Takatāpui, Lesbian, Gay, and Bisexual Scoping Exercise

Report to the Alcohol Advisory Council of New Zealand

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ALCOHOL ADVISORY COUNCIL OF NEW ZEALAND
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The Takatāpui, Lesbian, Gay, and Bisexual (TLGB) Scoping Exercise would not have been possible without the participation of TLGB community organisations, alcohol prevention and treatment providers, and alcohol policy-makers in focus groups and interviews. Many thanks to the focus group and interview participants for their generous contributions.

Frank Pega (Principal Investigator) developed and undertook research into and provided an analysis of current gaps in service provision, and identified and described future opportunities and strategies for consideration by the Alcohol Advisory Council of New Zealand (ALAC).

Ian MacEwan (Advisor) provided advice to the Principal Investigator and expertise in all aspects regarding the process and completion of the TLGB Scoping Exercise.

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ALAC commissioned Frank Pega and Ian MacEwan to conduct the TLGB Scoping Exercise.

The views and opinions expressed in this report are those of the authors and are not to be attributed to ALAC.

EXECUTIVE SUMMARY

BACKGROUND

Increasingly, high-quality studies on alcohol use amongst sexual minority communities are being conducted both in Aotearoa New Zealand and internationally. For instance, a recent study of data from the large-scale population-based New Zealand Health Behaviours Surveys on drug use conducted in 2003 and on alcohol use conducted in 2004 found that sexual minority women and men, respectively, were more likely to use alcohol than heterosexual women and men, respectively. Some government agencies have commenced acknowledging alcohol use amongst sexual minority communities as an important topic for public policy, and a body of information about how to address alcohol use amongst sexual minority communities effectively is now available.

The Alcohol Advisory Council of New Zealand (ALAC) is considering its role in the reduction of alcohol-related harm amongst sexual minority communities. To inform its considerations, ALAC commissioned the authors of this report to conduct the Takatāpui, Lesbian, Gay, and Bisexual Scoping (TLGB) Exercise. The exercise aims to scope relevant information to:

- allow a preliminary assessment of the need for reducing alcohol-related harm amongst sexual minority populations
- identify current gaps in service provision
- identify key stakeholders
- provide an analysis of the role that ALAC could play in reducing alcohol-related harm for sexual minority communities
- provide an analysis of future opportunities and strategies that ALAC can look to implement.

This document reports the methodology and findings of the TLGB Scoping Exercise.

METHODOLOGY

A multi-method research study was designed and implemented, combining literature review, policy analysis, and focus groups and key informant interviews with stakeholders.

Three sets of literature were reviewed and their findings synthesised: Firstly, papers on large-scale, population-based random studies comparing sexual minority people with heterosexual people with respect to the prevalence of alcohol use in Aotearoa New Zealand and internationally. Secondly, any papers on studies reporting prevalence rates of alcohol use amongst sexual minority people in Aotearoa New Zealand. Thirdly, a selection of papers on alcohol-related harm, as well as alcohol strategies, and alcohol prevention and treatment services.

A review of national alcohol policy from the Ministry of Health was conducted, screening relevant policies for references to sexual minority populations.

Four focus groups and six interviews were held with key stakeholders to capture their perspectives and insights on current services; to identify the perceived need for reducing alcohol-related harm amongst sexual minority communities; to identify key stakeholders; and to reflect on the role ALAC could play, i.e. strategies ALAC could look to pursue. Ten members of TLGB community organisations, ten providers of alcohol prevention and treatment services, and four alcohol policy-makers participated in the focus groups and interviews. A diversity of perspectives was ensured, including Māori, Pacific, Asian, new migrant, young, and rural perspectives.

The findings from these various research methods were used to inform our analysis.

SCOPING THE NEED

The most robust existing national figures estimating the prevalence of minority sexual orientations suggest that sexual minority communities constitute a sizeable segment of the general population.

There is conclusive evidence from high-quality studies that sexual minority women use alcohol at higher rates than are heterosexual women, both in Aotearoa New Zealand and internationally. There is a growing body of international evidence on the prevalence of alcohol use amongst sexual minority men compared to heterosexual men, with conflicting findings; but there is strong evidence from an Aotearoa New Zealand study that sexual minority men use alcohol at higher rates than heterosexual men. Further research is needed, requiring the collection of high-quality data on sexual orientation in surveys on alcohol use.

There is growing evidence about the types of alcohol-related harms that sexual minority communities experience. For sexual minority women, such harms include HIV risk-behaviours and domestic violence. For sexual minority men, harms include HIV risk-behaviours, domestic violence, and sexual coercion.

In 1997, the Ministry of Health published a review of alcohol use amongst sexual minority populations and, in its *National Alcohol Strategy 2000–2003,* made provisions for lesbian, gay, and bisexual populations. More recent alcohol strategies did not make any provision. An updated review of alcohol use by the Ministry of Health similar to that of 1997 and, in turn, a review of the provisions suggested in the *National Alcohol Strategy 2000–2003* would provide a good base for initiating the evidence-based work needed.

There is general agreement amongst stakeholders interviewed for the TLGB Scoping Exercise that there is a need to reduce alcohol-related harm amongst sexual minority communities.

In summary, these points make a strong argument for evidence-based work to reduce alcohol-related harm amongst sexual minority communities.

A conceptual model for alcohol and tobacco use amongst sexual minority populations is available that ALAC could use as a conceptual framework for action to reduce alcohol-related harm amongst sexual minority communities.

GAPS IN SERVICE PROVISION

There is only one service in Aotearoa New Zealand that targets TLGB people with alcohol prevention and treatment services. This service operates in Auckland only, and staff-time for this service has increasingly been reduced, limiting what this service can realistically achieve. Community initiatives have been trialed by TLGB community organisations, but they require significant additional resources to be effective.

With a few exceptions, non-TLGB targeted alcohol prevention and treatment services generally do not currently have the knowledge and workforce capacity to respond to the needs of TLGB clients and communities. Research participants said that existing general services for young TLGB people might be better placed to provide interventions. They felt also that rural TLGB people might not get appropriate support.

That sexual minority communities are not included in strategic and operational alcohol policy, both at the regional and at the national policy level, is an important issue that is recommended to be addressed.

In conclusion, a primary finding of this scoping study is that there are major gaps in service provision to TLGB populations, and as a result, these communities are under-served and at risk of disproportionate alcohol-related harm.

While research on alcohol prevention for TLGB communities is scarce, there is a good amount of research and evaluation that can be used to design TLGB-responsive alcohol treatment services. Such research and evaluation has been translated into several guideline documents addressing alcohol treatment practitioners, alcohol treatment service managers, and policy staff working in this field.

ALAC'S POTENTIAL ROLE

In the 1990s, ALAC played a significant role in reducing alcohol-related harm amongst TLGB communities by holding conferences on the topic, producing training resources and posters, and furthering knowledge through research. Research participants of the TLGB Scoping Exercise did not perceive ALAC to be currently involved in reducing alcohol-related harm amongst TLGB communities beyond services targeted at the general population.

However, the commissioning by ALAC of the TLGB Scoping Exercise was seen as an important signal from ALAC that the organisation is interested in re-engaging in a more targeted way with TLGB populations, which research participants welcomed and supported, often with considerable enthusiasm. There was general agreement amongst research participants that ALAC was well placed – and indeed had the responsibility – to head the agenda of reducing alcohol-related harm amongst TLGB communities in the future in close collaboration with TLGB communities. TLGB community organisations saw their role as supporting ALAC well in its leadership position by contributing their community expertise and working collaboratively with ALAC.

STRATEGIES ALAC CAN LOOK TO IMPLEMENT

Based on the analysis presented in the report, the current scoping exercise recommends that ALAC:

- increase knowledge on TLGB alcohol use by:
    - collecting data on sexual orientation in all surveys ALAC conducts or commissions and ensuring the analysis and reporting of these data
    - encouraging the Ministry of Health to collect data on sexual orientation in its next alcohol use survey and working towards ensuring that the Ministry of Health analyses and reports these data
    - contributing to addressing the research gaps
    - identifying funding opportunities for postgraduate students investigating TLGB alcohol use
- build relationships and consult with TLGB communities by:
    - supporting the establishment of a *TLGB Community Leadership Group in Mental Health and Alcohol and Drug* to assist ALAC in developing its approach to reducing alcohol-related harm amongst TLGB communities
    - working with the proposed *TLGB Community Leadership Group in Mental Health and Alcohol and Drug* to reduce alcohol-related harm amongst TLGB communities
    - working with the proposed *TLGB Community Leadership Group in Mental Health and Alcohol and Drug* in increasing visibility of TLGB communities in ALAC communication and marketing campaigns targeted at the general population
- facilitate meetings between *TLGB Community Leadership Group in Mental Health and Alcohol and Drug* and national alcohol and drug agencies
- conduct a needs assessment to inform programming
- provide policy advice and guidance with respect to TLGB populations by:
    - supporting the inclusion of TLGB populations in the harm-reduction strategies of other agencies as the opportunity arises
    - encouraging the provision by other agencies of appropriate funding for services concerned with reducing alcohol-related harm amongst TLGB communities
    - supporting the inclusion of TLGB populations in the operational policies of alcohol prevention and treatment service providers.

1 BACKGROUND

Increasingly, more methodologically robust studies on alcohol use amongst sexual minority communities[1] are being conducted both in Aotearoa New Zealand and internationally. For instance, a recent study of data from the large-scale, population-based New Zealand Health Behaviours Surveys on drug use conducted in 2003 and on alcohol use conducted in 2004 found that women identifying as lesbian or bisexual were more likely to have drunk alcohol regularly over the last year than heterosexual-identified women (Pega & Coupe, 2007). The same study found that men who identified as gay or bisexual were less likely to have abstained from alcohol and more likely to have drunk alcohol regularly over the last year than heterosexual-identified men (Pega & Coupe, 2007). Government agencies have acknowledged that higher rates of substance use amongst sexual minority communities than amongst heterosexual communities are a policy concern in Aotearoa New Zealand (Ministry of Social Development, 2006; Statistics New Zealand, 2008).

The causes of the differences in alcohol use are not fully understood, but Greenwood and Gruskin have developed the *Conceptual Model of LGBT Tobacco and Alcohol Use* on the basis of conceptual and empirical evidence (2007). This model provides an insight into the specific individual, family, societal, and environmental factors that influence alcohol use amongst sexual minority individuals. The model can be used to guide action to reduce alcohol-related harm amongst TLGB individuals and communities. What works with respect to preventing and reducing alcohol-related harm amongst sexual minority communities has also been, and is increasingly being, researched and research findings are available to effectively inform action.

The Alcohol Advisory Council of New Zealand (ALAC) is in the process of considering its role in the reduction of alcohol-related harm amongst sexual minority communities. To inform its considerations, ALAC commissioned the authors of this report to conduct the Takatāpui[2], Lesbian, Gay, and Bisexual (TLGB) Scoping Exercise.

The aims of the study were to:

1. scope relevant information that allows a preliminary assessment of the need for reducing alcohol-related harm amongst sexual minority populations
2. identify current gaps in service provision
3. identify key stakeholders
4. provide an analysis of the role that ALAC could play in reducing alcohol-related harm for takatāpui, lesbian, gay, and bisexual (TLGB) communities

[1] See Glossary

[2] see Glossary

5. provide an analysis of future opportunities and strategies that ALAC can look to implement.

This scoping study focuses on communities defined by minority sexual orientation. It needs to be noted that often transgender[3] and intersex[4] communities are erroneously referred to as sexual minority communities. This is questionable, because transgender people are defined by gender identity[5] and intersex people are defined by intersex condition, not by minority sexual orientation. This scoping study is about sexual minority communities, members of whom can be cisgender[6], transgender, or intersex.

We are of the opinion that transgender and intersex communities deserve their own research on alcohol-related harm. It is already known from the *Transgender Inquiry* conducted by the Human Rights Commission (2008) that transgender and intersex people face distinct barriers to accessing health services in Aotearoa New Zealand, and we strongly encourage ALAC to conduct a further scoping study focusing on reducing alcohol-related harm amongst communities defined by transgender identity and intersex condition.

This report describes the research methodology and study findings of the TLGB Scoping Exercise.

[3] see Glossary

[4] see Glossary

[5] see Glossary

[6] see Glossary

2 METHODOLOGY

A multi-method research study was designed and implemented, combining literature review, policy analysis, and qualitative research methods. The following steps were taken in the research process.

2.1 LITERATURE REVIEW

A first literature search was conducted to comprehensively identify papers on studies of large-scale population-based data from random surveys that compare sexual minority men and women with heterosexual men and women with regards to the prevalence of alcohol use. The search was restricted to papers in the English language published between 1990 and 2009. A set of keywords was applied in the PubMed search engine (i.e. alcohol, liquor, gay, lesbian, bisexual, homosexual, sexual orientation, probability survey, random survey). Through this search, eight papers were identified.

A second literature search was conducted to comprehensively identify papers on studies of random and non-random data on the prevalence of alcohol use amongst sexual minority communities in Aotearoa New Zealand. A set of keywords was applied in the PubMed and Te Puna search engines (i.e. alcohol, liquor, gay, lesbian, bisexual, homosexual, sexual orientation, survey, New Zealand). Through the search, six papers were identified.

A third literature search was conducted by ALAC Library Services to identify a broad range of literature on alcohol use and alcohol-related harm, as well as alcohol strategies and alcohol prevention and treatment services. Due to the large number of articles published on these topics, the search was restricted to papers in the English language published between 2000 and 2009. To broadly scope the research literature, the search used a range of keywords (i.e. alcohol, liquor, gay, lesbian, bisexual, and homosexual), applying these key words in several national and international search machines (i.e., Innz, ALAC library catalogue, SocIndex, Infotrac, Te Puna). Through this search, 94 papers were identified. After an initial screening of these papers by the researchers, 58 were identified as within scope and reviewed in-depth.

In total, 72 papers were reviewed and their findings synthesised in three separate sections on:

- the prevalence of alcohol use amongst sexual minority women and men (S3.3)
- alcohol-related harm amongst sexual minority women and men (S3.4)
- alcohol prevention and treatment services (S5.2).

2.2 POLICY REVIEW

A review of national-level, strategic alcohol policy was conducted, building on and updating a review conducted by the lead author in 2007 (Pega 2008). The Ministry of Health's (MoH) webpage on alcohol policy (http://www.ndp.govt.nz/) was used to identify

relevant alcohol policy papers published by the Ministry. In a second step, all papers listed on the webpage were screened for references to TLGB populations. The identified references are compiled in a section on the inclusion of sexual minority populations in alcohol policy (S3.5).

2.3 FOCUS GROUPS AND KEY-INFORMANT INTERVIEWS

Focus groups and key-informant interviews were conducted to seek stakeholder perspectives on ALAC's potential role in reducing alcohol-related harm amongst TLGB populations. The focus groups and interviews covered three groups of stakeholder groups that were separately interviewed either face-to-face, by e-mail survey, or via phone. These were TLGB community organisations, providers of alcohol prevention and treatment services, and alcohol policy-makers.

All focus group and interview participants were selected jointly by the research team. Participants from TLGB community organisations were selected on the basis of ensuring diversity of sexual minority perspectives, diversity of organisational perspectives, and broad geographic spread. Māori, Pacific, Asian, new migrant, young, and rural perspectives were secured. Participants from a broad range of providers of alcohol prevention and treatment services were selected from the Auckland and Dunedin geographical regions, including Māori and Pacific providers. Participants from government agencies were selected from amongst those policy staff developing national-level alcohol policy and those working nationally on TLGB policy issues.

All selected potential participants were approached and invited to participate in the study in the recruitment phase. Six of the 30 potential participants did not agree to participate. Their reasons for refusing participation were: being unavailable at the time or being of the opinion that they had insufficient expertise to meaningfully participate. Focus groups and interviews were conducted in five centres across Aotearoa New Zealand with an overall of ten participants from TLGB community organisations, ten participants from service providers, and four policy-makers, as shown in Table 1.

Table 1. Focus group and key-informant details

	Stakeholder group	Type of interview	Number of participants	Location
1	TGLB organisations	Focus group	5	Auckland [a]
2	TGLB organisations	Focus group	4	Wellington [a]
3	TLGB organisation	Key-informant interview	1	Invercargill [b]
4	Service providers	Focus group	4	Auckland [a]

5	Service providers	Focus group	4	Dunedin [a]
6	Service provider	Key-informant interview	1	Auckland [c]
7	Service provider	Key-informant interview	1	Palmerston North [c]
8	Policy-maker	Group interview	2	Wellington [a]
9	Policy-maker	Key-informant interview	1	Wellington [a]
10	Policy-maker	Key-informant interview	1	Wellington [a]

[a] interview conducted face-to-face, [b] interview conducted via e-mail survey, [c] interview conducted via phone

Many of the participating TGLB community organisations requested that they be named in the final report of the TLGB Scoping Exercise for the purpose of transparency and accountability to the members of their organisations. These organisations are:

- Āwhina Centre, New Zealand AIDS Foundation
- Body Positive Inc. New Zealand
- Hau Ora Takatāpui Team, New Zealand AIDS Foundation
- OUT THERE! Queer Youth Development Project
- OUTLine NZ
- Rainbow Wellington
- Rainbow Youth
- Tīwhanawhana Trust
- Wellington Gay Welfare Group.

In preparation for conducting the focus groups and interviews, a question catalogue was developed jointly by the research team. The catalogue covered questions in four areas:

1. a set of questions that aimed to identify current services
2. a set of questions related to the perceived need for reducing alcohol-related harm amongst TLGB populations
3. a question to identify key stakeholders
4. a set of questions on the role ALAC could play and strategies ALAC could pursue.

The question catalogue was implemented in all focus groups and key-informant interviews. The four focus groups were conducted face-to-face. Two key-informant interviews were

conducted face-to-face and two via phone. One TLGB organisation preferred to answer the question catalogue via e-mail.

In the focus groups and face-to-face and phone interviews, the implementation of the question catalogue lead to an informal, semi-structured interviewing format. Focus groups were of approximately 90 minutes duration, and key-informant interviews were of approximately 60 minutes duration. In these focus groups and interviews, audio recordings of the focus groups and key-informant interviews were taken with consent of the participants. In the key-informant interview conducted via e-mail, the participant answered the question catalogue as an e-mail survey.

The information collected in the focus groups and interviews was used to inform the following report sections:

- stakeholder perceptions for the need to reduce alcohol-related harm amongst sexual minority communities (S3.6.)
- key stakeholders (S4)
- gaps in service provision (S5.1)
- ALAC's potential role in reducing alcohol-related harm amongst sexual minority populations (S6)
- strategies that ALAC can consider implementing (S7).

3 SCOPING THE NEED

To inform its current consideration, ALAC required a preliminary assessment of the need for reducing alcohol-related harm amongst sexual minority communities. National prevalence estimates of minority sexual orientations were reviewed for the purpose of identifying whether sexual minority communities constitute a sizeable population. A conceptual framework was identified that provides an understanding of the factors that influence alcohol use amongst sexual minority communities. A review of evidence from comparative studies on the prevalence of alcohol use amongst sexual minority people, compared to heterosexual people, was conducted in order to provide ALAC with an evidence-base from which to judge the need for targeted action. Evidence on the types of alcohol-related harm that have been identified for sexual minority communities provides a second important body of evidence. Finally, the degree to which interviewed members of TLGB community organisations, alcohol prevention and treatment services, and policy-makers perceive a need for the reduction of alcohol-related harm is an important factor that can inform ALAC's consideration.

3.1 THE POPULATION PREVALENCE OF SEXUAL MINORITY ORIENTATIONS

Robust estimates of the prevalence of minority sexual orientations are currently not available. However, random studies of young people that have assessed minority sexual attraction, sexual behaviour, and sexual identity in Aotearoa New Zealand provide first national prevalence estimates (see Table 2).

The variance in these figures can partly be explained by the fact that the studies assessed different measurement concepts (i.e. sexual attraction, sexual behaviour, and sexual identity) and used different measures (e.g. any same-sex attraction versus major same-sex attraction). These figures are produced from data on young people only, meaning that they cannot be generalised to the general population, and the figures are likely to be underestimates of the actual population prevalence, considering that they have not been adjusted to account for non-response and misreporting. However, it becomes clear from these prevalence figures that sexual minority populations constitute a sizeable population.

Table 2. Figures for the prevalence of minority sexual attraction, sexual behaviour, and sexual identity in random samples in Aotearoa New Zealand

Measurement concept	Year	Measure	Sample	Prevalence
Sexual attraction	2003[a]	Any lifetime same-sex sexual attraction	Dunedin birth cohort	Females: 25.4% Males: 10.7%
Sexual attraction	2003[a]	Major lifetime same-sex sexual attraction	Dunedin birth cohort	Females: 2.1% Males: 1.6%
Sexual identity	1999[b]	Lesbian, gay or	Christchurch birth	2.8%

		bisexual sexual identity	cohort at the age of 21 years	
Sexual identity	2004[c]	Any non-heterosexual sexual identity	Representative national sample of high-school students	7.8%
Combination of sexual attraction, sexual behaviour, and sexual identity	2005[d]	Any same-sex attraction and/or any same-sex behaviour and/or lesbian, gay, or bisexual sexual identity	Christchurch birth cohort at the age of 25	12.8%

[a] Dickson et al. (2003); [b] Fergusson et al. (1999); [c] Le Brun et al. (2004) ; [d] Fergusson et al. (2005)

3.2 A CONCEPTUAL FRAMEWORK FOR ALCOHOL USE AMONGST SEXUAL MINORITY COMMUNITIES

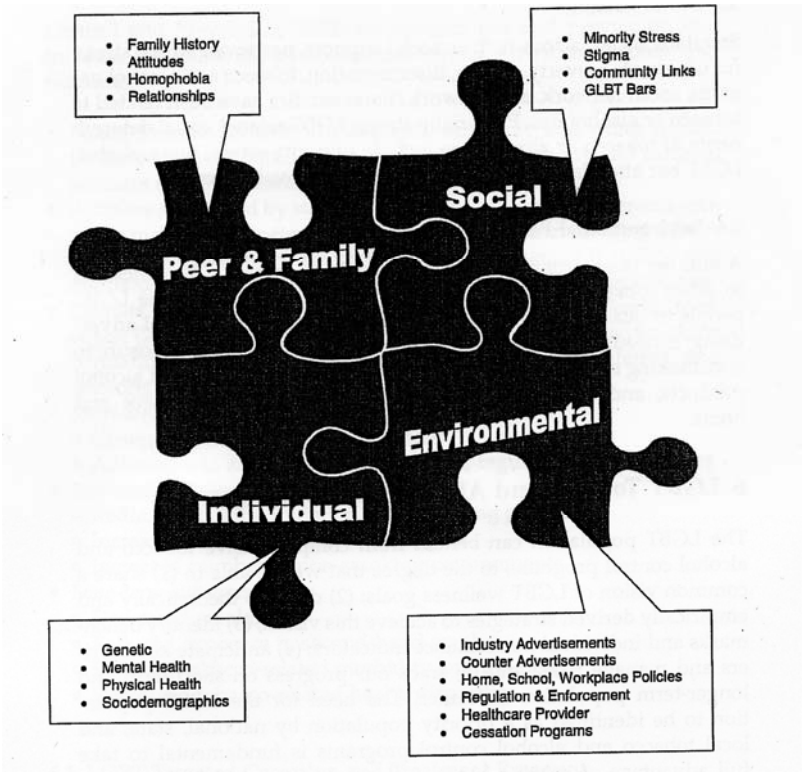
In 2007, Greenwood and Gruskin developed the *Conceptual Model of LGBT Tobacco and Alcohol Use* that synthesises the findings from conceptual and empirical research. The model identifies a complex combination of factors at the individual, peer/family, social, and environmental level, highlighting risk and protective factors for sexual minority communities. A diagram of the model is provided on the next page (p. 16).

According to the model, individual-level factors include genetic and socio-demographic factors, but also a range of psychological factors. Developmental factors include the developmental trajectory and acceptance of a sexual minority identity, and whether a sexual minority person is 'out' or not. Mental health issues (e.g. substance dependency, anxiety, and depression), internalised homophobia, attitudes, attributions, and behaviours (e.g. coping mechanism, and sexual behaviours) also play a role.

Family-level factors include family and parental history of and attitudes towards alcohol and tobacco use, alcohol and tobacco use amongst important peer groups, occurrence of adverse family events (e.g. domestic violence, sexual abuse, and other forms of victimisation), family or parental acceptance or rejection of minority sexual orientations, and family/parental homophobia.

Social factors include the available level of social support, social stress (especially stress related to sexual minority status), sexual minority stigma, perceived and actual homophobia, perceived and actual discrimination, as well as alcohol and tobacco use in social networks, attendance of lesbian and gay bars, and involvement in sexual minority communities.

Figure 1: Conceptual model of alcohol and tobacco use amongst sexual minority women and men



Source: Greenwood & Gruskin, 2007, p. 574

Environmental factors include inequitable access to health services, tobacco and alcohol industry advertising targeted at sexual minorities, exposure to health promotion messages (e.g. anti-drinking messages targeted at sexual minorities), regulation of and access to alcohol and tobacco, and policies related to alcohol and tobacco use at home and at work.

A conceptual model of alcohol use amongst sexual minority persons is useful in that it provides a conceptual basis for understanding the specific factors that influence alcohol use amongst sexual minority communities. The Greenwood and Gruskin model is the most recent such model, summarising the evidence to date, but developed to suit the United States context. A model that is more tailored to the Aotearoa New Zealand context (e.g. by including conceptualisation of alcohol use amongst takatāpui communities) might need to be developed in the future. However, the authors consider that the Greenwood and Gruskin model constitutes a suitable tool for ALAC to understand alcohol use amongst sexual minority communities better, and recommend that ALAC uses it as a framework to guide action.

3.3 THE PREVALENCE OF TLGB ALCOHOL USE

Research with sexual minority women and men encounters a number of specific conceptual, measurement, and data collection issues that are discussed in detail in Appendix 1. However, over the last 10 years, a considerable number of high-quality studies of data from large-scale random surveys have been conducted, which compare sexual minority people with heterosexual people in terms of their alcohol use.

The sections below (S3.3.1 and S3.3.2) review findings from such studies on abstention from alcohol, normative alcohol use, heavy alcohol use, alcohol-related problems, and alcohol dependency in a summary format. Findings are presented separately for adolescents and adults, and for women and men[7].

For the interested reader, a detailed description of the criteria applied to select only high-quality studies for the review, followed by a detailed review of study findings including a discussion of the individual sample sizes and limitations of each study, is provided in Appendix 2.

3.3.1 Sexual Minority Women

Comparative rates of abstention from alcohol amongst adult women have been assessed by four comparative studies of sexual orientation data from large-scale random surveys of United States populations (Cochran et al., 2000; Drabble et al., 2005; Drabble & Trocki, 2005; Gruskin et al., 2001). All four studies found that adult sexual minority women are less likely to abstain from alcohol than are adult heterosexual women. A large-scale longitudinal study also suggests that adolescent sexual minority women are less likely to abstain from alcohol than are adolescent heterosexual women (Corliss et al., 2008, Ziyadeh et al., 2007). There were similar results from a 2007 study of data from a large-scale random survey of the general population of adult women in Aotearoa New Zealand, which found that women with a lesbian or bisexual identity reported lower rates of abstention from alcohol over the last year than heterosexual-identified women (Pega & Coupe).

Normative alcohol use amongst women has been assessed by three comparative studies of sexual orientation data from large-scale, random surveys of United States populations. Two of these studies suggest that adult sexual minority women are more likely to use alcohol in a normative or moderate way than are heterosexual women (Burgard et al., 2005; Cochran et al., 2000), while one study found no differences (Drabble & Trocki, 2005). There is also emerging evidence from a large-scale longitudinal study suggesting that adolescent sexual minority women in the United States use alcohol normatively at higher rates (Corliss et al., 2008). There are similar findings in Aotearoa New Zealand from the Pega & Coupe (2007) study which found that women with a lesbian or bisexual identity reported consuming alcohol once or more per week over the last year at significantly higher rates than women with a heterosexual identity.

Heavy alcohol use amongst sexual minority women was investigated by five comparative studies of sexual orientation data from large-scale random surveys of United States populations (Burgard et al., 2005; Cochran et al., 2000; Drabble et al., 2005; Drabble & Trocki, 2005; Gruskin et al., 2001). All five of these studies found that adult sexual minority

[7]No reviewed study compared sexual minority groups with heterosexual transgender people or sexual minority groups with heterosexual intersex people. It needs to be assumed that transgender and intersex people did not have the option of identifying their gender identity or intersex condition in the surveys, meaning that they will have had to identify as ‘women’ or ‘men’ and are hence invisible in the data as separate groups.

women use alcohol heavily and binge drink at higher rates than heterosexual women. There is evidence from a large-scale random survey (Eisenberg & Wechsler, 2003) and a large-scale longitudinal study (Corliss et al., 2008; Ziyadeh et al., 2007) suggesting that adolescent sexual minority college students (women and men) and women, respectively, in the United States are at an increased risk from binge drinking. No study comparing sexual minority and heterosexual women's heavy alcohol use has been conducted in Aotearoa New Zealand, but one study reported prevalence rates of problem drinking amongst a non-random sample of adult lesbians (Welch et al., 1998).

In terms of alcohol-related problems, alcohol dependence, and seeking alcohol treatment, there are two comparative studies from the United States using data from large-scale random surveys (Cochran et al., 2000, Drabble et al., 2005). These studies found that adult and adolescent sexual minority women report a higher rate of alcohol-related problems, are more likely to be alcohol dependent, and are more likely to seek alcohol treatment. Findings from one meta-analytic study (Marshal et al., 2008) and a longitudinal study from Aotearoa New Zealand (Fergusson et al, 2005) found that young sexual minority women were more likely to be dependent on alcohol than are exclusively heterosexual sexual minority women.

3.3.2 Sexual Minority Men

Abstention rates among men have been assessed by two comparative studies of sexual orientation data from large-scale random surveys of United States populations. The Cochran et al. (2000) study found no differences between men who have sex with men (MSM) and heterosexual men, while the Drabble et al. 2005 study found that gay-identified MSM were less likely to abstain than exclusively heterosexual men. A large-scale longitudinal study suggests that mostly opposite-sex attracted and both-sex attracted adolescent men are less likely to abstain from consuming alcohol than exclusively opposite-sex attracted adolescent men (Corliss et al., 2008, Ziyadeh et al., 2007). Pega and Coupe's (2007) New Zealand study found that adult men with a gay or bisexual identity reported being significantly less likely to abstain from alcohol over the last year than heterosexual adult men.

The Cochran et al. (2000) study comparing the prevalence of normative alcohol use amongst sexual minority versus heterosexual men found no difference between MSM and exclusively opposite-sex behaved men. The Corliss et al. (2008) longitudinal study suggests that sexual minority adolescent boys drink a significantly higher number of drinks per typical drinking occasion than exclusively opposite-sex attracted boys. The Pega and Coupe (2007) New Zealand study found that adult men with a gay or bisexual identity are more likely to drink alcohol once or more per week over the last year than men identifying as heterosexual.

The prevalence of problem drinking amongst sexual minority men versus heterosexual men was considered by two studies. The Cochran et al. (2000) study found no sexual orientation differences in the prevalence of heavy drinking and binge drinking amongst adult men, the Drabble et al. (2005) study found that gay-identified men were more likely to drink until feeling drunk than exclusively heterosexual men. The Ziyadeh et al. (2007) and Corliss et al.

(2008) longitudinal studies suggest that adolescent sexual minority men might have an elevated risk from problem drinking, compared to exclusively opposite-sex attracted adolescent men. However, an earlier large-scale random study of male college students in the United States found that both-sex behaved male college students were less likely to binge drink than their exclusively opposite-sex attracted male peers (Eisenberg & Wechsler, 2003). No study comparing sexual minority and heterosexual men's problematic alcohol use has been conducted in Aotearoa New Zealand.

There is one study of large-scale random survey data that found no differences between sexual minority and heterosexual men with respect to alcohol dependency and seeking alcohol treatment (Cochran et al., 2000). Findings from one meta-analytic study (Marshal et al., 2008) and the longitudinal New Zealand study showed that young sexual minority men were more likely to be dependent on alcohol than were young exclusively heterosexual men (Fergusson et al., 2005).

3.3.3 Conclusion

A considerable number of large-scale population-based random studies on the prevalence of alcohol use amongst adult and adolescent sexual minority women, compared to adults and adolescent heterosexual women, have been carried out, primarily in the United States. These studies suggest that adult and adolescent sexual minority women use alcohol at higher rates than adult and adolescent heterosexual women. An Aotearoa New Zealand study had similar results.

There are a smaller number of large-scale population-based random studies on the prevalence of alcohol use amongst adult and adolescent sexual minority men, and this growing body of evidence is inconclusive. However, an Aotearoa New Zealand study suggests that adult gay and bisexual men use alcohol at higher rates than heterosexual adult men.

Because few studies have broken down alcohol use amongst sexual minority samples by sexual attraction, sexual behaviour, and sexual identity, information about certain sexual minority communities (e.g. takatāpui and bisexual communities) is unavailable. There is little epidemiological evidence about how alcohol use is distributed amongst sexual minority groups defined by key demographic variables such as ethnicity and geographic residency.

Key gaps are national research on:

1. prevalence of heavy alcohol use amongst TLGB communities
2. alcohol use amongst takatāpui communities
3. alcohol use amongst bisexual communities
4. alcohol use amongst rural communities.

The implications from these findings that ALAC might want to consider include:

1. ALAC might want to focus its efforts particularly on sexual minority women, considering that there is a conclusive evidence base indicating higher alcohol use amongst this

community. However, ALAC should also target sexual minority men, considering that there is strong evidence from an Aotearoa New Zealand study that sexual minority men use alcohol at higher rates than heterosexual men.

2. ALAC might want to conduct or support research that addresses national knowledge gaps.

3.4 ALCOHOL-RELATED HARM AMONGST TLGB COMMUNITIES

There is a growing body of research on alcohol-related harm amongst sexual minority communities, with a number of major studies (generally qualitative studies) focusing on sexual minority men. The sections below (S3.4.1 and S3.4.2) review findings from such studies in a summary format. A detailed review of the studies is provided in Appendix 3.

3.4.1 Sexual Minority Women

There are two (dated) studies on the association of alcohol use and partner violence amongst sexual minority women. Both studies found an association between alcohol use and domestic violence amongst same-sex female couples (Perry, 1995; Schilit et al., 1990).

One study found that alcohol use might put sexual minority women at higher risk from engaging in HIV-risk behaviours (Perry, 1995).

There is a lack of research on alcohol-related harm amongst TLB women in Aotearoa New Zealand. Currently, no research on takatāpui-identified women is available.

3.4.2 Sexual Minority Men

There is a good body of research on the association between alcohol use and HIV-risk behaviours, with most studies generally finding that amongst men who have sex with men (MSM), heavy drinkers tend to engage in behaviours that put them at a higher risk of infection with HIV than those who drink less alcohol (Irwin et al., 2006; Reback et al., 2007; Stall et al., 1999; Weinhardt & Carey, 2000), with some exceptions (Ramirez-Valles et al., 2008). Several studies suggest a potential causal relationship between alcohol use and HIV-risky behaviours (Bimbi et al., 2006; Irwin et al., 2006; Vanable et al., 2004, as cited in Bimbi et al., 2006; Parsons et al., 2004a, b).

Two studies suggest that amongst sexual minority men, alcohol use might aggravate or cause partner violence (Cruz & Peralta, 2001; Hellmuth et al., 2008), but one study did not reach the same conclusion (Dolezal et al., 2005). Alcohol appears to play an important role in unwanted sex, as found in an Aotearoa New Zealand study titled *Unwanted Sex among Men who have Sex with Men (MSM)* (Fenaughty et al., 2006), as well as a study from the United States (Houston & McKirnan, 2007).

There is a lack of research on other alcohol-related harm amongst TGB men in Aotearoa New Zealand. Currently, no research on takatāpui-identified men is available.

3.4.3 Conclusions

There is little research on alcohol-related harm amongst sexual minority women, but the available studies suggest that alcohol use might be related to partner violence and HIV-risky behaviours amongst this group.

A growing body of studies on alcohol-related harm amongst sexual minority men suggests that alcohol use might be related to HIV-risk behaviours, partner violence, and coercive sex.

The implications that ALAC might want to consider include:

- ALAC might want to conduct or support research on the prevalence and nature of alcohol-related harm amongst TLGB communities.

3.5 INCLUSION OF SEXUAL MINORITY POPULATIONS IN ALCOHOL POLICY

3.5.1 Public Reviews of Evidence

There are few recent reviews of evidence on alcohol use amongst sexual minority communities (Pega, 2008). In 1997, the Ministry of Health published *Mental Health in Aotearoa New Zealand from a Public Health Perspective*, which included chapters on lesbian women (Chapter 8 written by Johnson & James) and gay men (Chapter 10 written by Worth & Kelleher) (Ministry of Health [MoH], 1997). The chapter on lesbian women reviews Aotearoa New Zealand and international research findings on alcohol use amongst sexual minority women. It also reports on evidence on risk factors (e.g. fewer categories of social support, heteronormativity, actual and perceived homophobia, sexual orientation discrimination, and rejection as the result of coming out) and protective factors (positive lesbian identity; social, including family, support; and a high level of self-acceptance) for sexual minority women with respect to mental health (MoH, 1997). The chapter concludes with a review of consistent requirements to improve mental health services for lesbians[8] and

[8] These recommendations are:

'-providing a safe and comfortable environment for the client to discuss matters of sexuality; acknowledging and recognising the nature of living as part of a stigmatised minority; the provision of alternative services for lesbians or gay men; the provision of lesbian and gay role models; recognising internalised homophobia and working through that with the client (Welch1995). A majority of those surveyed by Welch (1995) found alcohol and drug services treated lesbianism as a pathology and outcomes for lesbians in these services were worse compared with those for heterosexual women.

-the inclusion of accurate lesbian information and current research on homosexuality into courses for all health, social and community workers. The proposition that some mental health professionals are homophobic or ignorant about differences in sexual orientation is supported in Welch's findings (Welch 1995). Information about homosexuality and gay/lesbian counselling, when of sufficient length and relatively comprehensive in content, can result in significant and possibly enduring modification of attitudes toward homosexuality and greater therapeutic effectiveness (Rudolph 1989).' (Johnson & James, 1997: 210)

by making recommendations for research (MoH 1997). The chapter on gay men does not make specific reference to the prevalence of alcohol use amongst gay men, compared to heterosexual men, and notes that Aotearoa New Zealand research on the mental health of gay men lags behind international research (MoH, 1997). However, it identifies risk factors (fewer categories of social support, heteronormativity, actual and perceived homophobia, sexual orientation discrimination, rejection as the result of coming out, and the mental health effects of the HIV and AIDS epidemics) and protective factors (positive gay identity; social, including family, support; and a high level of self-acceptance) for gay men (MoH, 1997).

The chapter further broadly discusses mental health issues and identifies a range of actions (MoH, 1997)[9].

A 2005 paper on the management of alcohol at large-scale sports fixtures and other public events does not consider TLGB communities (Allsop Pascal & Chikritzhs 2005). It has become clear that TLGB communities are targeted by the alcohol industry with alcohol marketing at big community events also in Aotearoa New Zealand (Adams McCreanor Braun 2007).

3.5.2 Public Alcohol Policy

TLGB populations are rarely included in public health policies on alcohol in Aotearoa New Zealand (Pega 2008). The *National Alcohol Strategy 2000–2003* dealt with gay, lesbian, and bisexual populations as one of a range of relevant minority groups for which there are indications of greater risk of alcohol-related harm (MoH, 2001). The strategy summarises the evidence base, stating that 'Although the evidence is mixed, some sources suggest that gay, lesbian, bisexual, and transgender people, especially younger members of these communities, are at greater risk of alcohol-related harm than other people (Smith et al 1999; Fergusson et al 1999; MacEwan and Kinder 1991; MacEwan 1994; Heffernan 1998).' (MoH, 2001, p. 31).

The strategy also notes that 'Strategies aimed at reducing alcohol-related harm amongst members of minority groups need to recognise and be in tune with the different life experiences and realities of the members of these groups.' (MoH, 2001, p. 31). Under the arm of demand reduction strategies, the strategic document sets one TLGB-specific objective and four strategic actions to reduce alcohol-related harm amongst TLGB populations as listed in Table 3.

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[9] These recommendations are:

'The development of public policy to promote mental health among gay men will require full consultation and participation in decision-making by the gay community and must acknowledge that others who may be involved, such as professionals, are not free from homophobia (Clare 1992; Rose 1994). Service providers must strengthen points of contact between themselves and gay community groups.' (MoH, 1997: 247)

Table 3. Objectives and strategies to reduce alcohol-related harm amongst gay, lesbian, and bisexual populations in the National Alcohol Strategy: 2000–2003

Objective	Demand reduction strategies
15. Reduce the likelihood of alcohol-related harm among gay, lesbian, bisexual, and transgender people.	15.1 Incorporate information on the effects of alcohol and on responsible drinking practices in queer health initiatives, and via gay and lesbian media. 15.2 Promote community activities for gay, lesbian, bisexual, and transgender people that are not oriented around drinking alcohol. 15.3 Ensure that alcohol-related health promotion strategies for men and women address the needs of people who are same-sex-attracted. 15.4 Ensure initiatives for all alcohol health promotion for young people address the needs of same-sex-attracted youth.

Source: MoH, 2001, p. 32

The 2004 *Action Plan on Alcohol and Illicit Drugs* fails to translate the provisions regarding sexual minority populations that were made in the *National Alcohol Strategy 2000–2003* into actions (MoH, 2001, 2004).

The 2007 *Review of the National Alcohol Strategy 2000–2003* makes reference to gay, lesbian and bisexual people in its review of provisions made by the *National Alcohol Strategy 2000–2003* with regards to demand reduction strategies targeted at at-risk populations (MoH, 2001, 2007). The review stresses that health promotion should be easily understood by the targeted groups, relevant, and in a form that makes it effective and stresses the need for consultation with the target groups in both the development of the information and with respect to the use of appropriate dissemination media (MoH, 2007).

3.5.3 Conclusion

The MoH last published a detailed review of evidence on the use of alcohol amongst sexual minority populations more than a decade ago. The most robust evidence on alcohol use amongst sexual minority populations has been published in the decade since then, as shown in the review of evidence in this document (S3.2).

Although the MoH set one strategic goal and four strategic actions in its 2001 *National Alcohol Strategy 2000–2003*, these were aligned under demand reduction strategies only

and provisions made in the national alcohol strategy have not yet been translated into actions as set out in the 2004 *Action Plan on Alcohol and Illicit Drugs* (MoH 2001, 2004).

An updated review of alcohol use by the Ministry of Health similar to that of 1997 and, in turn, a review of the provisions suggested in the *National Alcohol Strategy 2000–2003* would provide a good base for initiating the evidence-based work needed.

3.6 STAKEHOLDER PERCEPTIONS FOR THE NEED TO REDUCE ALCOHOL-RELATED HARM AMONGST TLGB COMMUNITIES

Research participants agreed that the need to reduce alcohol-related harm amongst sexual minority populations is high.

Almost all research participants from TLGB community organisations generally spoke about alcohol use and abuse being common in TLGB communities and as leading to significant harm that needed to be reduced. Research participants were aware of recent Aotearoa New Zealand research that had highlighted higher rates of alcohol use amongst sexual minority communities (Pega and Coupe's 2007 study), arguing that the government had the responsibility to reduce these inequalities.

The majority of sexual minority communities had started discussing the problematic nature of alcohol use in their communities, although there was a perception that some segments of TLGB communities had not started questioning alcohol use in their communities to date. The general opinion was that sexual minority communities and organisations were ready to start addressing problematic alcohol use in their communities.

Sexual minority research participants reported that although recent research and associated media reporting had created momentum for critical reflections and discussions within sexual minority communities, no actions had been taken to follow up from these discussions. Those sexual minority people who were aware of the need to reduce alcohol-related harm amongst sexual minority communities said that they needed to be resourced appropriately for the purpose of placing them in a position to do awareness-raising amongst their communities.

Research participants quoted a number of areas of risk specific to sexual minority communities that need addressing:

1. Research participants were concerned that the alcohol industry offered funding for TLGB community events on the condition of being able to promote alcohol to participants of these events. The lack of funding from sources other than the alcohol industry had made TLGB communities fiscally reliant on the alcohol industry, opening the doors for intense TLGB-targeted alcohol marketing. Funding from other sources would enable TLGB communities to conduct events that did not promote alcohol use.
2. It was noted that there was a concerning high concentration of liquor outlets in neighbourhoods with high TLGB density.
3. TLGB research participants pointed out that many TLGB community activities such as those in TLGB bars evolved around alcohol, critically noting the lack of community-

based activities that were not alcohol-related. This meant that TLGB communities often associated socialising with the use of alcohol, creating a culture that needed to be changed.

4. One research participant representing a TLGB organisation said that sexual minority persons often presented only after an alcohol addiction problem had developed, probably because they had not been reached by health promotion efforts.
5. Alcohol use was also seen as an important issue in relation to HIV prevention amongst same-sex men, domestic violence between same-sex partners, and, more broadly, violence affecting TLGB communities.
6. TLGB research participants also reported that alcohol use was not regulated in the same way in TLGB environments as it was in other social environments. For instance, the participants of one focus group with TLGB organisations reported that alcohol was being served to heavily intoxicated people in TLGB bars, that underage people were granted access to TLGB bars, and that there was less policing and enforcement of alcohol-related legislation in TLGB drinking environments as in non-TLGB drinking environments. The public agencies overseeing the regulation of alcohol use had failed to ensure that TLGB environments were equitably regulated by omitting TLGB communities from strategies. Work needs to be done to encourage TLGB bars to adhere to their host responsibilities.

Research participants noted the need to address alcohol-related harm amongst particular sexual minority communities. Māori, Pacific, adolescent, older, and rural sexual minority communities were regarded as groups requiring particular attention. Sexual minority women and men were seen as differing in their drinking cultures in that women were more likely to consume alcohol at home and men were more likely to consume alcohol in bars and clubs, creating the need for different alcohol prevention approaches to be developed.

Research participants perceived the provision of alcohol prevention and treatment services to sexual minority communities as deficient. For instance, several alcohol practitioners evaluated their services as non-responsive to TLGB clients seeking treatment due to a lack of TLGB-specific knowledge, training, and resources available to alcohol practitioners. However, many research participants that were providers of alcohol prevention and treatment services had a significant number of TLGB clients and all wanted to be able to provide these clients with appropriate and effective services. These alcohol practitioners saw the need to address the current lack of training about TLGB clients' needs, the lack of TLGB-targeted resources, that sexual orientation was not included in assessment, and that the environment they worked in was non-conducive to addressing institutional barriers for TLGB clients.

Policy-makers generally acknowledged that there was a need for reducing alcohol-related harm amongst sexual minority populations if evidence showed that these populations used alcohol at higher rates. However, one policy-maker, who acknowledged having a lack of knowledge about TLGB communities and TLGB use of alcohol, perceived only little to moderate need for the reduction of alcohol-related harm amongst sexual minority

populations. To explain this stance, this policy-maker used a set of arguments that have been identified by one of the current authors as discourses that policy-makers commonly use to justify an exclusion of sexual minority populations from public health policy-making in Aotearoa New Zealand (Pega, 2009)[10]. For instance, the policy-maker referred to the presumed small population size of the TLGB population and the relatively lower impact of sexual orientation compared to other social determinants of health.

In summary, there was wide-ranging agreement that the need to reduce alcohol-related harm amongst sexual minority populations is high.

3.7 CONCLUSION

The most robust existing national figures estimating the prevalence of minority sexual orientations suggest that sexual minority communities constitute a sizeable segment of the general population.

There is conclusive evidence from high-quality studies that sexual minority women use alcohol at higher rates than are heterosexual women, both in Aotearoa New Zealand and internationally. There is a growing body of international evidence on the prevalence of alcohol use amongst sexual minority men compared to heterosexual men, with conflicting findings; but there is strong evidence from an Aotearoa New Zealand study that sexual minority men use alcohol at higher rates than heterosexual men. Further research is needed, requiring the collection of high-quality data on sexual orientation in surveys on alcohol use.

There is growing evidence about the types of alcohol-related harms that sexual minority communities experience. For sexual minority women, such harms include HIV risk-behaviours and domestic violence. For sexual minority men, harms include HIV risk-behaviours, domestic violence, and sexual coercion.

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[10] In this study investigating discourses that are commonly used by policy-makers to exclude TLGB populations from health policy in Aotearoa New Zealand, a majority of the interviewed policy-makers expressed the opinion that:

- policy targeted specifically at LGB populations was infeasible and that the government of the day preferred 'blanket', population-wide strategies.
- the Ministry of Health was completely open to tackling the health concerns of LGB populations, broadly consulted with LGB populations, and was free of institutional sexual orientation discrimination.
- the health impact of sexual orientation was lesser than that of other social determinants of health.
- there was insufficient political advocacy for LGB health.
- the population size of LGB was too low to merit policy action.
- LGB health was the responsibility of regional, not central, public health authorities. (Pega, 2009)

In 1997, the MoH published a review of alcohol use amongst sexual minority populations and, in its *National Alcohol Strategy 2000–2003,* made provisions for lesbian, gay, and bisexual populations. More recent alcohol strategies did not make any provision. An updated review of alcohol use by the MoH similar to that of 1997 and, in turn, a review of the provisions suggested in the *National Alcohol Strategy 2000–2003* would provide a good base for initiating the evidence-based work needed.

There is general agreement amongst stakeholders interviewed for the TLGB Scoping Exercise that there is a need to reduce alcohol-related harm amongst sexual minority communities.

In summary, these points make a strong argument for evidence-based work to reduce alcohol-related harm amongst sexual minority communities.

A conceptual model for alcohol use amongst sexual minority populations is available that ALAC could use as a conceptual framework for action to reduce alcohol-related harm amongst sexual minority communities.

4 KEY STAKEHOLDERS

Stakeholders in the field of TLGB alcohol use are important partners for ALAC with regards to reducing alcohol-related harm amongst sexual minority communities. The tables below list key stake-holding TLGB community organisations (Table 4), national agencies providing leadership in alcohol, drug, and addiction prevention and treatment (Table 5), and other key stakeholders (Table 6).

Table 4. Key stakeholders: TLGB community organisations

National organisations	INA (Māori, Indigenous & South Pacific) HIV/AIDS Foundation
	New Zealand AIDS Foundation (NZAF) (includes Māori-specific service: Hau Ora Takatāpui Programme)
	OUTLine NZ
	OUT THERE! Queer Youth Development Project (includes Takatāpui-specific service)
Regional support and advocacy groups	Gaylink Waikato
	Rainbow Wellington
	Southland Gay and Lesbian Support (SGnLS)
Groups of TLGB Māori	Mangere East Family Services Centre (Auckland)
	Tiwhanawhana Trust (National)
TLGB groups of young people	Queer youth group network
	Rainbow Youth (National)
	Uni-Q groups

Table 5. Key stakeholders: National agencies providing leadership in alcohol, drug, and addiction prevention and treatment

National agencies	Alcohol Advisory Council of New Zealand (ALAC)
	Alcohol and Drug Association of Aotearoa New Zealand (ADANZ)
	Drug and Alcohol Practitioners' Association Aotearoa-New Zealand (DAPAANZ)
	Matua Raki – National Addiction Treatment Workforce Development Programme (NATWDP)
	MoH

	National Association of Opioid Treatment Providers (NAOTP)
	National Committee for Addiction Treatment (NCAT)
Alcohol prevention and treatment service providers	Community Alcohol and Drugs Services (CADS), Waitemata DHB
	Interested CADS teams of District Health Boards

Table 6. Other key stakeholders

Central Government agencies	Mental Health Commission
	Ministry of Social Development
New Zealand Police	Diversity Liaison Officers

5 ALCOHOL PREVENTION AND TREATMENT SERVICES FOR TLGB COMMUNITIES

This section reports on the current level of provision of alcohol prevention and treatment services to TLGB communities in Aotearoa New Zealand. It then reviews findings from a selection of studies on alcohol prevention and treatment services for TLGB communities, with the view of highlighting what works in terms of servicing TLGB communities.

5.1 ALCOHOL PREVENTION AND TREATMENT SERVICES FOR TLGB COMMUNITIES IN AOTEAROA NEW ZEALAND

Provision of alcohol-prevention and treatment services is reported on separately as:

- TLGB-targeted services
- non-TLGB targeted services.

5.1.1 TLGB-targeted services

There is currently only one TLGB-targeted alcohol service in Aotearoa New Zealand: Community Alcohol and Drug Services (CADS), of the Waitemata District Health Board. This TLGB-targeted service is a good model for other national services.

The TLGB-targeted CADS team services TLGB communities in the Auckland geographic region. It has established a satellite service at the New Zealand Prostitutes Collective: NZPC. Tupu-Pacific Service, of CADS, Waitemata District Health Board, also works in an affirmative way with Pacific TLGB clients.

The CADS team focusing on TLGB communities developed out of an ALAC-funded HIV/AIDS worker role at CADS in the late 1980s. It has been documented elsewhere how CADS, as an originally non-TLGB targeted alcohol prevention and treatment service, reoriented its services to be responsive to the needs of sexual minority populations (Semp & Madgeskind 2000). But it is worth noting that TLGB clients, TLGB CADS staff, heterosexual CADS staff, and external agencies took a positive stance towards CADS' reorientation towards reducing alcohol-harm amongst TLGB communities (Semp & Madgeskind, 2000). Today, CADS employs a small number of TLGB clinicians and the Regional Gay Communities Project Worker (0.5FTE) to work with TLGB clients and communities. In 2000, TLGB CADS staff expressed the wish for a Lesbian Project Worker to be employed, as well as more TLGB staff in general (Semp & Madgeskind). However, a number of research participants of the TLGB Scoping Study were familiar with CADS' work over a longer period of time, reporting with disappointment that the service had reduced the number of staff working with TLGB communities and clients significantly in recent times, creating constraints on its services.

CADS provide a range of alcohol prevention services. These include a monthly column about substance use in a gay/lesbian magazine, alcohol education at selected TLGB

community events such as the Hero Party and the Big Gay Out, and training for service providers.

In 2000, a service evaluation questioned how CADS addressed the specific needs of bisexual clients and encouraged CADS to improve its consultation practices with takatāpui communities to fulfil its commitment to Te Tiriti o Waitanagi/The Treaty of Waitangi (Semp & Madgeskind, 2000). Several TLGB research participants of the Scoping Exercise were concerned about the effectiveness of CADS' current prevention efforts, especially the service's ability to reach out to sexual minority women, takatāpui, and young sexual minority communities. One participant pointed out that good work had been done by CADS in training and up-skilling other services to be more responsive to TLGB issues.

CADS TLGB clinicians work with TLGB clients to address alcohol addiction issues in a TLGB-affirmative way through responsive counselling services. That CADS has visible TLGB staff at all levels of the service and supports these staff as TLGB individuals, is paramount to the effectiveness of the service and its credibility amongst TLGB communities (Semp & Madgeskind, 2000). In addition, the CADS treatment environment plays an important role in enhancing uptake of the TLGB-targeted service. For example, TLGB posters and magazines in the waiting room and inclusion of a question on sexual orientation in the assessment are effective in this regard (Semp & Madgeskind, 2000).

An outcome evaluation of the service (Semp & Madgeskind, 2000) and TLGB research participants of the TLGB Scoping Exercise pointed out the need for CADS to increase the visibility of its TLGB staff in TLGB communities, especially the visibility of its TLGB counsellors. External agencies need to be trained to refer TLGB clients on to CADS (Semp & Madgeskind, 2000).

To be clear, research participants of the TLGB Scoping Exercise felt that the limited impact that they perceived CADS' prevention and treatment services to currently have reflected the fiscal and staffing constraints within which CADS was currently working, rather than CADS' or its staff's ability to provide effective and excellent TLGB-targeted services.

There have also been sporadic TLGB community-initiated and -run alcohol prevention initiatives in the Auckland region. For instance, a TLGB youth organisation had held meetings in which alcohol use had been discussed by young TLGB people with their peers. However, TLGB research participants reported that such community initiatives required access to relevant health promotion knowledge and resources to be able to effectively reduce alcohol-related harm amongst their communities. The initiators of these initiatives had generally come to the conclusion that the establishment and maintenance of such initiatives exceeded their capacity.

5.1.2 Non-TLGB Targeted Services

Public and private non-TLGB targeted alcohol prevention and treatment services such as those of District Health Boards (DHBs), Alcoholics Anonymous, City Missions, and many faith-based services were regarded by participants of the TLGB Scoping Exercise as failing to provide appropriate services to TLGB communities and clients. Many research

participants from non-TLGB targeted alcohol prevention and treatment services generally reported that their and other services lacked responsiveness to TLGB clients and communities. There was consensus amongst TLGB research participants that non-TLGB targeted services currently did not respond sufficiently to TLGB clients' needs. Several cases of unresponsive service provision were reported. Overall, there was general agreement amongst the majority of research participants that current services concerned with reducing alcohol-related harm meet the needs of TLGB communities poorly.

Non-TLGB targeted services generally did not create a TLGB-friendly environment, for instance in that they did not provide TLGB magazines in the waiting room or did not have TLGB posters up. Few non-TLGB targeted services had openly TLGB staff that could signal that the service was TLGB-friendly and provided services from TLGB staff to TLGB clients.

A key point mentioned was that hardly any non-TLGB targeted services asked clients about their sexual orientation in their initial standard assessment. This meant that clients received the signal that their sexual orientation was not considered relevant to their alcohol use, creating a first barrier for TLGB clients. One participant reported that a Dunedin service (Moana House) had included sexual orientation into their initial assessment, which had opened up the opportunity for TLGB clients to address issues related to their alcohol use that were related to their sexual orientation.

The lack of any initial assessment of sexual orientation appears to continue into the counselling process. Alcohol practitioners who participated in the TLGB Scoping Exercise reported that, generally, sexual orientation was seldom discussed in their alcohol counselling. One focus group participant pointed out that alcohol practitioners who wanted to address TLGB alcohol use were faced with a working environment that failed to acknowledge sexual orientation as a relevant factor in alcohol treatment. The same alcohol practitioner noted a lack of training and resources for frontline counselling staff and service managers in this area. Another focus group participant who had provided sexuality training to alcohol counsellors, service managers, and policy staff reported that there was a very positive reaction to training and that participants were interested in obtaining knowledge that could improve the responsiveness of their services.

One participant suggested that services for young people might be slightly more well-placed to provide services that are responsive to TLGB young people's particular needs. The same participant said that especially rural TLGB people might not be able to access appropriate, non-discriminatory treatment services. Services needed to develop especially awareness to those sexual minority populations with multiple minority status. Several TLGB research participants said that they knew of many TLGB persons who were looking for appropriate alcohol treatment.

One reason for the lack of services appears to be that DHB funders and planners throughout Aotearoa New Zealand have not paid attention to the needs of local TLGB communities or to fund services to reduce inequalities in alcohol use between TLGB and heterosexual communities. This has led to the ongoing invisibility of TLGB communities and to significant unmet need. As DHB, hold significant alcohol-related funding, research participants wanted

planning and funding departments of DHBs to be encouraged to raise their awareness about TLGB community needs, to address discriminatory thinking amongst planners and funders, and to account for their funding for TLGB communities, possibly through the use of a TLGB auditing tool.

The need for making non-TLGB services more TLGB responsive was noted repeatedly, but a combination of raining awareness for TLGB communities amongst non-TLGB targeted services and of providing TLGB targeted services in TLGB centres was seen as providing optimal service coverage. Workforce development was needed to ensure the development of a sustainable body of TLGB alcohol practitioners.

In addition, service–communities relationships needed to be built over a long time and needed to foreground the needs of TLGB communities. TLGB communities needed to be valued by alcohol prevention and treatment services.

Policy-makers talked about the need to include TLGB communities in policy documents. For instance, one policy-maker noted that the national Health and Disability Sector Standards (HDSS) for accreditation of health services did not currently specify TLGB communities as an example of groups that services needed to address. If TLGB communities were included in these standards, operational policy in alcohol prevention and treatment services would need to address TLGB communities. The same policy-maker also wanted alcohol strategies to be inclusive of TLGB communities in terms of acknowledging and servicing the needs of these communities.

5.2 KNOWLEDGE ABOUT ALCOHOL PREVENTION AND TREATMENT SERVICES

This section reviews a selection of key literature on:

- alcohol prevention for TLGB communities
- alcohol treatment for TLGB communities.

5.2.1 Alcohol Prevention Services

There is a lack of research on alcohol prevention initiatives targeted at TLGB populations. However, MacEwan and Kinder (1991) used a World Health Organisation health promotion and problem solving model that emphasises the important role of the agent (e.g. alcohol or a drug), the host (the alcohol or drug user), and the environment (including factors such as peer pressure and role models) for alcohol prevention amongst TLGB communities (1991). The model explores the complex interaction of these three factors, with an emphasis on the complexity of socio-cultural factors at play (e.g. the roles that community groups have for health promotion and how to prevent drinking).

5.2.2 Alcohol Treatment Services

This review of literature on alcohol treatment includes a review of:

- a study on the initial assessment and treatment of TLGB clients in Aotearoa New Zealand
- outcomes evaluations of TLGB targeted treatment services
- guidelines, both for non-TLGB targeted treatment services and for counsellors working with TLGB clients

A study on the initial assessment and treatment of TLGB clients in Aotearoa New Zealand

In 1994, MacEwan conducted a study of the assessment and alcohol treatment of lesbians and gay men, compared to heterosexuals. Interviews with a small number of non-random sampled sexual minority (*N*=50) and heterosexual clients of specialist alcohol treatment services (*N*=50) were conducted, and the answers were compared statistically.

Key findings of the study were that:

- Sexual orientation was generally not considered in the drawing up of treatment plans, because sexual orientation was not assessed by alcohol practitioners in referral or admission forms. Many sexual minority clients perceived their counsellors as being of the opinion that sexual orientation was not significant for the treatment of substance abuse amongst lesbians.
- Half of the lesbian clients had not disclosed their sexual orientation by the end of the treatment. Mixed gender treatment settings were quoted as the principal reason for this pattern of high non-disclosure.
- There was a negative perception of group therapy amongst sexual minority clients. Sexual minority clients reported fear of violence from members of the group, other forms of homophobic reaction, the perceived expectation to act out gender-atypical roles, being reduced to their sexual orientation, and as being seen as having an interest in sex only.
- The majority of both lesbians and gay clients experienced the treatment service as understanding their sexual orientation as a pathology that was causally related to their substance use. However, clients believed that they shared with their counsellors the understanding that their socialisation as lesbians and gay men had significantly contributed to their alcohol or drug addiction.
- Sexual minority clients' partners and family of choice were often not invited to participate in the therapy.

MacEwan (1994) concluded that:

- sexual orientation should be assessed and included in a treatment plan
- group therapy might be less successful with sexual minority clients, especially mixed-gender groups for lesbian women

- partners and family of choice of sexual minority clients should be involved in the treatment and that it is important to work with the TLGB community as a whole to ensure good treatment outcomes for TLGB alcohol and drug addicts
- TLGB-targeted services are likely to be more effective than general services and that they have a better ability to reach out and attract sexual minority clients.

Outcomes evaluations of MSM-targeted alcohol treatment services in the United States

The effectiveness of an alcohol and drug use outpatient treatment service specifically targeted at MSM (18th Street Services, San Francisco, United States) has been described and evaluated by two studies.

A longitudinal study with alcohol and/or drug addicts using this service was conducted (Paul et al., 1996). The study found amongst clients of this treatment service, the prevalence of alcohol and drug use declined markedly over a twelve-month period. For alcohol, declines of prevalence of any use of around 50% were achieved over the first three months, which then stabilised over the course of the treatment (Paul et al., 1996).

Another study evaluated an intervention designed to reduce HIV-risk behaviours that was implemented at the same alcohol and drug treatment service (Stall et al., 1999). The evaluation found that gay and bisexual men who entered the alcohol and drug use treatment targeted at sexual minority men showed impressive reductions of sexual risk-taking behaviours, whether they received a safe-sex reduction intervention or not.

The findings of these two studies imply that the examined MSM-targeted service was effective in reducing alcohol use amongst a sample of gay and bisexual male alcohol and drug addicts.

A randomised controlled trial of goal choice interventions for alcohol use disorders amongst HIV-negative MSM was conducted by Morgenstern et al. in 2007. It found:

- that four sessions of motivational interviewing focused on reducing both alcohol use and HIV-risk behaviours were more effective in reducing alcohol use over a twelve-week period than twelve sessions combining the same motivational interviewing technique with coping-behavioural therapy, when outcomes were compared immediately after treatment;
- no differences between clients allocated to the two treatment conditions one year after treatment.

In summary, these three studies show that MSM-targeted services in the United States have been effective in reducing alcohol-related harm amongst MSM clients.

Guidelines for alcohol treatment services

Health authorities and researchers in the United States and Aotearoa New Zealand have published guidelines for alcohol treatment services about how services can be responsive to TLGB clients. Amongst the first such resources was MacEwan & Kindler's book titled *Making*

visible: Improving services for lesbians and gay men in alcohol and drug treatment and health promotion (1991). The book:

- provides a rationale for why alcohol treatment services should consider TLGB clients
- provides an overview of key terminology specific to the field of lesbian, gay, and bisexual (LGB) substance use and treatment
- discusses how many clients entering alcohol and drug treatment are LGB;
- provides a model of sexual identity development
- describes the unique stresses and factors that lesbians and gay men face (e.g. homophobia, friends and relationships, meeting places, sex, and families), as well as the particular needs of lesbian or gay parents and the specific networks of sexual minority communities.

The United States Department of Health and Human Services Centre for Substance Abuse Treatment published a comprehensive book about alcohol and drug treatment for LGB clients that is targeted at clinicians and project managers of treatment services in 2001. The book:

- provides an introductory overview of sexual minority issues by reviewing evidence on substance use and abuse amongst sexual minority communities and by discussing conceptual and technical issues of definition and conceptualisation, enumeration, sexual orientation fluidity over time, and assessment of sexual orientation
- discusses homophobia and heterosexism and the trajectories through which these impact on substance use amongst sexual minority populations
- discusses cultural issues of working with sexual minority clients are also described, including issues of working with ethnic minority LGBs and working effectively cross-culturally
- discusses legal issues such as the protection of confidentiality in treatment and examines discrimination and legal protection for sexual minorities
- provides an overview over treatment approaches, modalities, and issues of accessibility to health care closes the introduction.

The book then addresses clinicians. It:

- discusses the coming out process for lesbians and gay men as well as issues of family of origin, family of choice, and parenting that are specific to sexual minority populations
- discusses clinical issues with lesbians (Chapter 7), with gay males (Chapter 8), with bisexuals (Chapter 9), and with sexual minority youth (Chapter 11)
- reviews the specific health concerns, including mental health concerns, of sexual minority people that abuse substances and evidence about the connection between substance abuse and interpersonal violence amongst LGBs is reviewed. Related health

issues for sexual minority populations are reviewed and the book provides guidance to clinicians about how to counsel LGBs in treatment for substance abuse competently.

The book then addresses programme managers. The book advises about:

- policies and procedures that should be put in place (Chapter 14)
- training and education (Chapter 15)
- quality improvement (Chapter 16)
- using networks and alliances to achieve improvements for LGB clients (Chapter 17).

Finally, the book makes concrete recommendations for research, clinicians, training, and management.

Guidelines for alcohol counsellors

There are several guidelines available on counselling sexual minority clients in relation to alcohol use. In 2000, Cohen included a chapter on outreach and treatment issues for lesbian and bisexual women in her book on the counselling of women with addiction problems. This chapter includes a training manual for three staff activities that help create sensitivity to sexual minority women as a special population and seven client-centred activities that can be used to explore issues of sexual orientation that might be of particular relevance for lesbian and bisexual women with addiction problems.

The most comprehensive guidance with respect to counselling sexual minority clients with alcohol addictions comes from Finnegan and McNally's 2001 book. The book:

- provides useful background information such as a definition of terms specific to sexual minority communities
- discusses issues surrounding counsellor competency, detailing the scope of the problem and how to address it
- explores societal prejudice and oppression in the form of institutionalised homophobia and biphobia, sexual minority stress, and the specific role that religion, the medical/psychiatric/psychological profession, and the media have in maintaining various forms of prejudice and oppression
- discusses internalised homophobia and biphobia, exploring the basic reactions and effects of these phobias, and the defences against them, the role that the counsellor plays, especially in the early recovery process, and how internalised homo- and biphobia might differently affect those sexual minority individuals who are not easily recognised as a member of a sexual minority group
- explores treatment issues, especially the strengths and limitations of the specific setting of a treatment service in relation to servicing sexual minorities; the gathering of information; and how to work with the sexual minority communities

- describes special issues that can be addressed in treatment (i.e. socialising and sexual contact during recovery, significant others and family issues, parents or children of sexual minority people, religious guilt, confidentiality, HIV and AIDS)
- provides guidance to counsellors about how they can best support their clients to develop a positive LGB identity by reviewing stage models of sexual identity development and describing the psycho-social processes of sexual identity development amongst LGBs.

5.3 CONCLUSION

There is only one TLGB targeted service in Aotearoa New Zealand that targets TLGB people in the Auckland geographic region with alcohol prevention and treatment services, and staff for this service has increasingly been reduced, limiting what this service can realistically achieve. TLGB community initiatives have been trialled by the community but they found that they require significant resources to be effective.

Non-TLGB targeted alcohol prevention and treatment services generally do not currently have the knowledge and workforce capacity to respond to the needs of TLGB clients and communities, with a few outstanding exceptions. Research participants said that services for young TLGB people might be better placed to provide services responsively, but particularly rural TLGB people might not be serviced appropriately. In summary, there are major gaps in service provision to TLGB populations – there is little doubt that these communities are underserved.

Research on alcohol prevention for TLGB communities is scarce. But there is a good amount of research that can be used to design TLGB-responsive alcohol treatment services, including evaluations, and such research has been translated into several guideline documents addressing alcohol treatment practitioners, alcohol treatment service managers, and policy staff working in this field.

6 ALAC'S POTENTIAL ROLE

ALAC has, in the 1990s, played a significant role in reducing alcohol-related harm amongst TLGB communities by holding conferences on the topic, producing training resources such as the *Making visible* resource (MacEwan & Kindler, 1994) and posters, and furthering knowledge through research. A number of research participants interviewed for this scoping exercise remembered ALAC's past role in this respect and applauded ALAC's former work in the field of TLGB alcohol use, acknowledging that ALAC had played an important role for the reduction of alcohol-related harm amongst TLGB communities in the past.

Research participants did not perceive ALAC to be currently involved in reducing alcohol-related harm amongst TLGB communities beyond services targeted at the general population. Many of the current social marketing campaigns launched by ALAC were perceived as not relevant to TLGB communities, because these communities could not see themselves as part of the communities presented in ALAC's campaigns. However, the commissioning by ALAC of the TLGB Scoping Exercise was seen as an important signal from ALAC that the organisation is interested in re-engaging in a more targeted way with TLGB populations, which research participants welcomed and supported, often with significant enthusiasm.

There was general agreement amongst focus group participants and key-informants from TLGB organisations and providers of alcohol prevention and treatment services that ALAC was well placed – and indeed had the responsibility – to head the agenda of reducing alcohol-related harm amongst TLGB populations in close collaboration with TLGB communities. ALAC was regarded as the national agency that could most successfully reduce alcohol-related harm amongst TLGB populations, considering the leadership role that ALAC plays in the sector. ALAC's unique positioning as an autonomous Crown entity established by statute was regarded as enabling ALAC to put the concerns regarding TLGB alcohol harm on the public agenda, with support from TLGB organisations. ALAC's leadership role and relationships within the alcohol sector were seen as providing fertile ground for ALAC successfully taking a leadership role with respect to reducing alcohol-related harm amongst TLGB populations. TLGB organisations saw their role as supporting ALAC well in its leadership position by contributing their community expertise and working collaboratively with ALAC.

Participating informants representing providers of alcohol prevention and treatment services wanted ALAC to include training about TLGB communities and alcohol-related harm in their training programmes directed at practitioners at the service management and practitioner level. Besides providing training, practitioners wanted ALAC to produce high-quality health promotion resources targeted at TLGB communities and clients that practitioners could use to make their services more inclusive and responsive, allowing equitable access to effective resources also for TLGB clients.

Policy staff wanted to see ALAC influence the MoH and District Health Boards in their approaches to reducing alcohol-related harm amongst TLGB populations.

In summary, there was general agreement amongst the interviewed informants from key stakeholder groups that ALAC was well-placed to take a leadership role in Aotearoa New Zealand with respect to reducing alcohol-related harm amongst TLGB communities as long as ALAC collaborated closely with TLGB communities on this issue.

Experiences from successful services from within and outside of Aotearoa New Zealand should be used to inform Aotearoa New Zealand initiatives. For example, much can be learnt from the alcohol advocacy, prevention, and treatment work conducted by ACON, an non-governmental organisation working across New South Wales in Australia (see http://www.acon.org.au/alcohol-and-other-drugs).

7 STRATEGIES THAT ALAC CAN LOOK TO IMPLEMENT

The following section contains a set of strategies that ALAC can look to implement, namely to:

- increase knowledge
- build relationships and consult with TLGB communities
- facilitate meeting between the *TLGB Community Leadership Group in Mental Health and Alcohol and Drug* and national alcohol and drug agencies
- conduct a needs assessment to inform programming
- provide policy advice and guidance with respect to TLGB populations.

ALAC is encouraged to look at its FTE contribution to this work and examine whether current capacity could take on this work or if alternatives such as an increase in FTE or contracting out of the work would need to be explored.

7.1 INCREASE KNOWLEDGE

7.1.1 Sexual Orientation Data on Alcohol Use

Collection of sexual orientation data on alcohol use by ALAC, particularly through the regular ALAC surveys, and analysis and reporting of such data would increase ALAC's knowledge on alcohol use amongst sexual minority communities. A strategy which ALAC could adopt is to consult with experts in the field of sexual orientation data collection and analysis to identify the best direct question or set of questions on sexual orientation to include in ALAC surveys and to then collect, analyse, and report sexual orientation data on a standard basis.

7.1.2 Standard Collection of Sexual Orientation Data

Standard collection of sexual orientation data by the MoH in its surveys that collect information on alcohol use, especially those surveys with large sample sizes, and standard analysis and reporting of such data would increase national knowledge on sexual minority communities' use of alcohol significantly. ALAC could adopt the strategy to work with the MoH towards the inclusion of sound, direct sexual orientation questions in suitable MoH surveys and towards the regular analysis and reporting of such official data on sexual orientation.

7.1.3 Specific Alcohol-Related Research in the TLGB Field

Specific alcohol-related research in the TLGB field by academic and other institutions conducting research would further extend the crucial knowledge base. ALAC could consider developing a strategy for improving the carrying out of research by external bodies in this field. This strategy could include ALAC identifying funding opportunities for postgraduate research on alcohol use and alcohol-related harm among sexual minority communities.

7.1.4 Research Gaps

This report identifies the following key gaps in research on TLGB alcohol use and harm in Aotearoa New Zealand: the prevalence of heavy alcohol use amongst TLGB communities, alcohol use amongst takatāpui communities, alcohol use amongst bisexual communities; alcohol use amongst rural TLGB communities, the prevalence and nature of alcohol-related harm amongst TLGB communities, and TLGB targeted alcohol prevention and treatment services. Addressing these key national research gaps would contribute towards a comprehensive national body of evidence in the field. A strategy ALAC could adopt in this regard is to continue to identify emerging evidential and information needs relating to TLGB communities, and to include the identified gaps in its research planning taking note of needs in assigning priorities.

7.1.5 Needs Assessment

In the short term, until research gaps on TLGB targeted initiatives are addressed, specific knowledge could be produced by ALAC as the basis for the development of prioritised ALAC initiatives. As an initial strategy, directly following on from the work of this scoping exercise, ALAC could conduct a needs assessment focused on providing the information required for effectively developing priority TLGB targeted initiatives.

7.2 BUILD RELATIONSHIPS

7.2.1 Relationships

Strong relationships between TLGB communities and ALAC are the basis for effectively identifying and implementing ways of reducing alcohol-related harm amongst sexual minority communities in a collaborative fashion. One central strategy in this regard could be to build relationships with sexual minority communities across a number of current ALAC activities and to establish a *TLGB Community Leadership Group in Mental Health and Alcohol and Drug*, which could bring together key stakeholders from TLGB communities and organisations.

7.2.2 Transparency

ALAC following a consistently transparent approach with respect to its work with TLGB communities would contribute to ALAC maintaining a productive collaborative relationship with TLGB communities. To promote a collaborative approach with the TLGB stakeholder group, ALAC could consider ways and means of providing for two-way communication with TLGB communities about activities of relevance and a way of publicising such methods.

7.2.3 Harm Reduction Messages

The delivery of harm reduction messages to TLGB communities by ALAC would contribute to relationship-building with TLGB communities by signalling to the communities that ALAC has commenced taking actions aimed at reducing their alcohol-related harm. The suggested strategy is for ALAC to include TLGB communities and their members in ALAC's campaigns,

and to ensure that TLGB communities are not presented in a way that misrepresents or stigmatises them.

7.3 FACILITATE EXCHANGE AND COLLABORATION

7.3.1 Exchange and Collaboration between Stakeholders

Exchange and collaboration between key stakeholders is crucial for strengthening the agenda of reducing TLGB alcohol-related harm and for stimulating action on this agenda. To promote the strategies identified in this section of the report and assist collaborative action, ALAC could facilitate meetings:

a) of TLGB communities to discuss the issue of alcohol-related harm and its reduction and to guide strategic and programme developments

b) of national alcohol and drug agencies to discuss this report and its suggested strategies, as well as to identify ways for these agencies to jointly and individually contribute to the reduction of alcohol-related harm amongst TLGB communities

c) between TLGB communities and national alcohol and drug agencies to bring together findings from the previous meetings of these stakeholder groups for the purpose of collaborative goal-setting and action-taking.

7.4 PROVIDE POLICY ADVICE AND GUIDANCE

7.4.1 Working with Other Agencies/Organisations

Government agencies have acknowledged higher rates of substance use amongst sexual minority communities than amongst heterosexual communities, highlighting these as a policy concern in Aotearoa New Zealand. Yet, TLGB populations are rarely included in public health policies on alcohol in Aotearoa New Zealand. A suggested ALAC strategy is to work in the first instance with the MoH, District Health Boards, and Primary Health Organisations, and, in the second instance, with other government agencies by way of, but not limited to, policy and advice to those groups, with the aim of TLGB populations' inclusion in alcohol-related strategies and action plans.

7.4.2 DHBs

District Health Boards have the responsibility for servicing their local communities with respect to alcohol harm-reduction, including their local TLGB communities. A strategy by which ALAC can work to improve services to the TLGB community is to raise District Health Boards' and Primary Health Organisations' awareness of the need to allocate resources for alcohol harm prevention and treatment generally, and specifically raise awareness of the need to allocate resources to reduce harm amongst TLGB communities.

7.4.3 Alcohol Prevention and Treatment Services

Alcohol prevention and treatment services need to be responsive to TLGB communities and clients, considering that the degree to which they meet TLGB-specific needs determines both the degree of their uptake in the TLGB community and the degree to which treatment of individual TLGB clients is successful. As part of its overall strategy to promote alcohol harm reduction in sexual minority communities, ALAC could work with service providers across the board, from early intervention providers to treatment service providers, to improve their responsiveness to the needs of TLGB communities and clients.

7.5 REVIEW PROGRESS

7.5.1 18 Month Review Period

A review of the progress ALAC makes with respect to addressing TLGB alcohol-related harm would provide a basis for reflection for ALAC and stakeholders on the level of progress achieved, as well as vital learning and on potential barriers for progress. A strategy could be for ALAC to review progress achieved along the objectives and recommendations outlined in this section of the scoping exercise after a period of 18 months.

8 GLOSSARY[11]

Cisgender Cisgender (pronounced /ˈsɪsdʒɛndər/) is an adjective used in the context of gender issues and counselling to refer to a class of gender identities formed by a match between an individual's gender identity and the behaviour or role considered appropriate for one's sex. Cisgender is a "newer term" that means "someone who is comfortable in the gender they were assigned at birth". "Cisgender" is used to contrast "transgender" on the gender spectrum. (retrieved from Wikipedia, 20.05.09)

Gender identity Gender identity is an aspect of identity that can be understood as the psychological sex. It is an individual's internal sense of being male or female or something other, or in between. It may or may not correspond to a person's physical sex.

A person's sexual orientation cannot be assumed on the basis of their gender identity.

Intersex Intersex people are born with any of a number of physical variations that means they do not fit expectations of either male or female physical sex (e.g. they have genitals that are atypical, XXY chromosomes, etc). Intersex anatomy is not always visible at birth, and may become apparent at puberty, later, or not at all. Surgery is performed on some intersex infants and children to physically align them with the sex they are assigned. This practice is criticised, particularly by intersex people. A child's sex assignment may not match the gender identity the person develops as they grow up. This can mean that some intersex people can face gender identity issues similar to a transgender person.

Sexual minority communities This report refers to sexual minority communities as those groups of individuals with minority sexual attraction, minority sexual behaviour, or minority sexual identity. People defined by sexual minority attraction include those attracted to members of the same sex and those attracted to members of both sexes. People defined by minority sexual behaviour include those who engage in sexual behaviour with members of the same sex and those engaging in sexual behaviour with members of both sexes. People defined by minority sexual identity include those who identify as takatāpui, lesbian, gay, or bisexual.

Takatāpui In this report, the term 'takatāpui' refers to an identity claimed by some sexual Māori sexual minority men ('takatāpui tāne') and Māori sexual minority women ('takatāpui wahine') as a marker for a combined indigenous and minority sexual identity. The Ngata

[11] If not cited otherwise, the definitions listed in this Glossary are taken verbatim from Pega, Gray and Veale (in press).

Dictionary translates the Te Reo Māori term ‘takatāpui’ into English as ‘close companion’ or ‘homosexual’.

Some of the participants involved in the TLGB Scoping Exercise have defined takatāpui in the following way: “Takatāpui is a traditional Māori word which means ‘intimate companion of the same sex’. The term has been reclaimed for all Māori who identify as lesbian, gay, bisexual, trans, intersex, whakawāhine, fa’afafine, same-sex attracted, asexual, queer, and questioning” (OUT THERE! Queer Youth Development Project, 2009).

Transgender The term transgender is used by different groups in different ways. It is often used as a catch-all umbrella term for a variety of people who feel that the sex they were assigned at birth is a false or incomplete description of themselves.

Transgendered people may or may not use some form of medical intervention to better align their physical sex with their gender identity, and may or may not have any interest in such a procedure. Gender reassignment services are sometimes called gender realignment by trans-people. They include, but are not limited to, hormone treatment and surgeries such as mastectomy and genital reconstruction.

The term transgender can include a number of sub-categories, including, among others, transsexuals, cross-dressers, transvestites, genderqueer and consciously androgynous people.

The adjective “trans” is increasingly preferred as a general term, for example “trans-person”. If a gender term is also used, this refers to the person’s gender identity, e.g. a “trans-man” was born in a body defined as female but identifies as male.

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APPENDIX 1. METHODOLOGICAL ISSUE IN RESEARCH ON TLGB ALCOHOL USE

There are six central methodological challenges for research on alcohol use and alcohol-related harm amongst TLGB people:

[1] There is a *lack of standard conceptualisations, definitions, and classifications*: There are currently no standardised definitions for what constitutes a gay man, a lesbian, or a bisexual (Hughes & Eliason, 2002; Sell, 2007). This lack of standard definitions leads to inconsistent classification into the gay, lesbian, and bisexual categories across surveys, which is likely to result in variations in research findings (Hughes & Eliason, 2002). The difficulty of defining sexual orientation is related to the multi-dimensional nature of the construct: The three key components of sexual orientation are sexual attraction, sexual behaviour, and sexual identity and these three key concepts, although related, are not necessarily congruent (e.g. some people are same-sex attracted and engage in sexual behaviour with members of the same sex, but identify as 'heterosexual'). Adding further conceptual complexity, sexual orientation can be fluid over time and social context.

[2] There is a *lack of random samples*: The majority of gay, lesbian, and bisexual research on substance use has analysed non-random samples of LGB populations, but findings from non-random samples cannot be generalised as they can have various sampling-related biases (Hughes & Eliason, 2002). Data on alcohol use from random samples of gay, lesbian, and bisexual populations can be generalised, but there are very few random - studies on alcohol use amongst LGB populations to date (Hughes & Eliason, 2002). All analyses that compare random sub-samples of lesbian, gay, and/or bisexual with respective heterosexual sub-samples with respect to alcohol use stem from the United States, with the only exception being one such study from Aotearoa New Zealand (Pega & Coupe, 2007).

[3] There is a *lack of base-line data* on populations defined by sexual orientation: No country currently collects sexual orientation data through its population census, which means that robust base-line data has not emerged for sexual minority populations to date. This lack of reference data means that the quality of drawn samples cannot be assessed robustly.

[4] There is social *stigma attached to minority sexual orientations*: That minority sexual orientations are stigmatised means that an unknown number of LGB people, particularly 'closeted' lesbians, gays, and bisexuals, might misreport their sexual orientation even in studies using the best methods, resulting in measurement error to an unknown degree (Hughes & Eliason, 2002).

[5] Studies of sexual minority populations often aggregate distinct populations, leading to results that are not necessarily comparable across studies. For example, a study that compares alcohol use of bisexual-identified women with that of heterosexual-identified women might find different associations than a study that compares alcohol use of the combined group of bisexual-identified women and lesbian-identified women with that of heterosexual-identified women, considering that the two groups of sexual minority women

face distinctly different health and social challenges. If the sample sizes of different populations defined by sexual orientation are small, sexual minority respondents from different groups defined by sexual orientation might need to be aggregated to ensure statistical power of an analysis.

[6] There is a lack of adequate funding: In what Plumb (2001) has called a classic catch-22 situation, the described methodological challenges of research on LGB substance use have acted as obstacles for obtaining adequate funding for studies with a focus on LGB substance use, which, in turn, has contributed to a continued lack of high-quality evidence (Hughes & Eliason, 2002).

APPENDIX 2. THE PREVALENCE OF TLGB ALCOHOL USE - DETAILED REVIEW

The structure and scope of the review

This review of research evidence on the prevalence of alcohol use amongst sexual minority populations reports findings separately for lesbian, bisexual, and other sexual minority women and for gay, bisexual, and other sexual minority men, respectively, in an acknowledgement of the fundamental differences between female and male sexual minority populations. Findings on the prevalence of abstention from alcohol; normative alcohol use; heavy alcohol use; and alcohol-related problems, alcohol dependency, and seeking alcohol treatment are reviewed separately.

Each section follows a similar structure. Firstly, each section comprehensively and in a chronological order reviews findings from all international random studies and selected longitudinal studies that compare sexual minority with heterosexual adult and adolescent men and women with respect to the prevalence of alcohol use identified in this review which met the selection criteria. To ensure that only high-quality international research is presented in the review, very strict selection criteria were applied to studies: Only studies of large-scale random surveys with an overall sample size of $N \geq 6{,}000$ that compared sexual minority and heterosexual sub-samples from the same survey were included in the review of findings about adult sexual minority women and men. Selected studies of large-scale (overall $N \geq 6{,}000$) longitudinal samples of adolescents on sexual orientation and alcohol use were also included, because there is a lack of large-scale random studies on alcohol use amongst sexual minority adolescents. An overall number of eight such studies were identified and are reviewed.

In each section, the review of high-quality international evidence is followed by a comprehensive, chronological review of findings from research on the prevalence of alcohol use amongst TLGB populations in Aotearoa New Zealand. This review includes two random studies, one of which analyses country-wide, household-based survey data from over 15,000 people residing in Aotearoa New Zealand, and a number of non-random studies from Aotearoa New Zealand. An overall number of four such studies were identified and are reviewed.

Each section closes with concluding remarks that summarise the reviewed research findings in brief.

To ensure that readers can make their own assessment of the robustness of the cited study findings, crucial variables such as the sample population, the size of the sample of sexual minority populations, and study limitations are reported when each study is first introduced in the review.

Findings: Sexual Minority Women

Abstention

Four studies of data from random surveys and two studies of longitudinal data with large sample sizes, all from the United States of America, have been published that provide high-quality evidence on abstention from alcohol amongst adult and adolescent lesbian and bisexual women, compared to heterosexual women. A pioneering study of data from the population-based 1996 National Household Survey on Drug Abuse showed that a sample of adult women who had sexual contact with at least one same-sex partner over the last year (*N*=96) were less likely to abstain from alcohol than exclusively heterosexually active adult women (Cochran et al., 2000).

A 2001 study of a 1996 general health survey conducted with members of a large Californian health insurance company found that within the 20–34 age group, women reporting a lesbian/bisexual sexual orientation (*N*=120) were significantly less likely to report abstention from alcohol than heterosexual women (Gruskin et al., 2001). Abstention rates by sexual orientation were similar amongst the other age groups (35–59; ≥50) (Gruskin et al., 2001). The study is limited by a low response rate and by relying on data from mostly non-Hispanic white women who were enrolled in a specific health insurance scheme (Gruskin et al., 2001).

Two 2005 studies of data from the 2000 National Alcohol Survey were the first studies to compare a wider range of sexual minority women, combining sexual identity and sexual behaviour measures (e.g. lesbian-identified women who have sex with women (WSW), bisexual-identified WSW, heterosexual-identified WSW, and exclusively heterosexual women) (Drabble & Trocki, 2005; Drabble et al., 2005). The studies found significantly lower abstinence rates amongst bisexual-identified WSW (*N*=50) and heterosexual-identified WSW (*N*=71) when compared with exclusively heterosexual women (Drabble & Trocki, 2005; Drabble et al., 2005). Lesbian-identified WSW (*N*=36) also had lower rates of abstaining from drinking alcohol than exclusively heterosexual women, but the difference found was not statistically significant (Drabble et al., 2005). There was no difference between the three groups of sexual minority women with respect to abstaining from alcohol (Drabble et al., 2005).

Two analyses that took data from different waves of the longitudinal Growing Up Today Study (participants were male and female children of participants of the Nurses' Health Study) have provided analyses of abstention from alcohol amongst a large sample of adolescent girls by sexual attraction. The 2007 study found that after controlling for confounding variables, mostly heterosexually attracted girls (*N*=359) and the group of exclusively same-sex and both-sex attracted girls (*N*=61) reported significantly lower rates of abstention from alcohol over the last month than exclusively opposite-sex attracted girls (Ziyadeh et al. 2007). Adolescent girls who were unsure of their sexual attraction (*N*=117) did not differ from those who were exclusively opposite-sex attracted with respect to abstention from alcohol (Ziyadeh et al., 2007). The second analysis included a wider range of data (e.g. data from participants of the same longitudinal study that had reported their sexual attraction in one of the waves between 1997 and 2003) (Corliss et al., 2008). It

concluded that mostly opposite-sex attracted girls (*N*=980) and both-sex attracted girls (*N*=212), but not exclusively same-sex attracted girls (*N*=58), were significantly less like to abstain from alcohol over the previous month in comparison with exclusively opposite-sex attracted girls from the same age cohort (Corliss et al., 2008). The data from this longitudinal study is limited in that the cohort is not a representative random sample; in that all cohort members were children of nurses; and in that the sample, were predominantly non-Hispanic whites.

Two Aotearoa New Zealand studies recorded abstention rates amongst sexual minority women. In 1998, Welch et al. reported from the Lesbian Mental Health Survey that 9.8% of a large self-selected non-random sample of lesbians (*N*=561) recruited through lesbian newsletters and magazines abstained from alcohol over the last year. The study was limited in that the recruited sample of lesbians was predominantly Aotearoa New Zealand European, highly educated, residing in urban areas and between the ages of 25 and 50. In addition, no heterosexual sample was recruited, prohibiting comparisons to be conducted.

In 2007, the first study of large-scale population-based random samples of the general Aotearoa New Zealand population that compared alcohol use by sexual orientation was conducted by Pega & Coupe. The researchers studied data from the official New Zealand Health Behaviours Surveys on Drug Use conducted in 2003 and on Alcohol Use conducted in 2004 (Pega & Coupe, 2007). The study found that 5.2% of a randomly selected national sample of adult lesbian- and bisexual-identified women reported abstaining from alcohol over the last year, compared to 8.9% of heterosexual-identified women from the same random sample (Pega & Coupe, 2007). This study analysed the first national sexual orientation data from official large-scale random surveys of the general Aotearoa New Zealand population. It constitutes the strongest evidence about comparative alcohol use amongst populations defined by sexual orientation from Aotearoa New Zealand to date. Limitations to these findings include the use of a sexual orientation measure that combines sexual identity and sexual attraction to some degree and that a relatively small percentage of respondents identified as lesbian and bisexual (1.2%).

Summary: Abstention

Four comparative studies of sexual orientation data from large-scale random surveys of United States populations have been conducted to assess comparative rates of abstention from alcohol amongst women. All four studies found that adult sexual minority women are less likely to abstain from alcohol than adult heterosexual women. There is emerging evidence from a large-scale longitudinal study suggesting that sexual minority adolescent girls are less likely to abstain from alcohol. A study of recent data from a large-scale random survey of the general population of adult women in Aotearoa New Zealand found that women with a lesbian or bisexual identity reported lower rates of abstention from alcohol than heterosexual-identified women.

Normative use

Three overseas studies, all of which use data from the United States, compared the normative or moderate use of alcohol amongst sexual minority women with those of heterosexual women, using large-scale random or longitudinal data. Cochran et al.'s (2000) pioneering study found that the sub-sample of adult female respondents to the 1996 National Household Survey on Drug Abuse who reported any same-sex behaviour over the last year consumed alcohol more frequently, drank significantly larger quantities of alcohol, and had more drinks per typical drinking occasion than exclusively opposite-sex behaved women from the same sample.

Drabble & Trocki's (2005) study of data from the 2000 National Alcohol Survey found no significant differences between lesbian-identified adult WSW, bisexual-identified adult WSW, heterosexual identified adult WSW, and exclusively heterosexual adult women with regards to normative drinking.

A 2005 analysis of data from the Californian Women's Health Survey (1998–2000) found that adult WSW (*N*=350) were significantly more likely to report using alcohol in a normative way than exclusively heterosexually-experienced adult women, with disparities being most pronounced amongst the 26–35-year-old group (Burgard et al., 2005).

The 2008 analysis of longitudinal survey data of adolescents showed that all groups of sexual minority girls (mostly opposite-sex attracted girls, both-sex attracted girls, and exclusively same-sex attracted girls) reported consuming a significantly higher number of alcoholic drinks per typical drinking occasion than their exclusively opposite-sex attracted female peers (Corliss et al., 2008).

Two non-random studies and two random studies have been conducted about lesbian and bisexual women's normative use of alcohol in Aotearoa New Zealand. The Lesbian Mental Health Survey reported following prevalence rates: 53.8% of lesbians drank alcohol once a week or less often and 24.2% of lesbians drank alcohol once a month or less often, the median frequency of drinking was once per week, and 64.4% of those lesbians who drank alcohol had consumed one or two alcoholic drinks on a typical drinking occasion (Welch et al., 1998).

Saphira and Glover (2001) snowball-sampled a non-random sample of lesbians (*N*=795) and found that 57% of lesbians who were not out consumed alcohol weekly, compared to 42% of lesbians who were out. The study was limited by a low response rate (29%).

The Youth2000 team published a report titled *Non-heterosexual Youth: A Profile of Their Health and Wellbeing*, in which the research team reported rates of weekly alcohol use amongst female and male youth with minority sexual attractions (*N*=701) (e.g. exclusively same-sex attracted students, both-sex attracted students, 'unsure' students, and those ticking the 'neither' box when being asked to identify their sexual attraction) without comparing these rates with those from exclusively opposite-sex attracted youth (see Le Brun et al., 2004).

The 2007 analysis of data from the New Zealand Health Behaviours Surveys showed that adult lesbian-identified and bisexual-identified women (*N*=95) were significantly more likely than heterosexual-identified women to report having drunk alcohol on one or more drinking occasions per week over the last year (unadjusted prevalence rates: 60.0% versus 47.0%; adjusted odd ratio: 2.3; confidence interval: 2.2, 2.3) (Pega & Coupe, 2007). These findings were adjusted for demographic differences between the compared population groups defined by sexual orientation.

Summary: Normative use

Three recent state-of-science comparative studies of sexual orientation data from large-scale random surveys of United States populations have been conducted to assess normative alcohol use amongst women. Two of three studies suggest that adult sexual minority women are more likely to use alcohol in a normative way than heterosexual women, while one study found no differences. There is emerging evidence from a large-scale longitudinal study suggesting that adolescent sexual minority girls in the United States use alcohol normatively at higher rates. A study of recent data from a large-scale random survey of the general population of adult women in Aotearoa New Zealand found that women with a lesbian or bisexual identity reported engaging in normative alcohol use at significantly higher rates than women with a heterosexual identity.

Heavy use

Six overseas (United States-based) random studies and two studies of high-quality longitudinal data investigated the relative risk of problem drinking between sexual minority and heterosexual women. The pioneering study conducted in 2000 from data of the 1996 National Household Survey on Drug Abuse showed that adult WSW were more likely than exclusively opposite-sex behaved adult women to engage in heavy drinking and that WSW were also more likely to drink until feeling very high or drunk on three or more occasions over the last year (Cochran et al., 2000).

The 2001 study of a 1996 general health survey conducted with members of a large, Californian health insurance company found that women reporting a lesbian/bisexual sexual orientation (*N*=120) were significantly more likely to report heavy drinking than heterosexual women (Gruskin et al., 2001). This study demonstrated that age might play a major role in lesbian/bisexual women's use of alcohol in that it identified that lesbian and bisexual women aged 20 to 34 years reported the highest overall rates of heavy alcohol use and in that heterosexual versus lesbian/bisexual disparities were most pronounced in this age group (Gruskin et al., 2001).

The National Alcohol Survey 2000 found that lesbian-identified, bisexual-identified, and heterosexual-identified WSW were significantly more likely to drink heavily (Drabble et al., 2005). There was no difference in heavy drinking between the three groups of sexual minority women (Drabble et al., 2005). The same study found that compared to exclusively heterosexual women, bisexual-identified women had significant higher annual alcohol

consumption and binge drank more often (Drabble et al., 2005). The other study of the same data (Drabble & Trocki, 2005) showed that the mean number of days on which five or more drinks were consumed was not significantly different between the four groups of women defined by sexual orientation.

The 2005 study of data from the Californian Women's Health Surveys (1998–2000) demonstrated that WSW, when compared with exclusively opposite-sex behaved women, had higher rates of binge drinking and heavy drinking (Burgard et al., 2005). Amongst the group of homosexually-experienced women, those who were in the group of women 26–35 years of age and 46 years and over, as well as those who engaged in sex with both women and men, were most at risk from problem drinking behaviours (Burgard et al., 2005).

The 1999 College Alcohol Study surveyed a large random sample of college students, including both-sex behaved (*N*= 301) and exclusively same-sex behaved (*N*=134) female students (Eisenberg & Wechsler, 2003). Both-sex behaved female college students were approximately twice as likely to report binge drinking, compared to heterosexuals, while exclusively same-sex behaved female students' binge drinking rates were similar to those of exclusively opposite-sex behaved female students (Eisenberg & Wechsler, 2003).

The Growing Up Today Study found that both exclusively same-sex attracted adolescent girls and mostly opposite-sex attracted girls, but not girls who were unsure about their sexual attraction, were more likely than the group of exclusively opposite-sex attracted girls to have binge drunk during the last year (Ziyadeh et al., 2007). The 2008 analysis of a larger set of data from the same study added to these earlier findings that mostly opposite-sex attracted girls and both-sex attracted girls, but not exclusively same-sex attracted girls, drank a higher number of drinks per typical drinking occasion than exclusively opposite-sex attracted women (Corliss et al., 2008).

Only one study (a non-random study) on the topic has originated from Aotearoa New Zealand. The Lesbian Mental Health Survey provided prevalence rates for problem drinking amongst adult lesbians (Welch et al., 1998). It found that 3.8% of lesbians reported binge drinking (defined as ten or more alcoholic drinks per drinking occasion) (Welch et al., 1998). When asked how often they consumed four or more alcoholic drinks on one drinking occasion, 38.0% (which includes 9.8% of abstainers) reported that they never did; 42.7% did so once a month or less often; and 1.1% reported drinking at least four drinks on a daily basis (Welch et al., 1998). In this study, 48.5% of lesbians reported never drinking to the point that they felt drunk; 43.7% did so monthly or less often, and 3.6% drank enough to feel drunk at least once per week (Welch et al., 1998). Just under one third (31.0%) of lesbian respondents had at least once thought that they were an excessive drinker (Welch et al., 1998).

Summary: Heavy use

Five recent state-of-science comparative studies of sexual orientation data from large-scale random surveys of United States populations have been conducted on heavy alcohol use amongst sexual minority women. All five studies found that adult

sexual minority women make heavy use of alcohol and binge drink at higher rates than heterosexual women. There is emerging evidence from a large-scale random study and a large-scale longitudinal study suggesting that adolescent sexual minority college students and girls respectively in the United States are at an increased risk of binge drinking. No study comparing sexual minority and heterosexual women's problematic alcohol use has been conducted in Aotearoa New Zealand, although one study reported prevalence rates of problem drinking amongst a non-random sample of adult lesbians.

Alcohol-related problems, alcohol dependence, and seeking alcohol treatment

There are two international comparative empirical research studies on the relative prevalence of alcohol-related problems, alcohol dependence, and alcohol treatment, respectively, amongst sexual minority women, compared to heterosexual women. In Drabble et al., 2005 United States study, lesbian-identified WSW and bisexual-identified WSW reported a higher number of alcohol-related problems than exclusively heterosexual women and were more likely to have sought help for their alcohol use. The second international study, the 2000 study of data from 1996 National Household Survey on Drug Abuse (United States), showed that WSW more likely to meet the criteria for clinical alcohol dependence and more likely to have been treated for alcohol-related problems than exclusively same-sex behaved women (Cochran et al., 2000).

A meta-analysis of 25 studies that met various quality criteria was conducted, analysing data of *N*=11,971 sexual minority men and women (Marshal et al. 2008). It found that lesbian and bisexual women had higher rates of alcohol dependence than heterosexual women (rates ratio: 4.00, CI 2.85, 5.61) (Marshal et al. 2008).

One paper from Aotearoa New Zealand provides equivalent national evidence, but relies on longitudinal data from a smaller Christchurch birth-cohort. This 2005 paper from the Christchurch Health and Development Study published by Fergusson et al. reports that young female cohort-members with a predominantly heterosexual orientation had higher rates of alcohol dependence (6.0%) than those with an exclusively heterosexual orientation (3.2%) between the ages of 21 and 25. Exclusively homosexual female cohort-members had the lowest rate of alcohol dependence of the three groups defined by sexual orientation (0%) (Ferguson et al., 2005). However, there are multiple methodological limitations that prohibit the generalisation of these findings to the Aotearoa New Zealand general population, including the use of data from a Christchurch birth cohort, the use of different measures for the assessment of sexual orientation at different points in time and reliance on a very small number of predominantly homosexual (*N*=27) and predominantly heterosexual (*N*=88) male and female cohort members in the analysis.

Summary: Alcohol-related problems, alcohol dependence, and seeking alcohol treatment

In terms of alcohol-related problems, alcohol dependence, and seeking alcohol

treatment:

There are two comparative studies from the United States using data from large-scale random surveys. These studies found that adult and adolescent sexual minority women report a higher rate of alcohol-related problems, are more likely to be alcohol dependent, and more likely to seek alcohol treatment. Findings from one meta-analytic study and the longitudinal Christchurch Health and Development Study found that young sexual minority women were more likely to be dependent on alcohol.

Findings: Sexual Minority Men

Abstention

Four overseas studies from the United States (two random studies and two longitudinal studies) reported comparative rates of abstention from alcohol between sexual minority and heterosexual men. The 1996 National Household Survey on Drug Abuse was the first large-scale random study to report comparative abstention rates amongst adult men by sexual orientation (Cochran et al., 2000). It showed that adult men who had sex with men (MSM) (*N*=98) were equally as likely to abstain from alcohol as exclusively opposite-sex behaved men (Cochran et al., 2000).

In the analysis of data from the National Alcohol Survey 2000, gay-identified adult MSM (*N*=57), but not bisexual-identified adult MSM (*N*=27) and heterosexual-identified adult MSM (*N*=83), were significantly less likely to abstain from alcohol than exclusively heterosexual adult men (Drabble et al., 2005).

The 2007 analysis of data from the longitudinal Growing Up Today Study found no statistically significant difference in the rates of abstention from alcohol between the group of exclusively same-sex attracted and both-sex attracted adolescent boys (*N*=39), mostly same-sex attracted boys (*N*=130), 'unsure' boys (*N*=64), and exclusively opposite-sex attracted boys (Ziyadeh et al., 2007). However, the 2008 study, which used a broader set of data from the same study and hence had more statistical power, found that mostly opposite-sex attracted adolescent boys (*N*=340) and both-sex attracted boys (defined as equally attracted to members of both sexes) (*N*=56) were less likely to abstain from alcohol than exclusively opposite-sex attracted boys (Corliss et al., 2008). Exclusively same-sex attracted boys (*N*=88) and (a small sample of) unsure boys (*N*=10) were equally as likely to report abstention from alcohol as exclusively opposite-sex attracted boys (Corliss et al., 2008).

The New Zealand Health Behaviours Surveys showed that compared to adult heterosexual men and adult gay and bisexual men (*N*=79) were significantly less likely to have abstained from alcohol over the last year (unadjusted prevalence rates: unadjusted prevalence rates: 3.8% versus 6.4%; adjusted OR: 3.8; CI: 3.5, 4.1) (Pega & Coupe, 2007).

Summary: Abstention

Two recent state-of-science comparative studies of sexual orientation data from large-scale random surveys of United States populations have been conducted. One study found no differences between MSM and heterosexual men, while the other found that gay-identified MSM were less likely to abstain than exclusively heterosexual men. There is emerging evidence from a large-scale longitudinal study suggesting that mostly opposite-sex attracted adolescent boys and both-sex attracted boys are less likely to abstain from consuming alcohol than exclusively opposite-sex attracted boys. A study of recent data from a large-scale random survey of the general population of adult men in Aotearoa New Zealand found that adult men with a gay or bisexual identity are significantly less likely to abstain from alcohol than heterosexual adult men.

Normative use

Two overseas studies (both from the United States; one large-scale random study and one longitudinal study) have compared normative alcohol use amongst adults and adolescents by sexual orientation. Findings from the 1996 National Household Survey on Drug Abuse showed that adult MSM did not differ from exclusively opposite-sex behaved adult men in terms of prevalence of alcohol use, both in terms of frequency of consumption and amount of alcohol consumed (Cochran et al., 2000).

The 2008 analysis of the Growing Up Today Study found no significant differences when comparing both-sex attracted boys and unsure boys with exclusively opposite-sex attracted boys in terms of number of drinks per typical drinking occasion. But exclusively same-sex attracted boys and mostly opposite-sex attracted boys consumed a significantly higher number of drinks per typical drinking occasion than their exclusively opposite-sex attracted peers (Corliss et al., 2008).

That the Youth2000 study reported overall, gender-aggregated prevalence rates for adolescents with a minority sexual attraction, but did not compare these rates with those from exclusively opposite-sex attracted adolescents, has been reported above.

Adult gay and bisexual male respondents to the New Zealand Health Behaviours Surveys were significantly more likely to have drunk alcohol on one or more drinking occasions per week over the last year than adult heterosexual male survey respondents (unadjusted prevalence rates: 83.5 versus 82.0; adjusted OR: 1.4; CI: 1.4, 1.5) (Pega & Coupe, 2007).

Summary: Normative use

One study of sexual orientation data from large-scale random surveys of United States populations has been conducted that compares the prevalence of normative alcohol use amongst sexual minority versus heterosexual men. This study found no difference between MSM and exclusively opposite-sex behaved men. There is emerging evidence from a large-scale longitudinal study suggesting that sexual minority adolescent boys drink significantly higher number of drinks per typical

drinking occasion than exclusively opposite-sex attracted boys. A study of recent data from a large-scale random survey of the general population of adult men in Aotearoa New Zealand found that adult men with a gay or bisexual identity are more likely to engage in normative use of alcohol.

Heavy use

Two overseas, United States random studies and two studies of longitudinal data report comparative rates of problem drinking amongst sexual minority adult or adolescent, respectively, men versus exclusively opposite-sex behaved adults or adolescents, respectively, men. The pioneering 2000 study that took data from the 1996 National Household Survey on Drug Abuse showed that MSM and exclusively-opposite-sex behaved men had equal rates of problem drinking, that is binge drinking and heavy drinking (Cochran et al., 2000).

Drabble et al. (2005) found that gay-identified MSM, but not bisexual-identified MSM and heterosexual-identified MSM, were significantly more likely to drink until feeling drunk, compared to heterosexual men.

The 2003 study of data from the 1999 College Alcohol Study found that both-sex behaved male college students were less likely to binge drink than their exclusively opposite-sex behaved male peers; there was no difference in the prevalence of binge drinking between exclusively same-sex behaved and exlusively opposite-sex behaved male college students (Eisenberg & Wechsler, 2003).

The 2007 analysis of data gathered through the Growing Up Today Study in 1999 established that mostly same-sex attracted boys were more likely to report binge drinking than exclusively opposite-sex attracted boys, but the study found no significant difference in the prevalence rates for binge drinking between the group of exclusively same-sex attracted and both-sex attracted boys, 'unsure' boys, and exclusively opposite-sex attracted boys reported (Ziyadeh et al., 2007). The 2008 analysis of data from several waves of the same study confirmed the 2007 findings, reporting that that mostly opposite-sex attracted boys had significantly elevated rates of binge drinking, but that other sexual minority boys (e.g. exclusively same-sex attracted boys, both-sex attracted boys, and unsure boys) reported no significant difference in binge drinking in comparison to exclusively opposite-sex attracted boys (Corliss et al., 2008).

There is no Aotearoa New Zealand study of the prevalence of problem drinking amongst sexual minority men.

Summary: Heavy use

Two recent comparative studies of sexual orientation data from large-scale random surveys of United States populations have been conducted that compare the prevalence of problem drinking amongst sexual minority men versus heterosexual men. One study found no sexual orientation differences in the prevalence of heavy drinking and binge drinking amongst adult men; the other study found that gay-

identified men were more likely to drink until feeling drunk than exclusively heterosexual men. There is emerging evidence from a large-scale longitudinal study suggesting that sexual minority adolescent boys might have an elevated risk of problem drinking, compared to exclusively opposite-sex attracted boys. But a large-scale random study of male college students found that both-sex behaved male college students were less likely to binge drink than their exclusively opposite-sex attracted male peers. No study comparing sexual minority and heterosexual men's problematic alcohol use has been conducted in Aotearoa New Zealand.

Alcohol dependency and seeking alcohol treatment

There has been little comparative research on sexual minority versus heterosexual men's rates of alcohol dependency and use of alcohol treatment services. One United States study has compared sexual minority men and heterosexual men with regards to rates of alcohol dependency and receiving treatment for alcohol-related problems, finding that MSM and exclusively opposite-sex behaved men had equal rates of alcohol dependency syndrome and receiving treatment for alcohol-related problems (Cochran et al., 2000). For Aotearoa New Zealand, one longitudinal study provided insights into comparative rates of problem drinking. The 2005 paper from the Christchurch Health and Development Study reported that male cohort members with a predominantly heterosexual orientation had higher rates of alcohol dependence (14.3%) than those with an exclusively heterosexual orientation (7.3%) between the ages of 21 and 25 (Fergusson et al.). Exclusively homosexual cohort-members had the lowest rate of alcohol dependence of the three groups defined by sexual orientation (0%) (Ferguson et al., 2005). The limitations of this study have been pointed out above.

Summary: Alcohol dependency and seeking alcohol treatment

There is one study of large-scale random survey data that found no differences between sexual minority and heterosexual men with respect to alcohol dependency and seeking alcohol treatment. Findings from and one meta-analytic study and the longitudinal Christchurch Health and Development Study found that young sexual minority men were more likely to be dependent on alcohol.

APPENDIX 3. ALCOHOL-RELATED HARM AMONGST TLGB COMMUNITIES – DETAILED REVIEW

The structure and scope of the review

This review of research evidence on alcohol-related harm amongst sexual minority populations reports findings separately for lesbian, bisexual, and other sexual minority women and for gay, bisexual, and other sexual minority men, respectively, in an acknowledgement of the fundamental differences between female and male sexual minority populations. Findings on the prevalence of alcohol-related problems, alcohol dependency, and alcohol treatment as well as on different types of alcohol-related harm (e.g. the relationship between alcohol use and HIV-risk behaviour, partner violence, and sexual coercion respectively) are reviewed separately.

Because there are a smaller number of empirical studies on alcohol-related harm, the review was broadened to include not only findings from large-scale random studies, but also from longitudinal studies, non-random studies, and case studies from both overseas and Aotearoa New Zealand.

Concluding remarks that summarise the reviewed research findings in brief are provided separately for sexual minority women and men.

As with the previous review, to ensure that readers can make their own assessment of the robustness of the cited study findings, crucial variables such as the sample population, the size of the sample of sexual minority populations, and study limitations are reported when a new study is introduced in this review.

Findings: Sexual Minority Women

Alcohol Use and Partner Violence

Two studies have investigated the association between alcohol use and domestic violence: [1] The majority of a non-random sample of 104 lesbians reported that alcohol or drugs had been used before an incident of domestic violence had occurred (Schilit et al., 1990). The frequency of drinking alcohol was correlated with the number of violent acts that respondents had committed on their partner as well as with the number of acts that respondents had been victim of, but there was no correlation between quantity of alcohol consumed and incidence of partner violence (Schilit et al., 1990). This study of a non-random sample of 152 lesbian-identified and bisexual-identified women found that the frequency with which study participants consumed alcohol was correlated with having been physically injured by a past partner, having been physically injured by the current partner, unwanted sex, and having been raped by a male (Perry, 1995). “Increased alcohol use was related to currently being involved in an abusive relationship” (Perry, 1995 p418). However, this study is dated and was limited by a low response rate, non-random sampling, and disproportionate over-representation of white participants (Perry, 1995).

Alcohol Use and Sexual, HIV-risk Behaviour

Perry's (1995) study also found that those study participants who reported drinking larger quantities of alcohol per week were also more likely to have sex with another person than their primary partner, to drink alcohol prior to having sex, to use marijuana prior to having sex, to use intravenous drugs (with the risk of contracting HIV and other blood-borne diseases), and to have had anonymous same-sex sexual contact (Perry, 1995). This finding confirms the global association between alcohol use and risky sexual behaviour found by Weinhardt & Carey's 2000 review of evidence.

Summary: Alcohol-related harm

There are two (dated) studies on the association of alcohol use and partner violence amongst sexual minority women. Both studies found an association between alcohol use and domestic violence amongst same-sex female couples.

One study found that alcohol use might put sexual minority women at higher risk from engaging in HIV-risk behaviours.

There is a lack of research on alcohol-related harm amongst TLB women in Aotearoa New Zealand. Currently, no research on takatāpui-identified women is available.

Findings: Sexual Minority Men

Alcohol Use and HIV-risk Behaviours

Several independent studies conducted in the 1990s suggested that heavy alcohol/drug use is a strong predictor of both HIV infection or/and seroconversion amongst sexual minority men (Stall et al., 1999). Consequently, research on the relationship between drinking alcohol and engaging in behaviours that carry a significant risk of infection with HIV has been conducted. Weinhardt and Carey's 2000 review of studies on the association between alcohol use and HIV-risk behaviour (including studies on sexual minority men) concluded that there is a global association between these two factors. A review of the association between alcohol use and HIV-risk behaviour amongst sexual minority men found conclusive evidence in support of the general statement that amongst MSM, heavy drinkers tend to engage in behaviours that put them at a higher risk of infection with HIV than those who drink less alcohol (Irwin et al., 2006 p299–300). A recent study showed that amongst homeless MSM, alcohol dependence and engaging in HIV sexual risk behaviour is also correlated (Reback et al., 2007). However, for certain sub-populations of sexual minority men, this association might not exist: For instance, a recent non-random study found that amongst gay and bisexual Latino men residing in Chicago or San Francisco, heavy alcohol use was not correlated with unprotected anal intercourse (Ramirez-Valles, et al., 2008).

In terms of the causal relationship between alcohol and sexual risk-taking at the event-level, Weinhardt and Carey's (2000) review found that only about half of all studies they reviewed support the notion that there is a causal relationship between alcohol use and taking HIV-risk. However, more recent studies that focus specifically on gay and bisexual men have

identified event-level connections between alcohol use and unprotected anal sex (Irwin et al., 2006; Vanable et al., 2004 as cited in Bimbi et al., 2006). For example, a non-random - sample of 134 heavy drinkers, all of whom were MSM, HIV-negative, and abused alcohol or met classification criteria for alcohol dependency syndrome, reported engaging in unprotected anal intercourse, particularly high-risk, receptive unprotected intercourse, at higher rates after they had used alcohol (Irwin et al., 2006). A recent qualitative study found that HIV-seropositive gay and bisexual men described their use of alcohol as leading to sexual activity, facilitating having sex with other men, leading to infidelity, and as facilitating engagement in high-risk sexual practices that the men perceived as stigmatic when sober, indicating significant alcohol-related risk (Parsons et al., 2004). However, event-level research has failed to reach consistent conclusions about whether alcohol use is causally related to sexual risk-taking behaviour or not (Bimbi et al., 2006).

Psycho-social factors that might contribute to the connection between alcohol use and HIV-risk taking have been explored. A 2006 study using data from *N*=779 gay and bisexual men recruited at gay events in New York (non-random sampling) found that research participants who reported having had unprotected anal sex (insertive or receptive), who were HIV seropositive, and who had a higher rate of lifetime sexually transmitted infections scored significantly higher in outcome expectancies for taking sexual risks under the influence of alcohol or drugs (Bimbi et al., 2006).

In summary, while a global association between alcohol use and risky sexual behaviours has conclusively been established, research on the causal relationship between alcohol use and sexual risk-taking amongst sexual minority men at the event level is inconclusive, with some first research establishing psycho-social factors that could contribute towards the global association.

Partner Violence

Our literature search identified three recent United States studies of the relationship between alcohol use and partner violence amongst male same-sex couples. [1] An exploratory qualitative study of interview-data with 25 gay men who were in a violent same-sex relationship found that just over half of the participants thought that alcohol use had a causal relationship to partner violence, while only three respondents thought that alcohol use was the result of partner violence and only one participant believed that his partner was violent regardless of alcohol use (Cruz & Peralta, 2001). [2] One study of a non-random sample of 117 serodiscordant[12] gay male couples found that amongst these couples, alcohol use was not associated with domestic violence (Dolezal et al., 2005). [3] A case study that examined the effect of partial hospital alcohol treatment on the levels of partner violence within a same-sex male couple found that the treatment lead to a reduction in alcohol use as well as a decrease in physical and psychological aggression (Hellmuth et al., 2008). In summary,

[12] Serodiscordant is a term used to describe a couple in which one partner is HIV positive and the other is HIV negative.

research on the relationship between alcohol use and partner violence amongst male same-sex couples is emerging, but suggests that alcohol use might aggravate or cause partner violence amongst male couples, although not amongst serodiscordant male couples.

Alcohol Use and Sexual Coercion

Three studies have been conducted on the relationship between alcohol use and sexual coercion amongst sexual minority men. [1]A 2000 German study of a non-random sample of 310 men found that 44% of the participating MSM that had experienced sexual coercion reported that the coercion had happened when "a man exploited the fact that you could not resist (e.g. after too much alcohol and drugs)" (Krahé et al., 2000: 150 as cited and quoted in Fenaughty et al., 2006). [2] A 2006 qualitative study conducted in Aotearoa New Zealand in 2006 investigated forced, coerced, and unwanted sex amongst takatāpui, gay, and bisexual men finding that study participants frequently suggested that their alcohol-drinking had increased their susceptibility to sexual coercion (Fenaughty et al., 2006). A number of men reported experiencing sexual coercion when being intoxicated to the point where they were unable to resist the sexual approaches from another man (Fenaughty et al., 2006). Finally, one key-informant suggested that some MSM used alcohol before anal sex to counter the lack of desire for this sexual practice. [3] A United States quantitative study found that gay and bisexual men who suffered from partner abuse in their same-sex relationship were more likely to report more frequent or monthly intoxication with alcohol and problems caused by the use of substances (Houston & McKirnan, 2007). Abused men also reported frequent use of substances before or during sex at higher rates (Houston & McKirnan, 2007). To summarise, emerging research on the relationship between alcohol use and sexual coercion consistently suggests that alcohol use plays an important role in sexual coercion.

Summary: Alcohol-related harm

There is a good body of research on the association between alcohol use and HIV-risk behaviours, with most studies generally finding that amongst men who have sex with men, heavy drinkers tend to engage in behaviours that put them at a higher risk of infection with HIV than those who drink less alcohol, with some exceptions. Emerging research suggests a potential causal relationship between alcohol use and HIV-risky behaviours.

Emerging research suggests that amongst sexual minority men, alcohol use might aggravate or cause partner violence, but one study did not reach the same conclusion. It appears to play an important role in unwanted sex, as also found in an Aotearoa New Zealand study.

There is a lack of research on alcohol-related harm amongst TGB men in Aotearoa New Zealand. Currently no research on takatāpui-identified men is available.