Alcohol and Drug Foundation

Local Drug Action Team Program

Australian Government

Resource for working with LGBTI communities.

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Contents

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1. Purpose

The purpose of this resource is to educate and inform Local Drug Action Teams (LDATs) about key considerations when working with LGBTI communities, including information about LGBTI communities, substance use and strategies for increasing inclusivity of LGBTI people within LDATs.

2. What does LGBTI mean?

LGBTI is a collective acronym that is commonly used to refer to people who identify as lesbian, gay, bisexual, transgender and/or intersex.

Sometimes people are attracted to, or engage in, sex with people of the same gender, without identifying as LGBTI.[1]

2.1 LGBTI terminology

The following table provides definitions for key terms used in this resource.[2,3]

Term	Definition
Sexual orientation	This term refers to emotional, romantic or sexual feelings towards other people. A person's sexual orientation may be gay, lesbian, bisexual, heterosexual, for example. Sexual orientation is separate from a person's gender identity or expression.
Gender	This term refers to a person's sense of self and whether they identify as masculine, feminine, a combination of both, or neither. Gender roles are sometimes denoted by clothing, speech, interests, occupation and other factors not linked to biological sex. Sometimes gender will correspond to a person's assigned sex at birth, for example, when someone born with male sex organs will identify as male. Sometimes people will identify as non-binary or gender queer, meaning that they do not identify with either gender. Sometimes people will identify with a gender identity other than the one assigned to them at birth, for example, a transgender person.
Lesbian	This term is used to describe a sexual orientation, not the person's gender. A person who identifies as a woman, whose sexual orientation is centred on experiences of romantic, sexual, and/or affectional attraction solely or primarily to other women.
Gay	This term is used to describe a sexual orientation, not the person's gender. A term used to describe a person who identifies as a man, who has experiences of romantic, sexual and/or affectional attraction solely or primarily to other men. Sometimes lesbians may refer to themselves as gay as well.
Bisexual	This term is used to describe a sexual orientation, not the person's gender. A bisexual person is a person of any gender who has romantic and/or sexual relationships with and/or is attracted to people from more than one gender. Some people who fit this description prefer the terms 'queer' or 'pansexual'.
Trans/transgender	This term is used to describe a person's gender, not their sexual orientation. A trans or transgender person refers to someone who was assigned a sex at birth that they do not feel reflects how they understand their gender identity, expression, or behaviour. Sometimes they may use gender-neutral pronouns such as they/them/theirs rather than he/him/his or she/her/hers.
Intersex	The common medical sexual classifications assigned to people at birth typically include 'male' and 'female'. A person who is born with intersex characteristics will have variations of these sexes. Intersex is not about gender or sexual orientation, but about innate physical variations.

2.2 Lived experience of LGBTI communities

Understanding the historical and contemporary context for LGBTI populations is crucial to promoting an organisational culture that is inclusive. Historically, LGBTI communities have experienced widespread discrimination and stigma, including criminalisation, police violence, and reduced access to employment and housing. LGBTI people have also been barred from marrying, adopting children and participating in other key social institutions.[4,5]

This has led to ongoing inequality and social isolation within the LGBTI community. LGBTI people are more likely to experience homelessness, verbal and physical abuse, depression, anxiety and suicide ideation.[6,7,8,9,10]

Sexual minorities experience poorer health outcomes and are less likely to seek medical advice or preventative health. This is especially marked in relation to alcohol- and drug-related harms. One of the major contributing factors to alcohol and drug use is minority stress, which suggests that the discrimination, stigma and social isolation experienced by LGBTI people can affect their psychological health and well-being:

> "Although members of LGBTI and HIV positive communities use drugs and alcohol for many of the same reasons as the population at large, there is evidence to suggest that shared experiences of LGBTI related discrimination can lead to patterns of [alcohol and drug] misuse specific to LGBTI people."[11]

LGBTI people may experience increased vulnerability to dependency or substance use if they also experience a mental health disorder that is co-occurring or comorbid with substance dependency. Some people who are dependent on substances also have clinical depression, anxiety or other mood disorders or post-traumatic stress disorder.[12]

3. Why does alcohol and drug use in LGBTI communities matter?

Alcohol and other drug use in LGBTI communities is an important health issue.[12] Pervasive, frequent and heavy alcohol and drug use in LGBTI populations contributes to poorer health outcomes in LGBTI communities.[12]

3.1 Prevalence of alcohol and drug use

The LGBTI community has a higher prevalence of alcohol and other drug use compared to society broadly.[13,14] LGBTI people are almost twice as likely to use alcohol and drugs as their peers.[15]

The types of substances used in LGBTI communities also vary from the general population. While alcohol and cannabis use among LGBTI people is higher, the greatest disparities were found in stimulants. Lesbian, gay and bisexual people are up to five times more likely to use ecstasy, meth/amphetamines and cocaine than non-LGBTI people.[16,17,13] They are also more likely to report ever having tried drugs like heroin, ketamine, GHB (gamma hydroxybutyrate) and hallucinogens, although injecting drug use in general is lower among LGBTI people than in the general community.[17,13]

There is limited research on substance use and dependency among transgender and intersex populations. Of the studies that do exist, most examine male-to-female transgender substance use.[12] Nonetheless, early evidence suggests that there is a disproportionate use of illicit drugs, particularly methamphetamine and cocaine, and illegally obtained hormones.[12]

3.2 Initiation of use

LGBTI people may also initiate alcohol and other drug use at an earlier age than people in general.[12,16] Lesbian and bisexual women are more likely to use alcohol and illicit drugs earlier than their non-LGBTI counterparts.[17] LGBTI adolescents are also between three and four times more likely to use illicit substances than their non-LGBTI counterparts.[18,19]

Early-onset drug and alcohol use is associated with higher frequency of substance use, increased risk of dependency and developmental issues.[20,21]

3.3 Frequency and level of use

There is limited evidence on the frequency of alcohol and other drug use in LGBTI communities.[22] However, research suggests that LGBTI people may use alcohol and drugs more frequently than their non-LGBTI counterparts. While approximately a quarter of young people Australia-wide had used drugs within a twelve-month period, up to half of the lesbian, gay and bisexual youth surveyed reported using drugs in the preceding six months.[23] Approximately 70% of LGBTI people surveyed indicated hazardous alcohol use, compared to 13% in the general population.[24]

3.4 Dependency

The frequency, type of use, and the type of drugs used in the LGBTI community contributes to higher rates of alcohol and drug dependency. Dependency is defined by the Australian Drug Information Network as occurring:

> "when a drug is central to a person's life, they have trouble cutting down their use and experience symptoms of withdrawal when trying to cut down. [Symptoms] can be physical or psychological, or both. When a person's body has adapted to a drug and is used to functioning with the drug present, the person is said to be physically dependent upon that drug. When a person feels compelled to use a drug in order to function effectively or to achieve emotional satisfaction, the person is said to be psychologically dependent upon that drug."[25]

While data on dependency in LGBTI populations is sparse, studies have confirmed higher rates of dependency among bisexual and transgender people, particularly for alcohol and stimulants. Between 3–7% of LGBTI people are dependent on club drugs, compared to 0.5–2.8% in the general population.[23] Bisexual women also have higher rates of dependency for marijuana and cocaine.[12] Additionally, discrimination towards LGBTI people contributes to higher rates of substance use disorders and reduced help-seeking and access to healthcare services.[26]

4. What are the factors that contribute to differential use of AOD in LGBTI communities?

The causes of alcohol and other drug use among LGBTI people are complex.[18] Nonetheless, there are several factors that may contribute to alcohol and drug use in LGBTI communities, explored below.[19]

4.1 Minority stress

Minority stress is the idea that internal and external factors, particularly discrimination and stigma, can increase stress for people who identify as LGBTI. This may contribute to maladaptive coping mechanisms, such as using alcohol or other drugs to manage psychological distress.[27,28,29]

> "For some LGBTI people their experience of living in a homophobic and transphobic environment can trigger mental health problems and/or the use of drugs as a way of coping with the cumulative effects of being abused and discriminated against and made to feel less worthy than the heterosexual and gender normative majority."[30]

4.2 Social norms

Social norms and perceptions of peer use of alcohol and drugs is a predictor of substance use in society broadly.[31] This is particularly the case among LGBTI communities. Alcohol and other drug use is normalised in LGBTI communities due to widespread use and the types of settings around which the community is organised.[32,33] Due to historical criminalisation and ongoing stigma toward people who identify as LGBTI, many continue to socialise in gay bars and nightclubs, where alcohol and other drug use is commonplace.[24]

Many LGBTI people perceive alcohol and drug use to be common among other members of their community.[34] For example, a recent survey showed that 80% of gay or bisexual men reported that at least a few of their gay friends used illicit drugs.[35] The perceived acceptability of alcohol and drugs in social groups contributes to the likelihood of individuals to consume substances themselves.[35]

A qualitative study of LGBTI people identified that the majority of those interviewed believed that substance use in the community was a "major problem".[19]

4.3 Sexualised drug use

The use of illicit drugs to facilitate sex is not unique to the LGBTI community, however, it is more widespread. Gay and bisexual men in particular have reported using meth/amphetamines combined with erectile dysfunction medication, like Viagra®, to increase sexual function.[36,37] Approximately 61.8% of men from the LGBTI community who had used illicit drugs in the six months had used substances to enhance a sexual encounter.[38]

5. What does this mean for LDATs?

LDATs should strive for inclusivity in all aspects of their program, at all stages of program development, and for all minority groups.

Gay and Lesbian Health Victoria at Australian Research Centre in Sex, Health and Society (formerly Gay and Lesbian Health Victoria) is one of the peak bodies for the health and wellbeing of LGBTI people. GLHV has developed *The Rainbow Tick Guide to LGBTI-inclusive practice*, designed to help organisations evaluate and improve their practices and make their programs more inclusive for LGBTI people.[39]

The Rainbow Tick Guide recommends the following six strategies for improving inclusion for LGBTI people: organisation capability, workforce development, consumer participation, a welcoming and accessible organisation, disclosure and documentation, and culturally safe and acceptable services. These strategies are briefly outlined below, with some suggestions for best practice.

LDATs may want to consider the following strategies as part of their work to develop inclusive practice. This resource does not provide explicit instruction for how to implement these strategies, rather a guide on what LDATs may consider.

5.1 Organisation capability

Establishing an inclusive organisational culture for LGBTI people is crucial. This will ensure that the LDAT creates an inclusive and welcoming environment at all levels. Inclusive spaces strive to make LDAT staff, volunteers and program users feel safe and supported. This includes developing policies on equal opportunity, bullying and harassment for staff, volunteers and service users. Policies also provide an opportunity to include explicit consequences for breaches of these policies. This signals a commitment to inclusivity, provides a basis upon which to develop other practices for inclusion, and aims to reduce discrimination.[40]

By including LGBTI people within leadership, volunteer and committee roles, LDATs have an opportunity to create a culture of inclusivity. This enables participation of other LGBTI people, encourages engagement from LGBTI-specific stakeholders and strengthens LGBTI inclusive practices. Where possible, this should be measurable against indicators developed during the program planning and delivery phases, to ensure that LGBTI inclusion is prioritised and can be evaluated. When hiring subcontractors, LDATs may also want to consider inclusivity as a key criterion when assessing candidates.

5.2 Workforce development

Improving the cultural competency of employees and volunteers is necessary to facilitate LGBTI inclusivity.

LDATs may consider participating in training workshops provided by external consultants to deliver cultural competency training. This will provide employers, service providers, staff and volunteers with knowledge of LGBTI issues, terminology, barriers to and enablers of inclusivity and support to implement best practice. Organisations that provide cultural competency training include *Pride in Diversity* and *Pride in Health + Wellbeing*, national not-for-profit support programs that specialise in LGBTI inclusion. For more information, consult: prideinclusionprograms.com.au/contact-us

Including information on LGBTI lived experiences and measures to improve inclusivity in meetings, mentorship, newsletters, emails and organisational intranet systems can increase awareness of these issues among staff and volunteers.

5.3 Consumer participation

Consulting LGBTI people in designing and implementing activities will provide LDATs with insight into the needs of LGBTI people as service users, help to establish gaps in service provision, and improve the accessibility of the LDAT activity. This ensures that LGBTI people help to shape the activity from conception through to implementation. This can be achieved by establishing an LGBTI consumer advisory committee, focus group or ensuring that consumer satisfaction surveys capture feedback on LGBTI inclusion where possible.

Building relationships with LGBTI-specific organisations or services in the local area is also useful. This will ensure your program is accessible to LGBTI people and meets their needs. It also provides an excellent avenue for promoting your program.

Some organisations that may be helpful for LGBTI inclusion are listed below:

ACON: acon.org.au

A Gender Agenda (AGA): genderrights.org.au

Blacktown Women and Girls Health Centre: womensandgirls.org.au

Diversity ACT: diversityact.org.au

GASP Geelong: gaspgeelong.org.au

Gender Queer Australia: genderqueer.org.au

Intersex Human Rights Australia: ihra.org.au

Living Positive Victoria: livingpositivevictoria.org.au

Minus18: minus18.org.au

National LGBTI Health Alliance: gbtihealth.org.au

NSW Gay and Lesbian Rights Lobby: glrl.org.au

Positive Life NSW: positivelife.org.au

QLife: qlife.org.au

Queensland AIDS Council: quac.org.au

Rainbow Recovery Club: rainbowrecoveryclub.org.au

Star Observer: starobserver.com.au

Transcend: transcendsupport.com.au

Wendybird: www.wendybird.com.au

5.4 A welcoming and accessible organisation

The physical and social environment of an LDAT activity can have an impact on how the organisation is perceived by existing and potential LGBTI staff, volunteers and consumers. This can influence the extent to which the program is utilised by the LGBTI community. Safe and welcoming environments will encourage participation in LDAT activities.

LDATs can increase participation of LGBTI people in activities by ensuring that the built environment is welcoming to LGBTI populations. This includes providing private non-gendered bathrooms and change rooms where possible, to include intersex and transgender people, and secular venues such as local recreational centres.

It is also possible for LDATs to use publicly facing communications to demonstrate inclusivity, such as welcoming written, oral and print communications. This includes demonstrating LGBTI inclusion through imagery and language on webpages, information brochures, recruitment and advertising material.

5.5 Disclosure and documentation

LDATs can build in a culture of inclusivity and safety by ensuring that all information provided by staff, volunteers and consumers remains confidential. LDATs have a responsibility to ensure that any data, particularly related to sexual orientation, gender identity or intersex status, is confidential.[41] LDATs may consider providing training to staff and volunteers to support this need. Refer to the 'Workforce Development' section of this document for information on available training. LDATs may refer to the Ethics Resource for more information about managing sensitive data.[42]

5.6 Culturally safe and acceptable services

To ensure that LDATs provide culturally safe and acceptable services for LGBTI people, the needs of the communities should be considered in every aspect of the program design, promotion, delivery and evaluation. LDATs should regularly distribute information to staff, volunteers and consumers on measures to improve the cultural safety of their program; and organisational processes for responding to discrimination of LGBTI people.

Any breaches of cultural safety or anti-discrimination policies should be managed transparently and according to established procedures.

Another strategy for LGBTI inclusion and engagement is to celebrate community groups, events and dates of significance.[43]
These include:

Intersex Awareness Day
For more information consult:
- Intersex Human Rights Australia: ihra.org.au

Transgender Day of Remembrance
For more information consult:
- Transgender Victoria: transgendervictoria.com
- YGender: ygender.org.au

World AIDS Day
For more information consult:
- Thorne Habour Health: thorneharbour.org

Midsumma Festival
For more information consult:
- Midsumma Festival: midsumma.org.au

Pride March
For more information consult:
- The Australian Pride Network: australianpridenetwork.com.au

5.7 Other inclusionary strategies for working with LGBTI people

- Avoid making assumptions about a person's gender or sexuality
- Use the same terms that the person uses to describe themselves, their sexual or romantic partners, relationships, and identity. If you are uncertain about what terms to use, clarify with the person
- Avoid terms that may be considered derogatory such as 'hermaphrodite', 'tranny', 'transsexual', 'transvestite', 'cross-dresser', 'homo' or 'dyke', even if someone uses it to identify themselves
- If someone confides in you regarding their sexual orientation, gender identity or intersex status, you should not assume that they have also disclosed this information to others. Avoid sharing this information. If a child or adolescent speaks to you about their gender or sexuality, you are not obliged to tell the adolescent's parents or guardians. You should not tell anyone without the adolescent's permission, because to do so would be a breach of privacy and may put the adolescent at risk[44]
- LDATs may wish to consider gender and sexual diversity in relation to uniforms or dress codes. This may include permitting dresses or skirts, trousers or shorts, regardless of the sex or gender of the staff member, volunteer or activity participant
- Oppose homophobic or transphobic comments, jokes or behaviours.

5.8 Next steps

If your LDAT is looking to review LGBTI inclusivity, whether it's from an organisational perspective, or in the approach taken to specific activities, you may consider the following general steps:

- Where resources allow, and using the strategies outlined in Sections 5.1–5.7, consider reviewing your LDAT's current procedures and policies for inclusivity
- Identify any areas for improvement that are within the scope and feasibility of your organisational capacity or scope of your activity
- Determine if there may be existing organisations that represent LGBTI people, including those listed in Sections 5.3 and 5.6, that you could partner with to improve LGBTI inclusivity
- If you have further questions, contact your LDAT Relationship Manager.

6. References

1. Queensland AIDS Council & Queensland Network of Alcohol and Other Drug Agencies. (2019). *LQBTIQ+ inclusive training for the AOD sector.* Retrieved from Queensland Network of Alcohol and Other Drug Agencies: qnada.org.au/wp-content/uploads/eLearning/LGBTIQ/story_html5.html
2. National LGBTI Health Alliance. (2015). *'LGBTI' People and Communities.* Retrieved April 5, 2019, from National LGBTI Health Alliance: lgbtihealth.org.au/communities
3. Alex. (2016, May 27). *I'm Intersex: Here's what that means.* Retrieved April 12, 2019, from Minus18 Foundation Inc.: minus18.org.au/index.php/articles/item/2-847-imintersex-heres-what-that-means
4. Winsor, B. (2016, August 12). *A definitive timeline of LGBT+ rights in Australia.* Retrieved April 12, 2019, from Special Broadcasting Service (SBS) Australia: sbs.com.au/topics/sexuality/agenda/article/2016/08/12/definitive-timeline-lgbt-rights-australia
5. Willett, G. (2013). *Australia: nine jurisdictions, one long struggle.* In C. Lennox, & M. Waites, Human Rights, Sexual Orientation and Gender Identity in the Commonwealth (pp. 207–229). London: University of London.
6. Hillier, L., Jones, T., Monagle, M., Overton, N., Gahan, L., Blackman, J., & Mitchell, A. (2010). *Writing Themselves In 3: The third national study on the sexual health and wellbeing of same sex attracted and gender questioning young people.* Melbourne: Australian Research Centre in Sex, Health and Society, La Trobe University. Retrieved April 4, 2019, from acon.org.au/wp-content/uploads/2015/04/Writing-Themselves-In-3-2010.pdf
7. Beyond Blue. (2012). *In my shoes: Experiences of discrimination, depression and anxiety among gay, lesbian, bisexual, trans and intersex people.* Retrieved April 5, 2019, from Beyond Blue: resources.beyondblue.org.au/prism/file?token=BL/1013
8. Morris, S. (2016, July). *Snapshot of Mental Health and Suicide Prevention Statistics for LGBTI People and Communities.* Retrieved April 10, 2019, from National LGBTI Health Alliance: lgbtihealth.org.au/wp-content/uploads/2016/07/SNAPSHOT-Mental-Health-and-Suicide-Prevention-Outcomes-for-LGBTI-people-and-communities.pdf
9. Rosenstreich, G. (2013). *LGBTI People Mental Health and Suicide.* Retrieved April 4, 2019, from National LGBTI Health Alliance: beyondblue.org.au/docs/default-source/default-document-library/bw0258-lgbti-mental-health-and-suicide-2013-2nd-edition.pdf?sfvrsn=2
10. Leonard, W., Lyons, A., & Bariola, E. (2015). *A Closer Look at Private Lives 2: Addressing the mental health and well-being of LGBT Australians.* Melbourne: Australian Research Centre in Sex, Health and Society, La Trobe University. Retrieved April 5, 2019.
11. ACON. (2013). *Health outcome strategy 2013–2018: Mental health and well-being.* Sydney: ACON. Retrieved April 4, 2019, from acon.org.au/wp-content/uploads/2017/02/HOS-Mental-Health.pdf
12. Shelton, M. (2017). *Fundamentals of LGBT substance use disorders: Multiple identities, multiple challenges.* New York: Harrington Park Press.
13. Balsam, K. F., Molina, Y., & Lehavot, K. (2013, January 1). *Alcohol and drug use in Lesbian, Gay, Bisexual, and Transgender (LGBT) youth and young adults.* Principles of Addiction, 563-573.
14. 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.
15. Mereish, E. H., Goldbach, J. T., Burgess, C., & Di Bello, A. M. (2017, September 1). *Sexual orientation, minority stress, social norms and substance use among racially diverse adolescents.* Drug and alcohol dependence, 178, 49–56.
16. Australian Institute of Health and Welfare. (2016). *National drug strategy household survey 2016: Detailed findings.* Canberra: Australian Institute of Health and Welfare. Retrieved April 5, 2019, from aihw.gov.au/getmedia/15db8c15-7062-4cde-bfa4-3c2079f30af3/21028a.pdf.aspx?inline=true
17. Roxburgh, A., Lea, T., de Wit, J., & Degenhardt, L. (2016). *Sexual identity and the prevalence of alcohol and other drug use among Australians in the general population.* International Journal of Drug Policy, 28, 76–82.
18. Marshal, M. P., Friedman, M. S., Stall, R., King, K. M., Miles, J., Gold, M. A., . . . Morse, J. Q. (2008, April). *Sexual orientation and adolescent substance use: a meta-analysis and methodological review.* Addiction, 103(4), 546–556.
19. Demante, D., Hides, L., Kavanagh, D. J., White, K. M., Winstock, A. R., & Ferris, J. (2016, August 12). *Differences in substance use between sexual orientations in a multi-country sample: findings from the Global Drug Survey 2015.* Journal of Public Health, 39(3), 532–541.
20. Kim, M., Mason, A. W., Herrenkohl, T. I., Catalano, R. F., Toumbourou, J. W., & Hemphill, S. A. (2017, January 1). *Influence of early onset of alcohol use on the development of adolescent alcohol problems: a longitudinal binational study.* Prevention Science, 18(1), 1.
21. Little, K., Hawkins, M. T., Sanson, A., Toumbourou, J. W., Smart, D., Vassallo, S., & O'Connor, M. (2012). *The longitudinal prediction of alcohol consumption related-harms among young people.* Substance use & misuse, 47(12), 1303–1317.

22. Pienaar, K., Murphy, D. A., Race, K., & Lea, T. (2018). *Problematising LGBTIQ drug use, governing sexuality and gender: A critical analysis of LGBTIQ health policy in Australia.* International Journal of Drug Policy, 55, 187-194.
23. Lea, T., Reynolds, R., & de Wit, J. (2012, January 1). *Alcohol and club drug use among same-sex attracted young people: Associations with frequenting the lesbian and gay scene and other bars and nightclubs.* Substance use & misuse, 48(1–2), 129–136.
24. Lea, T., Reynolds, R., & de Wit, J. (2013, May). *Alcohol and other drug use, club drug dependence and treatment seeking among lesbian, gay and bisexual young people in Sydney.* Drug and Alcohol Review, 32(3), 303–311.
25. Australian Drug Information Network. (2018). *Glossary.* Retrieved from Australian Drug Informaion Network: adin.com.au/glossary
26. Lee, J., Gamarel , K. E., Bryant, K. J., Zaller, N. D., & Operario, D. (2016, August 1). *Discrimination, mental health, and substance use disorders among sexual minority populations.* LGBT health, 3(4), 258–265.
27. Wilson, S. M., Gilmore, A. K., Rhew, I. C., Hodge, K. A., & Kaysen, D. L. (2016). *Minority stress is longitudinally associated with alcohol-related problems among sexual minority women.* Addictive Behaviors, 61, 8--83.
28. Livingstone, N. A., Christianson, N., & Cochran, B. N. (2016). *Minority stress, psychological distress, and alcohol misuse among sexual minority young adults: A resiliency-based conditional process analysis.* Addictive Behaviors, 63, 125–131.
29. McCabe, S. E., Bostwick, W. B., Hughes, T. L., West, B. T., & Boyd, C. J. (2010, October). *The relationship between discrimination and substance use disorders among lesbian, gay, and bisexual adults in the United States.* American Journal of Public Health, 100(10), 1946–1952.
30. Victorian AIDS Council. (2017). *In focus: The primary health of LGBTI Australians: A brief priority needs summary.* Melbourne: Victorian AIDS Council.
31. Miller, D. T., & Prentice, D. A. (2016). *Changing norms to change behaviour.* Annual Review of Psychology, 67, 339–361.
32. Lelutiu-Weinberger, C., Pachankis, J. E., Golub, S. A., Ja'Nina, J. W., Bamonte, A. J., & Parsons, J. T. (2013). *Age cohort differences in the effects of gay-related stigma, anxiety and identification with the gay community on sexual risk and substance use.* AIDS and Behavior, 17(1), 330–349.
33. Lehavot, K., & Simoni, J. M. (2011). *The impact of minority stress on mental health and substance use among sexual minority women.* Journal of Consulting and Clinical Psychology, 79(2), 159–170.
34. Litt, D. M., Lewis, M. A., Rhew, I. C., Hodge, K. A., & Kaysen, D. L. (2015, December). *Reciprocal relationships over time between descriptive norms and alcohol use in young adult sexual minority women.* Psychology of Addictive Behaviors, 29(4), 885.
35. Boyle, S. C., La Brie, J. W., Costine, L. D., & Witkovic, Y. D. (2017, February 1). *"It's how we deal": Perceptions of LGB peers' use of alcohol and other drugs to cope and sexual minority adults' own coping motivated substance use following the Pulse nightclub shooting.* Addictive Behaviors, 65, 51–55.
36. Hammoud, M. A., Vaccher, S., Jin, F., Bourne, A., Haire, B., Maher, L., . . . Prestage, G. (2018, May 1). *The new MTV generation: using methamphetamine, Truvada,™ and Viagra™ to enhance sex and stay safe.* International Journal of Drug Policy, 55, 197–204.
37. Prestage, G., Hammoud, M. A., Jin, F., Degenhardt, L., Bourne, A., & Maher, L. (2018, May 1). *Mental health, drug use and sexual risk behavior among gay and bisexual men.* International Journal of Drug Policy, 55, 169–179.
38. Clackett, S., Hammoud, M. A., Bourne, A., Maher, L., Haire, B., Jin, F., . . . Prestage, G. (2018). *Flux: Following Lives Undergoing Change 2014–2017 Surveillance Report.* Sydney: The Kirby Institute, University of New South Wales. Retrieved April 24, 2019, from kirby.unsw.edu.au/sites/default/files/kirby/report/Flux-2014-2017-Report.pdf
39. Kennedy, P. (2016). *The Rainbow Tick guide to LGBTI-inclusive practice.* La Trobe University. Melbourne: Gay and Lesbian Health Victoria, Australian Research Centre in Sex, Health and Society. Retrieved April 26 2019.
40. State of Queensland (Public Service Commission). (2017). *Queensland public sector LGBTIQ+ inclusion strategy: A strategy for sexual orientation, gender diversity and intersex inclusion.* Brisbane: State of Queensland (Public Service Commission).
41. Parliament of Australia. (2012). *Privacy Amendment (Enhancing Privacy Protection) Act 2012.* Retrieved from Federal Register of Legislation: legislation.gov.au/Details/C2012A00197
42. Alcohol and Drug Foundation. (2018). *Ethics Resource.* Retrieved from ethical guidelines for working with the community: community.adf.org.au/implement/ethical-guidelines-working-community/
43. Department of Premier and Cabinet, State Government of Victoria. (2019, February 22). *DPC's LGBTI Inclusion Plan.* Retrieved April 24, 2019, from State Government of Victoria: vic.gov.au/dpcs-lgbti-inclusion-plan
44. Mental Health First Aid Australia. (2016). *Considerations when providing mental health first aid to an LGBTIQ+ person.* Retrieved April 24, 2019, from Mental Health First Aid Australia: mhfa.com.au/sites/default/files/considerations-when-providing-MHFA-to-an-LGBTIQ-person.pdf