where requested, and referral pathways into safe, competent other services. Finally it examines whether your staff have awareness of working with the different drugs that are emerging as prevalent amongst LGB & T people.

4. Outcome monitoring

[89] http://www.tht.org.uk/sexual-health/Resources/Publications/Trans/Trans-Women-Trans-Health-Matters
[90] http://www.tht.org.uk/sexual-health/Resources/Publications/Trans/Transmen-Trans-Health-Matters

This section looks at the essential issue of monitoring sexual orientation and gender identity. Specifically it looks at how you can improve monitoring and drive reporting of outcomes for your LGB & T service users. Research about LGB & T people remains relatively poor as a direct result of not recording these characteristics as standard practice. Outcomes cannot be disaggregated by these characteristics without routine monitoring of this data, which compounds the cyclical problem. LGB & T organisations regular cite monitoring as one of the highest priorities to improve knowledge and outcomes for these groups[91].

Monitoring service users' sexual orientation can be a sensitive issue, but need not be problematic. Concerns can always be addressed through simple training (and performance management if required). The NTA currently requests this information in some regions but completion rates are typically poor, with fields left blank, or staff assuming heterosexuality. As a provider you can performance manage better collation of this data. The Lesbian & Gay Foundation has produced a guide, commissioned by NHS North West, which provides further information on monitoring sexual orientation in health settings[92].

Monitoring gender identity requires some different considerations to monitoring sexual orientation. Care should be taken not to conflate the two. Many trans people who have undergone gender reassignment do not wish to be detected and will not be happy to disclose their trans history. Many may have experienced harassment or violence and be afraid to disclose if they do not know how safe it will be. However, not monitoring compounds the lack of information related to trans health needs and increases the invisibility of those trans people who wish to identify as such. It is essential that monitoring is carried out with sensitivity, but again this is something which can be easily addressed through training. The charity GIRES (Gender Identity Research and Education Society) has developed a quick-start guide which provides an introduction to some of the issues[93].

This section finishes by checking whether you report on outcomes disaggregated by these two characteristics. Reporting this provides you with performance indicators on how well your LGB & T service users are provided for, whether they are achieving drug-free outcomes and satisfaction with the service. Routine monitoring allows disaggregation across your full range of performance indicators.

5. Staff development

This section looks at ensuring your managerial and service delivery staff are equipped with adequate knowledge and experience to meet the needs of your LGB & T populations. It looks at whether you provide or facilitate access to equality and diversity training, and whether this also includes specific training on LGB & T issues. Diversity training is typically a minimum requirement, but often overlooks the specific issues related to sexual orientation, and particularly gender identity. As stated above staff have often never had the opportunity to

[91] http://nationallgbtpartnershipdotorg.files.wordpress.com/2012/07/national-lgbt-partnership-manifesto3.pdf
[92] http://www.lgf.org.uk/Our-services/Campaigns/sexual-orientation-monitoring-guide/
[93] http://www.gires.org.uk/assets/Workplace/Monitoring.pdf

consider these issues, and how their practice may impact on service users, in a professional setting.

This section also looks at providing training around new drug trends. The UKDPC research highlights that LGB & T people may be 'early adopters' of new drugs[94]. This has also been the experience of Antidote in relation to crystal meth and G.

6. Compliance with Public Sector Equality Duties

This section aims to support you in evidencing how you meet your Public Sector Equality Duties under the Equality Act 2010. The Act places general and specific duties on Public Bodies to demonstrate compliance[95]. Public Bodies include NHS Trusts, PCTs and local authorities. As a provider you essentially contracted to perform a function of a public body and you should be able to evidence that you have met the requirements of the Duty.

Although monitoring is not explicitly required by the Duty it has many other benefits in demonstrating outcomes for service users and commitment to diversity issues for service users and staff. The Duty does require you to be able to demonstrate how you have considered issues for the protected groups in the planning and delivery of your services, what the Act calls having "due regard". Any specific work you have done can help evidence your compliance, such as engagement, needs assessment, targeted commissioning, facilitating training etc.

The Duty applies at senior level, such as the requirement to publish equality information and objectives, but good practice also includes inclusion at your own provider level, so incorporating objectives into your own team or local business planning is an example of how equality is embedded throughout the organisation. You may wish to set general diversity objectives and consider the outcomes from an LGB & T perspectives, or set specific objectives relating to developing work with these groups.

The Act does not require the completion of a formal Equality Impact Assessment, but these tools, or similar equality analysis of your policies, practice, and planning are still extremely useful to complete as they provide assurance that consideration has not been overlooked, and will help evidence compliance with the Duty.

Finally this section asks about the use of any benchmarking tools you may use to help assess performance on equality, such as the NHS Equality Delivery System.

[94] http://85.13.242.12/publication/drugs-diversity-lgbt-groups-policy-briefing/
[95] http://www.homeoffice.gov.uk/equalities/equality-act/equality-duty/

Next steps

Once you have completed the audit you will have a clearer idea of where you are already performing well, and where more attention is needed. You can use it to begin action planning, and think about how you embed some of the issues and needs into the ongoing operation of your service. For example, you may wish to task a member of staff with ensuring your service environment reflects diversity, or you may include specific actions in your business plan for senior managers.

Achieving successful outcomes for all your diverse populations need not be difficult, but will require some additional thought. Antidote is available for support and offers a wide range of professional services to help ensure your practice is LGB & T aware and competent.

Appendix C: Audit tools & guidance for practitioners

LGB&T Audit for Substance Misuse Practitioners

This audit tool allows you to assess your own performance across a range of indicators in providing services that are inclusive of lesbian, gay, bisexual and trans service users. It also allows you to identify actions that can be taken to improve the overall competence of your ability to work effectively with people from these groups, and demonstrating successful outcomes for them.

The audit tool is a checklist; it is not expected to be the only action you will need to take. It will assist in identifying areas which require a change of practice, or that need to be incorporated into your own personal development plans or into personal objectives in appraisals, for example. You may also need to work with your colleagues and service managers and specialist LGB & T providers. A similar tool has been produced for commissioners and service managers to evaluate their own LGB & T inclusiveness.

A guidance document has been produced to accompany this audit, giving further detail on the rationale for some questions and tips for improving service provision. It should be read in conjunction with this audit tool.

Antidote @ London Friend is happy to provide further support, and this work forms part of a developing package of LGB & T support interventions. Antidote is the specialist substance misuse service run by London Friend, the UK's oldest charity working to improve LGB & T health and well-being.

Web: www.londonfriend.org.uk/antidote
Email: antidote@londonfriend.org.uk

1. Creating an LGB & T welcoming environment

Question	Yes	No	In Progress	Comments/Action	By whom; by when
Do your reception areas have an LGB inclusive diversity statement on display?	☐	☐	☐		
Do your reception areas have a trans inclusive diversity statement on display?	☐	☐	☐		
Do you display posters for LGB & T services?	☐	☐	☐		
Do you have leaflets for LGB & T services?	☐	☐	☐		
Do you have any other LGB & T media on display?	☐	☐	☐		
If you provide information sheets with contact details of other organisations does this include LGB & T organisations?	☐	☐	☐		
Do you provide sexual health literature that is relevant to same-sex behaviour?	☐	☐	☐		
Do you provide sexual health literature that is relevant to trans people and their bodies?	☐	☐	☐		
Do you promote your services in a way which reaches LGB & T people?	☐	☐	☐		
Do you challenge homophobic/transphobic language when used by service users?	☐	☐	☐		
Do you include LGB & T issues and perspectives in discussion groups with service users?	☐	☐	☐		

2. Interventions and referral pathways

Question	Yes	No	In Progress	Comments/Action	By whom; by when
When assessing a client do you explore the role a service user's sexual orientation or gender identity play in their treatment and support needs?	☐	☐	☐		
Do you have information about where to refer a service user looking for a community LGB & T-specific substance misuse service?	☐	☐	☐		
Do you have information about where to refer a service user looking for a residential LGB & T-friendly substance misuse service?	☐	☐	☐		
Do you have information about other LGB & T specific support services?	☐	☐	☐		
Do you have knowledge and experience of working with users of club drugs such as crystal meth, G and mephedrone?	☐	☐	☐		
Do you know how to make a referral to detox services that are experienced in providing G detoxification?	☐	☐	☐		
Do you feel able to discuss same-sex sexual risk and behaviour frankly with service users?	☐	☐	☐		
Are you able to give accurate sexual health advice relating to same sex activity?	☐	☐	☐		
Are you able to provide HIV prevention information relating to sexualised drug-use?	☐	☐	☐		
Are you able to give sexual health information that is relevant to trans people and the anatomy of their bodies?	☐	☐	☐		

3. Demographic monitoring

Question	Yes	No	In Progress	Comments/Action	By whom; by when
Do you monitor the sexual orientation of service users?	☐	☐	☐		
Do you monitor the gender identity of service users?	☐	☐	☐		
Do you know how to explain to a service user why you are asking about their sexual orientation?	☐	☐	☐		
Do you know how to explain to a service user why you are asking about their gender identity?	☐	☐	☐		
Do you know how to respond to a client who reacts negatively to being asked about their sexual orientation or gender identity?	☐	☐	☐		
Do you use a client's disclosure as LGB and/or T to direct appropriate further exploration of their issues?	☐	☐	☐		

4. Professional development

Question	Yes	No	In Progress	Comments/Action	By whom; by when
Have you had training on equality and diversity issues?	☐	☐	☐		
Have you had training on LGB issues?	☐	☐	☐		
Have you had training on trans issues?	☐	☐	☐		
Have you had training on new drug trends?	☐	☐	☐		
Do you set appraisal objectives that include addressing LGB & T issues?	☐	☐	☐		

5. Compliance with Public Sector Equality Duties

Question	Yes	No	In Progress	Comments/Action	By whom; by when
Are you already aware of the Public Sector Equality Duties under the 2010 Equality Act?	☐	☐	N/A		
Can you be sure that your practice is compliant with your organisation's requirements under the Public Sector Equality Duties in relation to sexual orientation?	☐	☐	☐		
Can you be sure that your practice is compliant with your organisation's requirements under the Public Sector Equality Duties in relation to gender reassignment?	☐	☐	☐		

LGB & T Audit for Substance Misuse Practitioners: Guidance Notes

These notes accompany our audit tool for practitioners in substance misuse services. They give further detail on the rationale for some questions and tips for improving your own practice working with LGB & T service users. They should be read in conjunction with the audit tool.

Introduction

The Drugs Strategy 2010 acknowledges the need for services to be responsive to the needs of certain groups such as lesbian, gay, bisexual and transgender (LGB & T) users[96]. Evidence indicates that these populations are more likely to use alcohol and other substances, and to be using different drugs in different contexts to those typically seen in many drug services, with more emphasis on 'party' or 'recreational' drug use[9798]. Services providing targeted interventions to LGB & T people are reporting an increase in drugs such as methamphetamine and dependent use of GBL requiring supervised detoxification[99]. Service users are also indicating a preference to access interventions targeted at LGB & T people for reasons of safety, and due to a perception these services will better understand their circumstances[100].

Practitioners working with LGB & T users will not generally be required to use different interventions, except where indicated by different drugs used, but successful outcomes are more likely where the practitioner can demonstrate robust understanding of the user's circumstances and experience as an LGB or T person. It is essential to create an environment which gains trust and allows the service user to be open and frank about their substance use and other risk behaviours such as unsafe sexual practices. Partnerships with e.g. sexual health services can help with an integrated approach to care. Training to improve knowledge and awareness of the issues commonly faced by LGB & T people can help with this; LGB & T-specific sessions offer more scope than generic diversity training for adequate consideration of such issues, which most staff will never have had the opportunity to discuss in a professional setting.

Commissioners can help to improve the treatment experience through service specifications which require providers to demonstrate measures for LGB & T inclusion; through monitoring sexual orientation and gender identity; and via performance management indicators which

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[96] http://www.homeoffice.gov.uk/drugs/drug-strategy-2010/
[97] http://85.13.242.12/publication/drugs-diversity-lgbt-groups-policy-briefing/
[98] http://www.lgf.org.uk/potp
[99] Antidote saw an increase from 0% of service users reporting crystal meth use in 2004/5 to 49% in 2013/4; 1.7% reporting G use in 2004/5 to 44% in 2013/4.
[100] http://85.13.242.12/publication/drugs-diversity-lgbt-groups-policy-briefing/

measure outcomes for LGB & T service users. Such measures will also assist to evidence compliance with the Public Sector Equality Duty under the Equality Act[101].

About this guidance

We have separated many questions into effectively two halves, asking the same question in relation to sexual orientation (LGB) and gender identity (T). This is to ensure attention is given to both LGB and T people equally. The needs of each group have some overlap but can be quite distinct, with people mistakenly believing trans issues are covered where in effect only issues relating to sexual orientation are.

The term gender identity is used throughout to denote the broad spectrum of identities that may fall under the trans heading. For the purpose of the Equality Act 2010, the 'protected characteristic' relating to trans people is 'gender reassignment'. A person is said to enjoy protection on the grounds of possessing this characteristic if they have undergone, are undergoing or intend to undergo any process of gender reassignment. A person is not required to be doing, or have done this, under medical supervision; social transition (living in a gender role which is different to the sex assigned at birth) is sufficient to be protected under the Act.

Some trans people fall outside of this description, because their gender identity does not fit a pattern of changing one binary gender role (male or female) to another; considering gender identity ensures that good practice is managed for all gender non-conforming people.

For most questions we have provided a yes, no, and in progress response, the later denoting where some consideration has been made but work is still yet to do on this issue. In general you should be aiming to moving from no to yes responses over a period of assessment and ensuing improvement actions.

1. Creating an LGB & T welcoming environment

This section is about how you can create an environment which allows LGB & T service users to feel confident that your service is a place where they can feel safe and be open about their issues. Past experience of discrimination in services can mean LGB & T service users are cautious about disclosure for fear of harassment of less favourable treatment by staff or other service users.

We all know how much first impressions count. LGB & T people will often look for visual clues as to how 'friendly' your service is. Displaying equality and diversity statements, that explicitly include LGB & T people, can provide reassurance, although statements alone are only part of the solution; they need to be backed up by competent service delivery. Other visual signs of inclusion include displaying posters for LGB &T-specific service, or carrying their leaflets, or including LGB & T lifestyle magazines if you carry a range of other publications.

[101] http://www.homeoffice.gov.uk/equalities/equality-act/equality-duty/

A common complaint of LGB & T people is that sexual health information and advice focusses on pregnancy and contraception; whilst this may be of relevance to some LGB & T people, when heterosexuality is assumed it can feel excluding, or the information be of no relevance. Sexual identity and behaviour (which may not always match identity) should be explored where relevant to the person's issues, and appropriate sexual health advice provided. Antidote has seen a sharp increase in the correlation between using certain drugs and sexual activity, with many people feeling guilt or shame when reflecting on their behaviour afterwards. It is vital that issues of sexual behaviour and identity are handled sensitively and with understanding. Sexual health information for trans people is available from THT[102][103].

This section asks about the way you publicise your services and whether this is accessible to LGB & T people. Good practice here may include ensuring local LGB & T services carry your literature, and whether this has indicators of relevance to LGB & T people. It also may include ensuring local LGB & T services, or services with higher levels of LGB & T attendance such as sexual health, are aware of how to refer, and that you offer an LGB & T competent service.

Finally this section asks you to think about whether you feel confident to challenge homophobic, biphobic, or transphobic comments and attitudes from other service users. For an LGB or T service user how effectively you are seen to do this could mean the difference between whether they come back to the service, or how comfortable they feel continuing to attend. One way of ensuring service users attitudes can be explored and challenged is by ensuring that the content of sessions, for example sessions which discuss social issues, includes discussion of LGB & T issues, or looks at them from an LGB or T perspective. Case studies featuring LGB & T people can also help here.

2. Interventions and referral pathways

This section looks at the service you provide and how you provide it. Assessments are the point at which the relationship between somebody's sexual orientation and/or gender identity and their substance use can be explored. There may be no correlation, but equally a person's use may be linked, e.g. as a coping mechanism for dealing with homophobic or transphobic harassment, or as an intrinsic link to their lifestyle. (Gay bars, clubs and other social outlets are often the place people will first explore their identity, so alcohol and drug use is often closely linked wit this.) Monitoring can also act as the trigger for further discussion of the relevance to their presenting issue. Over the years we have heard anecdotal evidence of people never disclosing their sexual orientation, even though their substance use was so closely linked, purely because they were never asked the question.

This section also looks at the information resources you have available for about LGB & T specific support services, where requested, and referral pathways into safe, competent other services. It examines whether you have awareness of working with the different drugs that are emerging as prevalent amongst LGB & T people.

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[102] http://www.tht.org.uk/sexual-health/Resources/Publications/Trans/Trans-Women-Trans-Health-Matters

[103] http://www.tht.org.uk/sexual-health/Resources/Publications/Trans/Transmen-Trans-Health-Matters

Finally this section looks at how comfortable you feel discussing sex and sexual risk behaviour with clients. Increasing we have seen clients using drugs to facilitate sex and it is essential that you can engage in these discussions without embarrassment and by creating an environment where a client feels they can talk openly without fear of being judged. It asks how competent you feel discussing sexual risk management and HIV prevention in connection with managing drug risk. It also asks about your competence to discuss sexual health with trans people in a manner which is appropriate and sensitive to their anatomy; people's sexual health education may have been at a time before their bodies changed (if they have undergone surgery), or they may require screening appropriate to birth sex (e.g. a trans man needing cervical smear testing).

3. Demographic monitoring

This section looks at the essential issue of monitoring sexual orientation and gender identity. Specifically it looks at how you can improve monitoring and drive reporting of outcomes for your LGB & T service users. Research about LGB & T people remains relatively poor as a direct result of not recording these characteristics as standard practice. Outcomes cannot be disaggregated by these characteristics without routine monitoring of this data, which compounds the cyclical problem. LGB & T organisations regular cite monitoring as one of the highest priorities to improve knowledge and outcomes for these groups[104].

Monitoring service users' sexual orientation can be a sensitive issue, but need not be problematic. Concerns can always be addressed through simple training (and performance management if required). The National Treatment Agency/Public Health England currently requests this information in some regions but completion rates are typically poor, with fields left blank, or staff assuming heterosexuality. As a provider you can performance manage better collation of this data. The Lesbian & Gay Foundation has produced a guide, commissioned by NHS North West, which provides further information on monitoring sexual orientation in health settings[105].

Monitoring gender identity requires some different considerations to monitoring sexual orientation. Care should be taken not to conflate the two. Many trans people who have undergone gender reassignment do not wish to be detected and will not be happy to disclose their trans history. Many may have experienced harassment or violence and be afraid to disclose if they do not know how safe it will be. However, not monitoring compounds the lack of information related to trans health needs and increases the invisibility of those trans people who wish to identify as such. It is essential that monitoring is carried out with sensitivity, but again this is something which can be easily addressed through training. The charity GIRES (Gender Identity Research and Education Society) has developed a quick-start guide which provides an introduction to some of the issues[106].

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[104] http://nationallgbtpartnershipdotorg.files.wordpress.com/2012/07/national-lgbt-partnership-manifesto3.pdf
[105] http://www.lgf.org.uk/Our-services/Campaigns/sexual-orientation-monitoring-guide/
[106] http://www.gires.org.uk/assets/Workplace/Monitoring.pdf

Integral to this section are questions about your competence in informing clients why you ask about this information. It is vital to be able to explain to a service user why this information is needed. It also asks about how you would respond to a service user who reacted negatively to these questions. Finally there is a prompt to remind you that disclosure as LGB and/or T is an opportunity to open up further discussion of the client's needs and to ensure appropriate care planning or referrals can be made.

4. Professional development

This section looks at ensuring you are equipped with adequate knowledge and experience to meet the needs of your LGB & T populations. It looks at whether you have had equality and diversity training, and whether this also includes specific training on LGB & T issues. Diversity training is typically a minimum requirement, but often overlooks the specific issues related to sexual orientation, and particularly gender identity.

This section also looks at training around new drug trends. The UKDPC research highlights that LGB & T people may be 'early adopters' of new drugs[107]. This has also been the experience of Antidote in relation to crystal meth and G.

The section also encourages you to think about setting professional development objectives that look at improving practice for LGB & T clients. Actions which arise from completing this audit could be incorporated into this to ensure progress can be recorded and monitored.

5. Compliance with Public Sector Equality Duties

This section aims to support you in evidencing how you meet your Public Sector Equality Duties under the Equality Act 2010. The Act places general and specific duties on Public Bodies to demonstrate compliance[108]. Public Bodies include NHS Trusts, PCTs and local authorities. As a provider your organisation is essentially contracted to perform a function of a public body and should be able to evidence that it has met the requirements of the Duty. As an employee you play a vital part in ensuring that the practice of your organisation does not discriminate on the grounds of a list of 'protected characteristics' which include sex, age, ethnicity, disability, religion & belief, sexual orientation, gender reassignment, marriage/civil partnership status, and pregnancy & maternity. In the terms of the Act this is known as paying "due regard" to these groups.

The Duty applies at senior level, such as the requirement to publish equality information and objectives, but good practice also includes inclusion at your own level, so incorporating objectives into your own or team planning is an example of how equality is embedded throughout the organisation.

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[107] http://85.13.242.12/publication/drugs-diversity-lgbt-groups-policy-briefing/
[108] http://www.homeoffice.gov.uk/equalities/equality-act/equality-duty/

This section asks you to consider your own role in ensuring your organisation complies with the Duty, and how you can ensure your own practice does not discriminate. Being able to demonstrate things such as having received LGB & T awareness training, or having used this audit to review your own practice could be evidence that you have paid “due regard” to diverse populations as required under the Duty.

Next steps

Once you have completed the audit you will have a clearer idea of where you are already performing well, and where more attention is needed. You can use it to begin action planning, and think about how you embed some of the issues and practices into your own work. For example, you may wish to take on responsibility to ensuring your service environment reflects diversity, or you may include personal development objectives to increase your knowledge of a particular issue such as HIV or the drugs commonly used by LGB & T people.

Achieving successful outcomes for all your diverse populations need not be difficult, but will require some additional thought. Antidote is available for support and offers a wide range of professional services to help ensure your practice is LGB & T aware and competent.

Appendix D: Focus group questions

These are the questions that were used to facilitate discussion with service users in focus groups.

1. Have you sought support from a drug and alcohol service which works specifically with LGBT people. Was this important to you, and if so why?

   a) What is your experience of accessing mainstream services? Do you feel your issues are understood?
   b) If you haven't accessed mainstream services why not? Why did you think Antidote would be a better service for you?

2. What do you feel are the biggest issues that need to be addressed for LGBT people who experience problems around drugs or alcohol?

   a) Have these changed in recent years? If so, how?

3. When you were using did you feel you had adequate information about the risks associated with the drugs you were using?

   a) If not, what would have helped?
   b) What information would have helped you be better informed?
   c) How should such information be available?

4. What kind of services would you like to be able to access?

   a)Prompts: Think about the locations, times, access, etc., and also about the types of support that services can provide.
   b) Prompts: drug treatment services, NHS, charities, GUM, hospitals, GP, elsewhere.
   c) Prompts: one-to-one, groups, drop-in, complementary therapies, relapse prevention, online, apps, SMS, telephone, 12-step, 'check-in'/'touch-base' services, etc.

5. Have you had any negative reactions relating to the fact you're LGBT when you've accessed health services?

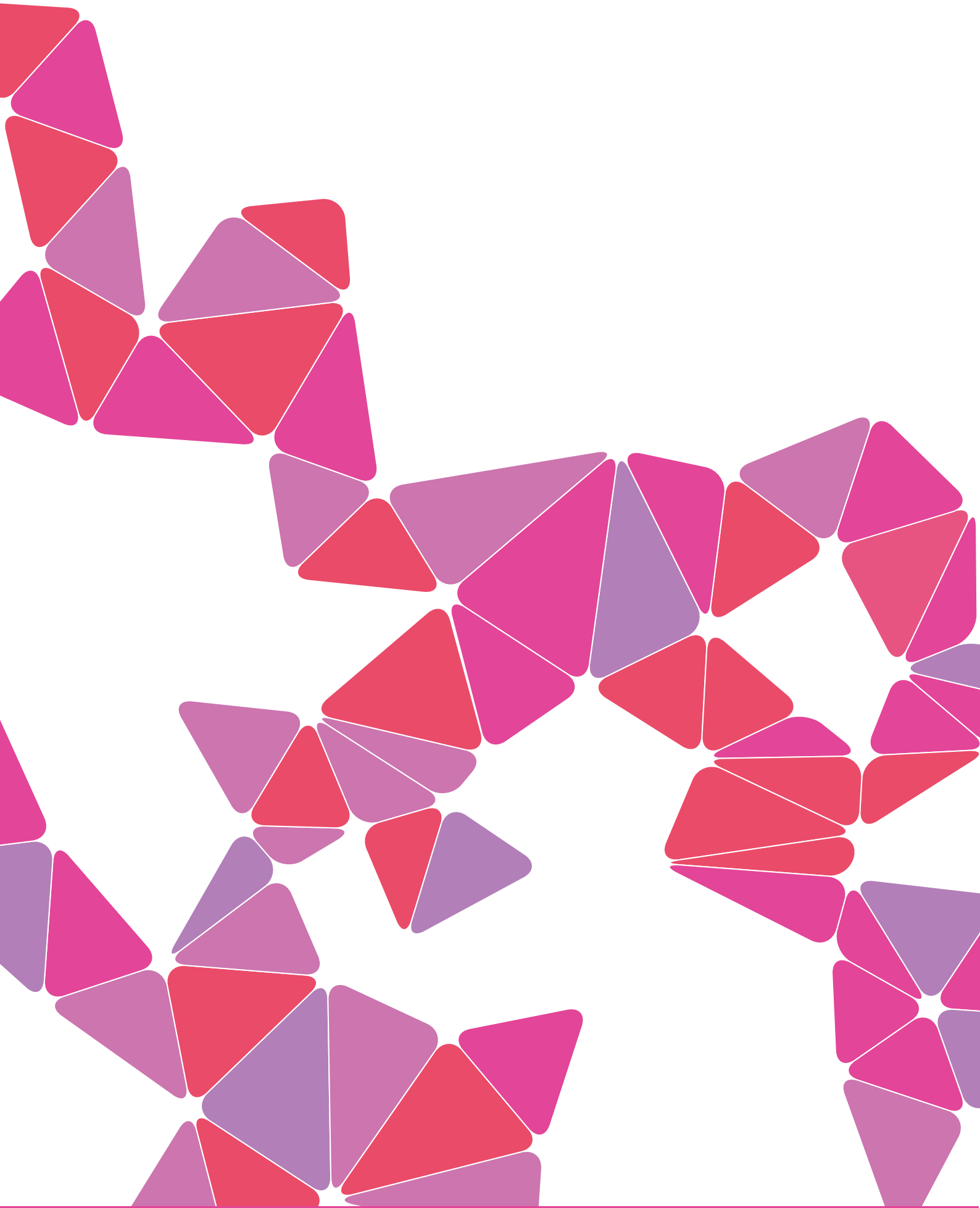
   a) Did this put you off going back?
   b) Would it put you off seeking support in the future?

6. The commissioning of drug services is done locally within local authorities, and most services are only open to people who live in that authority. Do you think this is the right approach?

   a) Do you think this approach meets the needs of LGBT people? Why?

7. What do you think is the best approach for services for LGBT people – specialist services or mainstream services that meet LGBT need? Why?

   a) What can mainstream services do to be more LGBT inclusive?!



London Friend
86 Caledonian Road
London, N1 9DN

+44 (0)20 7833 1674
www.londonfriend.org.uk
office@londonfriend.org.uk