ISUM #1271430, VOL 0, ISS 0

Comparison of Government and Non-Government Alcohol and Other Drug (AOD) Treatment Service Delivery for the Lesbian, Gay, Bisexual, and Transgender (LGBT) Community

Amy B. Mullens, Jane Fischer, Mary Stewart, Kathryn Kenny, Shane Garvey, and Joseph Debattista

QUERY SHEET

This page lists questions we have about your paper. The numbers displayed at left can be found in the text of the paper for reference. In addition, please review your paper as a whole for correctness.

Q1. Au: Please provide the department for affiliation d.
Q2. Au: Do you mean Mullins, Staunton, et al. 2009 or Mullins, Young, et al., 2009 here?
Q3. Au: A declaration of interest statement reporting no conflict of interest has been inserted. Please confirm whether the statement is correct.
Q4. Au: Please provide all author names, including first initials, for Hayes et al. 2004.
Q5. Au: Please provide the volume number and the page range in ref. Strodl et al., 2015.
Q6. Au: Please provide a complete reference in APA 6th edition style for Thorpy et al. 2008.

TABLE OF CONTENTS LISTING

The table of contents for the journal will list your paper exactly as it appears below:

Comparison of Government and Non-Government Alcohol and Other Drug (AOD) Treatment Service Delivery for the Lesbian, Gay, Bisexual, and Transgender (LGBT) Community
Amy B. Mullens, Jane Fischer, Mary Stewart, Kathryn Kenny, Shane Garvey, and Joseph Debattista

SUBSTANCE USE & MISUSE
2017, VOL. 0, NO. 0, 1–12
http://dx.doi.org/10.1080/10826084.2016.1271430

Taylor & Francis
Taylor & Francis Group

ORIGINAL ARTICLE

Comparison of Government and Non-Government Alcohol and Other Drug (AOD) Treatment Service Delivery for the Lesbian, Gay, Bisexual, and Transgender (LGBT) Community

Amy B. Mullens[a,b], Jane Fischer[c,d], Mary Stewart[c], Kathryn Kenny[e], Shane Garvey[f], and Joseph Debattista[g]

[a]Sexual Health & HIV Service, Metro North Hospital and Health Service, Brisbane, Australia; [b]School of Psychology and Counselling, University of Southern Queensland, Ipswich, Australia; [c]Alcohol and Other Drug Service, Metro North Hospital & Health Service, Brisbane, Australia; [d]Flinders University, Adelaide, Australia; [e]DRUG ARM Australasia, Brisbane, Australia; [f]QLD AIDS Council (formerly QLD Association for Healthy Communities); [g]Metro North Public Health Unit, Metro North Hospital and Health Service, Brisbane, Australia.

ABSTRACT

Background: Lesbian, gay, bisexual, and transgender (LGBT) populations are more likely to misuse alcohol and other drugs (AOD), compared to the general population. However, LGBT engagement with AOD treatment is often precluded by insensitivity and misunderstanding of LGBT issues. These treatment barriers may be a consequence of either worker attitudes, organizational factors or a combination of both. Few studies have compared service context as an impediment to AOD treatment. *Objectives*: This pilot study sought to examine and compare staff attitudes, knowledge and awareness of LGBT issues in two state-wide AOD services within Australia. One organization was a government service, whilst the other was faith based. *Methods*: A cross-sectional study of a convenience sample (N = 130) of workers employed in a state-wide government AOD service (n = 65), and a state-wide non-government service (n = 65) was conducted. Participants self-completed a questionnaire comprising tools previously used to assess staff attitudes, knowledge and awareness of LGBT issues. *Results*: Few significant differences in attitudes and awareness of LGBT issues between government and non-government respondents were found. Nearly all respondents were supportive of LGBT persons irrespective of organizational context, with a small number of negative views. Although most respondents demonstrated awareness of organizational policies and practices relating to LGBT clients, many were "unsure" or "neutral" of what these might be. *Conclusion*: It is confirming that the majority of staff report appropriate attitudes towards LGBT clients. Findings suggest that organizations need to continue to take leadership to strengthen organizational training and capacity to deliver LGBT friendly AOD treatment practices.

KEYWORDS
Alcohol and other drug services; attitudes; knowledge; policy; health workers; non-government organizations; LGBT; faith-based organizations

Studies involving lesbian, gay, bisexual and transgender (LGBT) populations in developed countries report higher rates of substance misuse compared to their heterosexual counterparts (Green & Feinstein, 2012; Leonard et al., 2012; Pollock et al., 2012; Roxburgh, Lea, de Wit, & Degenhardt, 2016). A number of factors contribute to these higher rates of misuse (Herdt, 1997; Mullens, Young, Dunne, & Norton, 2011a; 2011b). Alcohol, stimulants, and cannabis use have been historically embedded within gay subcultures (Mullens et al., 2011b; Prestage et al., 2007; Prestage et al., 2015), particularly in association with sexual contact (Bourne, Reid, Hickson, Torres-Rueda, & Weatherburn, 2015; Halkitis & Parsons, 2002; Rajasingham et al., 2012), sexually "adventurous" practices (Semple et al., 2009) and enhanced sexual experiences (Green & Halkitis, 2006; Mullens, Young, Hamernick, & Dunne, 2009). Reinforcing the role of alcohol within LGBT communities, licensed or sexual venues continue to be places where lesbians and gay men have felt comfortable socializing together without fear of stigma from the wider society (Jones-Webb et al., 2013; Mullens, Staunton, Debattista, Hamernick, & Gill, 2009).

LGBT people also experience unique challenges related to discrimination and stigma (Pachankis et al., 2014), victimization (Collier, van Beusekom, Bos, & Sandfort, 2013) and physical abuse (Goldbach et al., 2014; Ignatavicius, 2013) that can negatively affect psychological well-being (see Flentje, Livingston, Roly, & Sorensen, 2015), and for which some persons use substances to help cope (Mullens et al., 2009; Williamson, 2000). It is well established that some of the most powerful institutions in society have historically rejected homosexuality, including various religions, health systems and the media (Meyer, 2013).

LGBT persons commonly face a number of specific difficulties (see Leonard et al., 2012). Some of these include social stigmatization, rejection from families, minority

CONTACT Joseph Debattista Joseph.Debattista@health.qld.gov.au Metro North Public Health Unit, Bryden Street, Brisbane, QLD 4030, Australia.

stress and homophobic abuse (Barrett et al.,1995; Bontempto & D'Augelli, 2002; Kelly et al., 2015; Strodl et al., 2015; Thorpy et al., 2008), which has also been associated with an increased risk of psychological and substance use disorders (Chakraborty et al., 2011; Lyons & Hosking, 2014; Wright et al., 2000). This is exacerbated by barriers to accessing mental health and substance treatment services (Cochran & Cauce, 2006; Kaufman et al., 1997; Staunton, 2007). Experiencing anti-LGBT discrimination has also been associated with increased frequency of unprotected sex (Jarama et al., 2005).

To be effective, treatment must focus on and address cultural variables that influence onset, maintenance and relapse risk (Branstrom & van der Star, 2013; Flentje et al., 2015; Lombardi & van Servellan, 2000), including specific LGBT issues. However, there has been an historical reluctance by alcohol and other drug (AOD) services to include sexuality within standard assessment tools, thereby underestimating the number of LGBT clients utilizing those services (Centre for Substance Abuse Treatment, 2001). This lack of recognition of LGBT clients within services can create indifference and inhibit cultural and organizational change to servicing the needs of this community. Negative or ambivalent attitudes towards sexual diversity among some AOD counselors, and lack of sufficient inclusion of LGBT-specific issues, may also impact upon an LGBT individual's treatment (Eliason, 2000; Talley, 2013).

Compounding challenges to LGBT access and engagement with AOD treatment services there is a large variation amongst LGBT individuals, and unique issues and processes regarding coming out, gender identity and stigma may also impact upon treatment (Lemoire & Chen, 2005). As a result of these specific issues, LGBT people may have unique treatment needs and these can be overlooked in more traditional AOD treatment programs (see Eliason & Hughes, 2004; Lombardi & van Servellan, 2000). Consequently, failure to take sexual orientation and identity sufficiently into consideration may also have a significant negative impact on the success of treatment (Hershberger & D'Augelli, 2000; Talley, 2013).

Previous studies have suggested a range of strategies to enhance an LGBT individual's access to health services. Initiatives should involve education of staff on LGBT issues (Cochran, Peavy, & Cauce, 2007), establishment of specialist services for LGBT in place of generalist services (Senreich, 2010), inclusion of sexual orientation and more flexible gender options on intake forms (Eliason & Hughes, 2004), and the development by services of LGBT-sensitive policies and programs (Leonard et al., 2008). Spector and Pinto (2011) recommend counselors and clinicians working in the alcohol and drug sector improve awareness and understanding of how dominant cultural beliefs and counter transference can impact the therapeutic relationship and treatment, for example substance use and HIV prevention. There is limited information, to date, available regarding the effectiveness of LGBT awareness training (e.g., Flavin, 1997; Hayes et al, 2004) or LGBT-tailored treatment approaches (e.g., Green & Feinstein, 2012; Matthews et al., 2014). Initial studies within health contexts have demonstrated positive impacts regarding LGBT staff training (Hardacker et al., 2014; Kalinoski et al., 2013); however, data regarding secondary impacts upon client engagement and clinical outcomes are limited.

It is well established in the general clinical and counseling literature, that clients who feel accepted and understood, and are receiving "more culturally sensitive health care" (Lombardi & van Servellen, 2000, p. 295) are more likely to engage with therapy and experience enhanced treatment outcomes (Kelly et al., 2015; Talley, 2013). Thus, the purpose of this study was to better understand overall staff attitudes and knowledge, and awareness of LGBT issues, across two state-wide alcohol and drug services within Australia - a government agency and a faith based nongovernment agency. Specifically we sought to advance the following research questions: What are AOD treatment staff attitudes toward LGBT clients, familiarity with LGBT issues, and awareness of organizational LGBT policies?; and Do staff at governmental and nongovernmental AOD treatment services differ on LGBT attitudes, familiarity and awareness of organizational policies? Further, we sought to examine whether staff members of a religious affiliated organization may be more or less informed regarding LGBT issues than staff members of a government funded service; and the possible impact of religious affiliation on service delivery and staff attitudes (Hatzenbuehler, 2014; Meyer, 2013; White & Whiters, 2005).

Method

Survey instrument

A survey was developed adapting and adopting a number of existing survey instruments that have previously been utilized to assess staff and organizational attitudes towards LGBT persons (Eliason, 2000; Gay and Lesbian Health Victoria, 2013; Herek, 1984). The survey was divided into four domains designed to measure staff: attitudes, experience/knowledge/familiarity, demographics and awareness of organization policies and procedures. In total, the survey included 62 questions.

Items for the Staff Attitudes section were adapted from Herek's Attitudes Towards Lesbians and Gays (ATLG; Herek, 1984), with an additional 10 items modified and added to include specific attitudes regarding bisexual and transgender persons in the measurement tool; and

reviewed for acceptability among a focus group of AOD professionals with experience in LGBT issues. Question responses used a 9-point Likert scale ranging from Strongly Disagree to Strongly Agree. Examples of questions used include: "Lesbians just can't fit into our society," "Male homosexuality is a natural expression of sexuality in man," and "God made man and woman: anything else is abnormal." Questions in the "Attitudes" section were grouped regarding attitudes specifically regarding: gay, lesbians, bisexual and transgender people, to summarize views AOD staff may hold regarding one or more of these subgroups. An additional question asked about the respondent's religious denomination or personal spiritual beliefs related to LGBT people. Along with reporting the mean response to individual items, a summary score was also calculated, with a possible score range from 20–180. Cronbach α was 0.488 for the twenty items.

The Experience/Knowledge/Familiarity section included questions about the respondent's levels of comfort and familiarity with each of the four populations and knowledge of common issues for LGBT people. Questions were drawn from a literature review of issues identified to influence substance use treatment for LGBT people (e.g., Center for Substance Abuse Treatment [CSAT], 2001; Eliason & Hughers, 2004; Staunton, 2007). Responses used a 4 point Likert scale ranging from Not at all Familiar to Very Familiar. Along with reporting the mean response to individual items, a familiarity-term summary score was calculated, with a possible score range from 4 to 16. Cronbach α was 0.698 for the four items.

Respondents were also asked about training or education focusing on issues relevant to LBGT persons. Examples of questions include: "How familiar are you with the term: transgender persons?," "How familiar are you with the issue of: coming-out process?," and "How familiar are you with the issue of: heterosexism?." Along with reporting the mean response to individual items, a familiarity-issues summary score was calculated, with a possible score range from 13 to 52. Cronbach α was 0.921 for the 13 items.

The Organization Policies and Procedures section utilized the Sexuality & Gender Identity Organizational Audit produced by the Queensland Association of Healthy Communities (now the Queensland AIDS Council), which was originally derived from the Gay and Lesbian Health Victoria Sexual Diversity Health Services Audit (Gay and Lesbian Health Victoria, 2013). This section included 14 statements concerning organizational policies, procedures and staff competencies using a 5 point Likert scale ranging from Strongly Disagree to Strongly Agree. Examples of statements were: "Your service displays pamphlets and posters with positive images," "Your intake forms include gender-neutral options alongside standard terms," and "Staff have had equity, diversity or awareness training which includes working with LGBT people." Along with reporting the mean response to individual items, a summary score was also calculated, with a possible score range from 0 to 96. Cronbach α was 0.929 for 24 items.

Staff demographics included age, gender, sexual orientation, childhood and current residence (to determine if respondents were from metropolitan, regional or rural areas), level of education, and number of years' experience in AOD.

A pilot study with 20 respondents was conducted at a government AOD service in a metropolitan site (Brisbane, Australia) to determine the readability and acceptability of the survey, and minor adjustments were made accordingly.

Participants and recruitment

For this pilot study, two state-wide AOD organizations—the state-wide government Alcohol and Drug Service operated by Queensland Health with district based programs dispersed across the State, and a non-government AOD service, DrugARM Australasia, with community programs across Queensland and in adjacent states, participated in the recruitment of staff.

DrugARM Australasia is a not-for-profit organization founded upon Christian values and principles, with a stated aim to reducing harms associated with alcohol and other drug use. DrugARM (Drug Awareness, Rehabilitation and Management) provides education, awareness, prevention, rehabilitation, street outreach and support programs targeting individuals, families and communities throughout New South Wales and Queensland and South Australia.

Following ethical approval, each Health Service District in Queensland was approached and permission sought for paper based surveys to be distributed to all government AOD units (both hospital and community based) within each of 15 health service districts. Surveys were forwarded to each AOD unit by mail, and then distributed to individual staff for anonymous self-completion. A total of approximately 300 government clinical and administrative staff were approached.

The same survey was converted to an electronic format on Survey Monkey and the link distributed to all staff and volunteers of the non-government AOD agency, DrugARM. Approximately 150 non-government staff across 16 sites were approached.

A total of 65 AOD government staff from 15 Health Service Districts across Queensland (response rate 21.7%) completed the questionnaire over a one month period.

From the city of Brisbane, 35 surveys were completed with the remaining 30 completed by workers employed in regional and rural areas.

Through DrugARM a total of 65 staff from 16 sites completed the questionnaire (response rate 43.3%). These included staff working in the National Office (Brisbane), the New South Wales State Office (Sydney), and various counseling, support and treatment programs. Two respondents were student volunteers.

Data analysis

Data were analyzed using SPSS19. Data (overall findings and aggregated by service type) were analyzed, with percentages of respondents who Strongly Agree/Agree and Strongly Disagree/Disagree or Very Familiar/Familiar and Slightly Familiar/Not Familiar calculated. Using the numerical Likert scale, mean values were calculated for each response for both government and non-government respondents, which allowed a direct statistical comparison between government and non-government staff.

Ethics clearance

This project received ethics clearance from The Prince Charles Hospital HREC, Metro North Hospital and Health Service; HREC/12/QPCH/55

Results

Demographics

Table 1 provides a summary of self-reported participant characteristics based on site, regarding age, sexual orientation, region of residence (e.g., urban, regional, rural), and percentage of respondents reporting having had received "some training" or formal education focusing on issues relevant to LGBT clients.

Table 1. Demographic characteristics by organization.

Demographic characteristics	Govt. $n = 65$	Non-govt. $n = 65$
Age (average, range)	43; range 40–50	32; range 20–30
Gender		
Female	68.0%	85.0%
Male	32.0%	15.0%
Sexual orientation		
Heterosexual	83.0%	86.0%
Homosexual	9.2%	6.5%
"Other"	7.7%	6.5%
Residence		
Large urban area	47.7%	75.4%
Small regional city	23.1%	14.7%
Small town	9.2%	6.5%
Rural area	20.0%	3.3%

Among government service respondents, the majority of respondents had worked in a health service profession for over 10 years (62.9%). The main occupation of government respondents was nursing (41.5%), psychology (15.4%) and social work (13.8%). The remaining positions evenly spread over a variety of roles including clinician, manager, aboriginal health worker, counselor, administration officer, needle and syringe program worker, and mental health worker. This staff composition is generally reflective of the composition of roles within this government service.

Among NGO respondents, approximately a third had worked in drug and alcohol services for 1 to 5 years (33.9%) and 18.8% for 5 to 10 years. A third (33.1%) of NGO participants identified as "volunteers" with the remaining positions divided between non-clinical roles (38.1%), education and training roles (13.1%) and clinical roles (15%), which is generally reflective of the composition of roles within this service.

Comparison of government and non-government services

There was a significant difference in the median age of government and non-government respondents (43 years vs. 32 years). Non-government respondents were more likely to be female, and most respondents in both organizations identified as heterosexual (9.2% and 6.5% of the government and non-government sample, respectively, identified as homosexual; with inclusion of 7.7% and 6.5% identifying as "other" from each service, respectively). These estimates are higher than population estimates (Gates, 2011). Education levels were similar, but with a higher level of postgraduate qualifications within the government cohort. This may reflect the younger age and higher number of volunteers within the non-government sector.

A greater proportion of non-government respondents (75.4%) resided in large urban areas than government (47.7%) with far fewer residing and working in rural areas (<10% of non-government respondents compared to 29.2% of government respondents). There was a greater dispersion of government respondents across regional and rural areas. Almost a third of the nongovernment respondents were volunteers, a sub-set were non-clinical (38.1%) or engaged in education and training. Fewer non-government respondents compared to government respondents were clinical staff (15% vs. 70.7%). Government clinical respondents comprised nurses (41.5%), social workers (13.8%) and psychologists (15.4%). Twice as many government workers than non-government workers reported some training on issues relevant to LGBT clients.

Table 2. Comparison of government and non-government respondents' attitudes to LGBT clients.

Attitudes toward LGBT clients	Mean[a] 1 = strongly agree and 9 = strongly disagree				
	Govt. $n = 65$	Non-govt. $n = 65$	Mean difference	Total $n = 130$	Sig. difference (.05)
Attitudes summary score	123.74	123.30	0.44	123.50	$t(118) = 0.216$ $p = 0.829$ 95%CI:-3.56–4.43
Lesbians just can't fit into our society	8.43 (1.36)	8.12 (1.82)	0.46	8.28 (1.61)	n/s
State laws regulating private, consenting lesbian behavior should be loosened	2.95 (2.59)	3.06 (2.24)	0.35	3.01 (2.40)	n/s
Female sexuality is a sin	8.37 (1.89)	8.11 (2.12)	0.23	8.24 (2.00)	n/s
Female homosexuality …what society makes of it can be a problem	3.05 (2.31)	3.14 (2.22)	0.09	3.09 (2.23)	n/s
Lesbians are sick	8.55 (1.25)	8.51 (1.53)	0.28	8.53 (1.39)	n/s
Male homosexuals are disgusting	8.52 (1.38)	8.46 (1.28)	0.10	8.49 (1.33)	n/s
Male homosexuality is a perversion	8.40 (1.60)	8.19 (1.87)	0.27	8.30 (1.74)	n/s
Male homosexuality is a natural expression of sexuality in man	2.44 (1.80)	2.78 (2.25)	0.45	2.61 (2.04)	n/s
Homosexual behavior between two men is just plain wrong	8.29 (1.62)	8.17 (1.74)	0.12	8.23 (1.67)	n/s
Male homosexuality is merely a different kind of lifestyle that should not be condemned	2.08 (1.99)	2.08 (1.95)	0.04	2.08 (1.96)	n/s
Bisexuals are sick	8.38 (1.40)	8.19 (1.80)	0.40	8.28 (1.61)	n/s
All people are probably born bisexual	5.75 (1.94)	5.63 (2.01)	0.07	5.69 (1.97)	n/s
There is no place in the moral fabric of society of bisexuality	8.20 (1.41)	8.02 (1.73)	0.32	8.11 (1.57)	n/s
Bisexuality is merely one of many normal variants of human sexuality	2.44 (1.98)	2.67 (2.15)	0.17	2.55 (2.06)	n/s
There should be stricter laws regulating bisexual behavior	8.26 (1.45)	7.98 (1.76)	0.31	8.13 (1.61)	n/s
Transgender people are sick	8.19 (1.67)	8.27 (1.44)	0.23	8.23 (1.55)	n/s
Laws that regulate people's expression of gender should be removed	2.72 (2.10)	3.38 (2.64)	0.54	3.05 (2.39)	n/s
God made man and woman: anything else is abnormal	7.91 (2.01)	8.02 (1.91)	0.10	7.96 (1.96)	n/s
Having only two sexes is limiting …an expression of the continuum of gender	3.23 (1.99)	4.06 (2.44)	0.45	3.65 (2.26)	.044
It is necessary to have clear distinctions between women and men	6.78 (2.20)	6.10 (2.14)	0.68	6.45 (2.19)	n/s

[a]Based on a scale 1 = Strongly agree, 3 = Agree, 5 = Undecided, 7 = Disagree, and 9 = Strongly disagree.

Attitudes

The majority of both government and non-government AOD workers identified as supportive of LGBT persons, with a small number of respondents expressing negative views (see Table 2). The majority of respondents disagreed with adverse statements towards LGBT persons.

The results were more mixed when respondents were asked to consider statements concerning transgender persons, with more persons, both government and non-government undecided about the following statements: "it is necessary to have clear distinctions between women and men," "having only two sexes is limiting - transgender people are an expression of the continuum of gender." Respondents from both groups were most unsure about the statement "All people are probably born bisexual."

While there was a slightly higher rating of positive attitudes recorded amongst government respondents compared with non-government respondents, there were no statistical differences in mean scores, utilizing independent samples *t-tests* for comparisons (see Table 2). There was only one attitude item where a significant difference was found. On this item, the need for firm distinctions between male and female, appeared to be more flexible amongst government respondents.

Although not statistically significant, the largest differences in attitudes were on the following attitude items: "It is necessary to have clear distinctions between women and men" (0.68 mean difference) followed by "laws that regulate people's expression of gender should be removed" (0.54 mean difference), "lesbians just can't fit into society" (0.46 mean difference) and "having two sexes is limiting …" (0.45 mean difference). Government participants were more likely to agree with all of these statements than non-government organization participants.

When asked to consider whether they were "comfortable" working with LGBT clients, all respondents stated that they were comfortable with Lesbian, Gay and Bisexual clients. However, 3.1% of government and 10.8% of non-government staff stated that they were "not comfortable" working with transgender clients.

An overall majority of participants stated that LGBT clients should be "accepted completely," according to their

Table 3. Comparison of government and non-government respondents' experience, knowledge and familiarity with LGBT issues.

	Mean[a] 1 = not at all and 4 = very				
Experience/knowledge/familiarity	Govt. $n = 65$	Non-govt. $n = 65$	Mean difference	Total $n = 130$	Sig. difference (.05)
Familiarity—Terms summary score	11.25	10.05	1.21	10.65	$t(124) = 2.579$ $p = 0.11$ 95%CI:0.28–2.13)
How familiar are you with the term: lesbian persons	3.13 (0.83)	3.05 (0.87)	0.04	3.09 (0.85)	n/s
How familiar are you with the term: gay men	2.52 (0.96)	2.37 (0.97)	0.01	2.44 (0.97)	n/s
How familiar are you with the term: bisexual persons	2.08 (0.93)	2.06 (0.93)	0.00	2.07 (0.93)	n/s
How familiar are you with the term: transgender persons	3.52 (0.62)	2.57 (1.01)	0.39	3.05 (0.96)	.000
Familiarity—Issues summary score	33.70	30.43	3.28	32.08	$t(125) = 2.16$ $p = 0.033$ 95%CI:0.27–6.28)
How familiar are you with the issue of: substance misuse prevalence	3.17 (0.74)	2.73 (0.92)	0.18	2.95 (0.86)	.006
How familiar are you with the issue of: relationships	2.57 (0.95)	2.70 (0.99)	0.04	2.63 (0.97)	n/s
How familiar are you with the issue of: coming-out process	2.58 (0.93)	2.43 (1.00)	0.07	2.51 (0.96)	n/s
How familiar are you with the issue of: gay-bashing/hate crimes	2.31 (0.83)	2.25 (1.03)	0.20	2.28 (0.93)	n/s
How familiar are you with the issue of: domestic partnership laws	2.31 (0.97)	1.92 (0.97)	0.00	2.12 (0.99)	.018
How familiar are you with the issue of: legal issues e.g. power of attorney	3.08 (0.87)	2.37 (1.02)	0.15	2.73 (1.01)	.000
How familiar are you with the issue of: coping strategies	2.91 (0.88)	2.59 (0.91)	0.03	2.75 (0.91)	.043
How familiar are you with the issue of: appropriate terminology	2.94 (0.85)	2.75 (0.95)	0.10	2.841 (0.90)	n/s
How familiar are you with the issue of: homophobia	2.82 (1.03)	2.22 (1.08)	0.05	2.52 (1.09)	.002
How familiar are you with the issue of: heterosexism	2.43 (0.97)	2.16 (1.02)	0.05	2.30 (1.00)	n/s
How familiar are you with the issue of: internalized homophobia	3.02 (0.82)	2.68 (1.00)	0.18	2.85 (0.92)	n/s
How familiar are you with the issue of: family issues	2.31 (0.98)	1.89 (0.90)	0.08	2.10 (0.96)	.011
How familiar are you with the issue of: legal protection	1.47 (0.50)	1.75 (0.40)	0.10	1.61 (0.49)	.001

[a]Based on a scale of 1 = Not at all, 2 = Slightly, 3 = Quite and 4 = Very.

own personal religious beliefs (84.6% of both government and non-government respondents). However, 7.7% and 9.2% of government and non-government workers, respectively, responded that while LGBT people should be accepted, their behavior should be "condemned." Further 6.2% and 0.0% of government and non-government workers, respectively, felt that they were "sinful and immoral."

Experience/skills/knowledge

When asked to consider their familiarity with a range of terms relevant to LGBT people, most AOD respondents indicated that they were familiar (statistical comparisons were made utilizing independent samples *t-tests*, See Table 3). Government respondents were significantly more likely to be familiar with the term transgender persons, issues of substance misuse, domestic partnership laws, power of attorney, coping strategies, homophobia, heterosexism, internalized homophobia and family issues. Familiarity with legal protection was significantly lower ($p = 0.001$) among government than non-government participants.

The largest differences in familiarity were on the following issues: the term "transgender persons" (0.39 mean difference), "gay-bashing/hate crimes" (0.20 mean difference), "substance misuse prevalence" (0.18 mean difference) and "internalized homophobia" (0.18 mean difference). Government participants were more likely to be more familiar with these issues than non-government participants.

However, overall the mean scores for both groups indicated an uncertainty about most issues, particularly those of a legal nature. Alpha reliability calculations were conducted regarding the 17 items comprising Table 3 regarding self-reported familiarity with LGBT issues (alpha = .927.)

Organization policies and procedures

Overall, knowledge of organizational policies was similar across government and non-government respondents, with the mean score indicating uncertainty for most items (though government respondents tended to score slightly higher in awareness; statistical comparisons made via independent samples *t-tests*, See Table 4). However, with respect to bullying, use of gender-neutral terms (0.27 mean difference), personal definitions of "family," confidentiality protection, inclusion of both same sex parents, and access to diversity training, government respondents identified a significantly higher level of awareness of policies compared with non-government respondents.

Other items with the largest differences in awareness of policies between organizational and non-government organizations were: "inclusive language" (0.22 mean difference) and "training to identify and address basic health issues that may particularly affect LGBT clients" (0.18 mean difference). Government participants were more likely to be familiar with these policies than non-government participants.

Discussion

This pilot study has provided a snapshot summary regarding self-reported LGBT attitudes, knowledge and awareness across two Australian AOD service types. This study found that the majority of respondents held accepting attitudes towards LGBT clients, irrespective of service context, although respondents reported they were more unfamiliar with policies and procedures related to LGBT clients, and concepts such as 'gender identity'. Overall, there was strong concordance of knowledge, attitudes and awareness between the government and non-government sector, which indicated that government and NGO staff did not markedly differ in their perspectives (i.e., illustrated by significant difference found in the mean summary attitudes, familiarity and awareness scores).

The majority of respondents, whether government or non-government, were supportive of LGBT persons. Responses were more mixed with respect to transgender people (though still highly supportive), with a greater percentage of government and non-government respondents expressing uncertainty (24.6% and 30.8%, respectively) as to whether transgender persons are an "expression of the continuum of gender." There was also a greater unfamiliarity by staff with issues of gender identity. This may translate to a level of discomfort or uncertainty for some staff working with transgender clients. This finding is consistent previous research (Eliason, 2000), which demonstrated limited knowledge and awareness regarding LGBT issues and needs.

The majority of staff (both government and non-government) identified personal religious and spiritual beliefs that were accepting of LGBT persons. However, approximately 8–9% held personal religious or spiritual beliefs that all LGBT behavior should be "condemned," which warrant further attention. It is difficult to determine from these self-reports whether this is an expression of personal belief or a statement of their particular religious affiliation's views towards sexual diversity. Overall, this study would suggest that the religious tradition of the non-government service did not contribute to significantly adverse responses towards LGBT clients, compared to government service affiliation. Nonetheless, a small minority of staff employed by both government and non-government services did declare negative religious views and this could have serious implications for client access. Given the likelihood that one such staff member could be encountered during the client journey, the potential for negative personal or religious beliefs towards sexual and gender diversity to potentially harm a client's entire treatment experience cannot be underestimated. Further research and staff training should seek to better assess such impact and organizational policies to mitigate these.

Familiarity with LGBT terms indicate that most staff do have a certain degree of awareness of these issues, however, the results also show that there is a significant percentage of staff whom are not familiar. This was more pronounced for non-government respondents, which may reflect the higher proportion of respondents who were volunteers or operating in non-clinical positions. In particular, legal issues relating to "power of attorney," "domestic partnerships," and "legal protection" were familiar to only a minority of participants. Similarly, transgender issues were familiar only to a minority of staff (over 40% were slightly and almost 30% not at all familiar for both government and non-government respondents).

Most respondents demonstrated awareness of organizational policies and practices relating to LGBT clients. However, a significant percentage of both government and non-government respondents were unsure or neutral. For almost every item, a higher proportion of non-government staff indicated they were unaware or unsure of organizational policies that may particularly affect LGBT clients (e.g., written access, anti-discrimination or inclusive service policies). This greater uncertainty amongst the non-government respondents was especially apparent for policies relating to transgender persons and those of a legal dimension. Again, these differences may be reflective of the greater number of volunteer and non-clinical staff who responded from the non-government sector. However, the level of uncertainty by staff of both

Table 4. Comparison of government and non-government respondents' awareness of organizational policies regarding LGBT clients.

	Mean[a] 0 = strongly agree and 4 = strongly agree				
Organizational policies regarding LGBT clients	Govt. $n = 65$	Non-govt. $n = 65$	Difference between means	Total $n = 130$	Sig. difference (.05)
Awareness summary score	70.29	66.05	4.23	68.17	$t(110) = 1.80$ $p = 0.075$ 95%CI:-0.44–8.90)
Your service displays an anti-discrimination policy with a positive statement	2.51 (1.11)	2.29 (1.19)	0.08	2.40 (1.14)	n/s
Your service displays pamphlets and posters with positive images	3.03 (0.84)	2.89 (0.98)	0.14	2.97 (0.90)	n/s
Your staff use inclusive language which recognizes diverse relationships, sexuality and gender identities	3.59 (0.50)	3.40 (0.72)	0.22	3.50 (0.62)	n/s
Your service has agreed policy and procedures to respond to bullying, abuse or inappropriate behavior	2.98 (0.78)	2.60 (0.84)	0.06	2.80 (0.83)	.006
Your intake forms include gender-neutral options alongside standard terms	3.49 (0.56)	3.10 (0.83)	0.27	3.31 (0.73)	.010
Your service adopts each client's definition of 'family' which may include relatives by blood, same-sex partners, or spouses	3.02 (0.81)	2.69 (0.94)	0.13	2.86 (0.88)	.041
It is obvious to the client that confidentiality is protected and privacy respected	2.97 (0.80)	2.59 (0.80)	0.00	2.78 (0.82)	.008
When a transgender person attends your service staff addresses them as their presenting gender	3.36 (0.70)	3.18 (0.78)	0.08	3.27 (0.74)	n/s
Their partner is acknowledged or included in the same way a heterosexual partner is.	2.35 (0.92)	2.12 (0.98)	0.06	2.24 (0.95)	n/s
Staff use gender-neutral partner questions to ask about relationships and sexual behavior at all times	2.43 (0.93)	2.28 (1.07)	0.14	2.36 (0.99)	n/s
When a child has same-sex parents staff include both in discussions about the child's health care	2.95 (0.83)	2.47 (0.89)	0.06	2.73 (0.89)	.004
When a young person tells staff they may be LGBT, staff assure them of confidentiality and provide supportive responses	2.73 (0.80)	2.56 (0.93)	0.13	2.65 (0.87)	n/s
Direct-care staff have had training to identify and address basic health issues that may particularly affect LGBT clients	3.23 (0.73)	3.04 (0.91)	0.18	3.14 (0.82)	n/s
Staff have had equity, diversity or awareness training which includes working with LGBT people	3.26 (0.70)	3.00 (0.76)	0.06	3.13 (0.74)	.050
Staff know that Queensland legislation recognizes same-sex partnerships as 'defacto relationships'	2.81 (0.97)	2.54 (0.91)	0.06	2.68 (0.95)	n/s
Your service has written access, anti-discrimination or inclusive service policies with specific reference to sexual orientation and gender identity	2.16 (0.91)	2.23 (0.91)	0.00	2.19 (0.91)	n/s
Staff treat information about sexual orientation and gender identity as highly sensitive information	2.92 (0.80)	2.98 (0.77)	0.03	2.95 (0.78)	n/s
Your service has links to other agencies that can provide services and support to LGBT clients	3.13 (0.83)	2.98 (0.90)	0.07	3.06 (0.86)	n/s
The content of your health promotion activities and print resources is inclusive of diverse sexuality and gender identities	2.71 (0.78)	2.47 (0.91)	0.13	2.60 (0.85)	n/s
Your service consults LGBT clients in the development of health promotion activities	3.16 (0.73)	2.86 (0.90)	0.17	3.02 (0.82	n/s
Your service is able to refer LGBT clients to appropriate, 'LGBT-friendly' specialist services and resources	2.92 (0.80)	2.98 (0.77)	0.03	2.95 (0.78)	n/s
LGBT staff members at your organization are able to be open about the gender of their partner	3.13 (0.83)	2.98 (0.90)	0.07	3.06 (0.86)	n/s
Your organizational staff conditions or certified agreement recognize same-sex partners and their families under family leave	2.71 (0.78)	2.47 (0.91)	0.13	2.60 (0.85)	n/s
When recruiting staff your organization includes sexuality and gender identity in non-discrimination statements such as …..	3.16 (0.73)	2.86 (0.90)	0.17	3.02 (0.82)	n/s

[a]Based on a scale of 0 – 4 with 0 = Strongly Disagree, 1 = Disagree, 2 = Neutral/Not Sure, 3 = Agree and 4 = Strongly Agree.

service types towards their own organizations' LGBT policy and practice does underlie the importance of staff training and clear managerial instruction.

Study limitations

As with all voluntary, self-reporting surveys, this study has limitations. The self-selected sample may have attracted a greater proportion of respondents more supportive of LGBT issues. While participation was anonymous, social desirability may be a factor (but for different reasons) in both government and non-government respondent responses, and comparisons regarding demographic features were unable to be made among those who did not participate in the survey from each service. Government respondents may have modified their answers to satisfy perceived social and professional expectations, whereas non-government respondents, from a faith based organization, may have felt more secure in expressing divergent views that accorded with their own religious affiliation.

There were demographic and occupational differences between the government and non-government respondent samples that may account for some of the variation in attitudes and knowledge (e.g., higher proportion of volunteers and non-clinical roles and younger age amongst the non-government sample). However, these characteristics are likely to be indicative of many non-government services as a typical reflection of the staff composition rather than sampling bias per se. This would also suggest that the differences identified between the two services are indicative of this workforce composition rather than any underlying religious culture. Although based on service preference, methodological differences between staff completing with survey online (religious affiliated) versus via paper-pencil format (government affiliated), may also have impacted response rates and trends; as well as discrepancies in geographical areas represented by each group.

Implications for research and practice

Further research should focus on a comparison of self-reported attitudes and knowledge among staff compared to client perceptions as well as the impact of LGBT staff awareness training on rates of client access and engagement with services, and treatment outcomes (Kalinoski et al., 2013). Greater consideration should be given of staff beliefs based on workplace role and other demographic features (e.g., rural versus metropolitan; older versus young) and differences in attitudes towards varied LGBT subgroups. Although this study focused primarily on attitudes regarding sexual identity, including transgender clients, it will be important in future research to study attitudes regarding gender identity as distinct from sexual identify and orientation, to assist with identifying specific knowledge and training gaps (Lombardi & van Servellan, 2000).

Utilizing a similar survey process with staff from other community and health services may assist to identify staff barriers to service access and utilization among LGBT, and identify areas to target to heighten awareness and identify further training needs (Eliason, 2000).

Findings from this study could be used to encourage AOD services to adopt and strengthen strategies that improve and promote LGBT access, engagement and satisfaction with such services; and further enhance health staff knowledge, attitude and skills in screening, assessing and providing care to identified LGBT clients; and subsequently work towards improved AOD treatment outcomes for LGBT clients. Given that a small, but meaningful percentage of respondents noted personal, religious and/or spiritual views stating that LGBT persons should be 'condemned' or are 'sinful', this highlights the need for further diversity awareness training (Kalinoski et al., 2013), and/or supervision to explore and address counter transference or other process issues, which may be impacting upon the therapeutic relationship and treatment outcomes (Spector & Pinto, 2011).

This study highlights the need for a systems approach to address access and engagement of LGBT communities with AOD services. A systems approach comprises focusing on the interrelationship between the organization, teams/individuals and clients. Such a multifaceted approach builds the capacity and sustainability of organizations, whether government or non-government to address LGBT disparities in AOD use, and more broadly associated discrimination and stigma. Further, it moves the focus of removing barriers from the individual to the organization (Skinner et al.,2005).

A systems approach also recognizes the role or institutional policies and procedures in acting as a barrier to LGBT AOD treatment seeking. Organizational/service level initiatives include organizational responsibility for developing teams sensitive to LGBT issues, employing staff experienced with LGBT issues, leading organizational change e.g., introduction of new or modified guidelines, raising LGBT awareness, and alteration of office space to ensure that they are LGBT friendly (Skinner et al., 2005). These factors all play a role in developing the capacity of organizations and their staff in addressing barriers to treatment and also in providing effective AOD treatment for LGBT clients, and being mindful of unique socio-cultural features among LGBT (see Kelly et al., 2015; Lemoire & Chen, 2005; Mullens, Young, et al., 2009), which can impact upon predisposing and maintaining factors regarding substance misuse.

Issues at an team/individual level include increasing awareness among AOD workers and clinicians of LGBT cultural and contextual issues associated with substance use and building the capacity of these teams to assess associated harms (e.g., HIV) in a sensitive, respectful and non-judgmental manner (Stall & Purcell, 2000; Stevens, 2012). One means of achieving this is by encouraging teams to ask more questions regarding patterns and contexts of substance use and to consider the thoughts, feelings and behaviors associated with the temporal sequence leading up to substance misuse and underlying psychosocial mechanisms (Bimbi et al., 2006; Mullens, Young, et al., 2009).

Conclusion

Based on findings from the current study, the majority of AOD staff hold accepting self-reported attitudes towards LGBT clients. This study found few significant differences in attitudes and awareness of LGBT issues between government and non-government respondents, and a high level of expressed support for LGBT clients. In addition, the religious tradition of the non-government service did not appear to contribute to these differences. However, within both the government and non-government service, the negative religious beliefs of a small minority of staff could potentially affect the client's overall experience of treatment despite an organizationally supportive environment. This study confirms the need for organizations to take leadership in strengthening training for staff and improving service capacity to deliver LGBT friendly AOD treatment practices and to ensure that LGBT supportive policy and practice is understood by all staff. In particular, there is scope for improvement in staff awareness of LGBT issues, particularly among a minority of staff and in relation to transgender clients; and regarding organizational policies and procedures across government and non-government services relating to LGBT.

Declaration of interest

Q3

The authors report no conflicts of interest. The authors alone are responsible for the content and writing of the article.

Acknowledgments

We gratefully acknowledge the assistance of management, staff and volunteers of DRUG ARM Australasia and the management and staff of Queensland Health AOD Services throughout Queensland who participated in and supported this project.

References

Barrett, D. C., Bolan, G., Joy, D., Counts, K., Doll, L., & Harrison, J. (1995). Coping strategies, substance use, sexual activity, and HIV sexual risks in a sample of gay male STD patients. *Journal of Applied Social Psychology*, *25*, 1058–1072.

Bimbi, D. S., Nanin, J. E., Parsons, J. T., Vicioso, K. J., Missildine, W., & Frost, D. M. (2006). Assessing gay and bisexual men's outcome expectancies for sexual risk under the influence of alcohol and drugs. *Substance Use and Misuse*, *41*, 643–652.

Bontempo, D., & D'Augelli, A. (2002). Effects of at-school victimisation and sexual orientation on lesbian, gay or bisexual youths' health risk behaivour. *Journal of Adolescent Health*, *30*, 364–374.

Bourne, A., Reid, D., Hickson, F., Torres-Rueda, S., & Weatherburn, P. (2015). Illicit drug use in sexual settings ('chemsex') and HIV/STI transmission risk behaviour among gay men in South London: findings from a qualitative study. *Sexually Transmitted Infections*, *91*(8), 564–568.

Bränström, R., & van der Star, A. (2013). All inclusive public health—what about LGBT populations? *European Journal of Public Health*, *23*(3), 353–354.

Chakraborty, A., McManus, S., Brugha, T. S., Bebbington, P., & King, M. (2011). Mental health of the non-heterosexual population of England. *British Journal of Psychiatry*, *198*, 143–148.

Cochran, B. N., & Cauce, A.M. (2006). Characteristics of lesbian, gay, and transgender individuals entering substance abuse treatment. *30*, 135–146.

Cochran, B. N., Peavy, M. K., & Cauce, A. M. (2007). Substance abuse treatment providers' explicit and implicit attitudes regarding sexual minorities. *Journal of Homosexuality*, *53*(3), 181–207.

Collier, K. L., van Beusekom, G., Bos, H. M., & Sandfort, T. G. (2013). Sexual orientation and gender identity/expression related peer victimization in adolescence: a systematic review of associated psychosocial and health outcomes. *Journal of Sex Research*, *50*(3–4), 299–317.

Center for Substance Abuse Treatment (CSAT). (2001). *A provider's introduction to substance abuse treatment for lesbian, gay, bisexual, and transgender individuals*. DHHS Publication No.(SMA) 01–3498. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Eliason, M. J. (2000). Substance abuse counsellors' attitudes about lesbian, gay, bisexual, and transgender clients. *Journal of Substance Use*, *12*, 311–328.

Eliason, M. J., & Hughes, T. L. (2004). Substance abuse counsellor's attitudes about lesbian, gay, bisexual, and transgender clients: urban versus rural counsellors. *Substance Use and Misuse*, *39*, 625–644.

Flavin, C. (1997). Cross-cultural training for nurses: A research-based education project. *The American Journal of Hospice and Palliative Care*, *14*, 121–126.

Flentje, A., Livingston, N. A., Roley, J., & Sorenson, J. L. (2015). Mental and physical health needs of lesbian, gay and bisexual clients in substance abuse treatment. *Journal of Substance Abuse Treatment*, *58*, 78–83.

Gates, G. J. (2011). *How many people are lesbian, gay, bisexual and transgender?* UCLA: The Williams Institute. Retrieved from https://escholarship.org/uc/item/09h684x2

Gay and Lesbian Health Victoria. (2013). *GLBTI-inclusive practice audit for health and human services*. Melbourne, Australia: Gay and Lesbian Health Victoria, La Trobe University.

Goldbach, J. T., Tanner-Smith, E. E., Bagwell, M., & Dunlap, S. (2014). Minority stress and substance use in sexual minority adolescents: a meta-analysis. *Prevention Science*, *15*(3), 350–363.

Green, A. I., & Halkitis, P. N. (2006). Crystal methamphetamine and sexual sociality in an urban gay subculture: An elective affinity. *Culture, Health and Sexuality*, *8*, 317–333.

Green, K. E., & Feinstein, B. A. (2012). Substance use in lesbian, gay, and bisexual populations: an update on empirical research and implications for treatment. *Psychology of Addictive Behaviors*, *26*(2), 265–278.

Halkitis, P. N., & Parsons, J.T. (2002). Recreational drug use and HIV-risk sexual behavior among men frequenting gay social venues. *Journal of Gay and Lesbian Social Services*, *14*, 19–38.

Hardacker, C. T., Rubinstein, B., Hotton, A., & Houlberg, M. (2014). Adding silver to the rainbow: The development of the nurses' Health Education About LGBT Elders (HEALE) cultural competency curriculum. *Journal of Nursing Management*, *22*(2), 257–266.

Hatzenbuehler, M. L. (2014). Structural stigma and the health of lesbian, gay, and bisexual populations. *Current Directions in Psychological Science*, *23*(2), 127–132.

Hayes, , et al. (2004). The impact of acceptance of commitment training and multicultural training on the stigmatizing attitudes and professional burnout of substance abuse counsellors. *Behaviour Therapy*, *35*, 821–835.

Herdt, G. (1997). *Same sex, different cultures: Exploring gay and lesbian lives*. Boulder, CO: Westview Press.

Herek, G. M. (1984). Attitudes toward lesbians and gay men: A factor-analytic study. *Journal of Homosexuality*, *10*, 39–51.

Hershberger, S., & D'Augelli, A. (2000). Issues in counselling lesbian, gay and bisexual adolescents. In R. Perez, K. DeBord, & K. Bieschke (Eds.), *Handbook of counselling and psychotherapy with lesbian, gay and bisexual clients* (pp. 65–74). Washington, DC: American Psychological Association.

Ignatavicius, S. (2013). Stress in female-identified transgender youth: A review of the literature on effects and interventions. *Journal of LGBT Youth*, *10*(4), 267–286.

Jarama, S. L., Kennamer, J. D., Poppen, P. J., Hendricks, M., & Bradford, J. (2005). Psychosocial, behavioral, and cultural predictors of sexual risk for HIV infection among Latino men who have sex with men. *AIDS and Behavior*, *9*(4), 513–523.

Jones-Webb, R., Smolenski, D., Brady, S., Wilkerson, M., & Rosser, B. S. (2013). Drinking settings, alcohol consumption, and sexual risk behaviour among gay men. *Addictive Behaviour*, *38*(3), 1824–1830.

Kalinoski, Z. T., Steele-Johnson, D., Peyton, E. J., Leas, K. A., Steinke, J., & Bowling, N.A. (2013). A meta-analytic evaluation of diversity training outcomes. *Journal of Organizational Behaviour*, *34*, 1076–1004.

Kaufman, J. S., Carlozzi, A. F., Boswell, D. L., Barnes, L. L. B., Wheeler-Scruggs, K., & Levy, P. A. (1997). Factors influencing therapist selection among gays, lesbians and bisexuals. *Counselling Psychology Quarterly*, *10*, 287–297.

Kelly, J., Davis, C., & Schlesinger, C. (2015). Substance use by same sex attracted young people: Prevalence, perceptions and homophobia. *Drug & Alcohol Review*, *34*, 356–365.

Lemoire, S. J., & Chen, C. P. (2005). Applying person-centered counseling to sexual minority adolescents. *Journal of Counseling & Development*, *83*(2), 146–154.

Leonard, W., Mitchell, A., Pitts, M., & Patel, S. (2008). *Coming forward: The underreporting of heterosexist violence and same sex partner abuse in Victoria*. Monograph Series No. 69. Melbourne, Australia: The Australian Research Centre in Sex, Health & Society, La Trobe University.

Leonard, W., Pitts, M., Mitchell, A., Lyons, A., Smith, A., Patel, S., … Barrett, A., (2012). *Private lives 2: The second national survey of the health and wellbeing of gay, lesbian, bisexual and transgender (GLBT) Australians*. Melbourne, Australia: The Australian Research Centre in Sex, Health & Society, La Trobe University.

Lombardi, E. L., & van Servellen, G. (2000). Building culturally sensitive substance use prevention and treatment programs for transgender populations. *Journal of Substance Abuse Treatment*, *19*, 291–296.

Lyons, A., & Hosking, K. (2014). Health disparities among common subcultural identities of young gay men: Physical, mental and sexual health. *Archives of Sexual Behaviour*, *43*, 1621–1635.

Matthews, A. K., McConnell, E. A., Li, C., Vargas, M. C., & King, A. (2014). Design of a comparative effectiveness evaluation of a culturally tailored versus standard community-based smoking cessation treatment program for LGBT smokers. *BMC Psychology*, *2*(1), 12. doi:10.1186/2050-7283-2-12

Meyer, I. H. (2013). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence. *Psychology of Sexual Orientation and Gender Diversity*, *1*(S), 3–26.

Mullens, A. B., Staunton, S., Debattista, J., Hamernik, E., & Gill, D. (2009). Sex on premises venue (SOPV) health promotion project in response to sustained increases in HIV notifications. *Sexual Health*, *6*, 41–44.

Mullens, A. B., Young, R. McD., Dunne, M., & Norton, G. (2011a). The Amyl Nitrite Expectancy Questionnaire for Men who have Sex with Men (AEQ-MSM): A measure of substance-related beliefs. *Substance Use & Misuse*, *46*, 1642–1650.

Mullens, A. B., Young, R. McD., Dunne, M., & Norton, G. (2011b). The Drinking Expectancy Questionnaire for Men who have Sex with Men (DEQ-MSM): A measure of substance-related beliefs. *Drug & Alcohol Review*, *30*, 372–380.

Mullens, A. B., Young, R. McD., Hamernik, E., & Dunne, M. (2009). The consequences of substance use among gay and bisexual men: A consensual qualitative research analysis. *Sexual Health*, *6*, 139–152.

Pachankis, J. E., Hatzenbuehler, M. L., & Starks, T. J. (2014). The influence of structural stigma and rejection sensitivity on young sexual minority men's daily tobacco and alcohol use. *Social Science and Medicine*, *103*, 67–75.

Pollock, J. A., Halkitis, P. N., Moeller, R. W., Solomon, T. M., Barton, S. C., Blachman-Forshay, J, … Siconolfi, D. E. (2012). Alcohol use among young men who have sex with men. *Substance Use and Misuse*, *47*(1), 12–21.

Prestage, G., Degenhardt, L., Jin, F., Grulich, A., Imrie, J., Kaldor, J., & Kippax, S., (2007). Predictors of frequent use

of amphetamine type stimulants among HIV-negative gay men in Sydney, Australia. *Drug and Alcohol Dependence*, *91*, 260–268.

Prestage, G., Brown, G., De Wit, J., Bavinton, B., Fairley, C., Maycock, B., … Zablotska, I. (2015). Understanding gay community subcultures: Implications for HIV prevention. *AIDS and Behaviour*, *19*, 2224–2233.

Rajasingham, R., Mimiaga, M. J., White, J. M., Pinkston, M. M., Baden, R. P., & Mitty, J. A. (2012). A systematic review of behavioral and treatment outcome studies among HIV-infected men who have sex with men who abuse crystal methamphetamine. *AIDS Patient Care and STDs*, *26*, 36–52.

Roxburgh, A., Lea, T., de Wit, J., & Degenhardt, L. (2016). Sexual identity and prevalence of alcohol and other drug use among Australians in the general population. *International Journal of Drug Policy*, *28*, 76–82. doi:10.1016/j.drugpo.2015.11.005

Semple, S. J., Zians, J., Strathdee, S. A., & Patterson, T. L. (2009). Sexual marathons and methamphetamine use among HIV-positive men who have sex with men. *Archives of Sexual Behavior*, *38*, 583–590.

Senreich, E. (2010). Are specialized LGBT program components helpful for gay and bisexual men in substance abuse treatment? *Substance Use & Misuse*, *45*, 1077–1096.

Skinner, N., O'Connor, J., Pollard, Y., & Todd, C. (Eds.). (2005). *Workforce development TIPS (Theory Into Practice Strategies): A resource kit for the alcohol and other drugs field*. Adelaide, Australia: National Centre for Education and Training on Addiction (NCETA), Flinders University.

Smith, G., Worth, H., & Kippax, S. (2004). *Sexual adventurism among Sydney gay men*. Sydney, Australia: National Centre in HIV Social Research, University of NSW.

Spector, A. Y., & Pinto, R. M. (2011). Let's talk about sex: Helping substance abuse counsellors address HIV prevention with men who have sex with men. *Culture, Health & Sexuality*, *13*(4), 399–413.

Stall, R., & Purcell, D. W. (2000). Intertwining epidemics: A review of research on substance use among men who have sex with men and its connection to the AIDS epidemic. *AIDS and Behaviour*, *4*, 181–192.

Staunton, S. (2007). *Uneven ground: Mapping the terrain for LGBT young people: A Brisbane a mapping report on LGBT young people and the service providers who work with them*. Brisbane, Australia: Queensland Association for Healthy Communities.

Stevens, S. (2012). Meeting the substance abuse treatment needs of lesbian, bisexual and transgender women: Implications from research to practice. *Substance Abuse and Rehabilitation*, *3*(S1), 27–36. doi:10.2147/SAR.S26430

Strodl, E., Stewart, L., Mullens, A. B., & Deb, S. (2015). Metacognitions mediate HIV stigma and depression/anxiety in MSM living with HIV. *Health Psychology Open*. Q5

Talley, A. E. (2013). Recommendations for improving substance abuse treatment interventions for sexual minority substance abusers. *Drug and Alcohol Review*, *32*, 539–540.

Thorpy, L., et al. (2008). Action research report. There's no place like home: an investigation into the housing of Queensland's lesbian, gay and bisexual young people. *Brisbane, Open Doors Youth Service*. Q6

White, W., & Whiters, D. (2005). Faith-based recovery: It's historical roots. *Counselor*, *6*(5), 58–62.

Williamson, I. R. (2000). Internalised homophobia and health issues affecting lesbians and gay men. *Health Education Research*, *15*(1), 97–107.

Wright, E. R., Gronfein, W. P., & Owens, T. J. (2000). Deinstitutionalization, social rejection, and the self-esteem of former mental patients. *Journal of Health and Social Behaviour*, *41*, 68–90.