

What are LGBTQ+ people's experiences of alcohol services in Scotland? A qualitative study of service users and service providers

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Summary of our findings

LGBTQ+ service users

- We conducted individual interviews with a diverse sample of 14 respondents aged 19 to 65 years who had experienced alcohol services in Scotland. Two identified as lesbian, six as gay, three as bisexual, two as heterosexual and one as heteroflexible. Three identified as trans and 11 as cisgender.
- The impact of COVID-19 on respondents' drinking and on service provision form an important backdrop to our findings.
- Many respondents thought their drinking was inextricably linked to their LGBTQ+ identity, as a response to shame, stigma, or family rejection. Almost all spontaneously discussed connections between mental health, alcohol use and LGBTQ+ identity.
- Services are still perceived to be aimed at middle aged (straight) men who have been drinking for decades.
- Respondents were rarely asked about their sexuality / gender identity by service providers. They reported a lack of understanding or exploration about their identity and how this might impact drinking and service use. Lesbians reported assumptions that their partners were men.
- Respondents, particularly trans people, were wary of negative reactions from other service users. Lesbian and bisexual women reported feeling silenced and vulnerable in some group settings.
- There was agreement across the sample that trans people were particularly stigmatised and misunderstood and that barriers experienced by others in the LGBTQ+ community were amplified for trans people.

Service providers

- We collected data from 15 service providers. Nine were clinicians (Consultant Psychiatrists or Specialist Doctors) working for NHS addiction services, three worked for third sector alcohol prevention and support organisations, and three worked for third sector LGBTQ+ services.
- Service providers reported that many alcohol services were temporarily suspended and that COVID-19 had a negative impact on clients' wellbeing. They described the challenges of their increased workload and the difficulty of communicating without face-to-face meetings.
- Some service providers were uncomfortable discussing LGBTQ+ issues (particularly trans issues) given their lack of training, or did not see sexuality or gender identity as relevant to alcohol treatment. Others stressed the importance of a holistic approach where identity was an important aspect of clients' lives. Statutory service providers were particularly uncertain about how to ask clients about their sexuality / gender identity.
- Service providers suggested that training around LGBTQ+ issues (particularly trans issues) and appropriate language would help overcome their fears about 'making a mistake' and upsetting clients and improve the experience of alcohol services for LGBTQ+ people.
- Some third sector respondents suggested the need for a 'one stop shop' for LGBTQ+ health encompassing addictions, mental health, sexual health and a gender identity clinic. Others (both third sector and statutory respondents) argued that mainstream alcohol services should be tailored to be more inclusive of LGBTQ+ people.
- Service providers emphasised the multiple issues and inequalities faced by some of their clients (e.g. trauma, racism, homophobia, transphobia, lack of resources). They argued that increased public acceptance and understanding of LGBTQ+ issues and alcohol-free LGBTQ+ spaces would help reduce alcohol-related harm in this population.

3 Recommendations

- Alcohol-free spaces for LGBTQ+ people should be prioritised to de-normalise drinking in this community and to facilitate recovery.
- Services should monitor gender identity, trans status and sexual orientation to assess whether they are reaching LGBTQ+ people and consider how they might tailor and improve their services (see www.scottishtrans.org/trans-equality/equalities-monitoring/).
- When alcohol services are commissioned, there should be a requirement for organisations to demonstrate that they have appropriate inclusivity / diversity policies and processes in place and that staff receive training about the needs of LGBTQ+ populations.
- LGBTQ+ diversity training should be undertaken by all staff working in alcohol services. This should include information about the use of alcohol among LGBTQ+ populations, appropriate ways to ask clients about sexual orientation and trans identity, and how to discuss how central, or peripheral, LGBTQ+ identity is to clients' drinking. Trans-specific training is particularly necessary.
- Alcohol services should work toward the LGBT Charter which supports organisations to ensure they are inclusive and provide high quality services to LGBTQ+ service users (see www.lgbtyouth.org.uk/the-lgbt-charter/the-lgbt-charter-for-organisations/).
- Services need to signal LGBTQ+ inclusivity in both physical and online spaces. They should include content aimed at LGBTQ+ people on their websites and ensure they are advertising their services via LGBTQ+ organisations and in LGBTQ+ spaces where they will be seen by people in need.
- Services should ensure they are safe spaces (online and offline) for LGBTQ+ people. This includes both one-to-one and group settings. The separate needs of lesbian, gay, bisexual and trans people should be considered.
- Future alcohol research should focus on the needs of trans people and sexual minority women.
- Flexible, non-judgemental, low threshold services are required which emphasise discretion and are easy to engage with.
- More visible signposting to LGBTQ+ and women-only Alcoholics Anonymous (AA) groups and Fellowships would be beneficial.
- Alcohol services need stronger links to mental health, and other services, to ensure that clients receive seamless and timely care.
- At a broader level, more public understanding and acceptance of LGBTQ+ people would improve their health and make it easier for them to access services.



Introduction

A growing body of international research demonstrates that people who identify as LGBTQ+ (i.e. those who identify as lesbian, gay, bisexual, trans, queer, questioning, non-binary or otherwise gender or sexuality diverse) are more likely to drink excessively and become dependent on alcohol than those who identify as heterosexual or cisgender (Flentje 2015; Green & Feinstein 2012; Hughes et al. 2016; Pitman et al. 2021). For example, a systematic review found that the risk for past-year alcohol dependence among lesbian, gay and bisexual people was at least 1.5 times greater than for heterosexual people (King et al. 2008). Historically, most LGBTQ+ health research has focused on gay men (Moncrieff 2014). However, exploring the experiences of sexual minority women is crucial, given there are larger differences in the rates of drinking and alcohol-related problems between sexual minority and heterosexual women than between sexual minority and heterosexual men (Hughes et al. 2016; Hughes et al. 2020). Similarly, very little attention had been paid to drinking in the trans population until recent years. A Canadian survey found the prevalence of heavy episodic drinking may be 1.5 times higher among trans adults compared to the age-standardised general population (Scheim et al. 2016).

The UK does not routinely monitor gender identity or sexual orientation at a national level, despite government recognition of health inequalities in this group (Phillips 2021). However, the existing evidence suggests LGBTQ+ people in the UK are also more likely to drink (Bachmann & Gooch 2018; Bridger et al. 2018), and to drink at harmful levels, compared to the overall population. For example, a recent report based on a representative sample from the Health Survey for England found that one

third (32%) of lesbian, gay and bisexual adults reported drinking over 14 units of alcohol in a week, compared to 24% of heterosexual adults (Dinos et al. 2021). Health inequalities – including those for LGBTQ+ people – have been further exacerbated by COVID-19 (Phillips 2021). During lockdown, the loss of connection to the LGBTQ+ community – and to people's 'chosen families' rather than families of origin – resulted in increased loneliness and a loss of support, validation and sense of belonging (Bochicchio et al. 2021; Leven 2020; Riggle et al. 2021). Some LGBTQ+ people did not feel they had a safe place to stay during lockdown, either because of domestic violence or because of homophobic or transphobic relatives. Unsurprisingly, recent research suggests LGBTQ+ people used alcohol (and other drugs) to cope with the fear, isolation and boredom of the pandemic (Bochicchio et al. 2021; Drabble & Eliason 2021; Leven 2020; Riggle et al. 2021). For example, more than one fifth (22%) of LGBTQ+ respondents in a Scottish survey reported drinking more during lockdown, while over one third (36%) reported using other substances (Pink Saltire 2020).

There are a number of reasons why LGBTQ+ people are particularly vulnerable to alcohol problems (Bourne & Weatherburn 2017; Emslie et al. 2015; Emslie et al. 2017; Meyer 2003). First, the 'minority stress' perspective outlines how minority groups such as LGBTQ+ people exist within hostile environments (e.g. dealing with discrimination, rejection, stigma, hostility, homophobia and transphobia) which impact negatively on their physical and mental health (Meyer 2003). Coping responses may include health damaging behaviours such as substance use (Bourne & Weatherburn 2017; Hamilton & Mahalik 2009; Kcomt et al. 2020). Secondly, venues which sell alcohol play a central role in facilitating social connections

One third (32%) of lesbian, gay and bisexual adults in England report drinking over 14 units in a week, compared to 24% of heterosexual adults

for many LGBTQ+ people. While clubs and pubs on the commercial gay scene provide 'safe' spaces away from the heteronormative world (Peralta 2008), many LGBTQ+ people spend considerable time in 'intoxicogenic environments' (McCreanor et al. 2008) and experience strong peer pressure to drink across the lifecourse (Emslie et al. 2017). Sexual minority groups also overestimate the alcohol (and other drug) use of peers, perhaps because observation of peers tends to be in LGBTQ+ bars and clubs, and on social media sites and dating apps (Boyle et al. 2020). These theories also intersect; for example, there is evidence that gay men are more heavily influenced by peers' substance use when they experience more minority stress (Hamilton & Mahalik 2009). Finally, alcohol advertising is increasingly targeting LGBTQ+ people (Drabble 2000). Spivey et al. (2018) suggest we must critically appraise the 'marketing efforts of industries that sell products that disproportionately target and harm LGBT communities', while Drabble (2000) argues that LGBTQ+ organisations should adopt rules about accepting funds from the alcohol industry and question industry sponsorship of LGBTQ+ events.

In addition to the greater risk of substance use problems, LGBTQ+ people face specific barriers when accessing treatment services. These include concerns about judgment and discrimination from service providers who they perceive to lack understanding of their lives and cultural context, and about confidentiality within services (Hta et al. 2021; Keogh et al. 2009; McDermott et al. 2016). Recent reviews of substance use treatment interventions for LGBTQ+ people have identified the importance of cultural competence training for providers and adapting services for LGBTQ+ people (Dimova et al. 2020; McGeough 2021). LGBTQ+ people in Scotland

report similar barriers to accessing healthcare services to those reported in international literature. Emslie et al. (2015) found LGBTQ+ people perceived that alcohol services and peer support groups did not provide a safe space for LGBTQ+ people as they were 'macho' and 'intimidating'. One study (Bridger et al. 2018) found that one in four LGBTQ+ people reported inappropriate curiosity (such as intrusive questions about their personal lives; Shepherd et al. 2019) from healthcare staff because of their sexual orientation and/or gender identity, with numbers being particularly high among trans people (41%). A survey exploring trans inclusion in drug and alcohol services (Valentine & Maund 2016) found the majority of respondents did not approach services due to fears of silent harassment and concerns that their trans-specific healthcare (e.g. hormone access or surgery) would be refused or stopped because of their substance use. Finally, health needs assessments have highlighted barriers such as heteronormative assumptions from healthcare providers, worries about confidentiality, and concerns that diagnosis or treatment would be negatively affected by disclosure of sexual or gender identity (Leven 2020).

There remain many gaps in knowledge about the relationship between LGBTQ+ people and alcohol (Institute of Alcohol Studies Briefing 2021), but one particularly important gap is around improving alcohol services. Our previous work focused broadly on the social context of drinking among a diverse sample of LGBTQ+ people in Scotland (Emslie et al. 2015; Emslie et al. 2017). The current qualitative study focused specifically on LGBTQ+ people who had accessed alcohol services or peer support in Scotland to explore their experiences and discover how services could be improved. We also explored the views of service providers to provide a more rounded account.

5 Methods

Recruitment and data collection

LGBTQ+ service users

Given that LGBTQ+ people are not a homogenous group (Bloomfield et al. 2011; Green & Feinstein 2012), we adopted a purposive sampling strategy to recruit a diverse sample. Participants were recruited between February and October 2020. Study posters and flyers were initially placed in LGBTQ+ pubs and bars in Glasgow. However, after March 2020, recruitment was conducted remotely due to COVID-19. We advertised the study via alcohol services and LGBTQ+ third sector organisations. We placed study adverts on social media (Twitter, Instagram), on dating websites (Gaydar and GaydarGirls) and created a study Facebook page. We also employed snowball sampling by asking participants to discuss the study with people they knew who also met the inclusion criteria: 1) identified as LGBTQ+, 2) were 18 years of age or older, and 3) had sought help from an alcohol service or alcohol support group in Scotland. After a participant indicated they were willing to take part in the study, they were emailed the study consent form and demographics questionnaire. Ethical approval was granted by the Glasgow Caledonian University School of Health and Life Sciences ethics committee (HLS/NCH/19/026). Recruitment was time-consuming. Due to COVID-19 restrictions across Scotland, it was not possible to have informal, face-to-face conversations with potential respondents about the study. In total, 14 participants were interviewed. They heard about the study via Facebook (n=10), word of mouth (n=2), a support group (n=1) and through a third sector organisation (n=1). Respondents were given a £15 voucher to thank them for participating.

Given the sensitive nature of the topic, we conducted in-depth, semi-structured individual interviews where LGBTQ+ respondents had time and space to tell their stories. Our intention had been to conduct face-to-face interviews. However, only one interview could be conducted in this way, and the remainder were conducted remotely (by phone or online, depending on the respondent's preference) due to COVID-19 restrictions. Interviews were audio-recorded and lasted between 43 and 91 minutes. We explored each respondent's journey through alcohol services, their experiences of treatment, including barriers and facilitators (with specific prompts asking people to reflect on LGBTQ+ specific factors) and their suggestions for improving alcohol services. The interview guide was refined after discussion with the study steering group, which included service providers, health improvement experts, researchers and colleagues

who identified as LGBTQ+ and/or worked with LGBTQ+ people. All interviews were conducted by an experienced qualitative postdoctoral researcher (ED).

We interviewed a diverse sample of respondents in relation to age (ranging from 19 to 65 years old), socio-economic status, sexual orientation (six respondents identified as gay, three as bisexual, two as heterosexual, two as lesbian, one as heteroflexible) and gender identity (three participants identified as trans and 11 as cisgender) (see Table 1 for details). All were from the majority White population. Respondents sought help from statutory alcohol services, third sector organisations, Fellowships (such as Alcoholics Anonymous [AA] and Narcotics Anonymous [NA] and other support groups), and counselling services. To ensure participants' anonymity we do not present participants' precise age but instead split the sample into "younger" (under 40 years) and "older" participants (40 years and older).

Service providers

We adopted a convenience sampling strategy to recruit service providers who worked in alcohol services or with LGBTQ+ clients in Scotland. We emailed third sector organisations and asked them to circulate study information to their staff and utilised professional networks to identify appropriate NHS staff, and asked those interested to contact us. Permission and approvals for contacting NHS staff were obtained from the local health boards. Interviews with service providers were conducted remotely, using an online platform (MS Teams or Zoom) with the exception of one interview, which was conducted over the phone. Interviews explored a client's journey through the service, and prompted providers to reflect on whether this journey would be different for people who identified as LGBTQ+, compared to heterosexual and cisgender people. We also asked about LGBTQ+ specific training and policies at their organisation and views on how services could support LGBTQ+ people better.

We interviewed 15 service providers. Nine were clinicians, including Specialist Doctors and Consultant Psychiatrists working for NHS addiction services (often referred to as statutory services), while six worked in the third sector (three with alcohol organisations and three with LGBTQ+ organisations). They had worked in their role for between 4 months and 15 years. Among those willing to report their sexual orientation, eight identified as heterosexual, one identified as lesbian and four identified as gay men or queer. No respondents reported they were trans. Only one respondent reported they were not from the majority White population.

Data analysis

Interviews were transcribed verbatim and checked for accuracy. Names and identifying information were removed and pseudonyms used to refer to respondents. Thematic data analysis (Braun & Clarke 2006; Clarke & Braun 2016) drew on the Framework Approach (Ritchie et al. 2014) and was facilitated by QSR NVivo12 software. After data familiarisation and in-depth discussion with the research team, an initial descriptive coding framework was developed by ED and CE and applied to the data. Framework matrices to facilitate cross-comparison of data were then created. RO mapped each theme, initially wrote a descriptive account and then refined and developed the analytic account of the data, which was reviewed by the research team to ensure it remained grounded in the original data (Braun & Clarke 2006). Finally, the team discussed any data that may have been missed, ideas that needed to be developed, how the narrative might be organised, and different ways of interpreting data. The whole research team commented on drafts of this report. The steering group also played an important role across the duration of the project in helping interpret data and latterly to help formulate recommendations.

6 Findings

First, we present LGBTQ+ people's experiences of alcohol services in Scotland, including describing the context of seeking help during the COVID-19 pandemic. Next, we outline the perspectives of service providers.

What are LGBTQ+ people's experiences of drinking and alcohol services?

How did respondents discuss connections between identity and alcohol use?

There was general agreement that alcohol played a central role in LGBTQ+ people's lives in Scotland. Respondents noted that '(most) LGBTQ+ friends ... have struggled at some point with alcohol' (Mia) and discussed how easy it was to get 'caught up ... and end up drinking too much' (Iain) in the 'alcohol fuelled ... gay scene' (Jake), where 'gay clubs ... (are) open longer than straight clubs' (Harris). This echoes previous findings about the lack of alcohol-free places in Scotland for LGBTQ+ people to meet each other (Emslie et al. 2015; Leven et al. 2020).

When discussing their own drinking, only two respondents (Eva, Jake) – both younger bisexual respondents in further education – explicitly rejected any link between their LGBTQ+ identity and alcohol ('I didn't think sexuality was relevant to (my) drinking': Eva). In contrast, many respondents perceived their drinking to be closely linked to their sexuality or gender identity. They discussed the fear, shame and guilt associated with secrecy about their identity and how drinking helped them cope with this. The two oldest men in the study reflected on growing up gay in the 1950s and 1960s ('People ... in my age group ... hold onto that shame thing because that's the era that we come from': Kai). They described attempting to negotiate their sexual identity in an era where sex between men was illegal and homosexuality was considered shameful and then coping with the death of loved ones from HIV/AIDS in the 1980s. Older respondents suggested that younger LGBTQ+ people were less likely to be dogged by feelings of shame about their sexuality. However, several younger participants described how their heavy drinking at school was connected with pressure to hide their sexuality from peers and present themselves as straight.

Respondents across the age range used striking language to illustrate the imperative to hide their identity (e.g. 'lie' 'secret' 'suppressed' 'taboo' 'shut all that away'). The ubiquity and flexibility of alcohol is also demonstrated through its use as both a 'mask to pretend to fit in' and as a tool which 'gave me the courage to go out and just be who I wanted to be':

It's just such a secret (sexuality) ... You're constantly building walls to protect yourself from people knowing the truth and the alcohol would take that away ... I would get really drunk and try it on with some lassie (girl) ... It was alcohol ... giving me the mask to pretend to fit in ... It just felt so taboo ... I was emotionally not ready ... to let go of any shield. (Liam)

Alcohol gave me the courage to go out and just be who I wanted to be ... I felt that I was under pressure to be a sort of 'normal' person ... do boys' things ... and I had to shut all that away. (Ash)

(Alcohol) kinda suppressed it (being gay) ... It made it easier to lie to everybody that I was straight ... I couldn't talk to anybody (in my family) and I felt really alone. (Greg)

Negative family reactions to sexuality / gender identity were common. Respondents described drinking because of isolation, shame and to cope with the lack of understanding (and sometime outright rejection) from families. A younger lesbian respondent (Fay) and an older gay man (Iain) discussed pain, guilt and the effect on their wellbeing of these negative reactions:-

I've had a strange relationship with my own sexuality and figuring out where I am ... and most of that has been because of family backlash which has influenced my drinking habits. ... Initially, (drinking) was a way of just kind of ... "I've had an argument ... they (parents) don't approve of who I am, OK, I'm just gonna have a drink and I'm just gonna forget about it", to then constantly drinking. ... It was something that I started hating about myself, and then started drinking because of that. Being more open and honest with myself has definitely decreased how much I've been drinking, because it's no longer just shutting emotions away ... it's accepting them and acknowledging them, and then working through them. (Fay)

I think that alcohol drops the inhibitions or sometimes the guilt one feels if one's having a relationship. My family just did not accept that and never did. And they put me through quite a hard time when I was ... 16 and I came out ... My father thought it was a disease. And they sent me to a psychiatrist. They (services) concluded that I was a gay man. Problem wasn't me, ... my parents were the problem. (Iain)

While the extracts above illustrate how some issues were shared across the LGBTQ+ community, there was agreement across the sample that trans people were more stigmatised and discriminated against than other groups. Narratives from two older trans respondents described their extreme discomfort and lack of ease with their identity, and others' responses to it, and the pressure of hiding both their identity and drinking from others:-

(It) was very difficult juggling this dual life I was back to hiding everything again. I've only actually let anyone know about my gender identity about a year ago ... I've spent 10 years ... with people not knowing about my gender identity, and in AA and even where I live. (Daniel)

For me alcoholism is a, like a 'dis-ease' ... it means I am not at ease with myself. ... That might be a lot to do with (being) transgender and not being comfortable within my own skin (or) just being allowed to be who I wanted to be. Growing up, having to hide things away like that all the time, it was a lot of pressure ... It's like constantly questioning things over and over again. Gradually it gives you mental issues, mental problems ... You get conditioned to that day in, day out ... every day, every morning waking up and thinking ... 'I can't be me. I can't do this and I can't do that. What will they think of me?' ... (I'm) only starting to see that now after three years being in recovery and really looking at myself and talking to other people ... My head's getting clearer ... Forty-four years of drinking and hiding things ... That's probably part of my condition. I've always been ashamed of who I am ... that I was transgender or I was an alcoholic.

Well, it's the stigma. (Ash)

This extended extract from Ash (above) suggests that the cumulative effects ('day in, day out') of hiding one's identity in a hostile societal environment could be linked to poor mental health and drinking problems. Similarly, another trans respondent (Ben) explicitly linked his identity, alcohol consumption and mental health, stating that his drinking was '*an equal balance between gender identity and anxiety, but I also just think that they are interlinked as well*'.

Almost everyone in the sample discussed experiencing mental health problems, despite this topic not being raised by the interviewer. Respondents described consulting healthcare professionals about depression, anxiety, panic attacks, eating disorders, self-harming, suicidal thoughts, post-traumatic stress disorder (PTSD) and historic trauma. This connection between drinking and poor mental health

(see Chandler & Taylor 2021) was perceived to be so common that one respondent suggested that alcohol services should promote themselves via mental health support groups on Facebook. It could also cause additional problems. For example, Jake described how going to AA meetings was counterproductive, because telling his story to a group increased his anxiety which '*brought back the thoughts of drinking*'.

Drinking and alcohol service use during COVID-19

Data collection started in February 2020, shortly before the COVID-19 pandemic began to affect participants' lives and alter how alcohol services were delivered in Scotland (see <https://spice-spotlight.scot/2021/03/24/one-year-of-covid-19-in-scotland-key-milestones/> for key milestones). Unsurprisingly, participants reflected on drinking and service use during this period, although this was not the original focus of the study. Only a few respondents felt life was largely unchanged during the pandemic, either because they lived alone or suffered from social anxiety and so did not choose to socialise prior to the pandemic. Most of the sample experienced substantial life changes.

Younger respondents perceived the pandemic had increased alcohol consumption among their age group, with drinking during the day becoming normalised particularly among those who were furloughed ('*I've seen a lot of people saying on Facebook 'I don't know what I'm gonnae have to access first, AA or Weight Watchers!': Mia*'). Several younger participants said they had struggled to maintain routines that usually helped their recovery, particularly given additional pressures such as relationship breakdown or having to move out of student accommodation to return to live with parents who were not accepting of their sexuality. In contrast, other younger respondents reported the pandemic had allowed them time and space to change their lives for the better, either through new exercise routines, which also acted as a disincentive to drink, or a change of job.

Respondents across the age range described how isolation made it increasingly difficult to avoid drinking, particularly when it became clear that social restrictions could last for some time:-

It's very difficult to not get bored easily and see using alcohol as a way to sort of pass the time just ... to get you through the loneliness and boredom of isolation. (Jake)

I wasn't doing any work or anything like that (during the pandemic) ... I then really started from early March to proper 'hit the bottle' ... And that got progressively worse throughout April, and then ... the third week of May, it progressed to literally almost, well actually a litre, sometimes more, of spirits every day. Like complete blackout drunk every single day. (Harris)

Participants were concerned about how much support would be available to drinkers following the introduction of a national lockdown in Scotland and disruption to alcohol services. Participants who used statutory services discussed how difficult it was to have their connection to a service, or with specific workers, abruptly severed. Not knowing how long it would take until services would return to normal also created considerable anxiety:-

It's been one of ... the hardest times ... I would normally see (my workers) on a weekly or a fortnightly basis depending on their schedule, my appointments, and also depending on how I'm feeling ... With COVID ... obviously there was a complete stop on all face-to-face services ... What if we do go back into lockdown? Where do we go from there? (Jake)

To grind the whole of the system to (a halt) ... I just feel sorry for all the people that are ... really, really struggling ... It's very scary. (Kai)

Several participants compared the remote communication necessitated by the pandemic unfavourably with their usual face-to-face encounters with service providers. For example, one older gay participant (Kai) said he found the 'brief chat(s)' over the phone less 'personable' than face-to-face meetings, although he understood why services had to be delivered in that way, while a younger bisexual respondent (Jake) similarly felt that a phone conversation was not as beneficial as a face-to-face meeting with a worker who 'knows me, who knows my background, who understands me'.

Others found advantages in the opening up of online Alcoholic Anonymous (AA) and other Fellowship meetings. One trans man (Daniel) said he felt 'blessed' to have access to technology so he could join daily meetings across the world, and suggested that the pandemic had created opportunities for inclusion. Respondents valued online groups as particularly safe spaces: easy to leave if they wished to, a lack of pressure to share their experiences and anonymous, given the option to not switch on their camera:-

You don't necessarily have to even have your camera on ... I'm never gonna meet the people, ... I'm not self-conscious about what people think of me. It just gives me that bit of freedom ... I can just sit on my computer and listen and just ... and share back if I want to share back ... I can just enjoy the experience without the pressure of feeling that I need to share. ... Without this technology ... there'd be lots of people ... in real isolation at home struggling with their addictions. (Daniel)

I've been accessing the AA groups on Zoom, just since lockdown. And I hope they keep it up, because I think it'll be a lot easier for people ... it's a service that I think people would access ... You don't have to have your video feed on in the room. It does feel a bit more anonymous for people. (Mia)

What barriers do LGBTQ+ people report when accessing and engaging with alcohol services?

Participants described their trajectories through alcohol services, engaging with statutory services, third sector organisations, Fellowships (such as AA and NA) and other support groups, and counselling services (see Table 1). Some barriers to accessing and engaging with alcohol services are frequently reported in the literature and so are described briefly below. We devote more space to focusing on barriers which are specific to LGBTQ+ people.

Generic barriers

Many participants held gender and age-based conceptions about 'alcoholics', who were perceived to be '*middle-aged men who have been ... drinking for decades*' and who have '*lost everything*' by the time they seek help (Ben). These stereotypes could influence the stage at which participants felt they could ask for support and how comfortable they were seeking help from services. For example, one younger respondent who developed pancreatitis described the shame of having to access alcohol services '*at my age*' (Jake). Other younger respondents perceived that service providers had normalised their drinking as '*student behaviour*' or '*just what young people do*', which made it harder for them to ask for, and obtain, support (Ben, Eva).

Long waiting times for statutory services were also a source of stress. Respondents suggested that services could do more to simplify the engagement process: '*it is a daunting thing to ... be honest with yourself, and accept that you need help, and then actually reach out for it*' (Fay). Some participants reported being '*made to feel worse*' (Daniel) by service providers and feared facing judgement

if they failed to reduce their drinking or appeared to disengage from support. Other participants commented on the negative effect of a limited number of sessions with a healthcare provider. This was particularly important for respondents who had suffered trauma. As one older trans man commented:-

I've 30 years of alcoholic drinking, I don't know how anyone expects anything to be changed within eight sessions. Sometimes ... you just get to that vulnerable place of ... starting to open up, and then it's over. (Daniel)

Several participants described not having a choice about engaging with particular services. Some reported being required to attend Fellowship meetings as a condition of continuing support from a statutory service, while one participant recalled how a residential rehabilitation unit '*would pack us all in a bus (nightly) and we would hit a meeting*' (Liam). This could be problematic if the ethos of a particular service clashed with respondents' own values. As one gay man commented '*the 12 steps (are) a bit Godsquad - it made me switch off*' (Harris).

Finally, respondents described the importance of alcohol services being centrally located, having flexible opening hours and being discreetly housed and separate from drug services. They also referred to common barriers to accessing treatment such as lack of transport and financial resources.

Barriers specific to LGBTQ+ people

Participants reported rarely, if ever, being asked by alcohol service providers about their sexual orientation or gender identity. This experience cut across age and was relevant to every group (lesbian, gay, bisexual and trans) within the sample. It led to awkwardness and frustration, as respondents then had to decide whether to raise the topic themselves:-

Never, they never asked me up front, no ... If they asked me, then I wouldn't feel awkward having to come out when I was talking to them. I brought up that it was a female I was in a relationship with ... So maybe if they asked me first, I'd feel more comfortable. (Naomi)

I don't think they prodded enough in that area (sexuality), so it was just kind of brushed over. It's a bit bizarre in retrospect- that's a part of my life that needs addressing ... it wasn't addressed. (Kai)

I feel like I wasn't given a lot of support ... and not a lot of ways of managing it (sexuality). They don't want to talk about it ... it was very frustrating. Especially coming from somebody [counsellor] who you go to for help and for advice. ... I feel like they need to be more understanding that (sexuality) is definitely a factor in some cases. ... If it's not asked, and then you have to say ... it does get embarrassing and a bit frustrating, because obviously I have to correct them in the things where my issues lie. (Fay)

They didn't ask me about it (gender identity). They knew because ... I told them. ... I said I think this might be ... a big link as to why (I was drinking). But they didn't actually ask very much about it ... I felt like obviously they weren't really qualified to ... fully understand and probably didn't realise the extent of the link. (Ben)

When respondents themselves chose to disclose their sexual orientation, gay and bisexual men were generally positive about the response they received. However, younger lesbian and bisexual women reported more negative reactions or assumptions. Both lesbian respondents reported heterosexist assumptions ('*what does your husband do?*': Mia), while a bisexual woman felt that her sexuality was not taken seriously because of her age ('*kids are just confused*': Fay). Another younger bisexual woman (Eva) was the only respondent who reported being asked about her sexuality (as part of routine questions on her first visit). Unfortunately, the service provider made her feel '*judged*' and '*uncomfortable*':

It doesn't matter what service you're accessing, there is always a judgement. People say, "Oh, are you married?" Yes. "What does your husband do?" You know, that kind of thing. (Mia)

I feel like there was a little bit of a stigma – it's the kinda 'cause kids are just confused' (about their sexuality). They don't really know what's going on' which affected me. I have spent a very long time trying to figure out who I am, and accept who I am ... It's a concern when you go (to counselling), can I actually talk freely? It's letting people know that they can talk freely ... there is no judgement. (Fay)

What are LGBTQ+ people's experiences of alcohol services?

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(The counsellor asked) 'oh, what sexuality are you?' ... and like when I told her (bisexual) ... Do you know that look on someone's face ... they don't really agree? ... I always felt like I was being judged every time I talked to her. She was quite distant ... the minute I said that, she moved her chair back a wee bit. It ... made me feel uncomfortable, obviously. (Eva)

Many respondents had already experienced shame and stigma due to their LGBTQ+ identity, and this already heightened sense of shame was a further barrier to seeking help for alcohol problems. Some respondents felt that shame about their drinking was particularly acute for older LGBTQ+ people ('*a lot of people of my age group won't (seek help) ... it's a shame thing*': Kai). However, both younger and older respondents referred to shame in their narratives when discussing seeking help. For example, one younger trans man (Ben) talked about the importance of services being advertised in a way which made it clear that alcohol problems were not shameful, while an older trans woman (Ash) explained how being ashamed of their 'trans life' and 'alcoholic life' meant that it took a long time to trust service providers and receive help:-

I think (services have) got to be advertised in a way that isn't perceived to be shameful ... I really did feel like I was proper like scum, to be honest. I felt like, wow, I can't believe my life has come to this. I'm having to go to this (alcohol service). (Ben)

I didn't want to tell anyone my name (when first contacting alcohol services), I wanted to be completely anonymous ... I've always been ashamed of who I am ... (that) I was transgender ... (and) I was an alcoholic ... It's the stigma ... Growing up ... I (was) always ... hiding things ... I told people false names when I was initially starting to get help ... As I've started to get help, I realised there was a lot of discretion in the services. And that I could let that go. And that was a big help to me. 'Cause I started to really tell people who I was. (Ash)

One strategy that respondents used to overcome shame and stigma was to seek help for their alcohol problems from trusted services or health professionals with whom they already had a relationship. For example, one trans man (Ben) felt comfortable talking to his family doctor about his drinking because he '*never made me uncomfortable ... regarding transitioning*', while a gay man (Kai) waited four months to see a counsellor at a sexual health clinic, because he had used the clinic before

and knew it was used by gay men. University counselling services were accessed by some younger respondents who perceived they created a '*good atmosphere*' (Fay) for discussing alcohol, mental health and LGBTQ+ related issues.

Given the respondents' focus on their mental health problems in the interviews, it was important that alcohol and mental health services were '*joined up*', and worked well together. Some respondents were very positive about the care they had received. Two had been referred to mental health services, as part of an overall treatment plan to address drinking, following detox. One older gay man (Harris) described a tailored, joined-up system of care that was responsive to both the physical and mental health care needs of drinkers and was '*flabbergasted*' by the kindness and compassion of one consultant. Other referrals were made to mental health services via the Criminal Justice Team, specifically to address the links between trauma and drinking and from psychiatry to alcohol services, following hospitalisation for depression.

Unfortunately, some younger respondents did not feel that the important connections between their identity, mental health and drinking had been recognised and treated. One younger trans man (Ben) argued that, for him, these issues were inextricably interlinked but that services were not trained to understand the needs of trans people. A younger bisexual man (Jake) described feeling like a '*tennis ball ... getting batted back and forth*' between general practice and addiction services, while a younger lesbian respondent (Mia) commented that the two services did not '*work in tandem*'. Both respondents were frustrated that the underlying causes of their problems were not addressed:-

As soon as I go to my GP about my anxiety or my mental health, I'm either offered to be put onto an anti-depressant or I'm sent back to addiction services, and when I say the same thing to addiction services they tell me that because I've previously been an addict they'll not prescribe me anything (so advise me) to go back to my GP. I probably would benefit from speaking to a community psychiatric nurse just to see exactly what's underlying, what's causing the relapses ... You almost feel like a tennis ball, like you're just getting batted back and forth from one to the other 'cause they don't really know (how) to, or want to, deal with the situation ... (Jake)

Mental health services don't want to deal with someone who's drinking, and ... addictions team don't want to deal with the mental health aspect. ... It's very well giving someone medication, but you need to actually deal with why someone's drinking and using it as a coping mechanism. And the two services don't seem to cross over, or ... or speak to one another or work in tandem. (Mia)

Alcohol treatment also brought respondents into contact with other service users, which could create uncertainty and anxiety. Three respondents had concerns about discussing their sexuality in residential facilities, where they were housed with other service users day and night:-

I hadn't told any of my peers ... my anxiety was through the roof ... I was fine talking about drink, it was sexuality ... (that) just felt so taboo. I think it just came out (disclosing he was gay) ... it was like 'there we go, next topic'. I mean it was so un-notable, I forgot it, but I had so much anxiety about it. I was so relieved after it and I felt like I could be myself and just be more vulnerable around people and trust in people in recovery. (Liam)

It wasn't like you could openly discuss because you don't know what the other people who are in the group might think. If you're gonna share an experience that's specific to your (gay) lifestyle (you don't know) how that might come across to them. (Harris)

I didn't come out with it, I didn't scream it (lesbian identity) from the rooftops. Just kept myself to myself and got to know folk, but as time went on I was asked 'oh have you got a boyfriend'? I just had to say 'no, I'm single, but I'm not into kinda guys' ... It's hard 'cause you're walking in there and there's 12 girls and you've never met. You're not going to feel comfortable just coming out with it ... and it's not everybody that will accept you. 'Cause some people don't like LGBTQ+. (Naomi)

Many respondents had positive experiences of peer support from Fellowships such as AA. Hearing other people's stories and seeing their recovery had a powerful impact:-

You can talk if you want to talk (at AA). ... You can just sit and listen. You (can) come in and sit in a meeting for 10 minutes if you wanted to (or) you could go. ... It was definitely a safe place for me ... I could see other people coming in and looking better, sounding better, and me thinking, 'I want to be like that, I don't want to be like this anymore.' And I would take inspiration from other people's stories. (Eva)

However, some respondents (including cisgender men) described group meetings (within alcohol services or AA) as not always welcoming to women or trans people. For example, they described services as being '*full of men of a certain age*' (Mia) where (men's) '*egos kick in*' (Chris) and stressed the importance of female only groups for women's recovery. One younger woman (Mia) discussed how she had felt vulnerable at AA surrounded by older men. An online women's AA group eventually provided a '*safe space*' with women she could '*identify with*'. Similarly, Daniel explained how one-to-one support from another trans person attending the same AA group led to '*acceptance and being more comfortable with myself*':-

When I was 18, 19, a friend and neighbour who was attending AA encouraged me to go with him ... but it was full of older men of a certain age ... I felt quite vulnerable ... and I found it really difficult to speak at all in those services, because ... there was a certain type of client that was accessing them ... maybe ex-military ... It didn't live up to my expectations in terms of it feeling inclusive, and it didn't feel like a safe space for me at that time ... So the (online) women's groups were just a bit more easy for me to identify with ... A few of the women that I've met in the groups, we exchanged WhatsApp, and they're really good at supporting me and checking in that everything's okay and vice versa ... it's a bit more personal. (Mia)

I can share individually with people ... I felt comfortable doing that. My (AA) sponsor says that it was like drawing blood from a stone when ... we first met. It really did take (a) long (time). So one-to-one has been amazing ... feeling acceptance and being more comfortable with myself as well ... One of the people ... in my own group, that I ... get on really well with is another trans person ... We're able to support each other, and just talk to each other about how we're feeling ... about the process that we're going through. (Daniel)

Trans respondents had particular concerns about interacting with other service users, such as being outed or judged in situations where they did not feel safe. Those living in small towns were particularly anxious about anonymity. Daniel, an older trans man, described how vulnerable he felt attending an AA meeting:-

I went to my first meeting, and I sat in the meeting ... really scared, feeling really vulnerable. I turned up just before the meeting started, so I didn't need to speak to anyone. I sat in a chair next to the door, basically getting ready to run out the door, you know, I was never in a comfortable seat. And ... and I mean comfortable as in I never made myself comfortable, you know, I couldn't relax. (Daniel)

Other respondents agreed that trans people faced particular challenges. Naomi (a cisgender woman), discussing her fears about coming out as a lesbian at a residential facility, reflected that finding acceptance would be even harder for trans people. Chris, a gay man, had witnessed transphobia from both staff and service users at a housing service he used to work in, while another gay man (Harris) was concerned about the knowledge and training service providers had around trans issues:-

I don't think LGB (lesbian, gay, bisexual) need very much training because it's so much more socially acceptable nowadays. I would have no qualms about identifying as a gay man in any circumstances ... to any medical provider ... I think for the T (trans) part ... plus the gender fluidity ... everyone could stand to have a little bit more understanding ... The wrong pronouns ... it's a real kick in the teeth to anyone that's going through that journey ... Everyone in the medical profession should have a little bit of a refresher on how that works. (Harris)

Some respondents had found LGBTQ+ or gay recovery groups helpful. For example, Liam (a gay man) was positive about attending an LGBTQ+ Cocaine Anonymous group during his time in a residential facility, and reflected wryly about the expectations of some of his heterosexual peers. Similarly, Ash (a trans woman) who attended a gay recovery group connected with common experiences of hiding identity and coping with stigma:-

I remember they (heterosexual peers) were expecting drag queens ... Mardi Gras ... The Rocky Horror Show. ... and they just walk in and it's normal people! So the house (residential facility) liked going to that meeting. People did get a lot, they could share more. I was still quite a shy sharer. But (LGBTQ+) people definitely would be able to relate more. (Liam)

I have a (gay) group in my twelve-step recovery that's helped drastically And although I'm not gay ... I've still got a huge lot of connection and identification ... because it's something (sexuality / gender identity) that you had to deeply hide from and grow up with that stigma through our lives. (Ash)

However, one trans man (Daniel) said that simply labelling a group 'LGBTQ+' did not necessarily mean everyone would feel accepted. Even though he introduced himself as a man, other people at the Fellowship treated him as a woman, for example, kissing him as he arrived (as they did with women at the meeting), rather than shaking hands (as they did with the men):-

I went (to the LGBTQ+ group) ... as Daniel. But still people thought I was female. So ... it took a little bit ... of getting people (even) at (those) meetings to understand that I'm male. Just because somebody's part of an LGBTQ+ group doesn't mean that ... they're fully accepting ... or fully understand ... There's misconceptions everywhere. (Daniel)

The COVID-19 pandemic resulted in making Fellowship meetings (including those for women and LGBTQ+ people) more accessible for those who had access to the appropriate technology. Digital platforms enabled those anxious about anonymity to engage more readily; the prospect of not being seen, as well as choosing not to actively participate, was appealing for some respondents (see earlier section on COVID-19 for more information).

What would help LGBTQ+ people with alcohol problems?

Respondents were concerned that excessive drinking was normalised among LGBTQ+ people, and particularly on the gay scene, which made it difficult to identify when drinking started to become problematic. Respondents suggested that raising community awareness about drinking and challenging stereotypes about what a 'typical alcoholic' behaves like (Fay), might make it easier to seek help. The need for a 'safe place within the (LGBTQ+) community that doesn't revolve around alcohol' was also identified as a priority:-

When I first moved to Glasgow there was [venue] that you could meet up with friends and have lunch or a coffee. And there was also the old LGBTQ+ centre that again that you could meet up ... It wasn't based around alcohol ... Even at Pride or ... just going out for a night out ... or even LGBTQ+ ... restaurants or anything. (There's nothing) that ... (is) a safe place within the community that doesn't revolve around alcohol. (Mia)

Respondents suggested that alcohol services should advertise in physical and online spaces used by LGBTQ+ people, and that LGBTQ+ organisations and bars/clubs should signpost to alcohol services. One respondent contrasted the huge amount of information about sexual health available from LGBTQ+ organisations and on the gay scene with the lack of attention paid to alcohol services:-

There's a huge gap ... I don't really feel like there's many services ... run from LGBTQ+ Youth or ... any clubs or nights that run in the town that ... advertise or advocate for any sort of alcohol services ... I've definitely not seen as much help for people with alcohol issues ... An additional thing could be making leaflets (similar to sexual health service flyers) ... in gay nightclubs with addiction hotline numbers, Alcoholics Anonymous numbers, suicide awareness prevention numbers ... Cause it's not all just about sexual health. (Jake)

It was also suggested that any existing support specifically tailored to LGBTQ+ should be advertised more widely:-

There is a specific (AA) LGBTQ+ room, there's like women's groups ... basically they're running all the time at the moment. But again, unless you knew about it ... I accessed a Zoom meeting the first time, and it was a group of women from Glasgow that were on ... so they sent me a link to all of these meetings that are running basically 24 hours a day. And that information I didn't find accessible online. (Mia)

Participants were asked how services could make themselves more LGBTQ+ friendly. They suggested that training health care providers in LGBTQ+ issues would be useful to give them an '*understanding of where people are coming from*' (Fay). Some younger participants also liked the idea of alcohol services displaying the rainbow flag to signal inclusivity, as it would encourage LGBTQ+ people to use the service and indicate that service providers had been trained in LGBTQ+ issues. However, one older trans respondent suggested that the rainbow flag was

associated with the gay community rather than the trans community, and it was important to ensure that alcohol services were seen as inclusive to all:-

The rainbow flag is ... something that I would notice on a leaflet or a flyer, or a website ... I feel (it) would be one of the first things that I would notice, even before the content ... I think people would feel less intimidated ... (to come to these services (if they see that) (Ben)

Just even like a wee one (flag) displayed somewhere. I think it would make people feel a lot more welcome ... because you'd feel less judged, and you'd feel that these people probably have been trained. (Eva)

It's important to make sure that everyone knows that it's all inclusive, you know? ... When I see (the rainbow flag), I think it's been ... attached to the whole gay community. And not so much the trans community. (Ash)

Some older respondents did not feel it was as important that alcohol services were tailored to LGBTQ+ people given their perception that services should treat everyone the same. For example, one older gay man felt that he was '*long (enough) in the tooth and out that long*' that he wouldn't be put off by attending more generic services. He contrasted his approach with that of younger LGBTQ+ people who he believed wanted more tailored services ('*they want the rainbow!*'):-

I don't think that I would be put off ... For example ... in the GP surgery (if) you see a sign that says 'problems with smoking', and there's no indication that it's tailored to LGBTQ+, it wouldn't put me (off) ... going to that service ... I think I'm that long in the tooth and I've been out that long that I just - I find it more odd when I get negative responses to anything ... because ... it doesn't happen very often ... Other people have different experiences ... The 18 to 30 age group expect tailored services for LGBTQ+ rather than mainstream ... They want the rainbow! (Harris)

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Findings

What are service providers' experiences?

Overview of services

Fifteen service providers from statutory services (nine Specialist Doctors and Consultant Psychiatrists working for NHS addiction services) and the third sector (three from alcohol organisations and three from LGBTQ+ organisations across Scotland) shared their experiences of supporting people with alcohol problems and/or working with LGBTQ+ service users. We were unable to recruit nurses or other key workers to the study because of the COVID-19 pandemic.

NHS addiction services / statutory services

The specialist doctors and psychiatrists working within NHS statutory services described how dependency was usually assessed by the admitting clinician, although one clinic saw patients that self-identified as 'problem drinkers'. Clients were allocated a key worker (addiction worker, addiction nurse or a social worker) who worked with them to decide what treatment and support was required. If necessary, they were admitted to inpatient detox (usually for 2-3 weeks, although those with complex needs might stay longer) and seen by a nursing team and a psychiatrist (and sometimes other health professionals) on the ward. Others detoxed at home. Consultants prepared patients for discharge by liaising with general practice as well as mental health, sexual health, palliative care, older age and frailty services. Patients were then discharged to their key worker for ongoing support. Discharge was generally perceived as the end goal, enabling patients to re-engage with other services and community support.

Service providers explained how they set alcohol-related goals with their clients. For example, one service provider emphasised that while they might prefer clients to '*work towards abstinence*', the emphasis was on continuing engagement and moving '*the goal with the client*':-

We want to engage the person so that if they've reduced or even if they've gone through detox, and then started to drink again, it might be at that point that they think ... 'I don't have control of my drinking.' And they're still engaged with us, so it's really quite seamless to move the goal with the client. (SP9, statutory service)

Third sector services were also viewed as having an important role in addition to the standard care provided by addiction services. One psychiatrist (SP8) discussed the value in not being '*overly medical about things*' and providing '*starting points ... for people engaging in more*

holistic care' (SP8). However, he also flagged up the advantages in keeping patients within the NHS ('*At least I know what I'm dealing with (in the NHS) and I can chase it up ... myself in systems ... understanding what they're doing and how that affects my care and treatment to that person as well*' (SP8, statutory service)).

Third sector organisations

Three respondents worked for organisations which provided support to people with alcohol problems (SP1, 2 & 10), and liaised with the NHS, social work, criminal justice and other third sector organisations. Their services included alcohol brief interventions, needle exchanges and HIV testing facilities, a drop-in hub, counselling services, and an employability service for people in recovery. Two organisations also supported people with drug problems. All three organisations were currently considering how to improve their reach to a variety of groups, including LGBTQ+ people. One respondent reported that the legal requirements of the Equality Act (which protects users of services based on protected characteristics including sexual orientation and gender reassignment) were part of ongoing discussions at their organisation and that gender and sexuality were discussed regularly at team meetings and group supervisions. Another three respondents (SP4, 5 & 7) worked for third sector organisations who focused on improving the health or the human rights of LGBTQ+ people. Some worked directly with service users, while others focused on rights and legislation at a strategic level.

Some alcohol service providers described a gradual approach to discharge, reducing the regularity of meetings before stopping altogether, as well as contacting clients after discharge to offer a '*rapid return*' if they were struggling (SP2). They also signposted clients and their families to a wide range of support including counselling, peer support and LGBTQ+ organisations. One service provider flagged up the importance of a '*dialogue in partnership working*' between alcohol services and LGBTQ+ services:-

An LGBTQ+ person comes to us with an alcohol issue ... and they feel they would be more comfortable talking about any issues that come up around sexuality with an LGBTQ+ service ... we would look at the alcohol issue and then refer them on to the LGBTQ+ service.
(SP1, alcohol third sector)

The impact of COVID-19 on alcohol services

Service providers reported that COVID-19 had a negative impact on their clients' wellbeing. This was due to a decrease in support (from friends and family as well as from services) and an increase in damaging health behaviours and mental health problems:-

Isolation, losing their job, unable to see family and friends, their drinking might be increasing. They may have been using drugs for sex and they're having comedown, they're unable to access drugs. (SP4, LGBTQ+ third sector)

COVID has caused a huge increase in the amount of people needing detained under the Mental Health Act There's been a lot of people anecdotally saying that they went through their detox in February/March, and then ... they've relapsed as a result of not being getting ongoing support. (SP11, statutory service)

Some services were temporarily suspended due to COVID-19 restrictions. These included community alcohol brief interventions, walk-in appointments and inpatient units/wards and day hospitals where people with addictions receive follow-up care after being discharged. Face-to-face appointments continued in some clinics but on a very reduced scale. Strategies to mitigate risk included wearing personal protective equipment, meeting one client at a time in a large room to ensure social distancing, reducing the number of people in waiting rooms and scheduling breaks between appointments so rooms could be cleaned. Third sector organisations offered their clients telephone and online support, and some offered outdoor walking appointments to reduce the risk of transmission. Statutory services offered phone support to most service users but were sometimes slower in implementing digital support. They conducted needs-based assessments to prioritise the most vulnerable patients who required home visits, and staff would visit in pairs after conducting a risk assessment:-

They [NHS addiction services] stratified patients into a red, amber, green kind of level of worry and based how often they're in contact with people on that, and they have a duty system that if they can't get hold of people, they're sending people (staff) out for welfare checks. (SP12, statutory service)

Service providers experienced various challenges when unable to hold face-to-face meetings with clients. First, they were acutely aware that remote support was not suitable for clients perceived to be more vulnerable, some of whom did not have access to relevant devices or technical knowledge.

Sadly, the more chaotic people are, the less likely they are to be digitally savvy. It even comes down to losing your phone or not having a computer or breaking your computer or losing your laptop or tablet or whatever it might be. (SP7, LGBTQ+ third sector)

They also reported finding it much harder ('almost impossible' SP7; 'just impossible' SP11) to establish rapport and to assess clients' mental and physical wellbeing without the visual cues they usually depended on. This led to some service providers adopting new strategies such as more direct questioning:-

It's just so much of what a psychiatrist does ... mental health relies on face-to-face contact, and just responding to people's facial expressions and demeanour. And it's just impossible to do that when all you're hearing is their voice. (SP11, statutory service)

When you see somebody, you can tell if their skin is slightly yellow, or the whites of their eyes ... because their liver's not working. Or you can see if they've lost weight, or ... if they're tremulous. Whereas now it's like you've got to be much more direct, and just ask a whole load of different questions ... Even down to, "OK, what colour's your urine? (SP10, alcohol third sector)

Some said their workload increased due to COVID-19 (e.g. scheduling one call after another, whereas previously they would have breaks between appointments). Many clients required more interaction due to crises exacerbated by COVID-19 and/or because of loneliness. This took an emotional toll on service providers, and also led to some difficult conversations as they tried to negotiate appropriate boundaries:-

Most people find it (an hour on the phone) just too much. So instead of having either weekly or fortnightly (face-to-face) contact, some clients I'm calling twice a week, some three times a week. I've had a couple who were in real crisis, so it was sometimes twice a day ... For staff, ... it was always going to be difficult, but it's harder than we expected ... We've got to keep making our boundaries quite clear ... 'this isn't a friendly chat ... I'm your worker' Because for a lot of our clients, they're as isolated as we are. And when somebody phones them it's like, 'oh thank God ... somebody's phoning me ... ' So it's trying to get that balance right. (SP10, alcohol third sector)

Service providers also had concerns about the confidentiality of their consultations, given they did not know if anyone else (e.g. partners, family members) was in the room. They also shared worries that some clients could be in increased danger during lockdown (e.g. due to domestic violence) and they felt less able to assist over the phone.

What are LGBTQ+ people's experiences of alcohol services?

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Service providers' views on sexuality, gender identity and alcohol

How important is it to know about clients' sexuality or gender identity?

Most service providers perceived it was important to know about clients' sexuality / gender identity when discussing their drinking. Some saw this as important contextual information which would help them to provide patient-centred care. If sexuality or gender identity was salient, this would be considered when tailoring treatment to fit clients' needs:-

By asking that question (about sexuality and gender identity) it can give an indication of, sometimes, reasons for using drugs. (SP10, alcohol third sector)

The sexual act as part of that is not really an issue, it's much more about how a person responds to dealing with alcohol because of their background or because of their experience. (SP5, LGBTQ+ third sector)

Other service providers pointed to the evidence about higher rates of substance use and mental health problems in the LGBTQ+ population (particularly among trans people) as a reason for asking about gender identity and sexuality:-

The literature around alcohol and substance misuse in an LGBTQ+ population is still a concern, and if you don't ask, then ... you're missing a bit of the picture, or missing a risk factor ... They've got the right to not tell you, but I think you certainly have to ask the question.
(SP15, statutory service)

It would be useful to know (sexual orientation and gender identity) ... just to be able to get a better (sense) of what the scale of ... harmful hazardous drinking is among the LGBTQ+ population ... for us to design our services appropriately. ... Research shows you that trans-people experience even worse mental health and health, physical health outcomes than lesbian, gay, or bisexual people. And especially around sort of suicide and mental health problems. So they have some of the same issues, but more severe in a lot of cases. (SP1, alcohol third sector)

However, service providers also warned that it was important to be mindful of service users assuming they were being '*nosey*' (SP6) or making assumptions about the causes of harmful drinking:-

We focus on ... alcohol ... If their gender or their sexuality is ... causing problems for them, that's particularly important to know about. ... But I think there's probably nothing worse than feeling that someone's nosey just because of that and actually you're quite happy with where you are, you know? ... We certainly have other people where it's just – that's (sexuality or gender identity) part of their life and they're quite happy with it, and it's got nothing to do with the (drinking) problem.
(SP6, statutory service)

However, a few statutory providers were not convinced about the salience of sexuality and gender identity in relation to drinking, seeming unaware of higher rates of substance use among LGBTQ+ people:-

I don't think there's any difference in terms of pattern of use [between LGBTQ+ and heterosexual people]
(SP11, statutory service)

What are service providers' experiences of asking about sexuality and gender identity?

Service providers perceived that sexuality and gender identity could be very sensitive issues to raise with clients. Statutory services did not routinely collect information about sexual orientation and gender identity as part of their assessment process as this is not required by law. Some third sector organisations collected such data while others did not. Despite potential difficulties, third sector providers argued it was important to collect information about gender identity and sexuality from all service users. This would demonstrate to LGBTQ+ clients that '*we are interested in people and their whole life*' (SP1, third sector) and enable services to evaluate whether they were reaching the groups with most need, and if not, to revise their policies accordingly:-

It's very difficult for services to know that they are reaching minority populations if they don't gather data on how they are reaching minority populations. And it's a two-edged sword ... We need to know that data so we can make sure that our information is relevant and targeted for that population. But we also need to know why people might not be accessing services. (SP5, LGBTQ+ third sector)

In contrast, many statutory service providers found it difficult and uncomfortable asking clients about sexuality and gender identity and, in some cases, had doubts about the necessity of asking such questions. They were concerned about 'getting it wrong' (SP15), making people feel 'defensive' (SP13) or upsetting people (SP6) if they asked about identity too directly or in a way which was perceived to be inappropriate:-

There is always that feeling you might upset someone.
(SP6, statutory service)

I think people sometimes feel so scared of getting it wrong ... They feel that just by getting something wrong, it means that they're a bad ... terrible, bad person.
(SP15, statutory service)

Because of these concerns, statutory service providers often preferred to ask more obliquely about relationships and living arrangements:-

I tend to say 'who's at home?' It's a less sort of brutal way of saying, you know, 'tell me if you're straight, tell me if you're married, tell me if you're, you know, whatever.'
(SP15, statutory service)

I'll ask 'are you living alone just now?' ... And they'll say 'I'm living with my partner' ... Just by the nature of the English language it soon becomes obvious whether, what gender they're talking about. (SP11, statutory service)

I never specifically ask about it but as part of our history taking, we ask about social circumstances. So are they in a relationship? Do they have a partner? ... I suppose there is the possibility that there are patients who do identify as LGBTQ+ (and) that maybe doesn't come out when we ask those questions. ... I've had a few instances where ... I'd maybe assume the gender (of a client's partner) ... and they'll correct you and obviously I always feel a bit embarrassed ... So I think it's nice just to make sure that you're not using the wrong pronouns for partners. ... Usually I just apologise ... and correct it afterwards. (SP13, statutory service)

As the excerpt above from SP13 demonstrates, this indirect approach could be unhelpful if service providers made incorrect assumptions. Other statutory service providers were even less direct, as they perceived that

clients would tell them if identity was salient for their drinking and would also choose what they wished to disclose ('depends on if someone wants to tell you'; SP12, statutory service):-

If it was important for the person it would be important for us. That's all we would want to know about.
(SP3, statutory service)

It's for the client to tell us if we need to know or not ... Sexuality and gender, I don't class it ... as a risky thing. ... It's only risky if people tell us it's risky. ... It should be part of a conversation ... , and it's just about how compassionately you go about it ... If we do it as a tick-boxy type of thing (asking directly about identity), would we really get the same quality of information (compared to) if it came out organically?
(SP8, statutory service)

Only one statutory service provider stated she would ask about sexuality and gender identity directly, because of the potential connections with mental health and alcohol consumption, and taught her trainees to do this too:-

I generally take the kind of psychiatric history-taking approach. ... Those kinds of conversations often develop into a broader kind of discussion about gender identity and sexuality. I always ask if it's not clear, whether or not their relationship is with the same sex or the opposite sex, and I always teach my trainees as well – 'this is something you need to ask directly to people, because it might not occur to them that it's relevant, or they might not want to speak about it'. Obviously we wouldn't force someone to speak about something they weren't comfortable with. It's actually a really important thing, because it might be something that they're struggling with, and is relevant to their mental health in general, and/or their drinking. ... And they recognise that they've got an alcohol problem, but they might not have joined that up.
(SP9, statutory service)

When statutory service providers encountered situations where they did not feel comfortable (e.g. discussions about chemsex: SP13), they asked colleagues for advice. Service providers who had LGBTQ+ identifying colleagues in their team said their presence enhanced the quality of their service:-

We don't have a specific member of the team or service specifically for LGBTQ+ clients, but we're quite a diverse team, we certainly have gay men and lesbians in the team, and that's actually been really helpful for when we're matching up clients, if their sexuality or their gender identity has been an issue that they've been struggling with, and may actually be part of why they've developed their alcohol problem. (SP9, statutory service)

Similarly, some third sector respondents believed LGBTQ+ service providers may be in a better position to provide support to LGBTQ+ clients. One respondent was frustrated by the argument that all clients, regardless of sexual or gender identity or ethnicity should be treated 'the same' and with the lack of knowledge some health professionals displayed:-

I've got a few gay clients ... and I know that the conversations I have with them they would not be having with most straight workers. (...) I think I'm at an advantage ... with an LGBTQ+ client, that there's a trust there. You can be more honest, you can be more open. ... I've had some staff members, it's a long time ago now, say, 'but we treat everyone the same.' ... That's not good enough, you know? Because we're not all the same. ... Our cultural references are different from yours if you're a 50 year old straight man or woman or whatever. To say that we treat everybody the same ... it's bullshit, in my opinion ... It's insulting. I've spoken at GP conferences, ... A GP practice (has) 2000 patients or more, and I've heard a GP say, 'Well I think I've got one or two (LGBTQ+ patients) You know? (SP10, alcohol third sector)

How can health professionals improve alcohol services for LGBTQ+ people?

Training

Both statutory and third sector service providers suggested that training around LGBTQ+ issues (particularly trans issues), communication skills and appropriate language would help service providers overcome their discomfort and fears about 'making a mistake' (SP13) and so improve the experience of alcohol services for LGBTQ+ people:-

I think just encouraging people ... to be not afraid to say really simple things like 'what should I call you?' Learning to communicate better is really important. (SP15, statutory service)

You feel like as their doctor you should know about this ... But when something's just so new, it kind of throws you off a bit ... It's not something I've really had much teaching on through medical school or as a doctor and I think not having knowledge makes us feel a bit uncomfortable and it probably makes them feel uncomfortable and then we don't get anywhere. (SP13, statutory service)

I think most service providers need a basic 'Trans 101' which enables them to not be frightened of dealing with trans people. (SP7, LGBTQ+ third sector)

Some third sector organisations had already taken this step. For example, one respondent reported ongoing training to raise awareness about 'additional stresses and traumas for LGBTQ+ people and ensure the (alcohol) service appears more open and welcoming to LGBTQ+ service users' (SP1). This training also aimed to address staff hesitancy about discussing sexuality with clients. Similarly, another respondent (SP2) described training to educate and reassure alcohol service staff (particularly older staff) who were concerned about LGBTQ+ issues being a 'minefield':-

There was some discomfort from staff about asking about sexuality on the referral forms and in sessions. But ... over the last year or so have been doing a lot of LGBTQ+ inclusivity work So I think now they're going to move back towards asking about sexual orientation on the referral form for counselling as well. (SP1, alcohol third sector)

Not everybody understands gay, lesbian, bi ... Some people didn't understand what the difference between transgender was and transsexual, and transvestite ... I thought that was explained quite well (in the training). (SP2, alcohol third sector)

Statutory service providers reported that while they had mandatory Equality and Diversity training, they did not have specific training around LGBTQ+ issues. They identified various training needs for themselves and other staff and suggested ongoing Continuing Professional Development (CPD) to increase knowledge of LGBTQ+ specific issues:

The chemsex thing was definitely a big gap in my knowledge. I think with patients who identify as transgender that's a topic that I think a lot of the psychiatrists feel that we don't know enough about. (SP13, statutory service)

Education of staff is important as well ... They'd probably be aware of the really obvious things like gay men and the risks of certain pills ... I'm not so sure that people know that gay women drink more. (SP15, statutory service)

Our key workers, though very competent, are quite narrow in their skill set ... They come from quite wide-ranging backgrounds, which is actually a good thing, whereas us doctors are still mainly white and middle-class ... But I think again, that comes with its own problems in again different perceptions of sexuality or gender or whatever else. So it is just maybe making a more robust training aspect of key workers. (SP8, statutory service)

Some of the (psychiatry) trainees might come from cultures where being gay or being bisexual is something that wouldn't be spoken about and wouldn't be necessarily acknowledged. So I guess you have to think about the trainee's own cultural experience as well. (SP9, statutory service)

Finally, one psychiatrist (SP14) was extremely cautious about engaging with issues which he felt he could not address properly. While he felt equipped to treat people's substance use problems, he argued there was a need for 'specific professionals' when working with trans patients:-

If the issue is connected with transgender choice ... I don't think that I am the best person. ... I will address their alcohol problem or drug problem. And ... parallel with that, I will look for additional support ... from psychologists ... This person will need further advice ... with his or her transgender problems after the addiction problems ... You (should) not engage in situations which you are not able to address properly ... So I think we need specific professionals ... who can advise us or take the case, rather than wait to be trained to do something ... The professional has to be very careful, because the impact of this (gender transition) ... is extremely long-standing and important (and) has to be addressed by very, very experienced people in this field. (SP14, statutory service)

Strategies to signal inclusivity

Service providers (from both the statutory and third sector) reflected during the interview on whether their services were effective in communicating they were LGBTQ+ friendly. Unsurprisingly, LGBTQ+ third sector service providers had experience of tailoring their services to LGBTQ+ people (e.g. having the pride and trans pride flags in their reception, LGBTQ+ social media and website banners) and communicating with LGBTQ+ people ('basically, we'll go wherever gay men are going' SP5, third sector). One respondent was very clear about the importance of signalling inclusivity ('If your front-facing material is wrong, people won't come ... it's not a case that you're offering a good or bad service. People don't get that far.' SP7, third sector). However, some respondents felt they could do more. For example, one statutory service provider felt that addiction services should be a 'haven' for LGBTQ+ people, but reflected on how effective his service was in communicating an inclusive message to the people they wanted to reach, while a third sector provider challenged his colleagues to rethink their website to demonstrate that LGBTQ+ people were welcome:-

I'd want sexual health services or ... any other services that has strong links with any LGBTQ+ communities to be directing people to us. And I don't get much of that, really ... I would be hoping that addictions can be a bit more ... LGBTQ+-friendly, and be a relative haven to accessing services, mental health and addictions at least. But it's getting that message across ... to both professionals but also service users ... I mean we wear the occasional rainbow lanyards and stuff like that but it always feels quite internal. (SP8, statutory service)

(To colleagues) Look, if I didn't work here, and if I was queer and I had an alcohol or drug problem, and I went on to our website ... if I type anything LGBTQ+ into our search engine ... (it) comes up with nothing. So as a queer person, or a trans person with an alcohol problem or addiction problem, coming to our website, what does that say to me? It tells me you don't give a fuck. So why would I come through your door? (SP10, alcohol third sector)

Many statutory service providers were aware that trans people suffer particularly high levels of alcohol-related harm but had limited experience of trans people in their services, which concerned them:-

Dr Elena Dimova, Dr Rosaleen O'Brien, Prof Lawrie Elliott, Dr Jamie Frankis and Prof Carol Emslie



There's a gender (identity) clinic ... and we don't have any direct links, even though I think there's ... reports that there is quite a lot of substance use in people who attend that clinic. And I don't know if maybe they're uncomfortable coming to ... our (alcohol) services?
(SP3, statutory service)

I've only had one client who has been transgender. So my experience of that is really limited. ... Statistically we know that someone that's transgender is at an increased risk of having an alcohol problem. If we are not seeing them, where are they presenting? ... There could be more formal promotion of the service, I think, for the LGBTQ+ community. ... Particularly for transgender clients. (SP9, statutory service)

In contrast, third sector service providers appeared to have more experience and a better awareness of the challenges trans and non-binary people faced when accessing services, including concerns about being misgendered, worry about being judged, and fear of transphobic attitudes from staff and from peers:-

I think it's harder for some trans people to access services. ... For some trans people who - and I hate the phrase - but who 'pass' better in their chosen gender, I think it makes things a bit easier. But I think for some of the trans community it's difficult.
(SP10, alcohol third sector)

It's possible for LGB people to go into a meeting and not actually have to talk about the fact that they're LGB and nobody's gonna notice, so they don't have the same risks associated, whereas a trans person, unless you're really lucky and you look beautiful or like Brad Pitt or ... unless you are this ... (...) So yeah, safety is a massive concern in a mainstream environment. (SP7, LGBTQ+ third sector)

Other suggestions for service improvement

Statutory service providers discussed the importance of having accessible, welcoming services which included LGBTQ+ people as part of staff teams and offered a range of options including women-only groups. Some commented on how the structure of some inpatient environments was currently particularly problematic for women and LGBTQ+ people:-

(The) combination of people with different needs ... women who've experienced a lot of trauma, ... someone who was trans, you know? These things can pose a lot of problems when you've got things like shared toilet facilities ... So I don't feel terribly happy with the structure of our ward. (SP6, statutory service)

I can think of one patient who ... left the inpatient unit ... early ... because there'd been some sort of homophobic remarks from another patient. The inpatient environment, there's a mix of like 15 people and they're quite often in a group room together ... Sometimes people might want to keep things private if they think they could be a target ... That shouldn't happen. (SP11, statutory service)

Third sector providers suggested that LGBTQ+ people face multiple levels of stigma both because of their identities (e.g. gender, sexuality, ethnicity) and because of their substance use. They experienced stigma from the communities they live in, from health and social care services and from wider society:-

(One client said), 'I'm too black to be gay, but too gay to be black' ... and he finds it difficult knowing where he fits, because (of) the racism in the gay scene, the homophobia in ... his black community. (SP10, alcohol third sector)

I think people with any substance use do face stigma ... in health service or in social work, social care services as well ... The work we do is to try and challenge ... that kinda stigma. As soon as they say they've got a substance use problem ... they don't get the same access to care and treatment that they would do, and they obviously flag up as a potential difficulty or ... they're gonna cause problems and to be watched more closely or whatever.
(SP3, LGBTQ+ third sector)

This made it particularly important that alcohol services should provide a 'place where people ... feel they could come free of any sort of judgement, or stigma.' (SP10, alcohol third sector). However, service providers had different ideas about how this should be achieved. Some third sector providers suggested that these multiple levels of stigma could best be addressed through a 'one stop shop for LGBTQ+ health', with a specialised, centralised centre which offered a wide range of services (e.g. gender clinic, sexual health, addictions, employability, debt, racism, family issues):-

Whether the best way to go about it is to centralise all LGBTQ+ health services in an LGBTQ+ centre ... (and) ... have the ... substance use project as part of that. ... Mental health, sexual health, alcohol and drugs, physical health ... it's all tied in together (so) ... it seems to make sense that you would just have a one stop shop for LGBTQ+ health. (SP1, alcohol third sector)

I think there needs to be at least the option for it (centralised LGBTQ+ health services) ... because otherwise you'll lose people who won't feel comfortable anywhere. Or will feel that they don't want to have to keep on explaining themselves. It's very stressful - and anxiety is quite linked to alcohol use, as I'm sure you know. And if somebody's anxious or avoidant, you have to make extra efforts to get them in, or ... you'll never see them again. (SP15, LGBTQ+ third sector)

Other third sector service providers believed that the best approach was to make mainstream services more inclusive. For example, SP2 suggested that silos (separate services for different groups) were not helpful because of the similar causes of alcohol problems across different populations and the similar pathways for treatment. He argued that tailored investment within mainstream services, for example a link psychiatrist who could refer clients directly to gender identity clinics, would be more helpful:-

We shouldn't go into silos ... because ... the root cause is very often very similar. Mental health problems ... not conforming to some norm, or ... trying to conform to some norm ... trauma and exploitation. ... And obviously trans people will have additional stresses. But people from ... disadvantaged backgrounds, they will have more stress in life (too). ... It's the same (advice about the) amount of safe alcohol, ... withdrawals ... DTs. It's the same mainstream services if you need to go into rehab or detox, it's the same pathway for everybody. ... I think the issues are generic enough ... There might be a need for specialist interventions. That's something that (mainstream services) could invest in ... Maybe we could have a link worker or a link psychiatrist who we could access regarding gender issues. ... Because obviously we're not a gender specialist service ... It would be so great, maybe we could have direct referrals to a gender clinic. (SP2, alcohol third sector)

Statutory service providers also argued that the best approach was for mainstream services to be more inclusive, rather than setting up new services. They highlighted the importance of needs assessments to establish the gap between what was currently offered and what LGBTQ+ clients needed, find out why they were not coming forward for treatment and identify possible solutions. They also stressed the need for pragmatism and commented that many teams across Scotland would not be big enough to support specific subpopulations:-

If they're (LGBTQ+ people) not getting into the service ... And if they're not getting the treatment they should get, why is that? And I'd like to repair that rather than start a new service for them. I think that would be better. (SP6, statutory service)

For our service I would think that we would be too small to have separate sub-teams ... But I think it's really useful for us as a team to recognise what groups have specific needs. And it might be useful to have an individual within the team who has a particular expertise or interest in working with that group. So there's a kind of resource for the whole team, to be able to access for information and advice. (SP9 statutory service)

There was also recognition that improving communication and the interface between alcohol services and other services was a key priority:-

One thing ... that is a problem, and this again isn't just LGBTQ+ but I think quite a lot of services, is interfaces between addictions and other services. (...) We don't have those kind of clear communication channels, which would be lovely, actually, to again just tap into each other's expertise and stuff and ... and avoid pitfalls. (SP8, statutory service)

Finally, both third sector and statutory service providers argued that upstream socio-structural factors needed to be addressed to improve LGBTQ+ people's health before they reached services ('you're getting folk at a point where a lot of damage has already been done': SP12, statutory). There was recognition of the damage caused by discrimination and homophobia. One respondent alluded to deep-seated attitudes about what it means to be a man in some parts of Scotland, and how that culture affects LGBTQ+ people growing up ('For every 100 miles North of London you go, you go back almost 10 years in attitude ... there's just that mentality of quite overt masculinity': SP10, third sector). Other respondents referred to the need for

a society which was '*compassionate and open-minded*' so that these values would trickle down to services, and the need for everyone to realise that '*LGBTQ+ people are members of the community like everyone else*':-

A lot of the things that bring people these problems aren't necessarily contingent on how good the addiction service is. It's more general societal issues ... you're getting folk at a point where a lot of damage has already been done.
(SP12, statutory service)

You want a society and a culture and government ... to be ... compassionate and open-minded about these things, which then trickles down into the way we practice, but nothing works like that obviously.
(SP8, statutory service)

The provision of alcohol-free venues for LGBTQ+ people was also mentioned as a way to reduce alcohol problems, and to provide social support for people who had stopped drinking:-

We need more safe or more alcohol-free space, for everybody. ... For most young LGBTQ+ people, their first connection with the LGBTQ+ community is either a pub or a club. Because there's nowhere else for them to go to meet other people who are like them. And that's a horrendous introduction to our community, you know?
(SP10, alcohol third sector)

How do young gay people address their alcohol problem, and then continue to feel that they've got a social support network? ... 'Cause there's not much point helping somebody stop drinking and then realise that they've got nowhere left to go, I ... (We need) a gay club that one night a week is alcohol free.
(SP15, statutory service)

LGBTQ+ people are members of the community like everyone else

Discussion

This is the first qualitative study to explore both the experiences of LGBTQ+ people who have used alcohol services in Scotland, and the views of service providers. Many service users perceived their drinking was closely associated with their LGBTQ+ identity, as a response to shame, stigma, or negative reactions from their family and also reported connected mental health problems. Some service users had positive experiences. However, they reported that service providers rarely asked about their sexuality or gender identity, and did not understand or explore how identity might impact on drinking and service use. Some service providers (particularly in statutory services) were uncomfortable discussing LGBTQ+ issues (particularly trans issues) because of a fear of 'getting it wrong' and upsetting clients, their belief that identity was not relevant to alcohol treatment or the perception that service users themselves would raise this issue if they felt it was relevant (see also Brooks et al. 2018; Meads et al. 2019; Somerville 2015). Both service users and service providers reported concerns about the reactions of other service users to LGBTQ+ people. There was widespread recognition that trans people were particularly stigmatised and barriers experienced by other LGBTQ+ people were amplified for this group. Service providers suggested that training around LGBTQ+ issues (particularly trans issues) would help them improve the experience of alcohol services for LGBTQ+ people. At a broader level, respondents wanted alcohol-free spaces in the LGBTQ+ community, and increased public acceptance and understanding of LGBTQ+ issues to reduce alcohol-related harm in this community.

Many people experience difficulties in recognising their drinking as problematic and seeking help, but our findings demonstrate these challenges may be magnified for LGBTQ+ people. First, in agreement with previous literature (Emslie et al. 2017), participants in our study referred to the '*alcohol fuelled gay scene*'. When culture reinforces drinking norms, it is particularly difficult for LGBTQ+ people to recognise alcohol-related problems and seek help. Secondly, given that stigma "*functions as an intersectional lived experience, tied to race, gender and sexual orientation*" (Cerezo & O'Shaughnessy 2021), 'coming out' as someone with alcohol problems may be particularly challenging for LGBTQ+ people. Berg & Ross (2014) refer to this process as '*coming out of the second closet*'. LGBTQ+ people may experience 'dual stigma', where they are constructed as 'tainted' or 'undesirable' both because of their sexual orientation / gender identity, and because of their substance use (see Daftary 2021 discussing this concept in relation to HIV and tuberculosis). People resist stigma by managing the information they share with others (Martos et al. 2018).

Previous experiences of heterosexism or cissexism may well lead to service users concealing their identity to avoid discrimination from health care professionals (Pachankis 2007; Scheer et al. 2020). This makes it particularly important that alcohol service providers ask clients about identity and acknowledge the broader societal and structural factors which influence drinking practices (see also Keogh et al. 2009), rather than focusing narrowly on alcohol consumption. Patient-centred care should establish aspects of clients' identities which are salient to them in the context of alcohol consumption (e.g. sexuality; gender identity; ethnicity; age and life stage; social roles such as parent, carer, partner) bearing in mind this will vary between people and over time (McAllister 2018). As Phillips (2021) argued recently "*it's time to get comfortable asking about gender identity and sexual orientation as routinely as we do about age, postcodes, and disabilities. While systemic rollout of monitoring will be fundamental to overcoming disparities and reducing the erroneous assumptions that negatively affect patients' experiences and outcomes, some responsibility still lies with the individual doctor*".

An important priority for many participants was ensuring anonymity and discretion when talking about substance use. While the pandemic hindered the provision of face-to-face alcohol services, for some respondents it highlighted the benefits of online Fellowship groups as a space to hear and draw inspiration from others without necessarily being seen or heard. McDermott et al. (2016) also found that LGBTQ+ adolescents valued the anonymity of going online, as they did not need to verbalise conflicting emotions and were free to leave at any time.

We have explored the experiences of alcohol services and peer support groups among LGBTQ+ people living in Scotland. Their experiences are likely to be transferable to other LGBTQ+ people across the UK. Many of our findings (e.g. centrality of alcohol to the LGBTQ+ scene, relationship between sexuality, gender identity and alcohol, desire for person-centred alcohol services) resonate with previous studies. However, like all studies, our research has limitations. Although we attempted to reach a broad range of LGBTQ+ people, our sample were all from the majority White population. We did not succeed in recruiting any non-binary people and the study would have benefited from a larger sample of lesbian and trans respondents. Due to changes in services as a result of the COVID-19 pandemic (e.g. services being suspended, increased workload, focus on supporting vulnerable clients) we were unable to recruit addiction nurses or key workers who support patients through the whole treatment process. It is also important to remember that the statutory and alcohol service providers who agreed to take part may have had particular knowledge of, or interest in, working with LGBTQ+ people.

Our study suggests that stereotypes of 'alcoholics' and 'problem' drinkers need to be challenged to encourage people to seek help at an early stage (see also Morris & Melia 2019; Schomerus et al. 2011). This may be particularly hard to achieve among LGBTQ+ people as the commercial LGBTQ+ scene normalises heavy drinking, leading to an overestimation of the quantity that peers drink (Boyle et al. 2020). In addition, health services need to provide open and non-stigmatising environments for LGBTQ+ people (e.g. inclusive waiting rooms, health professionals trained in LGBTQ+ issues). The use of inclusive and non-judgmental language is important for creating a trusting atmosphere, and this refers to discussing not only alcohol problems but also sexuality and gender identity. A systematic review of sexual orientation disclosure in healthcare found that communication, welcoming body language and visual clues (e.g. stickers, leaflets) facilitated sexual disclosure among LGBTQ+ people (Brooks et al. 2018).

Meads et al. (2019) argue that health practitioners should be aware that treating people equally does not mean treating them the same. Instead, they should tailor services for different groups. According to the Women and Equalities Committee (2019) there is a need for mainstream services to increase understanding of LGBTQ+ issues among healthcare staff. Our study and a nationwide survey of LGBTQ+ people in the UK

(Government Equalities Office 2018) highlight the need for more targeted support and increased understanding about how negative experiences of being LGBTQ+ (including homophobia and transphobia) may be associated with alcohol and drug use. Addressing these issues is particularly important in the context of the COVID-19 pandemic, which appears to be exacerbating inequalities in relation to sexual orientation and gender identity (Pink Saltire 2020; The LGBTQ+ Foundation 2020). One local example of a successful way to engage with services to increase inclusivity of LGBTQ+ people is the Glasgow LGBTQ+ Substance Use Partnership and the #KinderStrongerBetter health campaign, which aim to signpost substance use resources to LGBTQ+ people (<https://kinderstrongerbetter.org/>)

At a broader level, more efforts are needed to address equality for LGBTQ+ people. Future work needs to build on UK and Scottish Government commitments (Government Equalities Office 2018; Scottish Government 2021). Given that some LGBTQ+ people use alcohol to cope with negative experiences such as stigma, prejudice and discrimination (Bourne & Weatherburn 2017; Hamilton & Mahalik 2009; Kcomt et al. 2020), it is vital to address homophobia, biphobia and transphobia on a societal level to help address problematic substance use, rather than only treating the symptoms.

At a broader level, more efforts are needed to address equality for LGBTQ+ people

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Table 1 Participant characteristics

Pseudonym	LGBTQ+ identity	Age (years)	SIMD score*	Employment	Highest Education Level	Services used
Ash	Trans woman	>40	4	Self-employed	High school	Peer support group
Ben	Trans man	<40	5	Student	Undergraduate	Third sector organisations
Chris	Cisgender gay man	>40	2	Full-time	College	Statutory/Mainstream, third sector, peer support group
Daniel	Trans man	>40	1	Full-time	College	Statutory/Mainstream, peer support group
Eva	Cisgender bisexual woman	<40	8	Student	College	Statutory/Mainstream, peer support group
Fay	Cisgender bisexual woman	<40	7	Student	Undergraduate	Counselling
Greg	Cisgender gay man	<40	1	Student	College	Phoned a peer support group but did not attend
Harris	Cisgender gay man	>40	6	Furlough	College	Statutory/Mainstream, peer support group
Iain	Cisgender gay man	>40	-	Retired	Undergraduate	Statutory/mainstream but did not meet their criteria for treatment
Jake	Cisgender bisexual man	<40	3	Student	College	Statutory/Mainstream, third sector, peer support group
Kai	Cisgender gay man	<40	8	Unemployed	College	Statutory/Mainstream
Liam	Cisgender gay man	>40	-	Unemployed	Undergraduate	Statutory/Mainstream, peer support group
Mia	Cisgender lesbian	<40	3	Unemployed	Undergraduate	Statutory/Mainstream, peer support group
Naomi	Cisgender lesbian	<40	3	Unemployed	High school	Statutory/Mainstream, peer support group

*The Scottish Index of Multiple Deprivation (SIMD) identifies areas of multiple deprivation in Scotland. Decile 1 contains the 10% most deprived data zones in Scotland.
www.gov.scot/collections/scottish-index-of-multiple-deprivation-2020/

11 Appendix

Service users interview schedule

How can we improve alcohol services for LGBT+ people in Scotland? An interview study.

Interview schedule

1. Warm up

- Thank participant for taking time out of their day to meet/speak with you
- Tell me about you. Who do you live with? Where do you live?
- Why were you interested in helping us with this project?
- COVID19

2. Journey to alcohol treatment

- What led you to reach out to alcohol services?
- Ask participants very briefly what their drinking was like prior to engaging with the service and the impact it had on their lives (if appropriate ask about drugs)
- What help did you think you needed and might be able to get?
- What motivated you to seek help/support from this service?
- Where/who did you turn to? (Prompt about GPs, AA or anyone else)
- What were your expectations about this service (prompt about concerns and how comfortable the participant felt about reaching out to the service)
- What treatment did you receive?

3. Barriers and facilitators to alcohol treatment

- I'd like to talk about your experience of having alcohol treatment with this service. Can you tell me how it's been for you overall?"
- How did you access the service? How easy was it to access this service? Did you encounter any difficulties doing so? (prompt about practical barriers)
- Talk me through your journey with the service starting with your very first meeting. What happened? How did they work out what you needed? (Prompt about shared decision making)
- Did service providers ask about gender identity and sexual orientation? If not, did you disclose your gender identity and sexual orientation to your treatment provider? (encourage participant to reflect on this: if so, did you feel comfortable with this? If not, why not? Do you think your gender identity impacted the service you received? Prompt about experience of discrimination or stigma)
- In what ways did the service support you? What did this involve? (prompt about shared decision making)
- Has the service helped you with your drinking at all? In what way? /Why not?
- What has gone well in terms of your experience with the service? Did you encounter any difficulties throughout your journey with the service? (if relevant & appropriate, prompt about LGBT+ specific factors) /Was there anything you didn't like, or found unhelpful about the service?
- Were you offered the option to bring someone with you to the appointments? (e.g. loved one, friend) / Would you have liked to have the option? / Did you bring someone with you?
- Were you referred/informed/given contact details for any other services?
- Tell me the best and worst thing about your experience with the service.
- Do you have any suggestions for ways in which your experience could have been improved?
- If relevant, can you talk me through your discharge/leaving of the service?
- How is your recovery being supported now and by whom?

4. Early impact and drawing to a close

- What's changed in your life, if anything, since you attended the service?"
- Would you recommend this service to other LGBT+ people? Why/why not?
- Are you involved with any other services currently? What about community support groups or other forms of support?
- What support do you receive for your recovery?
- If money wasn't an issue, what kind of service would you want? (prompt discussion around LGBT+ -specific alcohol services, if relevant)
- Is there anything about the way your alcohol treatment was delivered that we haven't discussed, and which you think is important I here?

Service providers interview schedule

How can we improve alcohol services for LGBT+ people in Scotland? An interview study.

Interview schedule

- 1. Insight into help/support available to LGBT+ clients within the service**
 - Thank the participant for taking time out of their day to meet/speak with you.
 - Could you please describe your service to me and what it offers to clients with alcohol problems? What is your role within the service?
 - What treatment do you offer?
 - How often do you encounter LGBT+ clients?
- 2. Journey through the service**
 - How do people come to your service?
 - Does your service collect information about gender identity or sexual orientation?
 - How do you find out about your client's gender identity and sexual orientation? /What do you ask? (Probe around the perceived ease/difficulty of collecting such information; how comfortable they feel about asking about it and why)
 - Do you think service providers should know their client's gender identity? (probe around pros and cons of asking and knowing the client's gender identity and sexual orientation)
 - Could you describe the journey that a person would make through your organisation? (Probe whether this is different for LGBT+ folk: How would you support LGBT+ folk? Do you offer clients the option to bring a relative, friend or loved one to the appointment?)
 - Do you have any LGBT+ specific information, strategies, policies or staff training within your service? Have you been offered or accessed LGBT+ specific training? If yes, what was the impact on your practice?
 - Are there different or similar issues for LGB clients compared to transgender clients?
 - What do you look for to know when a client is ready to be discharged from your service?
- 3. Networks/Outreach**
 - What other networks/services do you work with? (probe about signposting to alcohol services and recovery services)
 - How do you decide where to refer people to?
- 4. Early impact and drawing to a close**
 - Do you provide any kind of follow up or after care? Do you have links to recovery groups?
 - If money wasn't an issue, what kind of service would like to see? Would you like to see any changes in the way that alcohol • treatment programmes are delivered in your service? (prompt about LGBT+ -specific services)
 - Do you think there is a need for specific alcohol services for LGBT+ people? Why? What kind of training do you think is needed to make the service as effective as possible for LGBT+ people?
 - Is there anything else you would like to say or add before we close?

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