Project Title:

The ALICE study: “Alcohol and Lesbian/bisexual women: Insights into Culture and Emotions”

This research project was funded by beyondblue: the national depression and anxiety initiative, through a Victorian Centre of Excellence grant in 2011. Project Code: 6510:HS (MCNA11VCE)

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In association with

June 2014
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Main messages

The project outcomes fill an important gap in evidence regarding drinking and mental health amongst same sex attracted women. This evidence can now be used by various stakeholders including LGBT consumers, service providers and policy makers.

Messages for LGBT community

- The importance of the finding that the normalised culture of drinking is no different in the LGBT community than the general Australian community, therefore there is no need to accept any blame or stigmatise the LGBT community for alcohol use. Further, for many SSAW, drinking is a safe and harmless behaviour that enables social connection.
- Encouragement to access care for alcohol use, highlighting the high level of harmful use and current lack of perceived need for alcohol care.
- Encourage an increase in access for mental health, highlighting the relative under-utilisation compared with high levels of depression, anxiety, self-harm, suicidal thoughts.
- The importance of accessing a regular GP and disclosing if comfortable, because this will facilitate access to appropriate services for mental health and alcohol support.
- Work on increasing alcohol-free social events, particularly for people coming out, as SSAW start drinking at a much earlier age than heterosexual young people, which may be related to exposure to a drinking culture earlier during coming out, and increase their risk of harmful drinking in the future.

Messages for health care providers

- Barriers to access include fear of stigma regarding mental health and alcohol, as for any patient, and a lack of perceived need, particular regarding alcohol care. Almost one quarter of SSAW have had experiences of discrimination within health care.
- Open mindedness is vital to facilitating disclosure, which in turn encourages disclosure of other sensitive topics such as mental health and alcohol problems. Bisexual women need particular encouragement to disclose.
- Ask about sexual orientation and gender identity, understand the influences of minority stress on alcohol use and mental health, and the different experiences according to identity, but don’t assume it is the only reason for these issues.
- Avoid assumptions regarding heterosexuality, gender, and use neutral language.
- Access specific training around LGBT specific issues.

Messages for policy makers

- Facilitate awareness raising campaigns amongst general community and the LGBT community regarding the impact of discrimination, abuse and social isolation on mental health and alcohol use.
- Facilitate targeted health promotion initiatives for SSAW for primary and secondary prevention of problematic alcohol use, while ensuring that alcohol use per se is not problematised.
- Enable the development and sustainability of self-help and peer support programs for LGBT people regarding mental health support, using multiple platforms including online and social media.
- Increase the inclusion of sexual orientation and include gender identity in nationally representative datasets regarding mental health and alcohol use, to identify shifts in patterns of inequities over time.
Executive Summary

Terminology
We have chosen to use the term same-sex attracted women (SSAW) as the most inclusive for this group of women. They may identify as lesbian, bisexual, queer, pansexual, or not use a particular sexual orientation label. We also refer to lesbian, gay, bisexual and transgender (LGBT) people or communities where it is relevant.

Aims
1. Explore the complex relationships between hazardous drinking, and depression and anxiety in same-sex attracted women (SSAW);
2. Investigate the degree to which these relationships are shaped by the intersection of cultural norms and systemic sexual orientation discrimination;
3. Identify the predominant socio-cultural influences on mental health help-seeking among SSAW who are hazardous drinkers and/or have depression/anxiety;
4. Review and enhance an existing professional development module on substance use and mental health in sexual minority populations—with a particular emphasis on prevention and early intervention strategies for hazardous drinking, depression and anxiety.

Methods
Phase 1 - A web-based survey of same-sex attracted women, gathering data on drinking behaviours, socialisation, depression, anxiety and abuse history, and perceived links among drinking, mental health, and help-seeking. Survey respondents were asked to indicate their interest in participating in Phase 2 of the study.

Phase 2 - A purposive sample of survey respondents who indicated interest and gave permission to be contacted participated in an in-depth interview. A selection of these were part of participant observation.

Phase 3 - Development and piloting of a training module for health professionals on alcohol use and mental health amongst same-sex attracted women, culminating in a workshop for health professionals.

Key findings
Aim 1 - Relationships of drinking and mental health
- Over half of the sample did not drink at problematic levels. They commonly described drinking to socialise, for enjoyment, to feel comfortable, relax and to fit in.
- Problematic alcohol use over the past year occurred amongst 40.2% of the survey sample. While bisexual women were more likely to have been drinkers, queer and pansexual women were most likely to have problematic drinking, closely followed by lesbian women.
- Compared with population norms, survey respondents had high levels of depression ever (56.2%), and anxiety ever (46.0%); lifetime suicidal thoughts (58.6%), self-harm (50.3%), and suicide attempts (23.7%); and childhood abuse and intimate partner violence. There was a strong relationship between problematic drinking and depression and anxiety, and this was an association in both directions.

Aim 2 - The influence of systemic sexual orientation discrimination and cultural norms
• Discrimination related to sexual orientation or gender identity was experienced by 30.5% of women during the past year, more so by lesbian, queer and pansexual women.

• There was no direct relationship identified between alcohol consumption and sexual orientation, however LGBT-related stressors were strongly associated with problematic drinking, depression/anxiety and self-harm/suicidality. These minority stressors included experiences of discrimination, abuse and violence, family rejection, and social isolation. This is likely to explain why queer, pansexual and lesbian women had more problematic drinking because they are more likely to disclose their sexual orientation, therefore to bear the brunt of negative social attitudes.

• Coming out had a particular association with drinking – both to fit in, and to self-medicate during a difficult or confusing period.

• There were mixed perceptions regarding whether drinking was normalised within LGBT community. Some women believed that it is normalised and part of the ‘lesbian’ identity, while many more believed there was no identifiable SSAW women ‘subculture’ or ‘culture of drinking’. Many highlighted that the drinking culture was equivalent to that in the mainstream, and this view was confirmed during observations, apart from in small pockets of SSAW community events. This is a novel finding that contradicts much of the international research, particularly from the USA, and de-stigmatises the use of alcohol amongst women in the LGBT community.

Aim 3 – influences on help-seeking for mental health and alcohol

• Half (52.0%) participants had received treatment for mental health or alcohol-use in the last year. The most common service was mental health, followed by GP. Of these, only 1.5% accessed services for alcohol-use alone, 39.3% for mental health alone, and 11.1% for both reasons. The very low usage of services for alcohol support, and presumably a low perception of need, replicates the general population.

• Bisexual women were most likely to access services for mental health care while not having the highest level of need (apart from PTSD), and least likely to access for alcohol.

• A large proportion of survey respondents were reluctant to use services for mental health, most commonly due to concerns about being judged about the alcohol use or mental health (38.7%) and not being ready to seek help (38%).

• While 19% had experienced discrimination within health services, and a further 12% suspected discrimination, this was not a barrier to care.

• Having a regular GP and being out to that GP were the main enablers of health care utilisation for mental health and alcohol care.

• LGBT community connectedness was correlated with service use for mental health but not alcohol care. This indicates a level of encouragement or acceptance of the need for mental health care, but a denial of alcohol as a problem within the LGBT communities.

Aim 4 – professional development for health care providers

• While specialist LGBT services are appreciated, most participants wanted mainstream services to be sensitive to and knowledgeable about their needs.

• Piloting of the LGBT sensitive care module with a range of health providers indicated a high level of need for the training, and very positive evaluations.

Practical outcomes

An evidence based training module has been produced and piloted in 2 formats, face-to-face and online.

A community report will enable dissemination of key messages to the LGBT community.
Project report

Background
A literature review was conducted during the initial phase of the study, which is summarised here.

Higher rates of drinking and associated mental health disparities
Population-level studies have found higher rates of drinking, alcohol dependence, and other alcohol-related problems among SSAW when compared with heterosexual women. Research has also generally found that SSAW are more likely to have been treated for alcohol-related problems than heterosexual women [1-3]. For example, a study drawing on US national survey data found that the prevalence of any past-year substance use disorder was 25.8% for SSAW and 5.8% for heterosexual women [4]. The Australian 2010 National Drug Strategy Household Survey, which surveyed over 26,000 Australians about substance use, reported findings between heterosexual and homosexual/bisexual groups (2.2% of the sample) indicated that homosexual/bisexual people were more likely to be short-term risky drinkers on a weekly (26.5% versus 15.8%) and monthly (29.4% versus 24.6%) basis, and were more likely to be lifetime risky drinkers (29.2% versus 20.3%) [5]. Data from 8,850 women aged 25-30 years in the 2003 survey of the Australian Longitudinal Study on Women’s Health, showed that compared with exclusively heterosexual women, SSAW reported significantly higher levels of substance use [6]. LGBT populations are also more likely to experience mental health disorders such as anxiety, depression, eating disorders, self-harm and attempt suicide [7]. A meta-analysis concluded that the risk of lifetime mood disorders, anxiety disorders and substance use disorders were 1.5 times higher among LGBT populations compared with heterosexual populations, and sexual minorities were 2.47 times more likely to have attempted suicide [8].

Access to services for alcohol and mental health care
SSAW seek treatment for alcohol and mental health problems at higher rates than heterosexual women. Data from the Australian Longitudinal Study on Women’s Health revealed that SSAW were significantly more likely than heterosexual women to have more frequently used health services [9]. Other research indicates that the majority of SSAW have accessed some form of therapy or counselling in the past [6]. Despite their potentially greater need for, and willingness to seek treatment, SSAW face a number of barriers in accessing high quality substance use and mental health care. The Australian National Drug Strategy has stated that SSAW have difficulty accessing drug treatment services and achieving positive outcomes when the service is not specific to their needs (Australian National Drug Strategy 2010-2015). Research consistently shows that SSAW are less satisfied with treatment than their heterosexual counterparts [2, 9-11]. For example, using the Australian Longitudinal Study on Women’s Health data, McNair et al found that SSAW reported lower continuity of GP care and lower satisfaction with that care than heterosexual women. Studies continue to find that between 40 and 60% of SSAW report negative or mixed reactions from mental health service providers [7]. Barbara reported that many LGBT clients do not feel they can be open about their sexual orientation in mainstream AOD services [12], and this is partly because they have trouble finding providers who are knowledgeable about, and sensitive to, the unique needs of SSAW [13]. Cochran and Cauce found that most alcohol and other drugs (AOD) treatment providers receive limited or no training in working with SSAW and rarely discuss sexual orientation with their clients, although they believe that these issues are important [14].
Theories regarding causes of higher alcohol use and mental health disparities

A number of explanations have been proposed for the higher rates of alcohol consumption amongst SSAW. These can be categorised as a response to minority stress, a response to internalised homophobia, and normalisation of drinking within LGBT communities. SSAW may use alcohol or drugs as a coping strategy to deal with discrimination associated with sexuality or psychological stressors [14, 15]. Meyer terms this ‘minority stress’ [16]. A strong relationship has also been found between substance use and childhood physical abuse, childhood sexual abuse, childhood neglect, partner violence and being the victim of assault with a weapon [6]. Coming out is another time of particular stress. One study has noted that SSAW reported heavier alcohol use at two points in their lives – firstly, when they were becoming aware of their attraction to women, and secondly, as they began to immerse themselves in the lesbian community [17]. A greater number of rejecting reactions to sexual orientation disclosure is associated with higher alcohol use among SSAW, and conversely high numbers of accepting reactions can buffer the effects of negative reactions. Among youth with fewer accepting reactions, alcohol frequency and quantity increases as the number of rejecting reactions increases [2]. SSAW also might drink alcohol as a response to ‘internalised heterosexism’ [18], also referred to as ‘internalised homophobia’ [15], which describes feelings of shame, self-esteem or even self-loathing experienced by SSAW as a result of their sexual orientation.

Alcohol use may be highly normalised among sexual minority communities. Social pressures and discrimination may limit opportunities for SSAW to socialise. As a result, socialising is often limited to bars or other places where substance use is normalised [14, 15]. An Australian study indicates that there is a strong and normalised culture of heavy drinking amongst SSAW, and it is difficult for them to find spaces in which to socialise that are alcohol-free [19]. Women with heterosexual or mixed networks have lower levels of alcohol consumption than women with mostly sexual minority networks. Some research has shown that SSAW who ‘came out’ before age 21 reported earlier onset of drinking than those who came out later, perhaps as a consequence of being exposed to heavy drinking communities at an earlier age [20]. In addition, earlier age of coming out has been positively associated with current drinking and treatment for alcohol-related problems [2].

Problems being addressed by the ALICE study

There are two key gaps in the literature that the ALICE study has addressed:

1. Understanding the influences on SSAW’s drinking, including the relative roles of discrimination, the culture of drinking and other factors.

2. Understanding the health care needs of SSAW, and how to sensitisie mainstream health services to these needs regarding alcohol use and mental health, so as to enable greater access to and improved efficacy of services for SSAW.
Methodology

Research team
The team consisted of a collaboration between the University of Melbourne (Assoc. Prof. Ruth McNair-study leader, Prof Kelsey Hegarty – Director Researching Abuse and Violence group), Jodie Valpied-research assistant), Turning Point Alcohol and Drug Centre (Amy Pennay – ethnographic researcher, lead interviewer; Prof Dan Lubman –Director Turning Point), Gay and Lesbian Health Victoria (Liam Leonard – Director GLHV), Deakin University (Dr Rhonda Brown – Senior Lecturer School of Nursing and Midwifery), and included an international expert in alcohol use amongst SSAY from the University of Illinois at Chicago (Prof Tonda Hughes). The team met regularly every 2-3 months throughout the project. During the final year of the study, a research student joined the team (Scarlet Love). She is a medical student conducting a research project using secondary analysis of the online survey data as part of her degree.

Advisory Committee
The committee met for the first time in August 2012 and again in August 2013 and finally in May 2014. Membership came from Turning Point, Headspace, Youth mental health training, a community health drug and alcohol service, the Victorian Aids Council, Bi Victoria and Transgender Victoria. The terms of reference were to provide advice to the ALICE project team on survey participant recruitment strategies, key stakeholders in the field of lesbian/bisexual women and alcohol use, and training for health providers – content, process and format. Members of the committee also participated in piloting both versions of the training module.

Ethics approval
Ethics approval was granted by the University of Melbourne Health Sciences Human Ethics Sub-committee on 20 July 2012, ethics identification number 1237539.

Study design
The study used an ethnographic framework and a mixed methods approach to understand the socio-cultural influences of alcohol use, mental health and sexual orientation, and health service use. Ethnography provided a suitable framework to observe the cultural milieu of participants in relation to drinking and place it in context of drinking patterns within the broader Australian community.

Phase 1 - survey
An online survey completed by 521 same-sex attracted women gathered data on drinking behaviours, socialisation, depression, anxiety and abuse history, perceived links with drinking and mental health, and help-seeking. The survey used a range of validated scales including AUDIT-10 regarding alcohol, WHO-ASSIST regarding other drugs, CES-D on depression, the Perceived Stress Scale and the Medical Outcomes Study Social Support Index (Cronbach’s alpha internal consistency score of 0.97), both of which have been validated in the Australian Longitudinal Study of Women’s Health. Questions were included on diagnosis of depression, anxiety, PTSD and a range of other mental health problems, suicidal thoughts, suicide attempts and self-harm. Questions on intimate partner abuse and childhood abuse ever included physical, emotional and sexual abuse. Other measures were taken from the Private Lives survey, a national web-based survey of gay, lesbian, bisexual, transgender and intersex health [21] including experiences of sexuality-based discrimination, and LGBT community connectedness.

Health services questions included whether women had attended a list of services for mental health and/or emotional wellbeing, and for alcohol support. Those who answered “yes in the last 12 months” to the use of any service were asked how often they attended the service, with the option of selecting “once” or “more than once”. Questions on having a regular GP and whether women thought the GP was aware of their sexual orientation and/or gender identity were included. A question on barriers to service
access for each of mental health care and alcohol use was asked that included 8 specific barriers and a space for an open ended response on any other barriers experienced.

Finally, several open-ended questions were included throughout the survey:

- What benefits/good things do you get from drinking alcohol?
- What are the downsides for you from drinking alcohol?
- What are your perceptions of alcohol use within the LGBT community?
- How does this compare with your perceptions of alcohol use within the mainstream community?
- How does alcohol use in the LGBT community affect you?
- If ticked yes to LGBT specific services, which ones had been used for alcohol, and for mental health care?
- If ticked yes to experiencing discrimination in the health care system based on sexual orientation and/or gender identity, please explain.

**Phase 2 – in-depth interviews and participant observation**

A purposive sample of 25 survey respondents who indicated interest and gave permission to be contacted each participated in an in-depth interview. Interviews took place either at the organisation of the interviewer, the private home of the interviewee or a neutral location such as a cafe. Two interviews with women in rural areas were undertaken over the phone. Interviews lasted between 30 and 190 minutes and participants were offered a $50 Coles/Myer voucher as reimbursement for their time and any associated travel costs. Interview themes included the woman’s sexual orientation, her alcohol intake patterns, impressions of alcohol use in the LGBT community and whether this influenced her own drinking, her mental health status and associations with alcohol, and her health service experiences and satisfaction. Finally, women were asked to discuss key issues that should be included in health provider training regarding alcohol, mental health and SSAW. Participants were also encouraged to share their stories and elaborate on meaningful issues for them.

All 25 women interviewed were invited to participate in sessions of participant observation and 7 women agreed, which involved inviting the researcher to an upcoming session of alcohol consumption. The researcher observed conversations, behaviours and overall environment. The researcher also attended three social events that were specifically targeted to SSAW.

**Phase 3 – health provider training module – face-to-face and online**

A training module was developed for health professionals on providing sensitive services to lesbian, bisexual, gay and transgender people regarding alcohol and mental health care. A pilot workshop was run over half a day, involving 14 health professionals from primary health care (general practice, community health, district nursing), alcohol and drug, youth health, and mental health sectors. Ten participants completed a before and after evaluation survey, and participated in focus groups immediately after the training to provide feedback. The module was then modified and adapted for an online platform, video-clips were filmed and the online version is to be piloted in July 2014.

**Recruitment**

Recruitment of the SSAW to participate in the online survey occurred between November 2012 and April 2013. It was most successful using social media (Figure 1). A paid advertisement were placed in the leading print and online magazine for lesbian and bisexual women (LOTL), and also on Pink Sofa – a social
website for SSAW. Email lists were used of various SSAW social groups, and information was disseminated using snowballing.

**Figure 1 – Sources of online survey participants**

Recruitment of interview participants

Two-hundred and thirty-two (44.5%) participants who completed the ALICE survey agreed to be followed up for possible further involvement in the study. Of these, 102 participants were located in Victoria, and thus accessible for face-to-face interviews. All Victorian participants who agreed to be contacted were placed on a contact list in random order, stratified by age, locality (inner urban, outer urban, regional centre, rural area) and sexual orientation (to ensure adequate representation of those from smaller subgroups). Recruitment for interviews was conducted in the order presented on the randomised contact list. After 10 interviews the sample was assessed and it was noted that heavy drinkers were under-represented and so were subsequently targeted in further stratified sampling. After 20 interviews, the sample was again assessed, and it was noted that non-Anglo-Saxon nationalities were under-represented and so were targeted in the final phase of stratified sampling. Thirty seven women were contacted to achieve the final sample of 25 interviewees. The twelve women who did not participate could either not be contacted or declined further involvement in the study. Women were interviewed between December 2012 and October 2013.

**Sample**

**Online survey sample demographics**

These are included in Table 1.

**Interview participant sample**

The age of the 25 participants interviewed ranged from 19-71 years (with a mean age of 40.1 years). Eighteen women were born in Australia, with one identifying as Aboriginal; three women were born in the UK, one in New Zealand, one in the US, one in Russia and one in Singapore. Thirteen women
lived in inner-urban areas, eight lived in outer urban areas, one lived in a regional centre and three lived in rural areas. All women identified as female, except one transgender, one intersex and one gender queer participant. Thirteen women identified as lesbian/gay, five as bisexual, two as queer, two as pansexual, one as homo-flexible, one as a lesbian feminist and one was undecided. Nine participants were in relationships, six with women and three with men, and five participants had children. Women varied in their drinking patterns, with a mix of light, moderate and heavy drinkers.

Table 1 – Online survey sample demographics by sexual orientation

<table>
<thead>
<tr>
<th></th>
<th>Lesbian / Gay (N=297)</th>
<th>Bisexual (N=89)</th>
<th>Queer / Pansexual (N=99)</th>
<th>Other (N=30)</th>
<th>TOTAL (N=515)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, M (SD)</td>
<td>36.4 (13.1)</td>
<td>29.7 (10.2)</td>
<td>28.7 (9.3)</td>
<td>29.9 (10.4)</td>
<td>33.4 (12.7)</td>
</tr>
<tr>
<td>n (%)</td>
<td>288 (97.6)</td>
<td>81 (92.0)</td>
<td>78 (78.8)</td>
<td>33 (91.7)</td>
<td>480 (92.7)</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>288 (97.6)</td>
<td>81 (92.0)</td>
<td>78 (78.8)</td>
<td>33 (91.7)</td>
<td>480 (92.7)</td>
</tr>
<tr>
<td>Trans (identifying as female)</td>
<td>2 (0.7)</td>
<td>3 (3.4)</td>
<td>2 (2.0)</td>
<td>1 (2.8)</td>
<td>8 (1.5)</td>
</tr>
<tr>
<td>Trans (identifying as male)</td>
<td>0 (0.0)</td>
<td>0 (0.0)</td>
<td>1 (1.0)</td>
<td>0 (0.0)</td>
<td>1 (0.2)</td>
</tr>
<tr>
<td>Genderfluid / Genderqueer</td>
<td>1 (0.3)</td>
<td>1 (1.1)</td>
<td>13 (13.1)</td>
<td>1 (2.8)</td>
<td>16 (3.1)</td>
</tr>
<tr>
<td>Other</td>
<td>4 (1.4)</td>
<td>3 (3.4)</td>
<td>5 (5.1)</td>
<td>1 (2.8)</td>
<td>13 (2.5)</td>
</tr>
<tr>
<td>In a relationship</td>
<td>179 (60.2)</td>
<td>48 (53.9)</td>
<td>49 (49.5)</td>
<td>22 (61.1)</td>
<td>298 (57.2)</td>
</tr>
<tr>
<td>Has children under 18 years old</td>
<td>72 (24.2)</td>
<td>15 (16.9)</td>
<td>7 (7.1)</td>
<td>6 (16.7)</td>
<td>100 (19.2)</td>
</tr>
<tr>
<td>Income ≤ 40,000 per annum</td>
<td>67 (22.6)</td>
<td>31 (35.2)</td>
<td>32 (32.3)</td>
<td>9 (25.0)</td>
<td>139 (26.7)</td>
</tr>
<tr>
<td>Unemployed</td>
<td>26 (8.8)</td>
<td>15 (17.0)</td>
<td>16 (16.2)</td>
<td>5 (13.9)</td>
<td>62 (11.9)</td>
</tr>
<tr>
<td>High school not completed</td>
<td>20 (6.7)</td>
<td>5 (5.6)</td>
<td>6 (6.1)</td>
<td>3 (8.3)</td>
<td>34 (6.5)</td>
</tr>
<tr>
<td>Born outside Australia</td>
<td>47 (15.8)</td>
<td>15 (16.9)</td>
<td>14 (14.1)</td>
<td>12 (33.3)</td>
<td>88 (16.9)</td>
</tr>
<tr>
<td>Aboriginal or Torres Strait Is.</td>
<td>6 (2.0)</td>
<td>4 (4.5)</td>
<td>3 (3.0)</td>
<td>0 (0.0)</td>
<td>13 (2.5)</td>
</tr>
<tr>
<td>Lives in rural locality</td>
<td>43 (14.5)</td>
<td>9 (10.1)</td>
<td>6 (6.1)</td>
<td>3 (8.3)</td>
<td>61 (11.7)</td>
</tr>
<tr>
<td>State / territory of residence</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Victoria</td>
<td>127 (42.8)</td>
<td>33 (37.1)</td>
<td>40 (40.4)</td>
<td>19 (52.8)</td>
<td>219 (42.0)</td>
</tr>
<tr>
<td>New South Wales</td>
<td>82 (27.6)</td>
<td>23 (25.8)</td>
<td>31 (31.3)</td>
<td>9 (25.0)</td>
<td>145 (27.8)</td>
</tr>
<tr>
<td>Queensland</td>
<td>47 (15.8)</td>
<td>11 (12.4)</td>
<td>18 (18.2)</td>
<td>3 (8.3)</td>
<td>79 (15.2)</td>
</tr>
<tr>
<td>Western Australia</td>
<td>12 (4.0)</td>
<td>7 (7.9)</td>
<td>3 (3.0)</td>
<td>4 (11.1)</td>
<td>26 (5.0)</td>
</tr>
<tr>
<td>South Australia</td>
<td>11 (3.7)</td>
<td>6 (6.7)</td>
<td>2 (2.0)</td>
<td>0 (0.0)</td>
<td>19 (3.6)</td>
</tr>
<tr>
<td>Australian Capital Territory</td>
<td>6 (2.0)</td>
<td>7 (7.9)</td>
<td>5 (5.1)</td>
<td>1 (2.8)</td>
<td>19 (3.6)</td>
</tr>
<tr>
<td>Northern Territory</td>
<td>10 (3.4)</td>
<td>0 (0.0)</td>
<td>0 (0.0)</td>
<td>0 (0.0)</td>
<td>10 (1.9)</td>
</tr>
<tr>
<td>Tasmania</td>
<td>2 (0.7)</td>
<td>2 (2.2)</td>
<td>0 (0.0)</td>
<td>0 (0.0)</td>
<td>4 (0.8)</td>
</tr>
</tbody>
</table>

*a Denominators vary due to missing data.

Observation participant sample

The 7 women varied from 19-47 years of age. Events included drinking at home with their family, drinking at licensed venues alone or with friends or partners, and house parties. No participants involved in this component of the study invited the researcher to events specifically for SSAW or LGBT people, so a decision was made for the researcher and a colleague to attend three additional sessions of participant observation at specific SSAW events. Sessions of participant observation
ranged in duration from one to six hours. A total of 10 sessions of observation were undertaken over approximately thirty hours. During observational data collection the researcher interacted naturally with participants, while attempting to influence the scene as minimally as possible. Field notes were scribed immediately following sessions of observation.

**Analysis techniques**

**Quantitative analysis**

A total of 521 participants completed the ALICE survey. An additional 31 participants began the survey but were screened out early in the survey process due to not meeting criteria for participation (i.e. they did not reside in Australia, were male, and/or were not attracted to women). These ineligible participants were not included in the survey analyses.

Descriptive statistics were produced for each of the variables included in the ALICE survey. All variables were checked to ensure assumptions for each of the planned analyses were met. Bivariate Spearman’s rank-order correlations were performed on all variables of interest to assess for multicollinearity, and to identify any potential confounding variables. Participant age, income status (income ≤ $40,000 per annum versus income > $40,000) and parental status (whether or not participant has a child under 18 years old) were identified as potential confounding variables. Hence all subsequent analyses completed controlled for these three variables.

Associations between participant sexual orientation (lesbian, bisexual, queer/pansexual, other) and alcohol consumption, mental health, suicidality, service use and experiences of abuse and harassment were analysed using binomial logistic regression. Associations between levels of alcohol consumption as measured by the AUDIT scale (Low, Hazardous, Harmful, Dependent) and mental health, suicidality, and experiences of harassment were also analysed using binomial logistic regression. All binomial logistic regression analyses controlled for age, income status and parental status, and were performed in SPSS Version 22.0 [22].

A path analysis was also performed to assess the complex pattern of relationships between each main variable of interest, and the comparative strength of each relationship. The path analysis was performed in MPlus version 7 using weighted least squares parameter estimates with adjusted means and variance (wlsmv) with Theta parameterization. The path analysis controlled for participant age and parental status. Income was not included as a control variable in the analysis, as we wished to retain the influence low income may have within the model.

The student researcher conducted analysis under supervision regarding services use, barriers and enablers. Treatment utilisation was examined according to a number of sample demographic characteristics using cross-tabulations. 12-month treatment utilisation by service provider was examined separately for mental health and for alcohol-related problems. Frequencies were calculated for those who had used each service ‘once’ or ‘more than once’. In order to examine barriers to treatment utilisation, frequencies were calculated for those answering yes to each of the available answers to the question “have any of the following ever made you reluctant to seek help or advice about alcohol use” and “mental health/emotional wellbeing”. These frequencies were calculated only amongst those who were deemed to have a “service need” (i.e. scored in the depressed range on CES-D, were a problem drinker on AUDIT score, or had had a suicide attempt over the past 12 months) (n=314). Binary logistic regression was performed using ‘treatment utilisation’ as the outcome variable. Independent variables were included in the model simultaneously and consisted of ‘Social support’, ‘Having a regular GP’,
‘Disclosure of sexuality to GP’, ‘Experience or fear of discrimination within health services ever’, ‘Sexual orientation’ and ‘intimate partner violence’.

Qualitative analysis

Thematic analysis of all interview transcripts was undertaken in NVivo. Two researchers coded the first three interviews and compared and contrasted their thematic categories, before reaching agreement on a coding framework. One researcher then thematically coded the remainder of the interviews, as well as the field note transcripts. Another researcher thematically analysed the answers to the open-ended questions in the online survey. Given the focus of the research, the primary over-arching themes to emerge from the data were experiences of alcohol use, mental health and health service utilisation. However, variations in these themes were evident, and other themes such as sexual orientation, discrimination experiences, stress and family were also strong themes to emerge from the data.

Findings

Alcohol use

Almost all (98.8%) of the 521 women who responded to the ALICE survey had consumed alcohol in their lifetimes, and 93.4% had consumed alcohol during the previous 12 months. We have conducted a comparison with the women’s results from the National Household Drug Survey 2010 (Table 2). We have obtained these results for women respondents from the NDHS team and analysed them ourselves. These show that the alcohol use in our study is consistent with that amongst the non-heterosexual women in the nationally representative sample, and it was higher than for the heterosexual women in that sample.

Table 2: Comparison of alcohol use by sexual orientation with a nationally representative sample

<table>
<thead>
<tr>
<th>Alcohol use</th>
<th>ALICE lesbian women N= 297</th>
<th>ALICE bisexual women N = 89</th>
<th>ALICE queer women N = 99</th>
<th>ALICE all women N= 515</th>
<th>NDHS non-heterosexual women N= 270</th>
<th>NDHS heterosexual women N = 12,729</th>
</tr>
</thead>
<tbody>
<tr>
<td>Past 12 months</td>
<td>91.6% (272)</td>
<td>97.8% (87)</td>
<td>92.9% (92)</td>
<td>93.4% (481)</td>
<td>93.8% (244)</td>
<td>90.6% (10,452)</td>
</tr>
<tr>
<td>Ever</td>
<td>98.7% (293)</td>
<td>100% (89)</td>
<td>98.0% (97)</td>
<td>98.8% (509)</td>
<td>97.0% (262)</td>
<td>94.7% (12,025)</td>
</tr>
</tbody>
</table>

The level of current problematic alcohol use was high with 40.2% (n=207) women having an AUDIT score of more than seven, reflecting hazardous drinking levels over the previous year. Sixteen percent of women (n= 82) reported that they would find it difficult to reduce their alcohol intake over the next three weeks. Almost one quarter (24.7%) of women were concerned about their alcohol consumption over the past year, and half (47.2%) had been concerned at some time during their life. Other evidence of problematic drinking included that 25.2% reported they had failed to reduce their drinking at some point, and 27.2% had experienced health, social, financial or legal problems due to alcohol use.

The mean age of first alcohol consumption was relatively young, being 14.8 years old overall (SD = 3.3). Mean age at first drink was 15.0 years old for lesbian women, 14.7 for bisexual women, and 14.4 for queer/pansexual women. This compares with a mean age of 17.8 years amongst the heterosexual women surveyed in the National Household Drug Survey, 2010.
The level of drinking differed significantly according to sexual orientation. Bisexual women in the ALICE study were most likely to have consumed alcohol in their lifetime and over the past 12 months (table 2), while queer and pansexual women were most likely to report having been concerned about their drinking at some stage, followed by lesbian women (Figure 2).

**Figure 2 – Problematic drinking by sexual orientation**

Women completed open-ended questions in the survey regarding the benefits and downsides that they personally experienced from drinking. Regarding the benefits, a large proportion of respondents (297) stated that they drink to have fun and socialise. Many women (242) also commented that alcohol helps them to relax and be less anxious. A few women also highlighted health benefits such as feeling more energised, and gaining anti-oxidants. Negative perceptions included feeling hung-over (200), reduced self-control (104), cost (100), health effects including worsening mental health and weight gain.

Qualitative interviews with participants revealed that the most common reasons for consuming alcohol were sociability and relaxation, as well as taste and to treat or reward oneself. Some women reported that they found alcohol particularly useful in social situations where they felt uncomfortable, particularly during the initial stages of ‘coming out’, when they were entering new social scenes for the first time. Alcohol was used during this time partly to connect and fit in and partly to cope with feelings of anxiety or stress and to gain courage in these situations. This may be one explanation for the younger age of first drinking among non-heterosexual women found in the ALICE sample and in national samples. For example:

*That was a really hard time, coming out at that age, that was really difficult. I started drinking a lot and that, you know, I really got in the full swing because it helped me with the difficulty I felt in coming out ... It [also] helped me in social situations not to feel as anxious as I did and it helped me to fit in (Female, identifies as lesbian, early 50s, living in rural area).*

The most common problems that interview participants identified as arising from alcohol included physical health concerns, loss of control over behaviour and relationship problems. Importantly, more
than half of women identified a strong relationship between alcohol and mental health.

**Mental health**

A large proportion of survey respondents had experienced mental health problems during their lifetimes including depression (56.2%, n=287), anxiety (46.0%, n=234), and post-traumatic stress disorder (PTSD; 16.6%, n=83). These were also common during the last 12 months (Table 3): depression (21.9%, n=112), anxiety (19.4%, n=99), and PTSD (4.4%, n=22). The mean score for perceived stress over the past 12 months was 22.2 (SD=6.9). A high proportion of respondents reported lifetime suicidal thoughts (58.6%, n=302), self-harm (50.3%, n= 259), and suicide attempts (23.7%, n= 122).

**Table 3: Mental health over the previous 12 months comparing ALICE results with a nationally representative sample**

<table>
<thead>
<tr>
<th>Mental health past 12 months</th>
<th>ALICE All N = 515</th>
<th>ALSWH Lesbian N = 99</th>
<th>ALSWH Bisexual N = 100</th>
<th>ALSWH Mainly heterosexual N = 568</th>
<th>ALSWH Heterosexual N = 8,083</th>
</tr>
</thead>
<tbody>
<tr>
<td>CES-D score &gt;10</td>
<td>40.3%</td>
<td>28.6%</td>
<td>44.4%</td>
<td>33.9%</td>
<td>24.5%</td>
</tr>
<tr>
<td>Depression diagnosis</td>
<td>21.9%</td>
<td>25.0%</td>
<td>34.0%</td>
<td>25.4%</td>
<td>11.2%</td>
</tr>
<tr>
<td>Anxiety diagnosis</td>
<td>19.4%</td>
<td>14.6%</td>
<td>20.0%</td>
<td>10.9%</td>
<td>5.5%</td>
</tr>
<tr>
<td>Perceived stress</td>
<td>22.2 score</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-harm</td>
<td>15.3%</td>
<td>4.1%</td>
<td>14.1%</td>
<td>8.0%</td>
<td>2.0%</td>
</tr>
</tbody>
</table>

**Figure 3 - Mental health differences by sexual orientation**
Comparisons with nationally representative samples show high rates of mental illness amongst non-heterosexuals that are similar to the ALICE study, and significantly higher rates than for heterosexual women. In the National Household Drug Study, 27.0% of non-heterosexual women had had any mental illness in the previous 12 months compared with 15.3% of heterosexual women. Differences according to sexual orientation are also seen within the young cohort of the Australian Longitudinal study of Women’s Health (ALSWH) surveyed when women were 25-29 years old (Table 3).

Mental health again differed according to sexual orientation, with the bisexual women and queer/pansexual women in ALICE being worse on all measures over their lifetimes (Figure 3). The bisexual women in the ALSWH also had the worst mental health (Table 3). Stress scores were also higher for these two groups, with means of 23.2 (bisexual) and 23.6 (queer), compared with 21.0 for lesbians and 21.9 for others.

**Relationship between mental ill-health and alcohol use**

Experiences of depression, anxiety, self-harm and suicidality over the previous year each increased as the alcohol intake increased according to the AUDIT scores (Figure 4). Importantly, even women consuming low levels of alcohol had relatively high levels of depression, anxiety and suicidality compared with heterosexuals in the ALSWH, indicating that alcohol alone is not causative, nor universally used for self-medication. However, as drinking levels became more harmful, each measure of mental ill-health increased.

More than half of the women who participated in qualitative interviews identified a strong relationship between their alcohol consumption and mental health. The most common mental health problems reported by participants were depression and anxiety.

**Figure 4 - AUDIT scores versus depression and anxiety diagnoses and suicidality in the past year**

![AUDIT scores versus depression and anxiety diagnoses and suicidality in the past year](image)

**Experiences of abuse**

A high proportion of women completing the ALICE survey had experienced abuse as child and/or intimate partner abuse (IPA). Most striking are the rates of physical child abuse, experienced by 85.8% (n=440) of the sample, and emotional child abuse experienced by 55.7% (n=284). A total of 20.4% (n=104) women...
had suffered childhood sexual abuse, and 13.5% (n=69) neglect. Emotional IPA was the most common form of IPA experienced by 49.1% of the sample, then physical IPA by 26% and sexual IPA by 21.5%. By comparison in the ALSWH, experiences of abuse over the lifetime were also high for the non-heterosexual compared with the heterosexuals. For example, for mid-aged women (aged 50-54), 36.2% heterosexuals had experienced any type of abuse, compared with 50.4% mainly heterosexual, 57.1% lesbian and 74.8% bisexual women [23].

Rates of abuse also varied according to sexual orientation in the ALICE sample (Figure 5). Lesbians were significantly more likely to have experienced physical child abuse, and emotional IPA; whereas bisexual women were more likely to experience sexual IPA.

**Figure 5 – Intimate partner abuse ever and child abuse experiences by sexual orientation**

![Intimate partner abuse ever and child abuse experiences by sexual orientation](image)

**Associations/correlations with drinking**

Our hypotheses regarding the likely associations with heavy drinking based on the literature were first around the area of drinking to cope with minority stress including discrimination and fears of discrimination, lack of social support and connection, and experiences of abuse and violence. Secondly we hypothesised that drinking would be associated with LGBT community connections due to the presumed heightened culture of drinking within these communities. Findings from all sources including the bivariate, multivariate and path analysis of survey data, thematic analysis of open ended questions and interviews indicate that the first hypothesis was correct and the second was not.

**Evidence that problematic drinking is associated with minority stress**

Correlations in multivariate and path analysis of the survey data indicate a number of significant minority stress associations with problematic drinking (using the AUDIT score), including experiences of stress, homophobic harassment, hiding sexual orientation, and lower levels of social support, and lower levels of mainstream community connection. These are all linked with experiences or fears of discrimination.
Depression and/or anxiety are also directly correlated with heavy drinking, as well as via higher levels of stress and lower levels of social support. Experiences of discrimination influenced mental health only via their influence on stress.

Discrimination related to sexual orientation or gender identity was a common experience with 159 women (30.5%) experiencing various forms of discrimination during the past year. There were significant differences according to sexual orientation (Chi² p-value < .001), with more queer, pansexual and lesbian women experiencing discrimination than bisexual and ‘other’ (Figure 6). Discrimination experiences were more likely for those who were more connected with LGBT community, indicating this sub-group are potentially more open or public about their sexual orientation/gender identity, therefore exposing them to negative attitudes.

**Figure 6 - Experienced discrimination regarding sexual orientation/gender identity in the past year by sexual orientation**

![Bar Chart](chart1.png)

There was a strong relationship between discrimination experiences and problematic drinking, particularly at hazardous and harmful levels (Figure 7). Almost half of the women who had experienced discrimination believed that it had affected their drinking.

**Figure 7 – Relationship between discrimination and alcohol use**

![Bar Chart](chart2.png)
Women who participated in qualitative interviews also identified a strong relationship between alcohol consumption and stress. Participants reported numerous stressors related to their sexual orientation such as experience of interpersonal and institutional discrimination, abuse, social isolation and family and societal rejection, and also general life stressors not specific to sexual orientation such as work and relationship problems. It was very common for participants to identify factors such as fear of rejection, discrimination, abuse or social isolation as the main drivers of their drinking, for example:

*Before I came out to my family, I was drinking a lot, alone, at home on my own ... like just wiping myself out almost every night; a cask of red wine and cigarettes and ... I think, at that stage, I thought that I would never be able to come out to my family, so I was having a realisation that there was always going to be this massive big issue. That was very stressful (Female, identifies as lesbian, late 30s, living in inner urban area).*

*It’s an escape [alcohol and drugs]. I’ve seen people physically shaking with rage at something somebody has said on the street. Their immediate reaction is to go and have a drink (Identifies as gender queer and same-sex attracted, early 60s, living in suburban area).*

Women identified a strong relationship between sexual-identity-specific stressors and mental health that then indirectly influenced alcohol consumption. For some participants, and for most heavy drinking participants, alcohol was used as a form of self-medication to deal with mental health issues as a result of both LGBT and general stressors. It was rare for participants to report that heavy drinking preceded and then precipitated mental health issues, but drinking was commonly reported to exacerbate poor mental health. For example:

*Alcohol heightens my sense of sadness when I’m not in a good place for sure, but I kind of do it almost as a self-harming thing as well ... I punish myself in a way, if that makes any sense ... I’m already feeling bad so I’m just going to fuck it, you know just make it even worse just to have that sense of - I don’t know it’s just recklessness really ... And drinking exacerbates my depression or you know sadness - when I’m really in a sad place (Female, identifies as gay, mid 30s, living in inner urban area).*

Once mental health issues were treated alcohol became less necessary, for example:

*When I was younger I used to drink a lot ... That was before my mental health issues were diagnosed and it was a form of self-medication and I was drinking way, way too much ... When I finally started getting diagnosed and treated and on the right meds ... the need to drink reduced (Female, identifies as bisexual, late 20s, living in outer urban area).*

**Evidence that problematic drinking is not generally associated with LGBT community connection or a specific culture of drinking**

The path analysis revealed that there was no association between connection with LGBT community and problematic drinking. This was largely supported within the qualitative data, although a more mixed and nuanced picture of perceptions was obtained. Almost all (n=498) of the survey respondents completed the open-ended questions regarding their perceptions of alcohol use within the LGBT community and comparisons with drinking in the mainstream community. There were mixed views, although more women felt that alcohol use was about the same in each community (n=163) than felt that it was higher in the LGBT community (n = 141). Four women felt that drinking was lower in the LGBT community. Several women explained their statement regarding higher use as being related to discrimination and harassment (n = 39) or to the youth culture (n= 37). No women specifically discussed a culture of drinking.
within LGBT community. Answers to the question regarding whether alcohol use in the LGBT community affected them were much more homogenous and more reflective around cultural mores. The majority of women (n=237) stated that it does not affect them and a few women indicated this was the case because they were not connected to the LGBT community (n=12), or because they seek out social events that do not involve alcohol (n = 45). Some responded with examples of positive effects such as feeling more comfortable (n=10), and feeling safer drinking with other LGBT than heterosexuals (n =5). A minority of women made reference to what we have interpreted as a specific and problematic culture of drinking, including worrying about friends who drink heavily (n = 17), drinking more when they are with LGBT friends who drink heavily (n= 12), and drinking because it is expected (n = 6).

While some interview participants reported drinking heavily when they were young or during the coming out period, most women interviewed did not believe that their sexuality influenced their alcohol consumption. The most common cultural influences on alcohol consumption reported by participants was the normalisation of alcohol in mainstream Australian culture. Some participants reported a strong culture of drinking at LGBT events and in LGBT social circles; however, others suggested that this was no stronger or different to the influences that exist in mainstream licensed venues and social circles. These findings were corroborated by sessions of observation, in which it was obvious that there were some LGBT events where there was a strong focus on heavy alcohol intoxication and some events where this was not the focus at all. For example:

There was a lot more drinking and drunkenness at Hotel X than on the occasions that I have been there for mainstream events ... At around 9pm I walked through the venue and noticed the dance floor was completely full, there was loud dance music playing, and everyone seemed heavily intoxicated. There was lots of energetic dancing, and it is the type of scene I would expect to see in a mainstream venue at about 2am in the morning (Fieldnote January 2014).

There was not a strong emphasis on intoxication at this event at all, in fact the bar was vacant for the whole night. Most women in the room had a drink, but they appeared to be drinking slowly and there was more of a focus on conversing rather than pursuing intoxication or dancing (Fieldnote March 2014).

Perhaps as a consequence, there were mixed views among participants as to whether alcohol use in the LGBT community was heavier than the mainstream community. Some women reported that there was a stronger emphasis on intoxication in the LGBT scene. For example:

It's huge and pervasive ... it really annoys me. I often end up at alcohol-related events because that is how I get to see my friends, when I'd really rather just have coffee. (Survey respondent)

However, the majority of participants suggested that alcohol consumption at LGBT events was no different to alcohol consumption at mainstream events:

If I think about lesbian bars ... it really is just mirroring the same sort of behaviour that I recall seeing at straight venues (Female, identifies as lesbian, late 30s, living in inner urban area).
Overall, 271 (52.0%) participants reported having received treatment for mental health or alcohol-use in the last year. Of these, only 8 (1.5%) participants accessed services for alcohol-use alone, 205 (39.3%) accessed services for mental health alone, and 58 (11.1%) accessed services for both reasons. 314 (60.3%) of participants were hazardous drinkers, depressed or they reported attempting suicide within 12 months, all indicators of service need, therefore showing that treatment utilisation was lower than we would expect.

The type of service used is listed in Figure 8. The most utilised form of service provider for both mental health and alcohol-related problems was a mental health provider, that included counsellor, psychologist or psychiatrist: 206 participants (39.5%) sought help from such a service for mental health within 12 months and 37 (7.1%) for alcohol-related problems. Of the 206 participants who sought help from a counsellor, psychologist or psychiatrist for mental health, 91% attended more than once, compared with 69% of the 196 participants who sought help from a GP. Similarly, 89% of the 37 participants who sought help from a counsellor, psychologist or psychiatrist for help with their alcohol use attended more than once, whereas only 43% of the 21 participants who sought such help from a GP attended more than once.

Figure 8 - Treatment utilisation for mental health and alcohol-related problems by service provider during the past 12 months
Sixty-two participants (11.9% of the total 521) reported having attended LGBT specific services for mental health care; and 16 (3.1%) attended LGBT specific services for alcohol-related problems. Their responses to the open ended questions provided examples of the range of services accessed, and indicate there are relatively few LGBT-specific services on offer. For mental health, this included a mental health provider specialising in LGBT (n = 34), a GP clinic specialising in LGBT (n = 16), and a LGBT community agency offering phone support or face to face support groups (n = 16). For alcohol care, this included LGBT-specific alcohol support including AA or an AOD service (n= 5), an LGBT-specialist mental health provider (n = 4), LGBT-specialist GP (n = 3), and a LGBT community agency (n=2).

The majority of the survey respondents had a regular GP (72.2% = 372), and 61.6% (n=317) believed that their GP knew of their sexual orientation/gender identity. The use of services varied according to sexual orientation. More lesbians had a regular GP (78.8%), than bisexual women (68.5%), queer/pansexual (63.6%) and other (46.7%). Around two thirds of lesbians (69.4%) and queer women (63.6%) were out to their GP, compared with only one third of bisexual women (36%).

Service use for alcohol and mental health also varied by sexual orientation (Figure 9). Bisexual women were most likely to use services for mental health, and least likely for alcohol.

**Figure 9 - Alcohol and mental health service use at least once in the past 12 months by sexual orientation**

![Figure 9 - Alcohol and mental health service use at least once in the past 12 months by sexual orientation](image)

**Barriers and enablers to service use for mental health and alcohol care**

A large proportion of survey respondents were reluctant to use services for mental health, and there was much less reluctance to using services for alcohol (Figure 9). This is likely to indicate that the perceived need for alcohol support was low, rather than indicating an enthusiasm for using alcohol services. The most common reasons for reluctance to seek treatment for alcohol-related problems or mental health were “concerns about being judged about your alcohol use or mental health or emotional well-being” and “not ready to seek help or advice” (38.7% and 38%, respectively). The least cited reasons for reluctance to seek treatment were “fear of discrimination” (16.3%) and “prior experiences of discrimination based on sexual orientation or gender identity” (9.3%).

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While prior experiences of discrimination was not a common barrier to treatment, 19% (n=85) of women had experienced discrimination in health services over their lifetime (Figure 10). This varied considerably according to sexual orientation, with lesbian and queer/pansexual women experiencing much higher levels than bisexual women. This correlates with the degree of disclosure within health services. Importantly, 10-21% of women were unsure whether discrimination had occurred, indicating the subtle nature of discrimination at times.

Figure 10 Experiences of discrimination in health services ever based on sexual orientation/ gender identity

Women described their experiences of discrimination in the open-ended survey question. The most common was feeling judged or disrespected (n=34), also providers lacking LGBT knowledge such as saying that being gay is a phase (n= 22), not being acknowledged as next of kin (n=13), heterosexist assumptions (n=11), or other assumptions such as the mental health problem being due to sexual orientation (n=7).

Binary logistic regression findings regarding associations with treatment utilisation confirmed that experience or fear of discrimination was not a significant barrier (Figure 11). Two significant enablers were having a regular GP (odds ratio=3.02,95% CI:1.84-4.96), and disclosure of sexual orientation to the GP also increased the likelihood of service use (OR=2.421, 95% CI: 1.445-4.057). LGBT community connectedness was associated with service use in the individual analysis (Odds ratio 1.12) however the effect became non-significant in the full regression. Pleasingly, service use was associated with need, in terms of the combined past 12 months service need variable of problematic drinking, depression, or suicide attempts, and regarding intimate partner violence. Bisexuality was the only sexual orientation that was positively associated with service use. Low income is often a barrier to service use, however this was found to be non-significant.

The path analysis provided further evidence that depression and/or anxiety were correlated with service use for mental health and alcohol care. Problematic drinking was correlated with service use for alcohol but not for mental health. It confirmed that discrimination was not influential, but found a correlation between LGBT community connectedness and service use for mental health but not alcohol care. This
indicates a level of encouragement or acceptance of the need for mental health care, but perhaps a denial of alcohol as a problem within the LGBTI communities.

**Figure 11** - Binary logistic regression model of treatment received in past year for mental health or alcohol-related problems

Consistent with the survey findings, women who participated in interviews were far more likely to have sought previous treatment for mental health issues than alcohol. Despite approximately half of the women interviewed reporting drinking heavily at present or in the past, only two women had sought alcohol treatment in the past (both Alcoholics Anonymous (AA) and drug and alcohol counselling). While experiences of AA were generally positive, with three participants reporting that there was a good level of SSAW support in AA, one of the two women who had sought alcohol counselling had experienced discrimination:

*I did feel there was a level of discrimination ... about my sexuality - even though the person was lovely ... I felt like I wasn't taken as importantly as a person in society, you know? ... There were a couple of comments somewhere along the way that made me feel uncomfortable. I can't remember what they were but I remember thinking, mmm, no, not going to continue* (Female, identifies as lesbian, early 50s, living in rural area).
On the other hand, more than half of the women interviewed had sought either GP treatment or counselling for mental health issues. Experiences of mental health treatment were mixed, with some participants reporting positive experiences with GPs, counsellors, psychologists and psychiatrists, while others reported experiencing discrimination. Positive mental health treatment experiences were characterised as non-judgemental, lacking in assumptions and enabling honesty. Positive experiences were most often reported with SSAXW specific counsellors through specialist treatment services or through services that advertise as being LGBT friendly; however, a number of participants also reported positive experiences with non-LGBT specific treatment providers. For example:

*He gets it ... No problems there, I can tell him anything as well ... It’s really strange because I remember thinking I would be way more comfortable talking to a woman than a man but it’s the other way around, not the other way around, it’s the person rather than the gender ... the psychiatrist and psychoanalyst, it’s not because they are male, but it’s because they are open minded and educated. They get it (Female, identifies as queer, early 20s, living in inner urban area).*

Unfortunately, negative experiences of primary care and mental health treatment were common, and a significant number of these negative treatment experiences occurred with GPs. Negative treatment experiences included discrimination, hetero-sexism, feeling unable to be honest, insufficient management of issues, poor LGBT knowledge and negative attitudes. For example:

*General GPs have been not so cool, not overtly aggressive about it, but when I say I’m gay they’ll kind of take - particularly men of a certain age – kind of be baffled by it, almost to the point of they don’t get it. It’s not just a matter of fact which it should be, oh you’re whatever, but the fact that you even have to say it in some environments is offensive in a way. Not deeply hurtful but it’s kind of like you have to come out every - five times a day essentially (Female, identifies as lesbian, early 40s, living in suburban area).*

*I think lots of GPs could do with a bit of training in that regard ... sometimes you just run into an awful doctor and sometimes they just really actually are bigots. So it’s a case by case basis really (Female, identifies as gay, mid 30s, living in inner urban area).*

Participants in rural and regional areas reported negative treatment experiences more often than participants in urban areas, presumably because participants in urban areas had greater access to a range of services and also because of attitude differences between urban and non-urban practitioners:

*I've had others [GPs] I've felt clearly discriminated against and that's possibly because they haven't had any training or awareness or it's outside their experience. I'm talking about large regional towns where the level of ignorance and discrimination amongst the general population, you know, is pretty bad at times (Female, identifies as lesbian, early 50s, living in rural area).*

**Participant suggestions for improvement of health care services**

Participants involved in interviews offered numerous suggestions for the way health services – spanning alcohol, mental health and primary care – could be improved to encourage greater utilisation of services, and achieve greater levels of satisfaction. The point made most strongly was that staff at services should have greater open mindedness and make less assumptions about patients prior to treatment. One of the
One thing that is relevant for everyone, GPs, psychologists ... Using inclusive language. If you look at the intake form and it's all about married, single, sometimes de facto ... The language is very what is known as hetero-normative and I see it across the board (Female, identifies as gay, late 30s, living in inner urban area).

Further to this, some participants reported experiencing assumptions based on their LGBT status. Some examples were that practitioners assumed that pregnancy or sexual health checks did not need to be performed if women identified as LGBT, or that SSAW were generally promiscuous.

The second key message offered by participants was that specific training and upskilling about LGBT issues is needed to improve treatment quality. In particular, participants suggested that practitioners need to receive education about how factors such as alcohol and mental health are shaped by stress and experiences of discrimination that are LGBT specific, for example:

They could start by recognising there is a significant difference. The difference of the experience of the lesbian woman versus the average heterosexual person is radically different (Female, identifies as lesbian, mid 60s, living in regional area).

While women reported wanting more acknowledgement of how their experiences were likely to be influenced by their SSAW status, they also reported not wanting treatment providers to focus on their sexual orientation when it was not warranted, for example, when they were accessing treatment for a common cold or flu, or seeking counselling for work-related stress. For example:

The chap [psychologist] seemed to get a little bit preoccupied in sexuality ... they always tend to think that the reason why I might be having these sorts of issues or whatever is because I’m with a woman or whatever, and I’m like ... Are you listening to me? I’m saying that my boss is driving me insane and everything like that and you’re trying to tie it back to my orientation? (Female, identifies as lesbian, mid 30s, living in outer urban area).

Other key messages for improving services that were suggested by participants included greater sensitivity when treating SSAW, particularly where issues such as discrimination or abuse arise, and greater self-awareness of personal views about homosexuality and how they influence treatment. Other suggestions for improvements to services included having a visual display of the service being LGBT friendly such as a sign, or even just a rainbow sticker (of course services should actually be LGBT friendly if they are going to display such material):

I mean something as simple as that [a rainbow sticker] makes you feel safer about walking in the door (Female, identifies as lesbian, mid 20s, living in inner urban area).

I guess just having posters or something like that around. Like something that says we’re a gay and lesbian friendly service and actually being that (Female, identifies as bisexual, early 40s, living in suburban area).

While most participants reported that more LGBT specialist services would be appealing, they also recognised that general services needed to be upskilled to improve treatment for women who cannot attend specialist services, particularly in regional and rural areas where there are limited service options.
Outcomes

Implications for the LGBT community

The most important implication is that the community culture of drinking amongst SSAW is equivalent to that in mainstream Australia. This allows a review and de-stigmatisation of the ways that the community is perceived and described, both internally and externally. Associated with that can be an acknowledgement that for many SSAW, drinking is a safe and harmless behaviour that enables social connection. However, there are sub-groups of SSAW who are more at risk for problematic drinking, in particular young women who are coming out, and other groups within the community that resent the strong focus of drinking at community social events. The LGBT community should work to increase the availability of alcohol-free social events.

Women with problematic drinking are currently under-utilising health services for alcohol support, largely because there appears to be a lack of perceived need for alcohol care. This compares with much greater access to care for mental health, although there are still barriers, in particular fears of stigmatisation regarding mental health or substance use, and not feeling ready for help. Creating a culture within the LGBT community of support and encouragement to seek help will assist in overcoming these barriers. Encouragement to see a LGBT-sensitive general practitioner regularly and to be open with them about sexual orientation and gender identity will also assist in access to mental health and alcohol support.

Implications for service providers

Service providers need to be aware of the high levels of problematic drinking and mental health problems amongst SSAW and the unique triggers involving minority stress, including discrimination, experiences of abuse, and marginalisation. This creates an important need to know about sexual orientation and gender identity and therefore to develop skills in facilitating disclosure. Understanding the diversity within the LGBT community is also important so as not to make assumptions about risk and the influence of sexual orientation or gender identity on drinking or mental health. Avoiding assumptions of heterosexuality by using open and inclusive language and directly asking at times will be important.

There are many barriers to accessing services for SSAW, and apart from the fear of stigma regarding mental health and alcohol, a lack of perceived need, particular regarding alcohol care is most important to understand. Also, almost one quarter of SSAW have had experiences of discrimination within health care, which, while not forming a barrier to access, may reduce the willingness to disclose. So, providers will need to be more prepared to ask SSAW about alcohol use generally, and in the context of mental health problems. Accessing training around LGBT specific issues and sensitive, inclusive practice will help.

Implications for policy makers

Alcohol use amongst SSAW has not been on the policy agenda in Australia to date, and policy around mental health of LGBT people has tended to focus on youth mental health. The findings of the ALICE study make it clear that alcohol use deserves particular attention, as does the mental health of SSAW of any age. There are several areas that policy makers and government could raise the profile of these issues including:

a) Awareness raising for LGBT and general communities on the impact of discrimination, abuse and social isolation on mental health and alcohol use. This might include campaigns, inclusion in policy documents and strategic plans.

b) Targeted health promotion initiatives for SSAW for both primary and secondary prevention of problematic alcohol use, while ensuring that alcohol use per se is not problematised.

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c) Facilitate self-help and peer support, as these are popular and important methods to increase community involvement and encourage a culture of help-seeking. This needs to use multiple platforms to suit the varying needs of SSAW, including on-line, social media, and face-to-face groups. In general, these should be developed as women-only spaces, and also be specific to subgroups such as transgender, or bisexual women.

d) Data gathering about sexual orientation and gender identity in nationally representative datasets is crucial to understanding differential mental health and alcohol use patterns, and to identify shifts in patterns of inequities over time. For example, there is currently no inclusion of gender identity questions in the Mental Health Survey or the National Household Drug Survey. Neither sexual orientation nor gender identity is included in the Australian Health Survey. This will be very important into the future.

**Training module on LGBT sensitivity**

A training module has been developed that includes two platforms, face-to-face and online. This was developed in collaboration with Gay and Lesbian Health Victoria, expanding on their existing face-to-face module, and with Turning Point Alcohol and Drug Centre. Due to the broad expertise of the collaborative development group, it was decided to be inclusive of gay and bisexual men, and transgendered women and men, and to focus broadly on alcohol and illicit drugs.

**Aims**

1. To understand the impact of heterosexism on the health of LGBT people.
2. To understand the influences on alcohol and other drug use that are specific to LGBT people.
3. To develop strategies within services and individual practice that enable culturally effective support and care for LGBT people with AOD issues, including tips and techniques for sensitive interviewing.

**Target participants**

The module is particularly designed for health care providers working in the alcohol and other drugs field, mental health and primary care sectors. It can also be used by health professional students including medical and nursing students.

**Content**

This is an interactive module including

- a pre and post module evaluation;
- background information about the impact of heterosexism on health, and specific patterns of alcohol and other drug (AOD) use amongst lesbian, gay, bisexual and transgender (LGBT) people;
- activities to test participant’s awareness, attitudes and skills, that are then compared with peers’;
- video clips of LGBT health experts and consumers discussing best practice for sensitive LGBT health care;
- LGBT case studies to work through; and
- reference materials and key readings.
The module includes a new model of influences on alcohol and drug use amongst LGBT people derived from the ALICE data (Figure 11).

**Figure 11 Diagram of LGBT-specific influences on alcohol and drug use**

The model explains that there appear to be three specific areas of influence on higher alcohol and drug use amongst LGBT people: connection, coping and LGBT identity.

**Connection** – Connecting with like-minded people is very important for some LGBT people. LGBT events are often centred on AOD use, just as mainstream social events are. Alcohol or drugs may be used as a social lubricant, or for sexual enhancement. This is not problematic for some, while others find it difficult to escape.

**Coping** - AOD can also be used as a self-medication to cope with marginalisation and minority stress. This is particularly true for LGBT people who feel they lack social support, lack acceptance of their sexual or gender identity, or have been rejected by family. Alcohol may also be used to cope with experiences of discrimination or abuse.

**LGBT identity** - The strength or salience of LGBT identity varies. For some it is very important, and for others it is of little relevance in their lives. This influences preferred social connections (LGBT and/or mainstream), the preferences for disclosure (from very open to very closeted). It also influences how much discrimination a person may face (from repeated experiences to none, depending on how ‘out’ they are). This then influences whether connection and/or coping will become reasons for AOD use.

The module then provides examples of influences from each of the three areas, and encourages participants to apply the model to 6 different case studies, in which there are varying degrees of influence from the three areas. It emphasises that it is helpful to consider these LGBT-specific influences on AOD use when seeing LGBT clients, but not to assume that they always play a role.

**Final take-home messages:**

- Understand diversity within LGBT people in terms of
  - the importance they place on their LGBT identity
  - their preferred social networks – mainstream and/or LGBT
  - influences on their AOD use, be they mainstream and/or LGBT
• Understanding your own assumptions with regard to heterosexism
• Use your existing cross-cultural sensitivity skills modified for LGBT issues, given that you can understand LGBT communities as having particular cultural values, behaviours and beliefs.
• Be patient-centred and individualise care for any LGBT person
  ➢ This includes being willing to ask about sexual orientation/gender identity
  ➢ Determining how/whether LGBT identity is relevant in this situation
  ➢ Inquiring about whether AOD use is a positive or negative influence on the individual
• Build on clients’ existing resilience strategies
• Consider changes you can influence within your service setting to improve LGBT sensitivity

Evaluation survey

A 20-item survey was designed to be delivered as a pre-post evaluation tool. It uses a 5-point Likert scale: 1 strongly disagree, 2 disagree, 3 neutral, 4 agree, and 5 strongly agree. Part A questions are derived from the Cultural Awareness and Sensitivity Tool (CAST), a self-administered instrument to evaluate awareness of and sensitivity to cross-cultural issues in healthcare [Pasricha, 2012]. The original tool had 25 items and had a test-retest reliability of 0.931, and internal consistency of 0.756.

**Part A – Cultural awareness and sensitivity**

1. I can deliver appropriate and effective care to LGBT clients.
2. LGBT people can be understood as part of communities that have their own cultural practices, values and beliefs.
3. Understanding a client’s own perspective of their sexual orientation or gender identity will help me provide better care as a clinician.
4. It is challenging for me to interact with individuals from a cultural background different than my own.
5. For a healthcare provider, a client’s cultural perspective is secondary to other issues in the provision of good quality care.
6. LGBT people differ in the ways in which they interact with members of their own particular community versus other communities.
7. I am aware of prevailing beliefs, customs, norms, and values within LGBT communities.
8. Cross-cultural barriers between the client and healthcare provider can lead to negative consequences for health care.
9. I reflect on and examine my own cultural background, biases, and assumptions related to LGBT issues that may influence my behaviour.
10. Many aspects of LGBT culture influence an LGBT person’s decisions and perceptions about health and healthcare.
11. I am comfortable discussing LGBT issues with my friends and colleagues.
12. I am aware of specific health risks for LGBT people.
13. I would feel uncomfortable working with a colleague who makes derogatory remarks toward LGBT individuals.

**Part B – LGBT people and alcohol and other drug (AOD) use**

1. AOD use is significantly higher amongst LGBT people than heterosexual people.
2. Heterosexism in various forms (e.g. discrimination) influences AOD use amongst LGBT people.
4. Individual perceptions of sexual and/or gender identity plays a role in AOD use amongst LGBT people.
5. LGBT people experience multiple barriers in accessing services for AOD use.
6. LGBT people usually prefer LGBT-specific services over mainstream services for AOD treatment and support.
7. A client’s comfort with their own sexual orientation and/or gender identity is the most important underlying issue to address when working with a LGBT person with AOD related issues.

The post-evaluation survey also included 6 questions to evaluate the teaching and open ended questions on most useful elements and areas for improvement in the module. The pilot of the face-to-face module involved 14 health providers, and 10 completed the pre and post testing.

**Pilot Evaluation results**

Participants completing the evaluation in the face to face workshop included 4 people aged 18-35, 4 aged 36-50 and 2 aged over 50. There were 4 alcohol and drug clinicians, 3 mental health workers, 2 GPs and 1 HIV community nurse. There was a range of previous experience in seeing LGBT clients over the past 12 months, with 3 people estimating having seen 1 to 10, 2 had seen 11 to 20, 3 had seen 21 to 50 and 1 person over 50 LGBT clients (one was unsure).

**Table 4 – Pre-post workshop evaluation items that showed a significant change**

<table>
<thead>
<tr>
<th>CAST Items</th>
<th>t-statistic (df=9)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understanding a client’s own perspective of their sexual orientation or gender identity will help me provide better care as a clinician.</td>
<td>2.0</td>
<td>0.081</td>
</tr>
<tr>
<td>LGBT people differ in the ways in which they interact with members of their own culture versus other cultures.</td>
<td>2.7</td>
<td>0.025</td>
</tr>
<tr>
<td>I am aware of prevailing beliefs, customs, norms, and values within LGBT groups.</td>
<td>2.4</td>
<td>0.037</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LGBT AOD Specific Items</th>
<th>t-statistic (df=9)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Variations in the perceived importance of sexual and/or gender identity to the individual play a role in AOD use amongst LGBT people.</td>
<td>2.2</td>
<td>0.052</td>
</tr>
<tr>
<td>A client’s comfort with their own sexual orientation and/or gender identity is the most important underlying issue to address when treating a LGBT person with AOD issues.</td>
<td>-2.2</td>
<td>0.052</td>
</tr>
</tbody>
</table>
There were several significant changes in the pre to post evaluation questions (p < 0.05), indicating a positive shift in attitudes or knowledge following the workshop (Table 4). The final item regarding a client’s comfort in their own sexual orientation being the most important issue showed a negative shift, indicating more disagreement after the workshop, which is the desired effect.

The overall quality of the teaching (Table 5) was very well rated.

**Table 5 - Teaching evaluation results**

<table>
<thead>
<tr>
<th>Evaluation questions</th>
<th>Mean agreement</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>The pre-reading was a useful preparation for the workshop.</td>
<td>3.9</td>
<td>(0.3)</td>
</tr>
<tr>
<td>The subject matter was clearly presented in the session.</td>
<td>4.3</td>
<td>(0.5)</td>
</tr>
<tr>
<td>The subject matter was relevant to my discipline.</td>
<td>4.3</td>
<td>(0.5)</td>
</tr>
<tr>
<td>The facilitators created an excellent environment for learning.</td>
<td>4.4</td>
<td>(0.5)</td>
</tr>
<tr>
<td>The mixture of didactic and interactive sessions was effective.</td>
<td>4.3</td>
<td>(0.5)</td>
</tr>
<tr>
<td>There was a good balance between general information about the context of life for LGBT people and information about AOD use amongst LGBT people.</td>
<td>4.0</td>
<td>(0.8)</td>
</tr>
<tr>
<td>Evaluation Items Total (Mean)</td>
<td>4.2</td>
<td>(0.4)</td>
</tr>
</tbody>
</table>

Focus group responses were very positive.

Participants liked the model of influences and felt they could apply it in their work. One person said “I assumed the differences were all about discrimination, but now I have a broader framework to consider with other factors”. There was also a strong theme regarding being more aware of diversity within the group, and not using a one size fits all approach. For example, one person said “I need to be more aware that AOD use is not inherently bad, and I need to focus on how it is for the individual client”. Useful suggestions were offered regarding areas for improvement of the module. These fell into the broad categories of information and interventions:

- Information
  - More on resilience and strengths of LGBT people
  - Positive aspects of AOD use – e.g. use as a ‘rite of passage’
  - More on illicit drug use and harms versus benefits – how to measure harmful use
  - Broader discussion of society and discrimination- e.g. the role of the media
  - Comparison between drug use in the Australian/mainstream culture and LGBT

- Interventions
  - Information on LGBT specific interventions – do they exist, do they work or not
  - Tips from experiences of working with LGBT people
Violence/family violence and possible referral points
Organisational change principles adapted for managers – how managers can encourage change, and what to consider in policies
How to manage heterosexism in the workplace
More detail on the rainbow tick training and examples within each of the 6 standards

Several of these ideas were incorporated into the online version of the module.

Finally, participants provided feedback on the length and format of the face to face module. Generally they felt it needed to be longer (a full day) to enable more depth, and to apply to their own work. A half day would be adequate only if you were already LGBT experienced and had read the background reading. One idea was to offer a morning session with the main material and an optional afternoon to work through more cases.

Dissemination

The study findings have been disseminated to a number of groups:

LGBT Community
A presentation was given at the LGBT peak national health conference ‘Health in Difference’ in April 2013.

A community report that accompanies this final report will be available through beyondblue and also distributed to the National LGBTI Health Alliance and placed on the online clearinghouse at Gay and Lesbian Health Victoria. It will also be sent via a weblink to all ALICE participants that gave their contact details.

Health care providers
The training module will be freely available online from the University of Melbourne website on completion in approximately September 2014. It will be marketed widely to general practice, community health, AOD and mental health networks. It will also be added as core curriculum to the medical student curriculum at University of Melbourne and the nursing curriculum at Deakin University. It is planned that the face-to-face training will be embedded into Turning Point curriculum for AOD trainees.

Policy
Interim findings have already been presented to the Alcohol and drugs working group of the Victorian Ministerial Advisory Committee on LGBTI Health and Wellbeing. It has influenced the new Victorian LGBT Health and Wellbeing plan. It is planned to prepare a submission to the National Mental Health Advisory Commission inquiry into mental health services for disadvantaged populations.

Researchers and academic clinicians
Conference presentations

- National Women’s Health conference May 2013
- Primary Health Care Research conference July 2013
- Australian Mental Health Nursing conference October 2013
- Australian Professional Society of Alcohol and Drugs November 2013
- Kettil Bruun Society Asia Pacific conference August 2014
Publication plan

- Literature review on tailored interventions alcohol and smoking – submitted
- Descriptive paper - quantitative findings
- Associations paper – path analysis findings
- Qualitative paper – normalisation versus discrimination, the framework
- Health services enablers and barriers paper

Future research

1. **Development and piloting of an online alcohol intervention tailored for SSAW**
   This work was led by Dr Rhonda Brown at Deakin University in collaboration with Turning Point and the University of Melbourne. It was funded by a Faculty of Health Research Development Grant, Deakin University. It commenced in 2013, with aims to explore the needs and preferences of lesbian and bisexual women (LBW) for the type of smoking cessation and alcohol reduction support; and to design and develop a culturally appropriate and acceptable smoking and alcohol intervention that will target LBW. From this it was decided to focus on alcohol and exclude smoking at this stage.
   To date, two focus groups have been conducted with SSAW regarding their preferences. ALICE findings have also been used to then develop an online alcohol reduction intervention tailored to SSAW, which will be housed on the Turning point Online Counselling website. Recruitment for the pilot of the online intervention has commenced, with plans to test the acceptability of the tailored site against the existing mainstream online counselling site at Turning Point.

2. **Randomised controlled trial of tailored online alcohol intervention**
   An NHMRC project grant application was submitted by CIA Ruth McNair in March 2014. This proposed project is a randomised controlled trial of the piloted targeted online intervention for alcohol reduction amongst lesbian and bisexual women. This is a collaboration with Deakin University, and Turning Point.

3. **Development and piloting of tailored health promotion messages for alcohol and smoking reduction for SSAW**
   An ARC linkages project application is currently being developed, led by Ruth McNair at University of Melbourne. This is to develop and pilot tailored health promotion messages for primary and secondary prevention of alcohol and smoking amongst SSAW. An application is being prepared to VicHealth for partnership funding on this application, and beyondblue will also be approach for partnership funding.
References


