Part of the Picture
The National LGB Drug & Alcohol Database

Part of the Picture:

Lesbian, gay and bisexual people's alcohol and drug use in England

Case Studies: Experiences of accessing help, advice or support for drug and alcohol use

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Introduction

The nine case studies in this report are presented as a part of the data collected during Part of the Picture (POTP). Part of the Picture (POTP) is a five year study exploring drug and alcohol use among lesbian, gay and bisexual (LGB) people in England. It is funded by the Big Lottery and delivered in partnership between The Lesbian & Gay Foundation (LGF) and the University of Central Lancashire (UCLan).

The study's findings are available as a suite of reports at www.lgf.org.uk/potp. These present the current evidence base on LGB people's drug and alcohol use and highlight key issues such as substance dependency and help-seeking behaviour. A Case Studies report published in 2013 explored the experiences of three LGB drug and alcohol users, including the changing relationship of drugs and alcohol to their lives over time. This report presents a further nine case studies exploring LGB people's experiences of seeking help, advice or support for their drug or alcohol use.

Methodology

The nine people whose stories are told here responded to an advertisement in the The Lesbian & Gay Foundation's website and weekly e-bulletin throughout November – December 2013, or to an advertisement promoted through LGB&T groups nationwide. They were selected from a pool of possible respondents on the basis that:

- They identified as LGB people who use or have used drugs and/or alcohol
- They had accessed help, advice or support for a substance use issue

While we were clear that this could include help, advice or support from a range of services (e.g. substance use services, the internet, friends and family, a GP, a telephone helpline, self-help books etc.) the majority of respondents had accessed formal substance use services.

Respondents were offered the choice of telephone or face-to-face interviews. All respondents chose telephone interviews, and these were conducted in December 2013. They followed a structured approach with questions focussed on why the respondent felt that they needed help, advice or support; what help, advice or support they accessed; and what impact this had on them and their substance use.

The interviews were analysed by a panel of three researchers from the project team, written up as case studies and thematic analysis conducted across the nine, presented below.

We invite you to read the case studies below and to reflect on them in your own time in order to extract your own meaning. We hope you enjoy reading them and extend our warmest thanks to the respondents for their candour and for allowing us in to such intimate areas of their own lives. The names of the characters have been changed in order to preserve their anonymity and other identifying features of their stories have also been removed.

Thematic analysis

One of the key themes emerging from the interviews was that the journeys of LGB people accessing help, advice and support for their substance use are not linear. Most respondents had gone through ups and downs, and several had more than one distinct period of problematic use followed by recovery. Others had addressed their dependency on one substance and were now able to manage their use of other substances: more than one male respondent had overcome dependency on one drug, but was now managing use of other drugs without problems.

The majority also had positive experiences of substance use services, and had successfully addressed their substance use as a result. However, no experience was straightforward and there were issues that had to be worked out along the way.

A common theme among respondents was experience of being the 'outsider'. For Andy, this was a motivation for beginning to use drugs, as part of the acid house scene; he perceived substance use as something everyone was doing, and says he simply wanted to be the same as them. As he grew older, he felt he 'fitted-in' less, and in distancing himself from the scene, began to recognise his substance use as problematic.

Several respondents described feeling like an outsider when accessing mainstream services. Tom was referred to a methadone programme by his GP, but describes accessing the service as frightening and degrading. He describes some of the other service users as desperate, and he wasn't used to mixing with people like that. Ross accessed a drug and alcohol service, and acknowledges a certain snobbery in himself linked to his perceptions of what such a service would be like.

Other respondents talked about feeling like an outsider in services because they thought they were the only LGB person there and were afraid of coming out, or because they thought that others wouldn't understand their life experiences. This meant that they weren't able to be honest and open with support workers or peers, which had an impact on their ability to fully commit to the service. Victoria also complains about medical and support staff who had tried to ascribe her drinking to her sexual orientation, or to suggest that her sexual orientation was the problem rather than her drinking. She found this unhelpful, and concluded that you need to be fearless to be in services as an LGB person.

This anxiety about not fitting-in in services, and not being seen (or not wanting to be seen) as a stereotypical drug addict, is likely linked to the class, educational attainment level and employment status of the respondents. This must be considered in the context of changing patterns of drug use, such as the popularity of club drugs among 'high functioning' gay men. Outsider status was also linked to being LGB. Victoria describes being afraid to come out to group work peers in rehab, and unable to be honest with her AA sponsor for fear that she wouldn't understand her experiences. Susie is part of a recovery community, but isn't aware of any other LGB people within it. She doesn't talk about her sexual orientation and says she feels like an outsider when the other women talk about their husbands and children.

A significant number of the respondents disclosed that they had mental health problems, including autism, obsessive compulsive disorder, and bipolar disorder. There is evidence that LGB people are more likely to both experience poor mental health and to use substances than heterosexual people; the links between sexual orientation, substance use and poor mental health are not yet clear and deserve further exploration. David says that his drug use is related to his bipolar disorder, and recognises it as a form of self-medication. He describes it as a 'chicken and egg' situation, unsure which one causes the other. Matthew chose to access an LGB-specific counselling service to address his alcohol use because he felt that his issues were wider than substance use. The service allowed him to address the issues that had caused his excessive drinking and which drinking had then masked.

For Victoria and Ross, the original motivation to access help for their substance use was an attempt to save their relationships with others. Ross describes how he hadn't given much thought to what getting help for his drug use would involve before saying that he would do so in an attempt to persuade his partner to stay.

He was successful in addressing his problem with amphetamines, in part because of the practical support his partner was able to give him during his recovery. Victoria first accessed help for her alcohol use when it started to put strain on her relationships with her friends, family and partner, but admits that she did this for others not for herself and that she did not get the right help at the time.

Many of the respondents managed to hold down jobs while accessing substance use services, and for David and Matthew, the effect of their substance use on their ability to perform at work was the main motivation for the decision to get help. Conversely for Jan, it was when she lost her job and had, as she describes it, time to think that she realised she had a problem with alcohol. Victoria was successful in her career, but working from home enabled her to drink more regularly.

The majority of the respondents had gone to their GP for support with their substance use. This seemed to be based on a perception that a GP would be able to refer them to a professional service, and could deal with their range of issues, not just their substance use. Friends and family were mentioned as motivations for seeking help or sources of support while in recovery, but only Ross had gone to a close friend to seek help from him. While the internet was the most popular source of information, advice or help in the Part of the Picture questionnaire, only one respondent talked about using the internet and he felt that the information he needed was difficult to obtain.

Experiences of GPs varied. Andy describes his as amazing, someone who took the time to listen to him and get beneath the surface of what was going on. Jan had gone to her GP in the last three months to ask for help, but was still waiting for a referral for a mental health assessment and suspects that he hadn't actually made it. Tom's GP recognised his dependency on prescribed morphine and took him off it, but without a managed programme he went into withdrawal and decided to start using heroin as a replacement.

The most important factor in a successful relationship with a substance use service worker appeared to be trust in that person and in the organisation. Aoife was already accessing support for her mental health problems when she decided to address her substance use. An established relationship with her Community Psychiatric Nurse allowed her to talk about her substance use with that person; she says there had to be a trusting relationship there before she could have such a conversation, and she wouldn't have gone to a GP or anyone else who didn't know her.

Ross was reassured by the fact that his key worker was a recovered addict himself, and saw the benefit of the worker being able to draw on his own experiences to help him. The worker was a straight man, however, and Ross thinks that he may have been more open with an LGB&T worker who would have better understood his life experiences. Jan first accessed a service specifically for military veterans, and although she had lost her job in the military due to her sexual orientation, this particular service gave her a sense of community.

Talking therapies were popular among the respondents, as they allowed them to address the root cause of their substance use. David and Matthew specifically chose to access services which would address their mental health problems as well. Jan, who is currently experiencing problematic alcohol use, feels that having someone to talk to when she needs it would help her now and would positively influence her behaviour.

For several respondents, the structure of services had made their journey difficult or even created barriers to their recovery. Susie's substance use issues were identified at a young age by her school, and she was able to access a specific young person's service which she describes as very helpful. On reaching the age of 18 however, she felt forced into adult services, which were intimidating and made her feel like an outsider again. A gradual or supported transition between services would have better suited Susie, but this was not available.

Tom's experience of a methadone replacement programme was of a service not meeting his needs as an individual. He felt he had been labelled as a heroin addict and therefore seen as incapable of making rational decisions, and was actually dissuaded from trying to reduce his methadone intake by workers at the service.

Tom eventually managed to get off methadone himself, and says that an opportunity to negotiate a way of addressing his use would have improved his experience of help-seeking.

The service Victoria accessed to address her alcohol use offered her one-to-one sessions with a care navigator, but she found the service difficult to access as she could only be seen if sober on the day. She describes being turned away at times when she needed help and missing many appointments because of this policy. David too disliked the constraints that a substance use service put on him, such as attending regular drug tests that would disrupt his work and his ability to continue a relatively normal life. He felt that they didn't treat him as an individual and didn't have options that suited his needs.

Andy's experience of mental health services was of a psychiatric ward where no-one consulted him about how he felt, and of a mental health crisis team that didn't recognise him as being in crisis, even when he felt he needed their support. He talked about being passed from GP to psychiatrist to crisis team and back again, a situation he described as being in limbo. Both Andy and Jan had previously accessed group support services that suited their needs, but were left unsupported when these services were closed due to funding. Jan's story, too, suggested that although she now felt she knew what support she needed, her problems did not meet a certain criteria for referral to services.

For many respondents, support was needed when they had completed (or were close to) recovery in terms of social support and development of social skills away from scenes influenced by drugs and alcohol. Aoife managed to be part of an LGB&T scene by joining theatre and arts groups which weren't alcohol focussed, but she sometimes had to avoid places where she knew there would be lots of drugs and alcohol. Susie had found group support difficult as she felt she did not fit-in, and said that the option of a specific LGB&T group would have improved her experience of help-seeking. Ross also suggested that an LGB&T social and support group for recovered substance users would help him to stay on track as part of a community. Aoife had actually accessed a support group for lesbian and bisexual women which allowed her to meet people and make friends away from the scene. However, even here she faced biphobia from others, and stressed the importance of inclusivity in the LGB&T community.

Conclusions

The experiences of the LGB people presented in this report, while individual for each person, show some significant similarities and should be considered by those involved in designing and delivering substance use services and supporting the LGB&T community.

While almost all of those interviewed said that they had benefited from accessing specialist services, most also reported experiencing significant concerns and barriers that had made accessing services difficult. Given the findings reported elsewhere in this study that most substance dependent LGB people prefer to access support from anonymous and informal sources such as the internet and friends, families and partners and that many are put off accessing services because of feelings of shame and embarrassment, concerns about confidentiality and low expectations of services, there is much that mainstream services can do to improve access.

Mainstream services need to be inclusive of LGB people's need and recognise that coming out to majority heterosexual service workers and peers can be difficult, and provide appropriate support. Service providers should also consider the barriers and constraints that the service structure can create, and aim to offer a service that meets the needs of the individual.

Respondents commonly reported feeling like an outsider, whether related to their sexual orientation or other factors. Service providers could do more to prepare LGB people for what to expect when they access services and to publicise the positive experiences and outcomes that service users often report when they do access help. Given the popularity of anonymous and informal sources of help and support highlighted elsewhere in this study, service providers could also review the help and support offered online as well as that offered to the friends, families and partners of problematic substance users.

The LGB&T voluntary and community sector is well placed to offer specific support to the LGB community around substance use, whether social groups or specialised services. All services, whether delivered by mainstream providers or within the LGB&T voluntary and community sector, should consider their accessibility to and inclusivity of the whole community both in promotion and delivery of services. Finally, the LGB community itself has a responsibility to start talking honestly and openly about the use of drugs and alcohol and to support members of the community who are experiencing problematic use.

Susie

Susie is a lesbian in her late twenties. She began using cannabis and alcohol at around age 13 or 14 and then moved on to using other drugs (such as cocaine and ecstasy) in her late teens and early twenties. She was initially pushed in to services by her school which, in her words, "picked up on the fact that I was constantly going in to school out of it". She had wanted to move up to the Sixth Form, but they had told her that she could not come back unless she went to see her GP and a counsellor.

At the time, Susie had a fairly ambivalent relationship with services. As she says, "I had to go, but I was in a bit of denial. I was feeling a bit depressed, but I was quite happy to be drinking and smoking every day". She said that the counsellor was nice, and she went for a few weeks, but then she felt that she was doing OK and so she dropped out. It was only about a year later when things got out of hand again that she went back, this time re-referring herself voluntarily. She said that the process of having seen someone the first time around had enabled her to recognise that she had developed a problem. It was also less scary as she knew what to expect.

For the past decade Susie has drifted in and out of several different services. She described a specific young person's substance misuse service that she had been to aged 17 as very helpful. Susie had been able to access a key worker for one-to-one sessions and they had helped her to identify triggers for her alcohol use and link her in to a wide range of support around health and wellbeing. Unfortunately she had had to leave the service when she was 18, because it had an age cut-off. Thereafter Susie felt forced in to adult services, which she found very intimidating. Although the staff were always very nice, she found the other service users were not like her: many had been forced in to the service by the court; others had gone through the care system; and most had not engaged with the education system. Susie describes feeling like "an outsider". Sometimes this led to her feeling that she wanted to run away from services, and it was her desperation that enabled her to stay engaged.

Fortunately for Susie, the funding system for the young person's service changed so that they could see people up until the age of 25 and so she was able to return there. She valued the one-to-one support that she was able to access the most. She liked the fact that this had helped her to look at employment issues and voluntary work.

Originally from the North of England, Susie had spent some time in the South while at university. During this time she said that she noticed a difference between the type of services and help that was available in different parts of the country. She felt that there was a much broader range of support and help available in the North.

Susie had been initially reluctant to take up offers of group support. Partly, this was because of her personality, and she described herself as introverted. She also said it was related to her feeling like she did not fit in. Again, Susie referred to the difference in her background and how she felt that most of the other people in the group were different from her. It was only later when her drug and alcohol use had got really bad that she had been prepared to try group sessions. At that point she was prepared to give anything a go. Susie had had to try to focus on the things that she had in common with other group members – the fact that they all had a problem with drugs or alcohol – in order to make the group work for her.

Susie is now a part of a recovery community. She is not currently drinking or taking drugs. However, she is not aware of any other LGB people within the recovery community. Whenever the subject of sexual orientation came up, she tends to remain quiet. Susie commented that she had been offered the opportunity to take part in a number of specific women's groups and she has attended some of these. Again however, Susie commented that she sometimes felt like an outsider – for example, when the other women in the group talked about their husbands or their children.

Despite some of the misgivings Susie had about services, overall she said that they had "helped tremendously". She would definitely recommend services to other LGB people if they were experiencing problems. Susie said that she had relied on the support that services offered to get her to where she is today. However, there has been a downside to seeking help too: Susie has had to leave a type of lifestyle behind. A lot of her gay friends still go out at the weekend and are still drinking and taking drugs. Susie can't do that sort of thing anymore. She feels as though she been has split off from these friends.

Reflecting on what would have improved her experience of accessing services, Susie talked about having the option of a specific LGB group. She would have taken this up if it had been available.

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Andy

Andy is a gay man in his mid-forties. He began using LSD as part of the acid house scene and then progressed to ecstasy, speed, cocaine, MDMA and ketamine.

Andy describes a period of about ten years when he was "out continuously, sleeping around, doing whatever". He felt that everyone was doing it and he simply wanted to be the same as them: "you needed to take substances in order to fit in". Andy never felt like he had a problem with substances, he just felt normal.

It was only as Andy became distanced from the scene that he started to feel he had a problem. His distancing was caused my three main factors. Firstly, as Andy had fought to maintain the same highs he had started to experiment with different types of drug, which had brought him to contact with different types of people. Secondly, Andy found that he had less money to spend and he couldn't afford to use drugs in the same way that he had in the past. And thirdly, he had become increasingly self-conscious of his own body image: 'I am older now. I can't wear the same trendy boots or fit in to the same skinny shirts. I have put a bit of weight on. And I have greyed. I don't fit in like I used to.' Andy began to feel increasingly like an outsider and had tried to manage his moods by self-medicating with cannabis and diazepam – the latter he had either bought over the internet or from other people who lived in his neighbourhood.

Andy went to see his GP, not because he felt he had a problem with substances, but because he was finding it difficult to cope with his mood swings. He wanted something to replace the highs that he used to get in the early days of substance use.

He described his GP as amazing. She had taken the time to listen to him and to get beneath the surface of what was going on. She had referred Andy to a service where he could just turn up and have a meal or have a chat with other people. He had got a lot out of going here. He enjoyed the conversations with others. Even though Andy was the only gay person in the centre and everyone was different he felt as though he fitted in. "We were all different, but we were all the same". Unfortunately the service had its funding withdrawn and had to close down.

The closure of the service had left Andy feeling very isolated and alone. He had cut himself from the old scene as he didn't want to get back in to drugs, but felt he wanted someone to talk to and someone to cuddle. Andy stopped going out and started to feel increasingly paranoid. He locked himself in his flat and became worried that everyone was laughing at him. He couldn't even put the television on, as he felt that the television was laughing at him too. "I stopped eating, sat alone in the dark and climbed the walls". Andy stopped feeding his cat, which was found outside by a neighbour. One day he smashed his flat up and someone called the police. Andy was taken to A&E, where he was seen by a psychiatrist, but then sent home again. The next day he tried to jump in front of a bus with the intention of killing himself. He was admitted to A&E again, but this time he was kept in hospital and was admitted to a psychiatric ward. Andy was diagnosed with bipolar disorder and was kept in for two weeks. He was given a care plan, but he felt that this suited the ward rather than his specific needs. He would have liked to have had someone to talk to, but he doesn't recall anyone ever asking him how he felt or trying to talk to him. In the end, he couldn't wait to get out.

Andy has spent the last six months in what he described as "limbo". The old service that he used to go to has gone. His GP has moved on and he feels his new one doesn't listen to him. The psychiatrist sees him once every three months for a short appointment that seems like five minutes, and mental health crisis team never consider him as being in crisis, even when he calls them. They refer him back to his GP, and he ends up begging the GP for diazepam. Andy has had a further short admission to the psychiatric unit, but the temporary resolution of a crisis situation is followed by withdrawal of support as he is considered to be functioning adequately by services with a high entry threshold.

Andy doesn't feel like he fits in anywhere. He wouldn't go to an LGB&T-specific service, partly because he had a bad experience of such a service in the past. He also feels that they cater mainly for younger people, which

he feels in wrong. "I feel sorry for the young people today, because in 15 years' time they will be like me now and there will be nothing for them. There are a lot of older LGBT people but there is nothing for us". Andy has never thought about using specialist substance use services because he has never seen his use as anything other than normal. "It depends what lens you are looking at the world through. I didn't think I had a problem, I just thought this is a part of my life, this is a part of my identity, this is what I do".

In terms of service improvement there were two main things that Andy wanted to see. The first was around early intervention and preventative work: "the scene has always been very glitzy. There is lots of sex education and HIV prevention, but nothing on drugs. Club owners should have to do more. As long as they are getting your money, they don't care. If someone had said to me years ago here is what this drug can do, I might have taken some notice. Not in demonising way, but in a way that just guided you gently the right way."

The second was around safe spaces. Andy didn't feel that there were safe spaces he could go to where he would fit in. The only place where he had been able to fit in and feel normal had been shut down. He didn't seem to hit the threshold for a psychiatric service; he had never thought about substance use services because he thought that his use was normal; and he felt that LGB&T services catered to younger people. In terms of being able to access support, Andy feels it is key to have a good GP who will go the extra mile.

Andy was referred to a service where he could just turn up and have a meal or have a chat with other people. He had got a lot out of going here... Even though Andy was the only gay person in the centre and everyone was different he felt as though he fitted in. "We were all different, but we were all the same". Unfortunately the service had its funding withdrawn and had to close down.

Aoife

Aoife is a bisexual woman aged 40. She has had problems with both alcohol and drug use (mostly amphetamines but also cannabis) but doesn't use either alcohol or drugs now. Aoife also has long standing mental health problems, and at the time of deciding to seek help she was regularly self-harming and making increasingly regular suicide attempts. She decided to try being substance-free to see if this improved her mental health. The practical and health consequences of frequent substance use were also a consideration. She was frightened by her own vulnerability and wanted to feel safer and happier.

Aoife hadn't thought about accessing help for her drinking before, as she didn't think it was problematic. She felt that she was using substances as a form of self-medication to deal with her mental health problems. Aoife was receiving support for her mental health problems but had so far resisted attempts to control her alcohol use. An escalation in her drug use was what led to her seeking help. She had started injecting during drug binges, and when she was sober this frightened her and she was ashamed of it.

As Aoife was already accessing support for her mental health problems, she had a care programme in place. She had the support of, and an established relationship with, a Community Psychiatric Nurse who had helped her return to the community after hospital treatment. The nurse helped her to understand the impact of addiction and started her on displacement activities. Some of these were in a psychiatric setting and some via her GP, such as exercise on prescription. These gave Aoife a structure, which was essential to staying sober.

Aoife also accessed psychological therapies which helped her to deal with her overwhelming feelings. Previously, substance use had given her an immediate sense that things would get better, when in fact they actually made things worse. When she was close to breaking her sobriety or had broken it, she spoke to the AA over the phone.

Each of these sources was useful at different points. Aoife wasn't able to understand the connection between her mental health problems and her substance use until she was sober, and so she doesn't think that she would have accessed a service which required her to be sober first.

Prior to accessing these services, Aoife expected that they might be 'preachy'. She was fearful of being judged for the situations she had got herself into while under the influence of substance. She was also worried about the demands the service would place on her and her ability to meet them. Aoife recognises that she had to have a relationship and trust with a person before she could open a conversation about her substance use. She says she wouldn't have gone to her GP or anyone else she didn't know to tell them her story.

Her experiences of accessing services were in fact very positive, although she did avoid any sources of support that she thought might be as described above. The services she accessed allowed her to do things in her own time and in her own way. Aoife is now completely clean and feels that accessing services had a transformative effect on her. Her mental health has improved, and her self-harm and suicide attempts have stopped. Her confidence and self-esteem have also improved. She started volunteering, then paid work and is holding down a job. Accessing help gave her stability in her life, which she hadn't had before. There were practical impacts too: stable housing, being in safe relationships, and making safe choices in all areas of her life. The people surrounding her changed too; although Aoife at first felt lonely after leaving harmful friends and acquaintances behind, she felt like she was in a new world of positivity and safety.

For Aoife, the LGB&T scene is very alcohol focussed. To try and avoid this, she joined theatre groups and other arts groups, because even if they might be held in a pub, the focus isn't on drinking and partying all night. This is only offered at the fringes of the community, however and she sometimes has to avoid some places

where she knows there will be lots of alcohol and drugs. Aoife went to a social and support group for lesbian and bisexual women, which helped her to meet people and make friends away from the scene.

Reflecting on her experience, Aoife feels that she was relatively lucky, because help was there when she needed it. She says she wouldn't have gone anywhere near support services until she needed them, and when she did need to, being able to access practical support as well enabled her to make lifestyles changes in relation to housing and finances as well as her substance use and mental health problems. Aoife also recognises that she is an 'all or nothing' person, so an abstinence model suited her. She wonders whether she might have accessed a harm-reduction service at an earlier stage, if it had been available.

Aoife has also experienced barriers accessing services in the LGB community as a bisexual person. Even some organisations that are inclusive might not be explicit about it, and she feels that biphobia from other participants (such as comments suggesting that bisexuality isn't real) is almost guaranteed when accessing an LGB group. Facilitators need to make sure groups are inclusive and send a strong message to all that it is. Otherwise, Aoife says you can be stuck between LGB services where you don't belong, and mainstream services where there isn't recognition of your sexual orientation.

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David

David is a bisexual man in his fifties. He is 'out' to close friends but not family as he has only ever had long-term relationships with women and 'casual' relationships with men. He has previously sought help for methamphetamine and heroin dependencies and describes his drug use as a 'secret life'.

Marrying a woman at age 17, David became a young dad and had to juggle childcare duties with university studies. He remained in the marriage for his child but his relationship eventually broke down in the early 1990s. At this point, his use of methamphetamine became more frequent as he established himself as a regular on the dance club scene. Increasingly this drug made him feel fatigued and unable to properly perform at work. He describes being in a "black hole" of depression and tiredness and going through a stopping and starting process as he tried to end his methamphetamine use.

He sought support from his GP who he felt was best placed to deal with the mental and physical problems his methamphetamine usage had caused, including mental fatigue and weight loss. He was referred for psychiatric therapy and counselling. While receiving psychiatric therapy he was diagnosed as bipolar and says he gave up methamphetamine straight away, helped in part by the fact that methamphetamine was also becoming difficult to source. Talking therapies and counselling worked for him because he needed a platform to talk about various issues wider than substance use. He never discussed his substance use with his family but occasionally spoke with friends when feeling "emotionally wobbly" as they were a good distraction and listening ear. Through this support, his mental and physical health improved and by 1998 he was back working full time.

At this point David began to see his drug use as intertwined with his bipolar as he self-medicated uppers or downers dependent on his mood. He describes a "chicken and egg" situation in which he doesn't know which has caused the other. Across 1999-2001 he started experiencing more manic episodes where he became excitable and made "bad decisions". His friends were using heroin and he began smoking it occasionally for several years. He describes "waking up one day", however, to the realisation that he was using heroin every day and was building up financial debt. He felt his work was suffering too.

David successfully stopped using heroin on his own for 6-9 months but began self-medicating with it when new problems arose in his life. He went to his GP and was initially referred to a local treatment agency which didn't work for him. He felt they put too many constraints and conditions on him, such as telling him when to attend, where to go, what he should do etc. They also wanted him to test for drugs so regularly that he feels his work would have been affected, which to him showed that they were not used to dealing with people like him who weren't heavily involved in the heroin scene. David felt that they didn't understand him or have options available that suited his individual life and just wanted to "pigeon-hole" him. Failing to "gel" with his key worker, he also felt that the staff were curt and at times patronising towards him. On a personal note, he'd also worked within the substance use sector and felt embarrassed at the thought of people gossiping about him even though he knew everything was meant to remain confidential.

David was eventually put on the methadone programme which is the treatment he'd expected and wanted to receive. During the 10 months he was on methadone, he was able to work as the flexibility of the treatment meant he only attended a GP appointment once a month, received separate counselling, and collected his methadone once a week. He admits to using cannabis during this process as he found it helpful. Through methadone replacement, he stopped using heroin and retained a full time job. He is currently on prescribed medication for his bipolar which keeps him level and no longer uses "troublesome drugs" (i.e. opiates) although occasionally still uses stimulants and regularly smokes cannabis.

Reflecting on the two times he sought help for drug use, David has two main recommendations for services. Methadone worked for him because it was a slow detox that enabled him to maintain his work with little disruption. This would've been helpful when coming off methamphetamine as being made to immediately stop meant he relapsed and was unable to work. Services need to negotiate the impact certain treatments will have on a person's life. Based on his experience at the treatment agency, David also thinks services need to treat service users as individuals and be more flexible in providing individualised treatment plans that aren't based on assumptions about who they are and what their needs are likely to be.

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Jan

Jan is a lesbian in her early 40s. She had a career in the navy but lost her job there due to her sexual orientation, and afterwards had difficulty deciding on a career, finding work and settling into a job. She recently found out she is autistic and feels this has an impact on her working life. At this point, she began drinking heavily and her drinking has been particularly bad over the last 18 months following a relationship breakdown, which resulted in her being homeless and moving to a new city. Jan describes her drinking as a way of coping.

Jan was motivated to seek help for her alcohol use by an internal recognition that "this isn't really me". Family and friends had said that she was drinking too much, but hadn't offered help or support. She felt that she had reached a point of desperation with her life: she was isolated and lonely; she had lost her partner, her home and her job; and was sleeping on her mum's couch. There was no significant person with the necessary skills for her to speak to. Jan hadn't thought about accessing support before, as she hadn't seen her alcohol use as a problem. She had been busy with work, so while she was drinking a lot she hadn't stopped to notice it. When she had time to think, it hit her that she had a problem.

A NHS-run pilot service specifically for military veterans to address substance use was offered to Jan, which comprised supported alcohol reduction alongside 6 months of psychotherapy. Jan didn't have any expectations about the service, as she was "going to it blind", and at first she found it was distressing and upsetting to confront her drinking. But having someone to talk to gave her the impetus to reduce her use, and the service monitored her progress, which was an added incentive. Jan found this service really beneficial. It raised her self-esteem and managed to stop drinking for a couple of months. While accessing support she secured a job and thinks that the service helped her to do this. However, the pilot came to an end and so the service stopped.

Jan's alcohol use has increased again recently, and in the last three months she has been to her GP to ask for help to address it. At this point, she is homeless again and living in a house-share with a friend, which isn't going well. Her GP said he would refer her to a Community Mental Health Team for assessment, but she doesn't think he has made the referral, as she hasn't heard anything since going to see him. Jan felt she was pushed towards support from a voluntary group, but she didn't want this, preferring to wait instead for professional help.

Jan feels that what would help her now is having someone to talk to at times that suited her; she is working in one city and living in another, and having someone to talk to at either end, when she finished work or when she got home, would help her and influence her behaviour. As it is, she starts drinking cans of beer on the train home, but if she knew she had someone to talk to, she says she wouldn't do that.

Jan wants to access a professional NHS service because she thinks it would offer her talking therapy, which would help to diffuse the emotional element of her drinking. The military veterans' service was good because it was a rapid referral, and the counselling element helped to sustain the reduction in her drinking. Jan's recent experiences (loss of relationship, job and flat) have made her feel like she has no stability or security, and with her isolation and loneliness, have led to her drinking again. She found some helpful advice on the Drink Aware website and is able to not drink for 2-3 nights after reading it; but then something negative might happen at work and she's back to drinking. Jan says it is the connection between alcohol and self-esteem, the psychological element, that is hardest to address.

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Matthew

Matthew is a gay man. He started drinking alone most evenings and then got into a pattern of binge drinking and recreational use of cocaine, ecstasy and legal highs on weekends. He describes getting into a "cycle" in which he would struggle all day at work and look forward to a post-work drink, which was never just one. He started experiencing feelings of anxiety and low confidence and felt strongly that his work was suffering.

Self-realisation that his drinking behaviour was becoming problematic, coupled with his friends expressing concerns about his drinking, led Matthew to seek help. He thought about accessing help through his GP but chose not to as he didn't feel confident that they would give him the time, understanding or support he needed to address his issues, which he says were wider than his substance use. He also tried to locate information online using various advice and service websites but found the information difficult to obtain or irrelevant to his issues.

Matthew eventually decided to attend an LGB-specific counselling service that his partner had previously used, although he admits to feeling nervous as he didn't really know what to expect. He did, however, feel confident that being LGB-specific, the service would suit his needs, understand him, and make "no judgement" of him. Because he considered his drinking more a "bad habit" as opposed to addiction he also felt a dedicated alcohol service was not right for him either. In preparation for his first session at the LGB service he picked up some leaflets from them and looked on their website and felt reassured that the information was accessible, understandable and different to what he'd seen previously.

What appealed about the LGB-specific counselling service was that it wasn't offering quick fixes and that they took a longer-term approach to their clients, which meant he wouldn't be rushed, precisely the fear he had about attending a GP appointment. They offered 10 sessions of counselling and the waiting list wasn't long. Matthew liked that he had a regular dedicated time in which to talk about his anxiety and drinking with someone separate to his family or friends. Through talking therapy, he was able to recognise issues in his relationship and work life which his drinking had been masking and was able to get to the root cause of his drinking by learning more about himself. He liked that the service didn't tell him what to do but motivated him to choose his own path and discover himself. He feels this worked better for him as he doesn't like to be told what to do or being given targets.

Seeking this help had a positive impact on Matthew's life. He has made significant changes to his work life which helped him to drink less. His drinking patterns are now healthier and more sociable. He occasionally uses recreational drugs but feels in control of this. His relationship is still strong with his partner.

From his experience of seeking help, Matthew feels that information isn't always easy to find and should be made more accessible across a variety of different communication channels so as to reach different groups. He also feels that the language used by services can at times be patronising or full of medical jargon, meaning it doesn't speak to the average person looking for help. Likewise, imagery can be a barrier as some people may not think a service can help them if they can't identify themselves in their resources or advertising. Matthew, for example, wasn't sure what to expect at the service he attended as he doesn't feel that he fits the "typical" gay man stereotype. Matthew recognises the need for consistency in the information made available, regardless of the form it takes.

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Ross

Ross is a gay man in his thirties. He started using amphetamines when he was 16 years old and this continued throughout his teenage years when he experienced a period of homelessness. He managed to turn his situation around and got a job, home and partner but developed a dependency on amphetamines after regular usage over a long period of time.

He describes being in a relationship and for the first time feeling like he was part of a family unit. He regularly used amphetamines while socialising with friends however, but felt in control because his OCD meant he would only take them if certain conditions were satisfied. Eventually, however, his amphetamine use and erratic behaviour became problematic to his relationship and his partner wanted to separate. In an attempt to get his partner to stay, Ross agreed to get help but admits to blurting this out with little thought to what this would involve. All he knew was that he wanted to save his relationship.

Wanting honesty and advice, he sought help from a friend who was like a father figure. Ross wanted someone to tell him what to do. During this initial conversation he became aware that his close friends (even those he used drugs with) thought he had a drug problem but didn't want to say anything. The shock of hearing this was, as he describes, a "light bulb moment" and he felt "upset" and guilty. His friend knew of a local substance use service and took him to his first appointment a week later.

Although hailing from a poor background, Ross felt a certain amount of snobbery around accessing this service. It was based in a run down and unsafe area and he assumed it would mainly serve stereotypical "smack heads". He thought he would stand out as different. This expectation was met yet he wasn't treated any differently by staff. Ross was assigned a key worker. He was an ex-addict who drew on his experiences to help Ross implement some of the coping mechanisms that had worked for him. That said, Ross thinks the fact his worker was a straight man prevented him from being entirely honest as there were things he didn't want to share or thought his worker wouldn't understand.

He also acknowledges that there were times when he didn't want to go to this service because he felt unsafe in the area it was based. He tried attending another local substance use service but it wasn't personalised enough and he couldn't connect with the key worker who he found "too textbook"' Ross also went to his GP and was put on a waiting list for counselling but subsequently overcame a lot of his issues before he could use this service. Ross's partner remained with him during his recovery and while he never attended services with him, he provided practical support i.e. taking control of Ross's finances after he generated a good deal of debt.

Ross's recovery took about 2 years. He successfully saved his relationship for another 5 years. He says he will always be addicted to amphetamines so has taken an abstinence approach towards them although has used other drugs and alcohol to compensate. These, however, he can take or leave. He has maintained strong relationships with all the friends he used to take drugs with and they remain his support network. He did not feel the need to disassociate from them as they remind him of what he's been through which keeps him on track.

He thinks matching service users and workers with the same addictions would be helpful as he has never met an amphetamine addict but thinks this may have helped him during his treatment. He occasionally revisits the substance use service and thinks that long-term care helps keep people on track. He believes strongly that substance use is an issue within the LGB community and would like to see more harm

reduction messages presented through different channels to address this issue. He also thinks that a social or support group for ex-addicts would be welcome in his local gay space but that it should focus on social activities not therapy.

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Victoria

Victoria is a lesbian, aged fifty. When she started drinking she was a "happy drunk." She had a 9 year relationship with a partner, which became unhealthy due to drink but her following relationship was a happy one and she didn't experience drinking problems. She is very aware that her drinking patterns relate to her emotional state and after her mother died suddenly and unexpectedly in 2002 she turned to whiskey to cope with her emotions and eventually developed an alcohol dependency.

She describes how she "closed down" after the death of her mother and excused her excessive drinking by reasoning "wouldn't you drink if your mum died?" Eventually this became, "wouldn't you drink if… X,Y, or Z happened." Victoria's drinking increased and started putting strains on her relationships with friend, family and partner so she decided to seek help to show them that was trying to stop. They were her main motivation to get help.

In 2003 Victoria accessed an alcohol-specific support group outside where she lived as they were the only service she'd heard of. This was not the right support for her as she often found the group boring and admits to shutting down if not stimulated. Naturally a shy person, she only spoke a handful of times as she was afraid to make mistakes or use the wrong language. The group's ethos involved believing in a "higher power" for motivation yet Victoria struggled with this and often made it up. Her inability to tap into this left her feeling "shallow". The group also matched Victoria with an alcohol sponsor who was a straight woman with children. Victoria appreciated having a female sponsor but felt unable to share intimate and private truths about her life as a lesbian and also felt uncomfortable calling her sponsor in case she was intruding in her family life. Victoria relapsed constantly when accessing this service and describes times when she would leave the group and go straight to the pub.

By 2007 Victoria was drinking a bottle of whiskey a day. She had successfully been promoted at work and was increasingly working from home which enabled her to drink more regularly. Her partner at the time often worked away so wasn't fully aware of the extent of Victoria's drinking.

At this point, she accessed a service where she was assigned a nurse and a care navigator and would have one-to-one sessions with her care navigator who she still sees today. At times this service was difficult to navigate as they would only see her if she was sober on the day and if deemed too drunk on the day the door was closed on her. While accessing the service, she felt there was too much onus on her to have "self-strength" and be disciplined but she couldn't do this. At this time she admits to being chaotic and lonely and missing many of her weekly appointments. She was still drinking and her family relationships had broken down.

This service did, however, get her into a programme of detox and rehab away from her home town where she successfully experienced some sober months. During her two week detox she was given drugs which she felt helped take her fear and anxiety away and she describes feeling safe as she could access help 24 hours a day and was completely removed from her normal life. After detox she chose a rehab centre which focussed on cognitive behavioural therapy and liked being given the control to do this. This was a positive experience because although she felt that staff tried to push her buttons, they always brought her back to a positive place. She says she "flourished" while in rehab. That said, she did fear ridicule for being a lesbian as there were few women, let alone LGB women in the service. Victoria was reassured that one of the support workers was an out lesbian but she was never open about her sexuality in a group setting and Victoria felt isolated because of this.

When leaving the service in 2009 she was homed in a second stage house in a different city where she experienced relapse due to various issues relating to her housemates, which left her feeling vulnerable and

unable to be out. In 2011 she moved back to her hometown and experienced a long period of sobriety but relapsed in 2013, again due to her living arrangements. She feels disconnected from the LGB community and recently when trying to access a lesbian group got a pang of anxiety and had to leave hurriedly.

Describing the nights as very long, Victoria wished she'd been able to access a 24 hour service providing a safe space and support as it was only in detox and rehab that these things were offered was she was able to flourish. She also thinks that planning a "pathway to normality" is helpful so that service users can see what their future will look like in one year, five years etc.

Victoria also thinks it's important to have visible LGB staff in services as this can alleviate some of the anxiety service users have around coming out and enable LGB service users to be more honest. Peer mentoring can be a powerful tool when used correctly. The choice of LGB-specific groups or workers is necessary as services don't always understand how "fearless" you have to be if you're LGB in services. She recognises the importance of service users trusting the staff and advocates consistency so that people don't have to keep explaining themselves all the time. She did, however, describe how unhelpful it is when staff ascribe her drinking to her sexual orientation or try to suggest that her sexual orientation is her problem, rather than her drinking.

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Tom

Tom is a gay man in his mid-forties. He used cannabis and ecstasy as a young adult, and drank socially up until about 5 years ago when he gave up alcohol as it aggravated his chronic migraine. He was prescribed increasingly strong pain killers for this condition, resulting in high use of morphine. A new GP took him off morphine as she thought he was addicted and he went into withdrawal. Tom started taking heroin as a painkiller and to help him to cope with the withdrawal. However, after about 3 months he found that he couldn't cope with the lifestyle it brought, started to realise how street dealing worked, and wanted to get away from it quickly.

Tom hadn't previously thought about accessing help as he had not seen his substance use as a problem. Cannabis and ecstasy had been drugs you could use when you wanted to and leave when you wanted to, but heroin was compelling and he had to do it every day. Cannabis and ecstasy had also been social, but heroin was not.

Tom was referred by his GP to a methadone replacement programme, where the focus was on harm reduction. It took Tom 4 weeks to get into the service and 7 years to get off methadone. No-one had told him how long it would take, or how hard it was to come off methadone. Tom felt there was no encouragement to come off methadone, and he was even dissuaded from trying to reduce when he suggested it. He was told "you can't stop coming to the service, you're an addict". In the end, Tom managed to get off methadone himself over a few months. He set himself a target, starting with reducing by 1mm per month. When realised that he could do it, Tom increased the amount to a few mm and continued. This took about 8-10 months.

He had expected a more structured approached to coming off first heroin and then methadone, and integrating back into society. In reality, it was chaotic. Clients couldn't make appointments in advance, and sometimes could wait for up to 3 hours to see someone. Tom felt it was frightening and degrading. Other service users included people who were living on the streets, people who were desperate, and Tom wasn't accustomed to that. He says it felt like a punishment.

The service gave him a stable place to sort out his addiction, and he was appreciative of that. It allowed him a regular, safe supply of methadone and it allowed him to eat properly, as he wasn't spending all his money on heroin. But it became easy to stay there and felt like a stupid habit to be keeping.

Tom had kept his addiction and his therapy a secret from everybody. While using heroin and then in treatment, he was at University for 5 years and at work for 3 years and in that time, no one found out. He says they would have found out if he hadn't accessed the service, so it helped his relationships with people to get help. Accessing the service while still in work was difficult as you could only go on a given day, and couldn't make advance appointments, so he had to make up an excuse each time, which became difficult when it was every Friday. Tom hasn't worked since coming off methadone because of his medical condition and was medically retired because of this during treatment.

Reflecting on his experiences, Tom feels that it would have been better to spend more time talking to somebody before making the decision to go ahead with the programme would have; perhaps he then could have negotiated a better way of addressing his drug use for his circumstances. Tom thinks that once the service had labelled him a heroin addict, he was regarded as not capable of making rational decisions and was not taken seriously. It would also have helped to have continuity in the service worker, as he was seeing a different person each time and never got to see his key worker.

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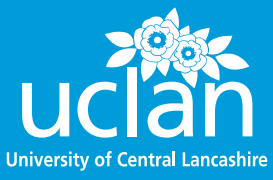

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