



Open Research Online

The Open University's repository of research publications and other research outputs

Wasted opportunities: Problematic alcohol and drug use among gay men and bisexual men

Other

How to cite:

Keogh, Peter; Reid, David; Bourne, Adam and Weatherburn, Peter (2009). Wasted opportunities: Problematic alcohol and drug use among gay men and bisexual men. Sigma Research, London.

For guidance on citations see [FAQs](#).

© 2009 Sigma Research

Version: Version of Record

Link(s) to article on publisher's website:

<http://sigmaresearch.org.uk/files/report2009c.pdf>

Copyright and Moral Rights for the articles on this site are retained by the individual authors and/or other copyright owners. For more information on Open Research Online's data [policy](#) on reuse of materials please consult the policies page.

oro.open.ac.uk

Wasted opportunities

**Problematic alcohol and drug use
among gay men and bisexual men**

Peter Keogh
David Reid
Adam Bourne
Peter Weatherburn
Ford Hickson
Kathie Jessup
Gary Hammond

Original Research Report

Acknowledgements

Thanks to all the men who took part in the National *Gay Men's Sex Survey* 2007 (GMSS), and the large number of health promotion and community agencies that help to design and recruit to GMSS. Thanks also to the Terrence Higgins Trust who fund both GMSS and this project as part of the CHAPS Programme and to our CHAPS Partners who hosted the qualitative interviews: The Lesbian and Gay Foundation (Manchester), THT Midlands (Birmingham) and THT South (Brighton). Finally our sincere thanks to the men who agreed to be interviewed for this study and who gave generously and openly of their experiences.

Questionnaire pre-testing: David Reid and Gary Hammond. Thanks to the management, staff and customers of Barcode Vauxhall (London) and both the Kazbar and the Two Brewers in Clapham (London).

Booklet design: Design by Clifford Singer at Edition. Printing by White Horse Press.

Booklet distribution: Co-ordination by Kathie Jessup and Gary Hammond. Thanks to all the agencies that distributed the booklet version of the questionnaire.

Online survey design: David Reid at Sigma Research using www.demographix.com. Thanks to Derek Cohen and Bobby Pickering at Demographix for all their help.

Online survey promotion: Co-ordination by David Reid. Thanks to the agencies that volunteered their websites to promote the survey, free of charge, and to the various web-masters for making it happen. Banner ads and buttons were designed by Clifford Singer at Edition.

Database design: David Reid and Kathie Jessup.

Booklet data input: Kathie Jessup.

Data handling & management: Peter Keogh, Adam Bourne, Ford Hickson, David Reid and Peter Weatherburn.

Analysis & text: Peter Keogh, Adam Bourne, Peter Weatherburn, Ford Hickson.

Draft readers: For suggestions and improvements on earlier drafts of this report thanks to Catherine Dodds of Sigma Research and Will Nutland of Terrence Higgins Trust.

Funding: The survey was funded by Terrence Higgins Trust as part of CHAPS, a national HIV prevention initiative funded by the Department of Health.

Peter Weatherburn
Director



www.sigmaresearch.org.uk

This report is available to download at:
www.sigmaresearch.org.uk/go.php/reports/report2009c/

Published by Sigma Research ©
February 2009

ISBN: 1 872956 97 1



www.tht.org.uk

Contents

1	Introduction and methods	2
1.1	Aims of the study	2
1.2	Study methods	2
1.3	Sample descriptions	3
2	Research and policy background	4
2.1	Research background	4
2.2	The UK policy context	7
2.3	Summary	12
3	The extent of substance use and concern among MSM	13
3.1	Levels of use and concern	13
3.2	Multi-drug use	15
3.3	Summary	16
4	Unease and escape: the uses of alcohol and drugs	17
4.1	Mitigating social unease	17
4.2	Alleviating loneliness and unhappiness	19
4.3	Enabling sexual encounters	20
4.4	Gay norms of alcohol and other drug use	22
4.5	Summary	25
5	Harm associated with alcohol and other drugs	26
5.1	Accounting for problematic alcohol and other drug use	26
5.2	Identifying a problem	28
5.3	The harms associated with problematic substance use	30
5.4	Summary	37
6	Managing use, reducing harm and seeking help	38
6.1	Managing use to reduce harm	38
6.2	Seeking help	40
6.3	Summary	44
7	Conclusions and recommendations	45
	References	47

1 Introduction and methods

1.1 AIMS OF THE STUDY

This report describes the findings from a qualitative and quantitative study of alcohol and drug use among gay and bisexual men and other men that have sex with men (MSM) in England. The qualitative element describes the experiences and understandings of men who identified themselves as being concerned about their alcohol or drug use. The quantitative element shows the broader picture of use and concern about use among MSM. So we go from a broad picture of the extent of alcohol and drug use and concern about it, to a narrower and more detailed focus on men experiencing concern and problems related to alcohol and drug use.

The aims of the study are to qualitatively explore the contexts and attendant needs of men who are concerned about their substance use, to locate that use within the broader MSM population and to suggest ways in which the drug-related needs of MSM might be better met. So we have specifically recruited men who were concerned about their substance use and investigated the way these men used drugs and alcohol, what drugs and alcohol mean to them and the harms caused by drugs and alcohol. Many men, perhaps the majority, use alcohol and other drugs without any mishap or unhappiness. However, the range of experiences described highlight the pervasive and often detrimental role that alcohol and other drugs play in the social and personal lives of many men.

Although there is some research which examines the effects of substance use treatments on sexual risk behaviour (that is, do drugs services reduce unsafe sex), there is little or no research which investigates the accessibility, acceptability or effectiveness of current substance use services for gay men and other MSM. So in the qualitative interviews we also sought information about the role services played in meeting drug-related needs, for example information, motivational and practical support.

1.2 STUDY METHODS

The study used a variety of primary and secondary research methods. Background information was sought through a review of the academic and UK policy literature. We also conducted eight informal interviews with key stakeholders and these helped inform a review of UK policy documents on drugs and alcohol. The research and policy background are described in Chapter 2.

In terms of original data, we used both quantitative and qualitative methods. We collected quantitative data from men living across the UK in a large community-based sexual health survey of gay and bisexual men. The *National Gay Men's Sex Survey 2007* recruited using two main methods. The survey was produced as an A6 self-sealing booklet which was distributed by community health workers during their work with MSM. It was also advertised and completed online. The survey offered respondents a list of fourteen drugs (including alcohol) and for each asked if they had ever used the drug, used it in the last year and if they were currently concerned about their use of it. This quantitative data is reported in Chapter 3.

We used the online element of the survey to recruit men to the qualitative arm of the study. Men living in England who completed the survey online and who said that they had a problem with alcohol or any specific drug they used were told about the current study and invited to take part in a face-to-face interview. Men were asked to submit a name and contact telephone number or email address if they were interested in taking part. Overall, 679 respondents said they were concerned about their drug or alcohol use and of those 455 (67%) submitted contact details for follow up. We interviewed 40 of these men, focussing on men living in and around London, Brighton & Hove, Birmingham and Manchester, and using purposive sampling to ensure a range of drugs used were represented. We emailed or phoned all men who were not invited to interview and thanked them for their interest.

Face-to-face interviews lasting between one and two hours were conducted at our own or another agency's offices or at the respondent's home. The interviews covered:

- history of alcohol and drug use;
- social contexts of alcohol and drug use;
- perceptions of problems, difficulties and risks associated with alcohol and drug use;
- strategies to eliminate or minimise harm;
- intervention and service needs;
- experiences of interventions and service use.

With appropriate consents, all interviews were digitally audio recorded and fully transcribed. An overall thematic analysis was accompanied by a range of sub-group thematic analyses. The findings from the qualitative interviews, which form the bulk of this report, can be found in Chapters 4, 5 and 6. These three chapters quote extensively from the men we interviewed. Each quote is accompanied by the respondents age, HIV testing history and the drug or drugs he indicated were a concern for him at recruitment to the study (not necessarily the same as the drug or drugs he ended up talking about in the interview).

1.3 SAMPLE DESCRIPTIONS

The men who took part in the qualitative interviews are a sub-sample of the men who indicated they were concerned about their drug use in the survey. The characteristics of the men who took part in the survey (reported on Chapter 3) and of the forty men who were interviewed in-depth (reported in Chapters 4, 5 and 6) are summarised below.

		Quantitative sample (n=6155)	Qualitative sample (n=40)
Age	median	33 years	36 years
	range	14 – 87	15 – 57
Sexual identity (%)	Gay	86	98
	Bisexual	9	0
	Other term	4	2 ('queer')
	No term	1	0
Ethnic group (%)	White British	79	78
	White other	13	10
	Black	2	5
	Asian	2	2
	Mixed / other	5	5
HIV testing history (%)	Never tested	33	8
	Last test negative	57	75
	diagnosed positive	10	17
Current regular male partner (%)	No	56	55
	Yes	44	45
Area of residence (%)	Greater London	32	68
	Greater Manchester	4	20
	Greater Birmingham	5	8
	Brighton & Hove	2	5
	Elsewhere in UK	57	0
Problem substance (%)	Alcohol only	See chapter 3	65
	Alcohol & other drug/s		20
	Cannabis only		5
	Other single drug		10

2 Research and policy background

This chapter presents the findings of the research and policy reviews about MSM and substance use which set the context for what follows.

2.1 RESEARCH BACKGROUND

Given that, historically, homosexuality and alcohol and drug use have been strongly connected in policy and the public imagination, the research into psychoactive substance use among MSM is surprisingly sparse and narrow. Aside from prevalence studies, investigations have focussed either on the causes of problematic substance use (such as low self-esteem, depression and childhood adversity) or, more recently, on the connections between substance use and sexual HIV risk. There is little research which investigates either the social contexts of substance use (although see Redback *et al.* 2003, 2004; Halkitis *et al.* 2003; Parsons *et al.* 2004) or how men perceive their own substance use (whether he sees it as personally problematic, having an impact on his health or contributing to sexual or other risk behaviours).

2.1.1 Prevalence of substance use and associated problems

There has traditionally been an assumption that gay and bisexual men drink more and use more recreational drugs than the general population and indeed, various studies appear to demonstrate this. However, the evidence is limited and the majority of research concentrates on gay men of limited age range within major urban areas. Moreover, there is very little longitudinal research that explores problems associated with alcohol and drug use over time (but see Ostrow *et al.* 1993). Comparison of the gay population with that of the general population is made difficult by the fact that few population studies ask about sexual identity or the gender of men's sexual partners.

Research undertaken by Cochran *et al.* (2004) provides some evidence that lifetime substance use is higher among MSM than among men with opposite sex partners only. In terms of recent use, MSM are more likely to have used cocaine than non-MSM. MSM are also more likely to self-report perceived problematic substance use than non-MSM. In a review of American research ranging from the early 1970s to the mid 1990s, Bux (1996) describes a more complex picture. As regards alcohol, he concludes that gay men are less likely to abstain altogether than their heterosexual counterparts but are no more likely to be heavy drinkers than heterosexual men. However, he cites the limitations of most research in not examining the cross-cutting or confounding factors of race and ethnicity, social class, age and relationship status.

An indicator of the extent of need is the percentage of men who consider their substance use to be problematic. The 2005 *Gay Men's Sex Survey* showed that 29.6% of drinkers were concerned about their alcohol use and that concern was associated with frequency of use, rising to 36.9% among the men who drank more than weekly (which was 67% of the entire sample; Hickson *et al.* 2006). While far fewer men used other drugs, a greater percentage of those who did use them were concerned about their drug use (38% of ketamine users, 38% of GHB users, 39% of crystal meth users and 40% of crack users). The user groups least concerned about their drug use were poppers users (18% concerned) and marijuana users (21% concerned). The picture of need is therefore mixed. Significant proportions of men both use alcohol and are concerned about their use. A much smaller percentage of men use other drugs, but a significantly larger percentage of these are concerned about their drug use.

2.1.2 Causes of substance use problems

More evidence exists regarding the causes of problematic substance use among gay men. The research in this area considers four hypotheses about causality. The first ascribes problematic substance use to psychological or personal factors such as childhood sexual abuse, increased mental health morbidity, internalised homophobia or gender role confusion (see Williamson 2000 or Hughes & Eliason 2002 for a critique of this hypotheses). The second considers structural factors, such as overarching societal stigma and discrimination, in generating problematic alcohol and drug use (see McKirnan & Peterson 1988, Meyer 1995, Heffernan 1998, Stall *et al.* 2001, Rosario *et al.* 2002). A third set of hypotheses explore the social role of alcohol and drugs. For example, gay men are less likely to have normative adult roles such as parenthood that discourage substance use, and that certain periods of stress or personal liberation lead to greater substance use and experimentation, such as when coming out (Rosario *et al.* 2004). The final hypothesis about the prevalence of problematic alcohol and drug use among gay and bisexual men suggests sub-cultural factors such as the overwhelming orientation of the gay social scene to commercial venues where substances are widely available (Cabaj 1996) and the targeted advertising of alcohol to gay men (Adams *et al.* 2007).

2.1.3 Establishing associations between substance use and HIV risk

Considerable research effort has been spent on the relationships between alcohol and various drugs and HIV risk among MSM. However, most studies in this area are limited by methodological concerns (Bonell *et al.* 2008). Although research has shown a correlation between alcohol or drug use and sexual risk behaviour on a population level, the nature of this relationship remains contested. It is very difficult to establish controls in incident based studies. That is, is risky behaviour associated only with the presence of the drug or are there other factors at work? Even where drug use and sexual risk are recorded in the same sexual episode, many studies do not explore the direction of causality (whether a drug is taken because sexual risk is anticipated or expected, or whether the presence of the drug leads to unusual sexual risk in the individual). Finally, as poly-drug use is common, it is difficult to ascertain the relationship between use of specific drugs and sexual risk.

Purcell *et al.* (2001) sorted studies on the association between substance use and sexual behaviour into three types:

- (1) global association studies look at the link between overall substance use and sexual behaviour, without requiring them to have occurred at the same time;
- (2) situational association studies examine substance use in the context of sexual behaviour; and
- (3) event analyses examine a small number of specific sexual narratives for a link between substance use and sexual behaviour.

The first two approaches are most common but cannot explain direct causation. Studies of the third kind have been inconclusive. However, there are useful studies in all three categories.

Among global association studies Purcell *et al.* (2001) concluded that substance use is correlated with risk behaviour, that there are higher rates of substance use among those men who engaged in sexual transmission risk behaviour with casual partners, and a higher proportion of transmission behaviours among men who used certain substances. Chesney *et al.* (1998) attempt to interpret these types of correlations emphasising the effect of consistent use of substances over time on sero-conversion rather than one incident of use on sexual behaviour. They give three possible explanations: that long-term use may lead to needing more time and energy to achieve sexual orgasm and therefore a greater chance of rectal trauma; that using drugs may be associated with a tendency to risk taking; and that drug use and HIV exposure and transmission take place within the same socio-sexual networks.

There are also useful findings from situational association studies. Clutterbuck *et al.* (2001) found that men who smoked marijuana or used poppers less than two hours before sex were more likely to have unprotected anal intercourse (UAI) with an unknown or serodiscordant partner during a specific encounter. A similar study using accounts of critical incidents (Stueve *et al.* 2002), found that self-reports of 'being high' during a last sexual incident with a casual partner was associated with greater UAI.

In a situational study of young gay men, Rusch *et al.* (2004) found marijuana, crystal meth and ecstasy and ketamine were associated with 'sexual situation' UAI whereas alcohol was not. Colfax *et al.* (2004) conducted a study of HIV negative men looking at both global and situational association by examining participants substance taking backgrounds and their alcohol and drug use prior to a specific sexual encounter. They found that a range of variables were correlated with sexual HIV risk behaviour (such as education, age, numbers of sexual partners and levels of depression). Poppers, amphetamine and sniffed cocaine were also associated on an ongoing basis. The identification of underlying tendencies towards engagement in UAI allowed researchers to control for these variables in analysing specific episodes. They found that heavy drinking, amphetamine and cocaine use before or during sex were significantly associated with unprotected anal intercourse (UAI) with a risk of HIV transmission. An event analysis study of gay men with recently diagnosed HIV found an association between crystal methamphetamine, an erectile dysfunction drug and UAI with a 'main partner' (Drumright *et al.* 2006).

2.1.4 Accounting for an association between substance use and HIV risk

In a 1994 review of research, Rhodes and Stimpson acknowledged the correlation between substance use and sexual HIV risk but questioned whether this relationship was causal. They posit a social and cultural analysis to question the assumptions that underlie explanations of a causal relationship between substances and risk. They stressed the role of the situation (social setting) as well as the role of cultural norms. The interpretation and experience of the pharmacological effects of say, alcohol, are thus influenced by other frames of reference. Moreover, people's expectations of what is likely to happen when they are drunk or taking certain drugs will influence the outcome. Therefore what happens will be influenced by psycho-social issues (is the drug used to heighten sexual arousal or to impress, for example) and by the socio-cultural setting (in the bedroom or a sex club) and other material factors (such as sex for money exchange). In short the influence of alcohol or a specific drug will vary, in the context of who is giving it to who and in what context. In this context we must consider the beneficial as well as the negative effects of substance use in the negotiation of sexual behaviour. Therefore, there is a need to analyse the connection between individual expectations, risk perception and behaviour and the wider social relations which frame and structure those perceptions and behaviours. Bearing this in mind helps us to examine research in this area.

The purpose of drug use has been found to be important. Myers *et al.* (2004) asked gay men why they used drugs and identified six roles of drugs which ranged from facilitating sexual encounters to enhancing sexual experiences. Social context and situation are also significant. In a diary study of Australian sex workers, Minichiello *et al.* (2003) found that the types and amounts of drugs used during commercial encounters depended on a range of situational variables (such as where the customer came from or where the encounter took place). Personal and group characteristics are also important. For example types and patterns of substance use varies according to ethnicity, age (Celentano *et al.* 2006) and level of 'outness' (Thiede *et al.* 2003) as well as education and economic class (Ibanez *et al.* 2005). Moreover, regional differences have been found in the popularity of different drugs (Hirshfield *et al.* 2004) which in turn will be influenced by other demographic factors such as seasonal fluctuations in gay tourism (Colfax *et al.* 2001; Darrow *et al.* 2005). Finally, temporal factors may play a part. Some studies found significant reductions in the popularity and use of substances (marijuana, poppers, cocaine, downers, heroin and amphetamines) among gay men

between the mid 1980s and the mid 1990s (Remien *et al.* 1995, Crosby *et al.* 1998). This has been attributed to an increasing care of the self and a greater caution amongst gay men in the early years of the HIV epidemic.

There is also a long tradition of research into the relationship between substance use and sexual risk emanating from psychological disciplines. For example, a study of men in substance abuse treatment cited perceived disinhibiting affects of substances and learned patterns of association between drug use and sex (Paul *et al.* 1993) thus highlighting the importance of men's perceptions of the drug's effects and perceived efficacy. McKirnan *et al.* (2001) suggest that substances contribute to a 'cognitive disengagement' where men disengage with safer sex rules and norms. Substances can be used to avoid the stress associated with negotiating safer sex in the face of HIV (termed 'cognitive escape'). This might be particularly the case in men who expect alcohol to reduce their anxieties and use it for this reason. These authors argue that this kind of 'escape motivation' might influence the nature of the relationship between alcohol and risky behaviour. Regular substance use *per se* does not lead to risk. Rather, risk becomes pronounced primarily among men who report strong expectations of 'cognitive escape' via substance use. Substance use might therefore be a strategy to reduce painful self-awareness. Kalichman *et al.* (1996) suggest that sensation seeking (a tendency to seek novel, exciting and optimal levels of arousal) are either overridden by, or work in conjunction with, substances to lead to risky behaviours. Hayaki *et al.* (2006) explored the relationship between substance use and impulsivity and concluded that impulsivity was an independent risk factor among men who use substances (that is, separate to substance use *per se*).

2.1.5 Substance use interventions and treatments for MSM

There is a limited research into the appropriateness and effectiveness of substance use treatments and interventions for gay men and bisexual men. One influential study found that openly gay users of substance treatment services present to the service with greater frequency of substance use, a history of more mental health treatments, higher rates of homelessness, a greater likelihood of having been a victim of domestic violence and more physical problems than their other men (Cochran & Cauce 2005).

Other research examines the acceptability of interventions. For example, gay peer support and identity network interventions have been found to be acceptable both for young gay men (Eisenberg & Wechsler 2003) and gay men who are chronic drug users (Wright-Deaguerro *et al.* 1999). There is some evidence to support the acceptability and partial effectiveness of twelve-step programmes for gay men. Lyons *et al.* (2006) found that both numbers of partners and behaviours likely to lead to HIV exposure dropped as men entered twelve-step treatment programmes. However, from qualitative data, they conclude that this is as a result of fear of engaging in sexual encounters because they are associated with drug use rather than the result of the programme *per se*. Moreover, other studies found twelve-step programmes to be less effective for gay men and other sexual minorities. The authors suggest that this may be because such interventions with their roots in spiritual or religious doctrine will be less acceptable to this group (Holleran & Novak 1989). However, there is no research on whether gay-specific twelve-step groups are more efficacious for gay clients than generic twelve-step groups.

2.2 THE UK POLICY CONTEXT

National, regional and local responses to health and social harms associated with substance use are fundamentally shaped by central government policy. Drugs strategies are driven by concern about the ill-effects of drug use on communities, often through the crime associated with selling and funding the purchase of drugs. Services therefore tend to concentrate on potential users (usually children) and the harm (usually crime) caused to non-users rather than the harm (physical,

mental, social) to users themselves. Opiate services are the bedrock of most drugs services. At present, there are few drugs or alcohol services aimed at gay men and the extent to which generic services are accessible, acceptable and effective to this group is largely unknown. In this section, we briefly examine such policy in order to assess its capacity to generate services acceptable to, and appropriate for gay men and bisexual men.

2.2.1 Protecting families and communities: the National Drug Strategy 2008-2018

The ways in which a problem is defined and the solutions offered will, in turn, be influenced by the body charged with developing a response. In the UK, this response has been drafted from within the Home Office in the form of an integrated drugs strategy. As the Home Office has responsibility for drugs policy, policing, migration and counter-terrorism, it should not surprise us that this strategy characterises problems associated with illegal drug manufacture, transportation, sale and use in terms of damage to communities and crime. We might expect a strategy produced by the Department of Health (who have produced the national alcohol strategy) or the Department of Communities and Local Government to more closely reflect the drug-related issues that are of specific concern to those departments.

The national drugs strategy sets out its overall objective as to 'reduce the harm that drugs cause to society, including communities, individuals and their families.' The strategy prioritises aims and activities by concentrating on three areas.

- *The most dangerous drugs.* The drugs strategy characterises the most harmful drugs as opiates (such as heroin) and secondarily crack, cocaine and ecstasy.
- *The most damaged communities.* The operational definition of 'community' in the strategy is limited to geographically bounded populations (such as an inner city neighbourhood or a housing estate) or communities defined in terms of race or ethnicity. The vulnerability of these communities to the harmful effects of drugs are caused by poverty and deprivation and the individuals most vulnerable (and most affected) are considered to be young people and by extension their parents and families. The strategy operationally defines 'damage' in relation to communities in terms of breakdown of community cohesion and increases in drug-related crime, which exacerbates poverty and deprivation.
- *Individuals whose addiction and chaotic lifestyles are most harmful both to themselves and others.* Again, the notion of harm here is seen primarily through the prism of crime and secondarily in terms of health and personal well-being. Thus the problem is defined in terms of offending (crime to acquire drugs) and the proposed solution is the assessment, treatment and care of people in the criminal justice system.

The strategy has four aims centred on *Communities, Treatment, Young People* and *Availability*. The *Communities* aim of the strategy is implemented through the Drug Interventions Programme which seeks to get problematic drug users into treatment via the criminal justice system. The *Treatment* aim seeks to increase the numbers in treatment (and to increase treatment effectiveness). The *Young People* aim seeks to prevent vulnerable young people from becoming (problematic) drug users. Finally, the *Availability* aim seeks to reduce the supply of illegal drugs in communities. These aims lead to four over-arching public service agreements which, shape drugs services at all levels. Three are to change the population parameters around substance use:

- To have a sustained impact on the supply of Class A drugs to the UK, and availability within its communities, to reduce the harm that drugs cause.
- Reduce the use of Class A drugs and the frequent use of any illicit drug among all young people under the age of 25, especially by the most vulnerable young people.

- Increase the participation of problem drug users in drug treatment programmes and the proportion of users successfully sustaining or completing treatment programmes.

The fourth public service agreement is an over-arching goal to “reduce the harm caused by illegal drugs.”

We can assess the capacity of the strategy to meet the needs of gay men and bisexual men, for whom drug use is a problem, by considering how it defines and measures the harm associated with drug use. The Drug Harm Index (DHI) was developed in order to establish national indicators of the harms associated with drug use by bringing together a range of measures of drug-related costs to individuals and society. The DHI is used to monitor the success of the Drug Strategy. The DHI restricts itself to what is measurable and thus does not encompass all the harms that drug use generates, but rather a subset of harms for which data are already collected in government-sponsored surveys and surveillance. It is therefore an index of change over time, rather than an estimate of the absolute level of harm. Despite this, the harms measured by the DHI become those around which targets and policy coalesce. The indicators set by the DHI are outlined below, with the proposed means of measurement in brackets.

Health impacts

- New HIV cases due to intravenous drug use (IDU), including those infected through heterosexual sex with someone who contracted the disease through IDU (Health Protection Agency).
- New Hepatitis B cases due to intravenous drug use (Health Protection Agency).
- New Hepatitis C cases due to intravenous drug use (Health Protection Agency).
- Drug-related deaths (Office for National Statistics, ONS).
- Drug-related mental health and behavioural problems (Hospital Episode Statistics).
- Drug overdoses (Hospital Episode Statistics).
- Drug-related neonatal problems (Hospital Episode Statistics).

Community harms

- Community perceptions of drug use and dealing as a problem (British Crime Survey).
- Drug dealing offences (Recorded Crime Statistics).

Domestic drug-related crime (All British Crime Survey)

- Burglary.
- Theft of vehicle.
- Theft from vehicle.
- Bike theft.
- Other theft.
- Robbery.

Commercial drug-related crime

- Shoplifting (Crime & Justice Survey & Arrestee Survey).
- Burglary (Commercial Victimization Survey).
- Theft of vehicle (Commercial Victimization Survey).
- Theft from vehicle (Commercial Victimization Survey).

It is likely that the majority of harms associated with drug use for MSM do not fit into the Home Office’s definitions, nor are measurable using the DHI indicators. The specified health impacts are related to diseases transmitted through intravenous drug use, heterosexual sex and neonatally. However, injecting drug use and the use of opiates are comparatively rare among gay men and bisexual men and as sexual identity has yet to be included on ONS surveys and Hospital Episode Statistics, the profile of mental health problems and the prevalence of drug overdoses among gay

and bisexual men are not known. The ways in which drugs harm gay communities is less likely to be associated with crime than with health and well-being. Therefore, it should not surprise us that despite significant drug use and potential drug-related harm among gay and bisexual men, there are few services designed to lessen this harm.

The 2008 update of the drugs strategy shows signs of a growing awareness of the limited applicability of both policy and services to gay men and bisexual men. In an appendix on equality and diversity, the strategy notes significant gaps in the evidence regarding patterns of drug use among sexual minorities and commits to commissioning qualitative research into the experiences and needs of lesbian, gay, bisexual and transgendered drug users accessing services (among other groups). It also calls for enhanced monitoring in respect of this group and commits to improving local equality practices (through equality impact assessments and bench-marking exercises) in respect of drug services.

2.2.2 Equalities mechanisms in delivering the National Drug Strategy

Overall responsibility for delivering the strategy lies with the Home Office supported at a central government level by the Department of Health, the Department for Education and Skills and the Treasury, and at a judicial level by the police service and HM Courts Service.

Local responsibility for delivering the strategy falls to Drug Action Teams (DATs) who are made up of representatives from local authorities (education, social services and housing), the health services, the Probation Service, the Prison Service and the voluntary sector. The 149 English DATs have been aligned with local authority boundaries since April 2001. DATs ensure that the work of local agencies is brought together effectively and that cross-agency projects are co-ordinated successfully. They take strategic decisions on expenditure and service delivery within four areas of the Drug Strategy: treatment, young people, drug-related crime and supply. DATs are supported by Home Office teams and centrally by the Crime and Drugs Strategy Directorate.

The Crime and Disorder Act 1998 (amended 2002) requires responsible authorities to work with local agencies and organisations to develop and implement strategies to tackle crime, disorder and drug misuse. These statutory partnerships are known as Crime and Disorder Reduction Partnerships (CDRP). In Wales, they are known as Community Safety Partnerships. The responsible authorities are: police forces; local authorities; fire authorities; police authorities; and Primary Care Trusts (in England) or Local Health Boards (in Wales). These authorities are required to work in co-operation with local education and probation authorities and to invite the co-operation of a range of local private, voluntary and community groups and other public bodies. In unitary authorities, DATs and CDRPs are expected to integrate. This may mean that they merge to become a single partnership, or that they opt to align existing structures locally. In two-tier areas, DATs and CDRPs work closely together.

All partnerships are required to develop a diversity action plan which assesses the needs of the local population, produces a diversity statement, consults, represents, establishes equalities outcomes and performance monitors and promotes identified good practice. However, at present partnerships are required only to monitor on the grounds of race and gender and not on sexual identity.

Although more central equality mechanisms are in place to ensure that the Drug Strategy does not lead to unequal treatment or discrimination, these are primarily concerned with compliance issues rather than tailoring services to meet specific needs of minority groups. Moreover, the majority of these mechanisms and groups are concerned with race equality issues and in particular the impact that a concentration on drug crime has on ethnic minorities (examples include, the race and diversity strategy, the visible minorities' confidence in policing group, the stop-and-search group, the racist incident group, the police, security and Islamophobia group).

Additional equality mechanisms include the Diversity Lead's Forum (nine government office representatives from the regions), an Equality and Diversity Scrutiny Panel and consultation with some voluntary groups (for example, The Federation and Drugscope).

2.2.3 *The Alcohol Harm Reduction Strategy for England*

The responsibility for drafting and delivering on the national alcohol strategy falls to the Department of Health. Like the drugs strategy, it seeks to describe and reduce the harms associated with alcohol use. Because alcohol is not illegal, the strategy attends equally to harms related to health, social cohesion and crime. The strategy concentrates on:

- harms to the health of individuals;
- crime, anti-social behaviour, domestic violence, and drink-driving and its impact on victims;
- loss of productivity and profitability; and
- social harms, particularly problems within families.

These harms are linked to costs associated with alcohol misuse which include policing costs, alcohol treatment costs, accident and emergencies, working days lost and suicide. The strategy takes a broad approach, attempting to engage various stakeholders on many different levels. Aims and interventions include:

- **Improving education and communication**

The strategy stresses the need not only to educate, but to create the social conditions where individuals are enabled to make healthy choices. Interventions include public information messages, information provided by the drinks industry, school education, workplace interventions, and legislation about alcohol advertising.

- **Improvements in diagnosis and treatment**

Interventions include piloting of early diagnosis interventions; increasing knowledge and awareness among health staff; auditing alcohol treatment; improving and standardising commissioning and monitoring of alcohol services; developing integrated care pathways for vulnerable people; and improving the detection and diagnosis of problematic alcohol use at key points in the NHS.

- **Combatting alcohol-related crime and disorder**

This is intended to be achieved through fixed penalty notices and anti-social behaviour orders, developing a code of good practice for licensees, engaging with local authorities, improving alcohol education for young people, and providing better socialising alternatives for young people.

The alcohol strategy cites evidence for two types of drinking behaviours considered as problematic. Binge drinkers are at increased risk of accidents, alcohol poisoning, violence and sexual assault. Chronic drinkers tend to be older and are at increased risk of a variety of health problems such as cirrhosis, cancer, haemorrhagic stroke, premature death and suicide.

In addition, the alcohol strategy identifies a range of vulnerable groups such as ex-prisoners, street drinkers, survivors of childhood abuse, children of those who misuse alcohol and young drinkers. It argues these groups are more likely to have problems with alcohol and they are more likely to experience a whole range of other problems, such as mental illness, drug use and homelessness. However, the strategy does not identify patterns and social contexts for problematic drinking among different social groups (for example, sexual and ethnic minorities, young women, older men *etc.*).

A specific investigation regarding sexual minorities is required to identify the ways in which the various interventions cited in the alcohol strategy could be applied to this population.

2.2.4 Implementing the Alcohol Strategy

At a government level, although the strategy is the responsibility of the Department of Health, it seeks to join up the disparate activities of a number of departments on alcohol including the Home Office (crime), the Department of Communities and Local Government (planning and local night time economies as well as services to vulnerable people and the homeless), the Department of Education and Skills (schools and educational settings), the Department for Transport (dealing with drink-driving), the Department of Culture, Media and Sport (Licencing) and the Treasury (setting levels of alcohol excise and VAT).

On a local level, responsibility for delivering the alcohol strategy falls to a variety of partnerships. The Home Office requires integration or closer working of Crime & Disorder Reduction Partnerships and Drug & Alcohol Action Teams (or Drug Action Teams). Drug & Alcohol Action Teams set standards for and commission treatment services in around 70% of areas of England. Local Strategic Partnerships provide an overarching and voluntary forum for co-ordination of local priorities. However, they do not have statutory responsibilities.

2.3 SUMMARY

Disappointingly, at a national level, neither the drug nor the alcohol strategy are orientated toward creating the infrastructure whereby drugs and alcohol-related harm for gay and bisexual men are addressed. This is because both strategies employ narrow conceptions of harm and of affected communities and groups. It is essential that national policy stop defining communities only in terms of their geographical, ethnic or economic characteristics and include 'communities' based on identity or culture (such as gay men). Because national policy is not oriented towards measuring and meeting the needs of gay and bisexual men (among other groups), national and local services are not organised or delivered in a way which addresses these needs.

3 The extent of substance use and concern among MSM

This chapter locates the findings of the in-depth interviews that form the main body of this report within the wider context of the gay and bisexual population. We do this by looking at answers to drug use questions in the *National Gay Men's Sex Survey 2007* among the much larger group from which the men interviewed were recruited.

The final sample consisted of 6155 men aged 14 and over, living in the UK, who had sex with a man in the last year and/or identified as gay, bisexual or some other non-heterosexual identity. The demographic description of the men is given in Section 1.3 above.

3.1 LEVELS OF USE AND CONCERN

Men were presented with a list of fourteen drugs and were asked to indicate for each of them whether they had ever used it, whether they had used it in the last year and whether they were currently concerned about their use of the drug. The following table shows the findings from these questions, ordered by the proportion of men who had used the drug in the last year.

Use and concern (n=6155, missing 51)	% ever used	% used in last year	<i>% of ever used who had used last year</i>	% concerned about use of that drug	<i>% of users in last year who are concerned about that drug</i>	<i>% of users who are concerned about ANY drug</i>
Alcohol	92.7	84.7	<i>91.4</i>	11.1	<i>13.1</i>	<i>18.8</i>
Amyl nitrite	62.8	42.0	<i>66.9</i>	3.6	<i>8.6</i>	<i>25.4</i>
Cannabis	56.4	27.7	<i>49.1</i>	2.7	<i>9.7</i>	<i>30.4</i>
Cocaine	34.5	21.2	<i>61.4</i>	2.8	<i>13.2</i>	<i>35.1</i>
Ecstasy	34.4	20.7	<i>60.2</i>	2.6	<i>12.6</i>	<i>34.2</i>
Ketamine	20.5	12.2	<i>59.5</i>	1.9	<i>15.6</i>	<i>39.6</i>
Amphetamine	29.3	9.5	<i>32.4</i>	1.4	<i>14.7</i>	<i>40.1</i>
Tranquillisers	21.1	8.7	<i>41.2</i>	1.7	<i>19.5</i>	<i>42.5</i>
GHB / GBH	12.9	7.0	<i>54.3</i>	1.8	<i>25.7</i>	<i>46.3</i>
Crystal meth	9.5	4.7	<i>49.5</i>	1.9	<i>40.4</i>	<i>54.5</i>
Magic mushrooms	18.7	3.9	<i>20.9</i>	1.2	<i>30.8</i>	<i>49.8</i>
LSD	17.3	3.9	<i>22.5</i>	1.4	<i>35.9</i>	<i>56.1</i>
Crack	6.8	2.8	<i>41.2</i>	1.6	<i>57.1</i>	<i>70.3</i>
Heroin	5.7	2.3	<i>40.4</i>	1.7	<i>73.9</i>	<i>85.6</i>

The three additional columns (figures in italics) show the proportion of men who had ever used that drug who had used in the last year (an indicator of currency of use), the proportion of those who used in the last year who are concerned about their use (an indicator of relative rather than absolute concern in the population) and the proportion of users of that drug who are concerned about their use of any drug or alcohol (an indicator of the extent of concern arising from multi-drug use).

We can make a few general observations from these data. Firstly, these men have a relatively high familiarity with illicit drugs. Three quarters (76.1%) of the men had ever used at least one of the thirteen drugs other than alcohol on at least one occasion. Exactly half (50.5%) had ever used at least one of the eleven drugs other than alcohol, amyl nitrite or cannabis.

The three most commonly used drugs (both ever taken and taken in the last year) were alcohol, amyl nitrite and cannabis. However, these three drugs were also the three drugs least likely to cause concern in their users.

As a proportion of those who used the drug in the last year, the three drugs which were most likely to cause concern in users were heroin, crack and crystal meth. Users of these three drugs were much more likely to be concerned about their use than users of alcohol, cannabis and amyl nitrite. However, because relatively few men used them, they generated overall fewer men concerned about their use.

So, for example, although 73.9% of heroin users were concerned about their heroin use, only 2.3% of men used heroin in the last year, resulting in 1.7% of all men being concerned about heroin use. On the other hand while 'only' 13.1% of alcohol users were concerned about their alcohol use, 84.7% used alcohol in the last year resulting in 11.1% of all men being concerned about alcohol, six and a half times more than were concerned about heroin use.

This brings us to the prevention and care paradox associated with drug use. Community, research and policy responses to drugs tend to focus on those drugs with a high potential for harm in their users (and usually a corresponding capacity for dramatic media stories). Most recently, this focus has been on crystal methamphetamine. However, although harm is less likely with many other drugs, if they are far more commonly used their contribution to overall drug-related harm may be much larger. Fortunately, drugs that cause concern for a large proportion of their users are used by relatively few people.

Overall, 16.9% of men indicated they were concerned about their use of alcohol and / or other drugs. As can be seen from the table 11.1% were concerned about their alcohol use. This is a larger proportion of respondents than the proportion concerned about the use of *any* of the other drugs, which was 8.6%. That is, 8.6% of men said they were concerned about one or more of the other thirteen drugs. Alcohol caused concern for more men than all the other drugs did together.

3.1.1 Age and recent use

All drugs were used across the age range, with users of every drug in each of the age bands. However, the patterns of use across the age range varied widely by different drugs.

Six drugs were significantly ($p < .05$) more commonly used by younger rather than older men: alcohol, cannabis, cocaine, ecstasy, amphetamine and magic mushrooms. For these six drugs, the group of men who used the drug in the last year were younger than the group of men who did not.

However, it was not the case that the youngest group of men most commonly used all these drugs.

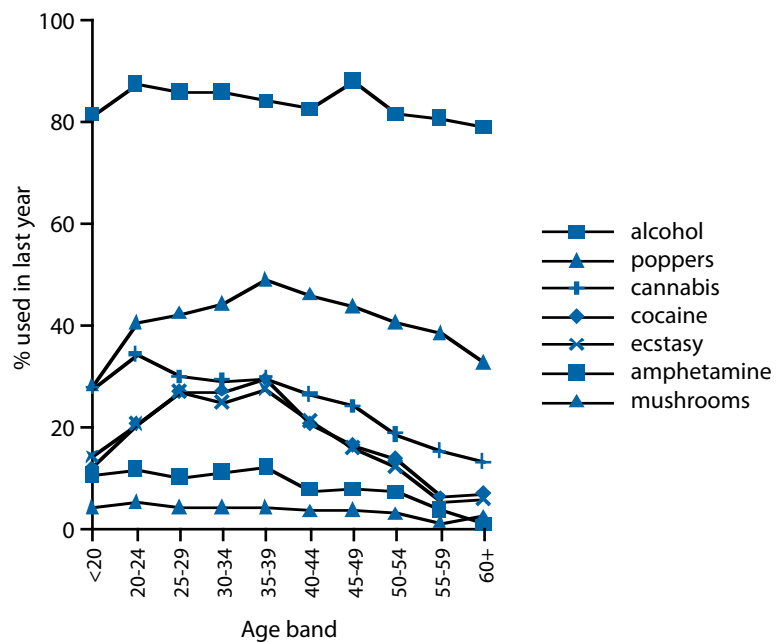


Figure 1: Drugs for which users were younger (or older in the case of poppers) than non users – annual prevalence of use across the range.

Figure 1 shows the proportion in each age band who used each drug, for which users were older or younger than non-users. Alcohol, cannabis and magic mushroom use peaked in the 20s, while cocaine, ecstasy and amphetamine use was most common among men in their 30s. Only one drug was more popular among older men rather than younger men: amyl nitrite users were marginally older than non-users (median age of 34 years versus 32 years). Its use was also most common among men in their 30s but its use did not decline with age as dramatically as for other drugs.

Users of the less commonly used drugs (crystal meth, crack, GHB/GBH, heroin, ketamine, LSD and tranquillisers) were not, as groups, older or younger than non-users.

However, the use of ketamine, tranquillisers, GHB/GBH and crystal meth were all highest among men in their 30s, then the 20s and 40s and lowest in teens and over 50s (see Figure 2 and note the change of scale on the side axis).

The use of LSD, crack and heroin were remarkably flat across the age groups.

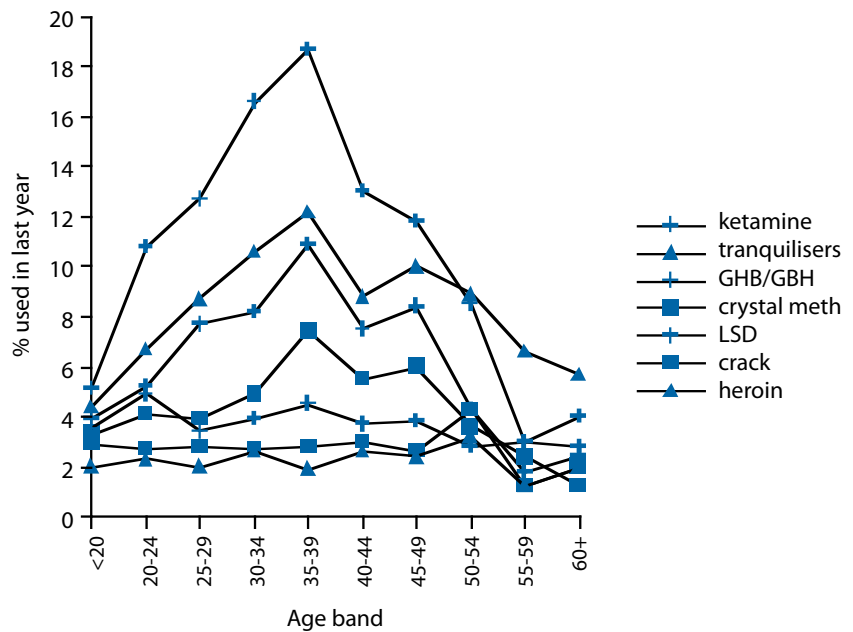


Figure 2: Drugs for which users were not older or younger than non-users: annual prevalence of use across the range.

3.1.2 HIV testing history and recent use

All the drugs except alcohol, heroin and magic mushrooms were significantly more commonly used in the last year by men with diagnosed HIV than those without diagnosed HIV (use of these three drugs were equally common in the two groups). Positive men were almost twice as likely to have used tranquillisers (odds ratio 1.86), crack (odds ratio 1.93) and amphetamines (odds ratio 1.97) in the last year, more than twice as likely to use cannabis (odds ratio 2.07), LSD (odds ratio 2.09), poppers (odds ratio 2.31) and ecstasy (odds ratio 2.83), over three times more likely to have used cocaine (odds ratio 3.15), GHB/GBH (odds ratio 3.79) and more than four times more likely to have used crystal meth (odds ratio 4.20) and ketamine (odds ratio 4.32).

3.2 MULTI-DRUG USE

Men who use drugs tend to use a variety of drugs. Few men used one drug only, other than alcohol. Among the men who took part in the survey, use of every drug in the last year was positively and significantly associated with use of every other drug, excepting that alcohol use was not associated with use of crystal meth, crack or heroin. That is, for any of the fourteen drugs, users of that drug were more likely than non-users of that drug to have used every other drug (except that users of alcohol were not more likely to have used crystal meth, crack or heroin and vice versa).

The two drugs most strongly correlated were ecstasy and cocaine: 76% of men who had taken cocaine had also taken ecstasy and 78% of men who had taken ecstasy had also taken cocaine.

The seven drug pairs most closely associated with each other formed three groups: what we could call the club drugs (ecstasy, cocaine, ketamine, GHB, crystal meth); the hallucinogens (LSD and mushrooms); and heroin and crack. Future analysis of drug use patterns may profitably use these categories of drugs for describing patterns and change.

3.3 SUMMARY

Use of illicit drugs is fairly common among gay and bisexual men, with half having used at least one drug in the last year other than alcohol, amyl nitrite or cannabis. Men living with diagnosed HIV are much more likely to use almost all drugs, and use of most drugs peaks among men in their thirties. The less commonly used drugs are more likely to raise concern among users. However, because alcohol is almost universal, it generates more concern in the population than drugs usually thought of as more problematic, such as heroin or crystal meth.

4 Unease and escape: the uses of alcohol and drugs

In this chapter, we explore what men use alcohol and other drugs for. What does substance use do for them, and what does it allow them to do? Of particular interest is the role alcohol and drugs play in their lives and how they enable them to handle the range of contexts they encounter as gay and bisexual men.

Our respondents described a range of uses for alcohol and other drugs which fell into three categories: dealing with social unease, escaping boredom and other negative feelings (stress, depression, loneliness) and dealing with sexual unease. These themes are covered in sections 4.1 to 4.3.

In this chapter, we also deal with how gay social or sexual norms facilitate alcohol and other drug use. To what extent are they integral to gay social life as experienced by our respondents. An account of the ways in which gay social and sexual norms facilitate alcohol and other drug use for our respondents is presented in section 4.4.

4.1 MITIGATING SOCIAL UNEASE

The overwhelming majority of men said that they used alcohol and drugs to help them to relax and to be more sociable.

So it is more of a social thing. I think of alcohol associated with having fun normally [...] just like a joke you might have told half an hour ago, two drinks later and it might just be a bit funnier.

[aged 22, last test negative, alcohol & ketamine]

This seemingly banal description of alcohol and other drugs as ‘social lubricant’ is worth exploring because it reveals some men’s deeper unease, with themselves and the social environment they find themselves in. Many men talked about using substances in order to enter gay social scenes. This was often connected with coming out.

I think [coming out] put me into a new world that I wasn’t very confident about and a new... a new set of pressures that I hadn’t experienced before. [I didn’t feel] that I understood what was going on... on the gay scene [...] how it all worked and feelings of insecurity about the way I looked and that kind of stuff which would have led me to definitely drink more. [I felt] self-conscious of the way I looked, self-conscious about the way I was behaving, what was going on, you know, and still feeling a little bit because it had been quite a difficult process, coming out to my family and friends, still sort of having some feelings of anxiety around them.

[aged 35, last test negative, alcohol]

Other men talked about using substances in order to deal with very conflicted feelings they had about their emerging sexuality.

I started taking a lot of drugs on a regular basis, from about seventeen and a half to eighteen onwards. I was becoming more and more mentally unbalanced. Because I hadn’t come out to anybody. And I was extremely confused about what I was supposed to do about my sexuality. I suspect that’s another reason why I was taking a lot of drugs. I was trying to escape from that in some way. Not that drugs are a direct escape route from coming to terms with your sexuality. But it does help maybe to block your sexual drive. Especially if it’s... if you... if there is nowhere to put it to use. I think what I was confused about really was that it wasn’t whether or not I was gay. That was fairly obvious. I knew from quite early on.

[aged 25, last test negative, alcohol]

Men also talked about substance use to deal with a deep sense of personal insecurity. Indeed, the capacity to drink or take drugs in social situations could often go hand-in-hand with social identity and social esteem.

I feel the need to get drunk really to, to lose concerns about, about the environment I'm in and about me being gay.

[aged 18, last test negative, alcohol]

This man uses alcohol to shield himself from perceived persecution, or criticism experienced in the gay venues he uses.

I wouldn't go into a gay club sober [...] because I think people are looking at me, staring at me, saying things [...] I'd feel as though I'm being judged as I walk in. [...] Because when you walk into a gay club, everybody's looking for that next bit of eye candy that walks in [...] And in my opinion I'm not. I wouldn't want people to think that, you know uugh. So when you're on coke or something or you're drunk or you're tipsy you don't care so much. It goes over your head a bit more. [...] I'm acting happy. But I'm not happy because I'm happy, I'm happy because I'm on drugs.

[aged 35, never tested, alcohol]

Because of his unease with gay venues, the following respondent avoided them unless he was away from his normal social network or routine. He suggested that his unease caused him to drink much more than he normally would.

So you were saying before that actually you're quite talkative and that you're reasonably good in social situations?

Yeah. But it's when I go to the gay bars I'm not.

OK. Why is that the case?

I don't know. I think I feel pressurised. I feel my age, how old I am and sort of single at the moment [...] if I go into a straight bar I'm more comfortable.

So is most of your socialising then in straight places or gay places?

It depends. If I'm away with work then I'll go to gay bars. If I'm on my own in a hotel and nobody knows me. But like last week it was straight places that I went to.

Are you likely to drink in a gay place or a straight place?

If I'm on my own and I wasn't meeting friends, then I would probably go to a gay place. But I'm more likely to drink in a gay place than I would be in a straight place. Straight places I wouldn't feel uncomfortable with a bottle of water [...] where in a gay place I feel like I have to order a gin and tonic.

[aged 38, last test negative, alcohol]

Thus one of the main uses of substances was to deal with an over-arching sense of social unease on the gay social or commercial scene. Such an unease ranged in severity from a certain nervousness to strong feelings of discomfort or persecution.

Alcohol and drug use also enabled men to socialise more, while holding down busy jobs. Men reported using alcohol and drugs to maintain their social and work life during the week, often after heavy use at weekends. Some talked about using cocaine at the end of the working day, in order to find the energy to socialise. Others described drinking at lunchtime as a means to get through a workday, with a hangover or a drugs-related comedown.

And you're knackered and you can't work and then of course you think well maybe if I had a drink... and then you know [...] And then it's simply just a self-fulfilling prophecy of a downward spiral.

[aged 31, last test negative, alcohol]

Alcohol and cocaine were also used to keep awake while men were out in gay venues.

And it enables you to have some time for you and like go meet up with your friends or if you drink longer because if you've been working all day sometimes you're just really tired and you want to go to bed but you also want to have some time to yourself so it kind of facilitates that as well.

[aged 34, last test negative, alcohol & cocaine]

So substances are used to manage anxiety when out on the gay commercial scene. Rather than being havens of tolerance, gay venues were often experienced as sites of personal discomfort and unease. Alcohol and drugs were also used to manage the negative states they themselves generated, such as tiredness and lethargy, thereby providing a negative feedback mechanism for dependency. Also some men felt their substance use enabled them to socialise (or party) while holding down demanding jobs.

4.2 ALLEVIATING LONELINESS AND UNHAPPINESS

Like many people, the men in our sample used drugs and alcohol to escape negative or distressing feelings: as a form of insulation or sedation. The majority of the men talked about using substances to relieve boredom and isolation or to help them sleep. This was especially common among older men, and those who were not working or who had experienced illness.

Well I just get so bored here at times [...] and when you're sitting here looking at that box [television] day in, night in, night out. We don't have an uninteresting life, I mean we travel a lot, but sometimes you know [partner] works shifts and my friend moved [away] [...] I'm not one to go and stand in the pub on my own [so] it's drinking at home really.

[aged 45, diagnosed with HIV, alcohol & tranquillisers]

Similarly the following man talks about using alcohol to escape negative mood states and to relieve boredom. He feels his HIV infection means he will never find a partner.

Whereas if I limit it to the evening I seem to be able to keep that... and it's when I'm bored. When I'm a bit lonely. When I've nothing really to do. When I'm feeling stressed out after a hard day's work, whatever I'm doing. And then at that stage, yeah you just want to let go and it gives you an immediate ... it relaxes you immediately.

And that relaxation is?

I guess again it's about forgetting where you are. Forgetting the situation you're in. Because sure, I would far rather be, I guess you know, spending the evening with a partner or there's a lot of things I would rather be doing. But you just get to a point where you know it's not going to happen. [...] And so what the hell. You might as well. As long as you don't drink enough that you're going to be in a state the following day.

[aged 45, diagnosed with HIV, alcohol]

Others resorted to alcohol to deal with the stresses of their jobs.

My other job is a social worker, which can be quite stressful at times [and] so sometimes I come home after a particularly difficult day... emotional stuff with people and I then think I need a drink. [...] I don't know whether worrying about [how much I drink] has heightened my awareness of it so there's a kind of pressure about not drinking as well [...] because, 'Oh fuck it' you know I can't maintain this and I want to have a drink, 'Why shouldn't I have a drink?', that sort of stuff.

[aged 49, last test negative, alcohol]

4.3 ENABLING SEXUAL ENCOUNTERS

Men used alcohol and other drugs to cope with a range of issues around intimacy, sex and sexual negotiation. How to meet and approach possible partners was widely discussed by respondents.

Whereas you wouldn't normally like, approach somebody or just like have a chat or whatever, alcohol sort of makes you think, 'Oh, you know I might as well just go for it because I've got nothing to lose'.

[aged 22, last test negative, alcohol & ketamine]

However, many reported deeper anxieties about meeting others in gay venues and used alcohol to gain confidence in this respect.

It's like I'm thinking, 'What do they want? Why are they talking to me? Oh my god, they probably think I'm a fun person and I'm not', and you know there's all this stuff going on ... and by the time I've answered them they've got bored and wandered off [...] whereas like when you're drinking you pick up on the flow, catch someone's eye and before you know it you're chatting to them. I never do that when I'm sober and it's quite interesting because I notice I caught someone's eye but I don't do anything about it if I'm sober.

[aged 45, diagnosed with HIV, alcohol]

This sense of being ill at ease, of not being in the social flow, is exacerbated by a fear of rejection which is mitigated by alcohol. The notion of social interaction leading to sex while sober was unfamiliar to many of the men.

Do you ever meet men for sex when you haven't been drinking?

Yeah. [...] But only in cruising grounds.

And you feel comfortable engaging with them without drinking?

Yes. No conversation. It's just you like what you see. Just go off and do it.

So is it conversation that can be difficult?

Yeah. Or just anything like that.

What about casual sex in bars and clubs. Is that a different thing?

Yeah [...] Depending on how many I've drunk.

[aged 38, last test negative, alcohol]

However, such unease about meeting potential new partners was not restricted to commercial gay venues. The following respondent meets most of his partners online. Alcohol serves to diminish his concerns about the safety of the encounter.

There are often times when I've made a date and someone's coming here [...] and I will have two vodkas up to there [makes a gesture] [...] quickly because I get very nervous and very like, 'Oh, god what you doing, he could put an axe through your head?'

[aged 45, diagnosed with HIV, alcohol & tranquillisers]

For some of the men with diagnosed HIV, substance use enabled them to suppress anxieties about disclosing their HIV infection to potential sexual partners and the risks associated with sex. The following man talks about how he found socialising in sexualised gay venues stressful because of his fear of rejection, and how his use of ecstasy helped with this.

[Ecstasy] obviously disinhibits you. [...] It takes you out of yourself [...] which sometimes you need, especially with HIV. Because I'm sure you've spoken to guys in the same predicament as me and obviously your worry about your status does tend to be a bit of an issue. And things like the drugs do tend to kind of whack it to the back of your mind.

What sort of concerns or worries does it whack to the back of your mind?

Fear or rejection I suppose. [...] But I think it's all of it. I mean when you go into a social context you sort of get nervous. And imagine that, sort of a hundred times worse because of the HIV. Instead of just sort of thinking about, 'Oh, I'm just chatting to somebody or whatever will progress'. You're thinking in terms of the HIV which isn't relevant.

[aged 45, diagnosed with HIV, alcohol]

The following respondent with diagnosed HIV talks about how alcohol enables him to deal with conflicted feelings about anonymous sex, sexual safety and disclosure.

[You said that] your willingness to have unprotected sex with someone who you don't know the status... that's greater if you've been drinking?

Yes [...] but then again if I've been drinking its much easier to say, 'Oh, by the way I'm positive,' because it slips out. It can slip out very, very easily. [In backrooms], I think actions speak loader than words and if I want to use a condom I'll use one [...] If somebody is determined not to do so [...] so its all to do with this ... this undescribed [sex venue] code that we all have. [...] If I go to the [sex club] and [see] a bloke that I've seen out regularly, I'd assume that he knows about HIV [...] and if he says, 'Shall we go back to yours?,' you know I might say, 'Well look before we go, I'm positive.'

[aged 52, diagnosed with HIV, alcohol]

Negative and untested men also described the use of substances to reduce (or mask) their anxieties about sex.

The other thing is I don't normally ... I would say I wouldn't really... I've never ever, ever, ever have sex with the light on. Ever! [...] Lights are off always. [On] ecstasy I don't care. The lights can be on and have spotlights on me, I don't care. [...] It makes you feel better about yourself if you've had those things, and more confident sexually.

[aged 35, never tested, alcohol]

In addition to dealing with difficulties around sex and intimacy, substances were often used to broaden sexual experiences. Men reported using alcohol to add excitement to the process of seeking sex.

[Alcohol makes sex] more pleasurable [...] because it was often very spontaneous [...] usually you know late at night, in the middle of the night that type of stuff. Sort of, Jeckyll and Hyde sort of thing [...] going on the internet at 2 or 3 in the morning and meeting people and driving and going and seeing them and coming back and nobody knew about it [...] made it even more exciting you know.

[aged 46, last test negative, alcohol]

Others reported using alcohol in order to become more assertive or adventurous during sex.

Sexually I can go a bit crazy and [laughs] particularly when I'm drunk [...] I think [the sex] is a lot more, what's the word, raucous. [Laughs]

Ok what about the actual things that you do, are those different?

[...] I don't know, I'm not really closed to anything really, I'm quite open to trying new things whatever. I think alcohol does kind of push that further, where I will kind of take the initiative to actually try them or I don't know given the confidence to ask them to try this [...] or to just do it basically.

[aged 18, last test negative, alcohol]

For other men, drug use allowed them to experiment with sexual practices that were unfamiliar.

I suppose I'm more adventurous [...] some guy asked me to fist him once and I... I'd never ever... never ever think of doing that.

What were you on at the time...?

... ecstasy and cocaine.

[aged 45, diagnosed with HIV, alcohol & tranquillisers]

In addition, certain drugs are specifically used to enable men to relax enough to engage in certain sexual acts.

[Ketamine] is quite sort of chilling [...] physically relaxed [...] It's been quite good. [...] I think it's because you're not sort of quite with it, you're almost detached. It is quite different in terms of the experience. [...] I think you're aware your body's there, but it's not quite. Well usually you can feel your arm or your leg or something, but you know it's there but it's not quite like you can feel it there. It's quite difficult to describe. Everything's sort of much easier to do. [...] Like fucking and that kind of thing. Because you're just more relaxed.
[aged 24, last test negative, alcohol]

Certain drugs also increased intimacy during sex with their regular partners.

... to me sex is like you should only do it with somebody you love. And I do love [partner name]. [Ecstasy] just brings you closer in the mind and all that kind of stuff. And the feeling is intense.
[aged 35, never tested, alcohol]

Finally, men also talked about drugs inhibiting functioning. Therefore, men tended to mix drugs in order to bring about the right balance. The following respondent talks about sex on amphetamines, ecstasy and cocaine.

Well sex on [amphetamines or ecstasy] is very good [...] it just takes more time, the feeling you get relaxed and [...] the sensation as well is different, its just more relaxed. [But] when I'm on drugs I don't come anyway [...] most often I don't even get an erection. [...] Cocaine [and ecstasy] kill my erection. I can get an erection if I take a viagra with it [...] but it does take me longer to come [...] And often I don't. [...] but the actual sex is very enjoyable [...] just the touching and the feeling and the sense of... if someone's on the same level as you it's nice.
[aged 45, diagnosed with HIV, alcohol & tranquillisers]

So drugs and alcohol increased men's pleasure in sex in a range of contexts, they broadened men's sexual repertoire and facilitated both meeting and talking to potential sexual partners. However, the same drugs, in different contexts or combinations, can have different effects.

4.4 GAY NORMS OF ALCOHOL AND OTHER DRUG USE

We asked respondents to talk about the way that being gay and their social and sexual lives might facilitate their use of alcohol and other drugs. Almost universally, respondents talked about the norm of (often excessive) substance use on the gay commercial scene and in gay social networks generally. Others talked about such norms within their own intimate relationships. These norms influenced the ways in which they used substances as well as their attempts to control their own use. The following respondent relates these norms to how he feels about himself and contrasts them with those of his heterosexual friends.

I am who I am as a person, I don't think that's necessarily defined by me being gay. Its just like, I'm a human being and I have certain kind of ways of behaving. But some of my experiences as a gay man and some of my anxieties as a gay man have undoubtedly contributed to some of my [drug using] behaviour. So yeah, in the sense they do seem to be closely connected and I would never have done some of the things that I've done in terms of drinking and taking drugs had I not been gay because I certainly wouldn't have been exposed to them.

On the gay scene or...?

I think so I [...] most of my friends are straight and I feel reasonably confident that they would say, 'I just don't, I can't relate to what you're talking about here', the sorts of levels of excessive consumption that lead to risk-taking sexual behaviour, [and] that sort of stuff.
[aged 35, last test negative, alcohol]

Others described situations where these permissive norms became problematic for them personally. The following man felt if he wanted to have a social life, he needed to use cocaine.

I was taking it [cocaine] too often and sometimes I feel like I do it and I haven't wanted to do it and I've just gone along with what people are doing because I wanted to be with them, in a way, I wanted to stay with them. I don't just want to go home and the only way I can sort of stay with them if they're all buying coke or whatever [...] a bit frustrating sometimes I don't quite want to do that and [...] it makes me feel worse the next day because I didn't actually want to have that kind of evening.

[aged 34, last test negative, alcohol & cocaine]

Men described gay social networks where the use of alcohol or a drug was integral to socialising. That is, they did not initiate the use of the drug, nor did they buy it, but using the drug was simply part of being within their gay social networks.

I would never do [ecstasy] at home. [...] It would have to be with a group of friends where kind of like... it's the same as smoking and drinking really. If they're smoking and drinking and they're enjoying it and you're enjoying it, then you will do it. Because you enjoy it with other people kind of thing. [...] I've never bought it. [...] I've given somebody some money towards it. But I've never actually brought it myself.

[aged 35, never tested, alcohol]

How men accessed drugs demonstrates the extent to which their use is normal on the commercial gay scene. Many men did not purchase illegal drugs as this would contravene their sense of themselves as unconnected with crime. Men spoke of taking drugs only with 'trusted' friends who insulated them from the need to purchase them, or to consider the safety of using them. However, the status of such friends (as dealers or purchasers) was often uncertain. The following respondent was typical in this respect.

I take ecstasy with a friend I trust. And he gets it from a reputable source.

What do you mean by reputable source?

Someone who's not likely to be spiking them. [...] Like if he said these are good pills then I'd take his judgement on them and I'd go with it. Always been with that one man. [...] Again the trust thing. [...] He's actually a bit of a dealer. He's a friend of mine. Yes. But he gets them from his source and sells them as well. [...] I've never bought them. [...] When my friend comes over he's sort of like... he'll normally stay over as well. And so we'll just smoke what he's got.

You never think of buying it yourself?

No. [...] I do know of places where I could potentially get it. But I'm a scaredy-cat and just want to keep my hands clean.

And that's about the worry about being caught?

And not wanting to be with those kinds of people, kind of thing. I know it sounds awful but it's true.

And when you mean those kind of people, you mean...?

Drug dealers.

[aged 38, last test negative, alcohol]

Although both alcohol and other drugs are readily available at many gay scene venues and through networks of gay men, these same networks can insulate users from the negative aspects of using them. Many men who use drugs are insulated from what they perceive as undesirable criminality associated with 'dealing'. In addition, they are reassured of the quality (and therefore safety) of the drugs they are taking. Men are thus able to maintain their self-image as law-abiding and responsible while still engaging in illegal and dangerous activities.

Men also talked about the extent to which drug or alcohol use with their partners was often a norm that supported their excessive use.

[My partner] really was a drinker [...] And I drank with him socially and I think that's what increased my levels of tolerance to alcohol [...] which never went down after that.

[aged 45, diagnosed with HIV, alcohol & tranquillisers]

Others talked of past relationships which were often based on a common use of drugs.

One [relationship] in particular was quite drug-fuelled I suppose and that kind of led to a very dramatic kind of heightened, 'I'm in love with you' and I wasn't really [laughs]. [...] It was a sort of male pride thing and sort of taking ecstasy and stuff and it just all felt very, I don't know, right but looking back it was actually quite ... we did quite a lot of drugs together, which I don't think was good. [It lasted for] ten months living together and then three years kind of co-dependence, not sleeping with each other, kind of attached.

[aged 31, last test negative, alcohol]

Some men pondered the extent to which drug use had influenced all the major relationships in their lives.

Its just the places you are and the people you meet they tend to be doing coke. I don't think I've gone out with, been out with someone who doesn't use drugs... I don't know if that's just London gay life or [...] the circles you mix in, or there's one commonality that you all have.

[aged 34, last test negative, alcohol & cocaine]

Gay social norms also mediated men's capacity to control their use of substances. For example, it was common for men to talk about how their resolve to control use or abstain was undermined by gay friends, acquaintances or partners.

I also think there's sometimes where I haven't wanted to do [cocaine] and I've just gone along with it and that annoys me. I don't want there to be those occasions.

Right, and you've gone along with it because?

Because of other people, my boyfriend or, because I wanted to be with them [...] and to be with them you want to be on the same level.

[aged 34, last test negative, alcohol & cocaine]

Some respondents talked about having diagnosed HIV and their perceived lowered life expectancy as a way of normalising substance use that might compromise their health.

I sometimes wonder whether I really do want help [controlling drinking] because I think to myself, 'Do you really want to take that one last piece that you enjoy away?' [...] I've got this disease. I'm not going to make old bones. I know that, I mean they all sit there and say, 'Oh you're going to have the life span you know the same as everyone else', but I know that's not true. I mean if I make 60 or 65 I'll be kicking my heels I really will. [...] I wouldn't like to go without alcohol altogether [...] And [my partner] says to me, 'Well why don't you just stop?' and I say, 'No, because well what do you want me to do, take away the lot?'

[aged 45, diagnosed with HIV, alcohol & tranquillisers]

Therefore that many social norms associated with being gay or having HIV facilitate excessive or problematic substance use. Moreover, men are often insulated from confronting negative or socially unacceptable aspects of their use. As heavy alcohol use is a norm, men are rarely prompted to consider whether their use is damaging them or whether or not they are developing a problematic relationship with alcohol. Likewise, as other drugs are so readily available through social contacts, men are less likely to be directly confronted by the illegality or danger associated with their actions.

4.5 SUMMARY

We have described a range of social and sexual uses of alcohol and other drugs. What is noteworthy is the extent to which substance use is integral to many aspects of men's lives – their social lives, their work lives, their intimate and sexual lives. We have also seen, the extent to which the gay social and commercial (and even personal or intimate) environments they inhabit serve to reinforce the norms of alcohol and other drug use. For some of the men, alcohol and other drug use was closely bound up with their identity as gay men, their sexual desires and expression, their capacity to form intimate and loving relationships, and their broader social life.

The men interviewed described a gay culture suffused with alcohol and other drugs, which extended into their intimate life, their home lives and their social and sexual lives. This culture made it harder for men to respond to, or control their, alcohol or drug use even after they identified it as problematic.

This social and cultural aspect is important. These are men who have self-identified as having a problematic relationship with alcohol or other drugs. Whereas a minority were clearly finding it difficult to live with chemical addiction or dependency, the majority were not. For most of the men we interviewed, their problems with drugs and alcohol might be described as a personal or social unease. That is, although many used drink or drugs in order to deal with conflict or negative feelings, their use is reinforced by the norms described. Therefore, not only are these men dealing with difficulties around being gay, but the gay culture they have entered tends to enable them to continue to self-medicate as a response. Thus, they find that they are not at home within the culture they have entered or built around themselves.

5 Harm associated with alcohol and other drugs

All of the men in the study had self-identified as having problematic relationships with alcohol or other drugs. This chapter explores the ways in which substance use became problematic. We first explore men's views on the causes of their problematic substance use and then move on to describe the ways in which they identified that they had a problem. Finally we examine the harms that were associated with their problematic use.

5.1 ACCOUNTING FOR PROBLEMATIC ALCOHOL AND OTHER DRUG USE

We asked men whether they could identify one or more root causes to these problems. Just over half could do so and we discussed these causes in detail. The men's accounts fell into two categories: those concerned with genetic or family influences, and those that involved a traumatic event or difficulty. Individuals tended to give an account that fitted into just one of those two categories. Only two men gave accounts that included both genetic / family explanations and trauma explanations.

Genetic or familial accounts were in the minority and all the men who gave them discussed their problem with alcohol rather than other drugs. Some men talked about having a genetic propensity to addiction to alcohol.

It's not that I'm making excuses for my drinking but there's a chemical kind of relationship there. Both my parents... my dad was alcoholic, and my mother a heavy, heavy drinker.
[aged 43, last test negative, alcohol]

Others talked about family norms of heavy alcohol use.

My mother's alcoholic [and] my father also drank fairly regularly although he did stop a few years ago. He had an attack of pancreatitis. [...] They both drank fairly regularly as part of the kind of pub host and hostess kind of thing [...] My grandfather also, my mother's father was also an alcoholic and so there was kind of like ... drinking was really very much part of the culture of the family.
[aged 49, last test negative, alcohol]

Others were aware that their parent's alcoholism gave them insights into the problematic nature of their own use.

My grandfather is actually an alcoholic [...] which sometimes quite concerns me [...] I don't think it's genetically like a disease as such but it does scare me a bit.
Why's that?
I don't know to be honest, I suppose because I've got experience of what alcoholism is, whereas I think the people around me who are doing probably more or less the same things as me don't.
[aged 18, last test negative, alcohol]

A more common narrative concerned some kind of personal trauma or difficulty as the cause of current problems with drugs or alcohol. Men talked about problematic substance use as a response to pressures associated with coming out. For some, this was to deal with the negative responses of families and friends.

A few of my family and friends weren't very supportive [and] my father kicked me out the house for being gay. My friends didn't speak to me because I was gay. I mean I became hugely depressed and started drinking and smoking spliff a lot back home. [...] I grew up being Catholic and so I felt an immense amount of shame about being gay and so I used alcohol and spliff to try and control myself. I mean I was going through a downward spiral and being really depressed and alcohol and spliff were just there. And that's when I first... I think that's when it became more excessive.

[aged 29, last test negative, alcohol]

Respondents also used substances to deal with their own conflicted feelings about their sexuality and to manage difficult disclosures. The following respondent came out later in life after the break-up of a heterosexual relationship.

I kind of drank when she left me. Because she left me. To blot it out. And then normal drinking I suppose. The last couple of years I would say [...] it is getting really out of hand. [...] I think one of the main things is I hadn't accepted that I'm gay. And I used to get really embarrassed about it. [...] My dad doesn't know. My mum knows, my sister knows [...] I told my mum and my sister when I was sober. Which was really hard. Everybody else in my family that knows was because I was drunk and told them. I have to keep away from my family when I've been drinking [...] because I'll tell anybody. I don't care then. I just don't care. [...] I just... well if I had a family wedding and [male partner] comes with me, I know that they [family] know. And when you have a drink it's courage, you know, 'Whatever! Think what you like, I don't care'. Sober I'd be like: 'Are they looking at me?, Are they looking at me? What are they thinking?, What are they thinking?'. And it plays on my mind constantly.

[aged 35, never tested, alcohol]

However, families and parents sometimes recognised their son's unhappiness concerning his sexuality and tried to be supportive. The following respondent tells of the situation after he was admitted to hospital with acute mental health problems related to alcohol and drug use.

The first time I was admitted they asked me if I wanted to get in touch with someone and so I used to contact [my parents] quite frequently probably every other day on the phone. And [my parents], against my wishes, came down to the hospital to see me. And I was sobered up and my mum and dad said, 'I think you've now finally accepted your sexuality'. [...] And it was only afterwards I stopped drinking and came out. Got my life back together again, that my mother said that she thought that... both her and my father said the same thing. You've finally accepted your sexuality. It was me dealing with my sexuality that caused me to drink.

[aged 38, last test negative, alcohol]

Men also talked about difficulties around being diagnosed with HIV. For some, their increased drinking was due to depression and a loss of self-esteem.

I think it's about self-esteem. I think that's what it boils down to. Obviously you feel humiliated if you like, a piece of shit when you're first diagnosed. That was my main feeling when I first found out. I didn't get much support from friends. They also made me feel even more of a piece of shit. And I guess you're very much on your own with your diagnosis. And that's my experience. You see you have to find your way through. And I guess that's why I drink.

[aged 45, diagnosed with HIV, alcohol]

Others reported increasing drinking or drug use as a result of early retirement or job loss associated with an HIV diagnosis. The following respondent talks about a traumatic incident (attempted blackmail) associated with his HIV diagnosis that, he believes, led him into a dependent relationship with alcohol.

I met a couple of wrong people and basically I was set up by these con people [who] were trying to blackmail me [and] that's when I started drinking. [One evening I went out to the pub] and there's one of these people and of course it went from well, 'Well you gave him HIV', which I certainly didn't to the next revelation was that he's claiming that I gave him GHB, which I've never had and raped him and that's why he was HIV and I was the one who did it. [...] so the word's got round and I don't know when I might bump into either of them. [...] So I think to myself as least I've got some sort of reason, some understanding about why I started [drinking].

[aged 52, diagnosed with HIV, alcohol]

However, not all the traumas concerned being gay or being diagnosed with HIV. Men also reported the kind of difficulties that most people have such as the death of a parent or the break-up of a relationship. For others, it was a combination of factors.

I'd say about three years ago [I started to drink] every day and the amount was going up and up and then it became where I'd crave to have a drink and I couldn't not go an evening without one.

Why was that do you think?

I went through a break-up in a relationship that wasn't very good anyway. I hadn't handled it well... and then I chased my biological mother [...] which was disastrous.

[aged 46, last test negative, alcohol]

Thus, for those who can identify a 'cause' to their problematic use, it was usually associated with personal and social problems which in turn hinged on the individual's own intimate relationships. In this sense, the men in our sample are like any other group who have a problematic relationship with drugs or alcohol. However, when thinking about interventions or responses, it is vital to take into account the particularities of gay men's intimate and social lives.

5.2 IDENTIFYING A PROBLEM

In addition to asking about the causes of problematic substance use, we were also keen to investigate how respondents first identified their problem. Responses can be divided into three main categories: problems that were self-identified; problems that have been pointed out by others; and problems that came to light when respondents were diagnosed with physical or mental health problems that were related to their substance use.

For the majority, aspects of their drugs or alcohol use had started to unnerve or upset them and as a result, they started to define themselves as having a problem. Most men in this group tended to conclude that their substance use was causing them unhappiness.

The most common 'symptom' of problematic alcohol or drug use was a lack of control over the amount they consumed. The over-arching problem was that many men simply did not know when to stop or could not stop once they started. For some, this emerged when they realised that they were drinking or taking drugs in spite of a clear need not to do so. Others realised that they had a problem when they started to drink alone.

Well you know there's a point where you've coming to the end of the bottle of wine and you're thinking shall I go and get another one. And you think, 'Yeah, I could do with [one], why should I want to stop now. I'm having a good time.' And often I will probably have staggered down to the corner shop and brought a bottle of wine and I probably won't even remember doing it. [...] I'll wake up and I'll see two bottles of wine there. So I must have gone out.

[aged 45, diagnosed with HIV, alcohol]

The following respondent realised his use of cocaine was a problem when it started causing problems in his work and domestic life.

We were out and about with some friends for dinner and they were friends who do coke and we ended up you know, 'Lets go and get some coke', and it was a midweek thing, I had a really important meeting the next day. And my partner was saying, 'You've got that meeting tomorrow', and I said, 'Oh you know we'll just have a gram between us'. And then it turned out a lot more and a lot longer [...] and I realised I couldn't say no at that point. And I thought, 'Shit this is really got a hold of me'.

[aged 42, last test negative, alcohol & cocaine]

Others reported black-outs or memory loss as the defining symptom of a problem.

So self-identification usually occurred when men became aware of their lack of control over their substance use, or through disruption to their everyday lives. Respondents also cited the actions of other people as having alerted them to a problem. For some a partner noticed their excessive drinking. For others, it could have been as subtle as looks from strangers or shopkeepers.

I hadn't really considered [that I had a problem] before, [...] I lived in [town] then and I remember a shop would sell you two bottles of red wine for a fiver. Which was a good price. And so I would go in there and it got to be a stage where I could feel the bloke behind the counter just look at me and smirk. And that's when I realised, 'Shit, that's the last thing I need'.

[aged 45, diagnosed with HIV, alcohol]

Some men reported key incidents such as losing their driving licence. Others told of how their work colleagues or employers intervened because of their drinking.

[I noticed I had a problem] about a year ago [...] I've only been sent home [from work] once, but [employer] said, 'You have a problem you know, we don't want... we don't want to sack you but [...] if you can't stop, don't do it during the week' and I was referred to the [...] Drink and Alcohol Service or something and I saw this doctor because that was part of the agreement when I was sent home.

[aged 43, last test negative, alcohol]

A third way in which men became aware of a problem was through the presence of clinical symptoms. In a minority of cases, these were self-diagnosed.

Sometimes I go for weeks and not have a night without drinking. And then sometimes I'd get like bouts of diarrhea and I'm sure it's from that like drinking too much. And then do you know my weight fluctuates because of it. I was a good stone and a half heavier than I am now. And then I got a yeast infection. Which turned out to be too much blood sugar. And it's having a negative impact on my health.

[aged 25, last test negative, alcohol]

The majority of men noticing direct negative health impacts were older, often with other problems which alcohol or drug use exacerbated. The following respondent reports his concerns with a growing list of health problems.

I have always been concerned about how much I've drunk but I think its gotten worse recently. I've got more concerned recently. I was diagnosed with diabetes 2 or 3 years ago [and] last year I had septicemia, as a result of gall stones and so they did various scans then and they told me that I've got fat in my liver. [...] And they said you know there's two reasons for that, one is being grossly overweight for a long time, I know I'm overweight but I'm not grossly overweight. [...] The other thing is alcohol and the fat in your liver is a precursor to potential things like cancer and sclerosis and other types of alcohol-related liver disease.

[aged 49, last test negative, alcohol]

Some men were also worried about their mental health which they felt had deteriorated as a result of drug use.

I've had some mental health problems [in the past] and I now know an awful lot more about whether the links, the specific links of cannabis [to mental health] [...] If you're not feeling in a good place to start with [...] that's not really going to help in the long-term.

You said you made a conscious decision [to reduce cannabis use], how long ago was that?

Probably about a year ago I made a more conscious effort. Before that it was becoming less, I was doing it less anyway because I realised that it wasn't making me feel that good.

[aged 35, last test negative, alcohol]

So men came to recognise a problem with substance use through a variety of routes. Self-awareness occurred through identification of a lack of control over moderating or stopping use, and through disruption of day-to-day life or through health problems. Some men also had problems pointed out by friends and family or health care providers.

5.3 THE HARMS ASSOCIATED WITH PROBLEMATIC SUBSTANCE USE

A key element in developing strategies to control or abstain from substance use is to identify the damage they do. This is central to any harm reduction approach. We therefore asked respondents to discuss what they thought were the harms associated with their substance use. We have divided their responses into the following categories: harms to social and personal well-being, harms to physical and mental health and harms to emotional and sexual health.

5.3.1 Social and personal well-being

One of the main harms reported was the amount of time, money and energy wasted using substances. Often men lamented the loss of weekend daytime (usually spent sleeping off the night before) and workday evenings. Many felt their lives had become centred around a social and cultural scene which was mainly concerned with alcohol and drug use. Men talked about wanting to do other things with their time that were more enriching for them. The following respondent, who had recently controlled his cocaine and alcohol use through therapy, talked about some of the effects.

It was time wasted I think. I mean one of the first things I noticed when going into recovery was that I got my weekend back [...] And I would go to work on the Monday and I actually feel as though I'd achieved something at the weekend. You know, go shopping with friends, go to an art gallery, go to a concert [...] It used to start on a Friday and it could go on until Sunday. I mean you'd go out Friday night then we'd all be back at somebody's house, the coke would come out... it would be 7 in the morning... you get a bit of sleep... then you think, 'Oh, I just want to drink'... and then you have a drink and then somebody would have more coke and before you know it... it's Sunday and you just want to crawl into bed [...] And then it's Monday and you feel like shit.

[aged 39, last test negative, alcohol]

Allied to concerns about time wasted was the impact that substance use was having on their finances. Although a few men reported facing severe financial hardships through substance use, it was more common for men to talk about merely spending money recklessly. Spending was both on the substances themselves and the social life surrounding their use.

[Cocaine] is way too expensive and it's not just that – we will spend a lot of money on drinks as well because [you] drink with it and you feel quite rubbish the next day.

[aged 34, last test negative, alcohol & cocaine]

Another major concern was the impact substance use had on their capacity to work and productivity. A minority of respondents had either been suspended from work or had lost their jobs through substance use. However, most concerns with regard to employment were more low key and concerned the ability to function and the feeling that they were not attending to their work as much as they should.

I don't like feeling bad the next day and although it's quite rare that I'll be really badly hung-over the next day I often spend whole mornings at work, often whole days at work, firing on one cylinder, which kind of at my age its really not good. [...] I quite like my job and I don't like to sit there feeling lousy and being unproductive.

[aged 32, last test negative, alcohol]

Unlike more dependent users who might argue drinking or drug use at work helps them get through the day, for these men, their hangovers made work very difficult. In addition, the fear of making a major mistake or being found out was ever present.

It's hard to believe but I do airport security [...] and its not something they would tolerate [...] if we had random checks [for alcohol or drugs].

[aged 45, diagnosed with HIV, alcohol & tranquillisers]

Men who were obliged to engage in social activities for their work (hospitality, events, PR) often found it difficult to monitor their behaviour and to trust themselves not to become overtly affected by their substance use.

I used to do events at work at [a theatre] and there was few occasions where I may have got a little bit too drunk in front of supporters and stuff. [...] Yeah, and that kind of waking up and feeling quite panicky at what I'd said.

[aged 31, last test negative, alcohol]

Men reported growing accustomed to feelings of being unreliable or untrustworthy which, in turn, tended to impact on their self-esteem and their capacity to benefit emotionally from the work that they did.

I mean the work situation does bother me a lot. I mean I'm slightly paranoid anyway as an individual. [...] But I've got good reasons. You know there's certain things that people have said and people coming up and sniffing your breath and that sort of thing you know. I think I've got a reputation [...] I don't like that at all.

[aged 52, last test negative, alcohol]

Another harm associated with substance use was the damage done to self-esteem by inappropriate behaviour when drunk or on drugs. Some men experienced embarrassment at the way they had behaved socially, or the way they feared they might have behaved. Often this was associated with blackouts or memory lapses.

And sometimes you [...] forget like what club you'd been to like the night before. Or like whether you'd like seen somebody and took them back. Things like that. At the time I was always thinking well I know exactly what's going on. But the next day I'd have like little lapses in my recollection. I can't remember exactly what went on. That would be like quite bad because I'd think, did I do anything bad?

[aged 22, last test negative, alcohol & ketamine]

However, remembering the night before was often worse. The following respondent had recently changed a prescription for valium and anti-depressants with the result that he was now more aware of how he behaves when he is drunk and remembers more the next day.

I loath, particularly in public, being out of control in such a way that I feel I embarrass myself. [...] I don't mind taking drugs, I don't mind drinking to excess, I don't mind any of that as long as I still appear to be reasonable. But since I stopped the valium and reduced the anti-depressants, the same amount of alcohol will now make me stagger and unfortunately as my memory's improved I remember staggering and remember talking rubbish and being slurred and that I can't cope with particularly. So it's now a problem in a way that it wasn't before.

[aged 46, diagnosed with HIV, alcohol]

Sometimes men considered the desirability of a particular drug based on how it affected self-presentation. The worst thing was to *appear* drunk. The same respondent continues.

I just don't like being pissed [...] by the time I'm staggering or feeling nauseous or talking rubbish. The thing about being stoned or taking ecstasy or whatever is that you don't necessarily look like an idiot but there's something about being pissed that you do.

[aged 46, diagnosed with HIV, alcohol]

Another respondent talks about the effects of ketamine on his self-presentation.

The only thing I'd say is that if you're on a night out and you take it and it can make you look like, very drunk. Even if you've just had a couple of drinks. If you mix it with the alcohol it can make you appear like you're very, very drunk. Like make you slur and things like that. [...] And I'd regret the fact that I'd been out in public and people had like seen me like that basically.

[aged 22, last test negative, alcohol & ketamine]

Others talk about losing physical control when drunk.

...pissing myself... I've done that a few times. Wetting myself as an adult's not that good is it?

[aged 31, last test negative, alcohol]

Problematic substance use results in a variety of harms to social well-being. Use can come to dominate men's lives, consuming money, time and energy. It can generate insecurity, embarrassment and panic. These are similar to the challenges men used substances to overcome in the first place, thereby creating the potential for a vicious circle of problems and substance use.

5.3.2 Physical and mental health

We have seen how men suffered a range of substance-related health symptoms (such as pancreatitis, liver and blood problems, peptic ulcers, mental health problems *etc.*) These men tended to be older or longer-term users. However, there was a milder and more pervasive concern about the harms done to health among many of the men interviewed. Often, this was expressed in terms of looks, attractiveness and self-presentation. Men were aware that they were looking older than their years.

I'm pretty healthy [but] I probably worry that [alcohol] is bad for my skin and bad for my looks. [...] A typical gay man worries about his complexion before anything else. [...] I'm sure it's not good for my liver either.

[aged 32, last test negative, alcohol]

Others were becoming aware of more severe indicators of deteriorating health.

My liver is such a martyr and sometimes it does, kind of, twinge and I know that when I look in the mirror that under my eyes they're just so sunken like a real sign of liver and kidney problems.

[aged 43, last test negative, alcohol]

Older men reported being less able to deal with the consequences of heavy drinking. This was often seen as a marker of advancing age and physical deterioration and was often confirmed by the diagnosis of conditions either brought on by substance use or exacerbated by it.

So did the [diabetes] diagnosis trigger alcohol as a concern or a problem?

No, because before that as well I was aware that I couldn't drink as much as I used to be able to. You know as you get older you [...] can drink as much but the effect on you is a lot worse the following day. [...] I can remember sort of going out on a bender and going straight to work the following morning when I was in my twenties and, you know, you'd sort of do that seven nights a week but I talked to all friends of similar age and we all agree how it takes a week to get over it now. Once a week's enough! [laughs]

[aged 53, last test negative, alcohol & amyl nitrate]

Mental health was also discussed. Some men were aware of the role of substance use causing them to be depressed or anxious.

[Ecstasy has] Varying effects. It depends on what mood I'm in when I take it. It does sort of make me sort of quite happy and smiling kind of thing. But it can actually also make me feel quite depressed as well. [It] becomes sometimes pretty hard for me because I've got a depressed nature. [...] I think the alcohol makes me depressed. And perhaps you know I'm more borderline depressive. But the alcohol doesn't help.

[aged 38, last test negative, alcohol]

For others problematic substance use was seen as connected with pre-existing mental health problems or symptoms. The following respondent talks about the night prior to the interview and the extent to which this behaviour had become common. He also expressed concerns that his alcohol use often led to suicidal feelings.

I went home after a birthday party and I continued drinking. And I obviously called someone and they called me back and I had a missed call this morning. I called them on my home number and when I woke up this morning, I was trying to flick through the calls on my phone. Because my place is trashed. And I couldn't find [my phone]. I don't know who it was. And I'm going to go back home later on [and] check the damage and try and see who I drunkenly dialled.

So is that something that happens quite regularly?

It can be [...] My usual pattern, to be honest, is rather embarrassing. Is that normally I ring the Samaritans. [I call] my partner as well. [...] Or seek help from somewhere else. The alcohol tends to... what I've learnt is it tends to make me feel suicidal. So I go into self-destruct mode. [...] My old next door neighbour, I used to go round and see her. And she would come in and check on me if I'd got home in a state.

OK. How often does that happen?

More often than I'd like to admit really. Probably weekly.

[aged 38, last test negative, alcohol]

The men with diagnosed HIV were often acutely aware of the possible impact of alcohol and drug use on their health. The following respondent establishes a clear connection between specific episodes of drug use, ongoing alcohol use and his CD4 count as a marker of his health.

My drinking is out of control. It's the one thing about my life that worries me, I mean I try to eat well, I try to exercise. I take all kinds of multi-vitamins and yet I still throw copious amounts of alcohol down my throat which I know is doing me no good [...] My CD4 count was 200 when I started on medication and its never climbed above about 400. When I came back from holiday this time I had a really bad viral infection. I've just had my bloods done and my CD4's dropped from 380 to 290, [and my viral load is] still undetectable [...] but my consultant's not bothered he says, 'No, no, no you've had a virus you've been ill, your CD4's dropped because of that but you're still undetectable so the medication's still working' [...] But when I spoke to [friend] last night he said, 'Its because you're a drinker, you drink too much. And that's why your CD4 won't climb'.

[aged 45, diagnosed with HIV, alcohol & tranquillisers]

Others were concerned about the effect on their liver or kidneys, of long-term substance use and anti-HIV drugs.

Men identified a wide range of personal health harms associated with excessive substance use. Overall, they were usually well aware of the potential damage they were doing to themselves. However, this awareness and knowledge was insufficient to give men control over their alcohol and drug use.

5.3.3 Sexual and emotional health

Problematic substance use was identified as the source of difficulties concerning sexual and emotional health. The main concern however, was that men felt that they weren't having fulfilling sexual lives. Although they may be having lots of sex, it was not necessarily the sex they wanted to have. Moreover, substance use often became associated with sex to the extent that some men felt they could not have sex (or become intimate) without it. Others felt that they were using alcohol and drugs to mask their own negative feelings about sex or sexual health problems.

Some men talked about having sex in anonymous settings, or sex they had little recollection of because of alcohol or drug use. The following man tells how he has become so used to this, that it was surprised to be able to have sex in a bed with a man he had actually spoken to.

I've never really chatted anybody up in a bar or a club because of the rejection thing. I've always been the wall flower just waiting to be picked – fingers crossed by the end of the evening. And [my therapist] said, 'You've got to get out of that rut' and I have [...] I've had more of chatting up people, getting home with people and having sex in a bed, which for some people is quite normal, for me is a bit out of the ordinary.

[aged 39, last test negative, alcohol]

Many talked more generally about the experience of never actually having sex sober. For these men, the sex they were having was unsatisfactory for a range of reasons. Some found it physically difficult because of nausea. Others talked about a lack of intimacy. In addition, it was common for men to talk about their libido and their capacity to maintain an erection being badly affected.

If I've drunk too much I can't get my cock up. So I think that's probably the one bad effect [and] again if you've drunk too much sometimes you don't feel in the mood or you feel a bit sick and then you just want to sleep.

[aged 24, last test negative, alcohol]

A minority of men talked about broader problems with loneliness, depression or intimacy which were emphasised by their substance use and dealt with through sex.

Because when I'm drunk I'm lonely and I don't want to go home alone. And so I'll give in to whatever they want. Not necessarily bareback [...] Sometimes you'll go home with someone for company.

[aged 38, last test negative, alcohol]

All respondents were asked to recall sexual encounters while they were drunk or on drugs, and that they felt carried risk of exposure to, or transmission of, HIV. What was most notable about these accounts was their variability not only in terms of the circumstances in which they took place, but also in terms of motivations, attitudes and mental state. What was common to all accounts however, was the notion of substance use relaxing boundaries. That is, unsafe sex generally occurred when social or personal boundaries were breaking down and men were not being as cautious as normal. The following respondent gives an account of a period in his life where he took lots of drugs and engaged in lots of unprotected sex.

[I was drinking] a lot, taking a lot of ecstasy. Sometimes coke but not very often. But I just thought, 'Oh, this is the last summer before I start my course.' [...] And I began sleeping with a lot of people a lot of the time. Because obviously if you're drinking a lot and there's drugs involved, it's much easier to meet people and safe sex doesn't seem so much of an issue. [...] You know if you go to a club and you take pills and you drink... lots of people in the clubs are on drugs and they're drinking as well. And you can't get a much better mix for a social lubricant than ecstasy and alcohol. [...] And it makes you want to have sex with people. [...] So I was having a lot of sex. Most of it unprotected. And I actually thought at the time that I didn't care whether I caught HIV.

[aged 25, last test negative, alcohol]

In these accounts, unprotected sex was part of a general relaxing of social and intimate boundaries which was facilitated by a common use of drugs. Another common element of accounts was the placing of unprotected sex and sexual risk within the context of other risks as a result of substance use. Here, the respondent has lowered his boundaries or standards of self-care and self-awareness.

When friends would say that they were going home I would stay out [on] my own. That was fun and sometimes that was messy [...] leaving my wallet, waking up at the end of a bus line or a tube not quite sure where I am, kind of thing. I got myself into a couple of scrapes and this was a while ago now but I have been assaulted [...] I really was in a grey zone where I wasn't really functioning, not quite aware of what was going on or just maybe kind of picked-up an inappropriate sexual partner [...] I try not to beat myself up about things but you know I have some feeling of kind of you know, 'Why on earth did I do that?'
[aged 35, last test negative, alcohol]

Other men talked about substance use lowering their inhibitions around sex generally. That is, they were willing to engage in sex acts that they would not if they were sober.

But when I'm drinking I'll sort of do oral and [...] I'll allow things to happen to me that I wouldn't normally do. And I get fucked and I normally will do the fucking. Things like that.
[aged 45, diagnosed with HIV, alcohol]

A key element of all of these accounts was a comparison of themselves when sober with themselves when using alcohol or drugs. Sober they were responsible and able to take decisions on risk and harm. When using alcohol and drugs the individual described themselves as incapable of making these decisions.

Guys that I've met on the internet and I see on a regular basis, that will flag me up on Gaydar and say, 'Oh, you know are you free?' [...] And these particular guys that I have regular sex with will always use safe sex [...] I'm quite happy then when I'm not on drugs to have sex with them because I know it's not going to put me at risk because these guys never have unsafe sex. But if someone came up and I was off my head and said to me, 'I want to take you home and fuck you in the ass and I don't want to use a condom', then I would most probably do it.
[aged 45, diagnosed with HIV, alcohol & tranquillisers]

Accounts of unprotected anal intercourse (UAI) or other risky sexual activities fell into two categories: those in which men were unaware of what was occurring or had occurred and those where men reported that their perceptions of the risks attached to their actions were altered by alcohol or drug use.

The majority of accounts which fall into the former category were among men who had experienced memory loss or blackouts as a result of alcohol use. The following respondent regularly wakes up having had sex with men about whom he has no recollection.

I'd go home and I've met somebody. And I won't remember really. But I vaguely remember meeting them. But then I won't remember going back to theirs. And then will remember maybe a little bit of then, but wake up and like, 'Oh what actually happened. How did we meet?'. [I don't talk about it to partners] because I've always been dead embarrassed and the worst one was when I didn't even remember their name and sort of went to the toilet and was searching through the bathroom because I couldn't remember their name.
That time you had a HIV test after it. How did you know that you'd done something that was less safe than what you normally do?
Because that person had my phone number and had texted me. And had said that we'd had sex without a condom.
[aged 26, last test negative, alcohol]

Not all accounts of this nature involved alcohol. Men talked about crystal methamphetamine, ketamine and GHB causing them to feel radically disconnected from what they were doing and not being in control.

In the past I have been sexual on 'K' and that's been a bit strange really it was a bit...I lost the plot [laughs], forgot who I was having sex with because I just went off in this own little world [...] and for how long I don't know it could have been for like a second or two or, or longer.

What about the type of sex that you had?

It was unsafe sex.

[aged 42, last test negative, alcohol & cocaine]

Accounts where respondents reported that their perceptions of the risks attached to their actions were altered were more common than those where they had little or no recollection of the sex. Some men reported that their perception of the risk attached to what they were doing was mediated by a sense that they were personally invulnerable.

I have sat there and taken a gram of coke, and goodness knows what else I've been going through in a day, and there's this different point at which I've felt almost, you know, invincible you know, on certain substances [and] therefore more likely to undertake risky behaviour.

[aged 35, last test negative, alcohol]

Other men described how substance use interrupted their reasoning and undermined good intentions.

[When you're sober] you're more [...] aware. You don't get talked into it or you don't try and talk someone else into it, you know you're sort of more, you reason with yourself, reasonably in your mind.

And you don't reason as much when you've drunk?

No well I don't anyway [...] it probably does come into my mind [...] but my resistance is down.

[aged 53, last test negative, alcohol & amyl nitrate]

Respondents also talked about a feeling of disconnectedness or a lack of care for the enjoyment or welfare of their sexual partners.

Yeah, it's that ability to take [receptive anal intercourse] which is always pleasurable but take it to a sort of different level of enjoyment by having, you know, other chemicals in the mix.

What about intimacy?

I think there's less intimacy because I think it's about [...] It's like being a slightly sort of more selfish, egotistical kind of behaviour. [...] other people become almost objects.

[aged 35, last test negative, alcohol]

Responses to incidents of UAI also varied. For many men, UAI was part of a larger tendency to put themselves at risk, to lower their boundaries or to relinquish control. For some, this was merely how they lived their lives. They accepted this aspect of their personality. Others, who were unhappy about this, tended to see unprotected sex as another indication that their lives were out of control or that they had a problem with drink or alcohol. Finally, there were those who were concerned about incidents of risk and found ways of continuing to take the drugs or alcohol they wanted while avoiding sexual risks. The following respondent talks about his use of GHB at sex parties.

[On GHB] I've found myself having sex without condoms because I never have unprotected sex.

Were you very concerned about that?

Yes I was...the second time it didn't really happen that...

Why do you think it was different that second time?

Because I was in control [...] because I don't like to put myself in situations whereby I'm putting myself at risk.

Why was it different [from] the first time?

It didn't occur to me the first time, because I mean you're very clear-headed, it's just you just have these urges going on and then afterward, the next morning, you realise that you have had sex without a condom. I was very angry with myself for doing so because I didn't want to put myself in that position and so the second time I know that the effect it has would be to make me want to have sex without a condom, so I controlled myself.

[aged 29, last test negative, alcohol]

Perceptions of the risks of unprotected anal intercourse are socially mediated and are part of a larger narrative of risk taking. Men tended to respond to it depending on their current emotional or personal state. For some, it was an isolated incident brought on by the use of an unknown drug, while for others it was a sign that they were 'living on the edge' or that they were going through a particularly transgressive phase of their lives. For others still, it was seen as an indication of the extent to which they lacked control over their lives. It's important to remember however, that sexual HIV risk took its place among a raft of potential harms associated with problematic substance use.

The final way in which drugs or alcohol caused difficulties in terms of sexual and emotional health was in long-term relationships. Some men reported their substance use was connected with problems in their relationships. A minority reported physically abusive relationships with their partners. Others reported ongoing difficulties with their partners trying to control their drug or alcohol use or persuade them to use less.

For about 8 years I've been quite a heavy drinker and my partner is the one that is always saying to me, 'You drink...I can hear you in that cabinet what are you doing now?' [...] It's a constant [...] nagging about drink. [...] And [partner] always says to me when we're going to Tesco's to buy wine, he will say to me, 'I've heard this ones supposed to be quite nice' and I would look at it and say, 'I don't want that its only 11%' [...] And he said, 'But why are you buying it? What does it matter what percentage it is? Surely we're buying it for the taste'. And I'm saying to him, 'Well no I'm buying it to get pissed'.

[aged 45, diagnosed with HIV, alcohol & tranquillisers]

Others talked about the extent to which they felt that their own use of drugs or alcohol masked problems their partners may have.

I sort of worry [...] my boyfriend has highlighted to me he takes too much cocaine and is like more than me and that's sort of made me think about my own use. [...] Yeah he's only finally admitted that [...] I mean he fucks up a bit on it [...] Cocaine provides him with ... it's a different reason he takes it... it provides him with an escape...

[But] you sometimes take it together I presume?

Well yeah, lots.

[aged 34, last test negative, alcohol & cocaine]

As well as being a context for, and response to, unsafe sex, alcohol and drug use creates problems in gay relationships, with sexual performance, with relating to sexual partners and with lack of control.

5.4 SUMMARY

Uncontrolled alcohol and drug use can generate many harms. These include a loss of social and personal esteem, wasted time and money and ill health. None of these are necessarily catastrophic but each can be a cause for concern. Given that substance use can create (or exacerbate) precisely those problems that men use substances to mask, usage and the problems it gives rise to can become self-sustaining. For example, men may use alcohol to better achieve sexual and emotional intimacy with other men, but excessive use instead creates barriers to intimacy. Men may use substances to temporarily cope with a life problem, but excessive use creates obstacles or barriers to resolving problems and to moving on in life.

We therefore need to examine sexual risk behaviours within the context of 'messy lives'. Problematic substance use generates a range of risks, including sexual risks. It is not that men are wanting to take risks or wanting simply forgetting about safer sex. Problematic substance use is much more generalised and we cannot 'deal' with the problem of sexual risk in the presence of substance use without addressing the broader context of that use.

6 Managing use, reducing harm and seeking help

Having examined the nature of men's problems with alcohol and drug use we move onto examine the ways in which men either controlled their use or attempted to reduce the harm associated with it. At the end of this chapter, we discuss the various sources of help including friends, family and a range of services and organisations.

6.1 MANAGING USE TO REDUCE HARM

A central part of this research involves investigating how men responded to alcohol and drug use that they saw as problematic. Although a minority had not developed a response, most had a range of tactics they used either to control the amount they consumed or to reduce the harm associated with their use.

A small minority of the men had chosen to abstain completely from the substance that caused them problems. Some of those who we might describe as addicted to alcohol were struggling with the need to abstain for the sake of their immediate health. However, the majority could be described as experiencing dependency rather than addiction. While they exhibited a social or personal unease about their use, the option of complete abstinence was not considered by many. As their problems were often specific to their (gay) social contexts, it was precisely these contexts that made abstinence more difficult. The following respondent now only drinks and uses cocaine on special occasions and while socialising will normally be sober.

I do sometimes put myself in situations where there is a lot of drinking and a lot of drugs going on and I don't do any. It's very much a case of [...] especially if its free booze and I'm drinking water, they freak out because... they have perception of who I was and somebody who would be like a party girl and go out and drink and have a laugh and they find it strange that I can still do all that... without alcohol and coke.

[aged 39, last test negative, alcohol]

The same respondent described a period of abstinence in the past.

I did stop alcohol and smoking for three months, just completely cold turkey off my own back and had a fucking miserable three months because I would be going out and I'd have a [soft drink] and I'd just be like, that miserable. I'd done it for all the wrong reasons I think ... and I'd done it without any sort of help or advice. [After] 3 months I had a drink and I went bang and everyone was like, 'Yay [name's] back! [...] that miserable bastard whose been around for 3 months is back on the booze... we like him!'

[aged 39, last test negative, alcohol]

The strategy of controlled use or using only on a special occasion or in certain contexts was used by many respondents. However, because of the gay social contexts inhabited, this had to be a constantly thought through and reinforced approach.

I'm not abstaining from alcohol or drugs but I'm doing what my therapist [calls] 'purposeful using'. That means that [on a special occasion] I'll maybe have a few drinks, maybe a couple of lines of coke, or if I'm on holiday [I'll drink]. But what I have to do is be very careful what I break down as being an occasion because working on the gay scene you can have an occasion every day. [...] That's how I really have to really break it down because otherwise I'll just be back, sort of, where I was.

[aged 39, last test negative, alcohol]

Allied to this was the goal of using substances less often but enjoying it more when they were used.

I think the point I want to reach is a not a hard-line like, 'I never want to take it again' [...] I'd like to take it less and to enjoy it more, when I'm doing it. So less is more [...] which I think is maybe a bit harder than just, 'I'm never taking it again'.

[aged 34, last test negative, alcohol & cocaine]

However, there were a range of other strategies to reduce harm while maintaining pleasure. Some men reported avoiding certain types of drinks (such as wine or spirits) while others talked about efforts to drink less.

The best way, if I really didn't want to get drunk, was to make sure I'd drunk a soft drink between each drink.

[aged 26, last test negative, alcohol]

Also some men talked about avoiding certain friends at certain times.

Certainly in the last four or five months whereas I used to see [friend] four times a week, now I only see him once a week and sometimes he's so hung-over that he's not out at the same time I am so I'll go out about 4pm and come home about 6pm [before friend arrives].

[aged 46, diagnosed with HIV, alcohol]

Restricting drinking to certain times was also a popular tactic. Some men talked about putting off drinking until a certain time of the evening while others set themselves 'going home' times. Others ensured that they would not break their own rules by purposely driving or cycling to social occasions. It was also common for men to make agreements with partners or friends about how much they would consume and when they would do so. The following respondent talks about his cocaine use with his partner.

With my boyfriend [...] I don't want to do coke tonight because we're having friends 'round for dinner tomorrow [...] We've got to do lots of things and we have this agreement with each other so it's kind of, 'Lets not do it, even if it's there'. So it's recognising that you're going to be in the situation [...] Having a chat about it first.

[aged 34, last test negative, alcohol & cocaine]

Others made agreements with friends to help them stick to their limits.

Sometimes if I've gone out with people and they've gone home and I've had enough alcohol, that I feel like I want to stay out, then I make sure they say, 'No, go home'.

So does that work?

Yeah that works. As I've not reached the point where I'm so drunk that I'm like, 'Oh, sod it I'll just go out'. But I've had a few drinks...and it's like 'Oh I could stay out a bit longer'. If they remind me, 'Well you said you didn't want to'. [...] I'll go home.

[aged 26, last test negative, alcohol]

These kinds of tactics for control were all dependent on contextual or social factors. The following respondent talks about a range of tactics.

[Before I go out] there'll be a vague thought process, 'Who I'm going out with? How long I'm going to be out? Where are we going to go?' Possibly thinking a bit about where I should stop. [...] Sometimes I might just decide I'm only going to take out a certain amount of money [or] depending on who I'm with, because with some friends it's really easy because they don't drink very much and my rule would be never to drink more than they do.

[aged 35, last test negative, alcohol]

So men used a variety of tactics to bring control to their substance use. These included deferring use to a particular time or stopping at a particular time, limiting the means for use by taking out less money, alternating alcoholic and non-alcoholic drinks, and managing exposure to high usage scenes.

6.2 SEEKING HELP

Of key importance are the sources of help men turned to in order to deal with their problematic alcohol or drug use, and the extent to which these various forms of help were useful and acceptable to them.

The most commonly cited source of support were friends; either as sources of advice or to turn to at times of crisis. Men tended to talk about needing friends who were outside of their immediate circle. Often these were friends who were not part of gay club or pub scenes. The following respondent talks about feeling he had to leave such an atmosphere and get away completely in order to 'dry out'.

That's when I phoned my friends in [town] and spoke to them and I asked them, 'I do need help' and so I went back to [town] for two weeks and stayed with some friends of mine and they kept me completely clean and it was really, really horrendous and that was the point where I felt I needed to drink [...] and I was getting shakes and feeling really, really awful because I was just going completely cold turkey and not having alcohol at all and I found that really, really hard. And when I got back then I phoned the AA but I didn't find that very helpful to me personally, it wasn't what I was looking for. Discussing my problems with other people wasn't helping me sort my problem I just needed people around me who were aware of it.

[aged 29, last test negative, alcohol]

The following respondent talks about his heterosexual friends who no longer go out to clubs.

I think all my friends have done it, absolutely, but their lives changed or they've got kids or you know this kind of thing, things are different so they can be a bit more objective about it. Oh, so they've all done coke in the past?

Some still do, yeah, some do.

And do some of them have problems as well with it?

Not really, no.

[aged 34, last test negative, alcohol & cocaine]

However the disconnect between helpful supportive friends and a gay social life could often be counterproductive. The following man talks about hiding the fact that he has started to drink again from family and friends. This is relatively easy because he only drinks in gay contexts.

Have you talked about it with friends? Have they talked about it with you?

No. Because the people I'm drinking with are not in the close circle who know about my problem. They [my friends] wouldn't allow me to drink [...] like tonight I'm meeting my sister and she doesn't know that I have a problem with alcohol. So I won't be drinking tonight at all.

So your closest friends don't know that you've been drinking for the last year and a half?

No. [...] well my ex knows [because I've] drunkenly dialed [him]. So...you know [he] came round to pick up the pieces really.

You say it's normally with other people. It's normally you go out socialising and then...?

Yes. Well because I work away quite a lot from home as well. I'm often in hotels. The last few months sort of at least weekly. So I go out to a gay bar in the city two nights a week or something. It depends on where I am. Normally it's only an overnight stay that I do. But pretty much guaranteed that I would drink.

[aged 38, last test negative, alcohol]

Therefore the capacity of friends to help can be undermined by their role in the social life of the respondent. If their gay social or sexual life was kept separate from other parts of their lives, the help friends could offer was limited.

It was far less common for men to approach either health, social or voluntary sector services or organisations for help. The minority who did so, were often responding to loss of control through

substance use. These were men who had either self-diagnosed or had been diagnosed as alcoholic and for the most part, abstinence was the goal.

I was suicidal and I lost my job and didn't want to be sectioned because it would have caused more problems. But in the end I checked in voluntarily. I was hospitalised for two and a half months. [I'd been drinking very] heavily [...] Seven days a week [for] probably six years. [In the hospital] I was diagnosed dependent alcoholic [...] I can't just have one drink. Once I start I can't stop, even though I know that it'll end in disaster.

[aged 38, last test negative, alcohol]

However, these men were in a small minority. For the majority the question of seeking help was mediated by whether or not the individual could classify themselves as having a serious problem or could identify themselves as an alcoholic or as having an addiction to drugs. This in turn was influenced by the specifically social nature of their substance use. The majority of the men we interviewed did not class themselves as alcoholic or as having addiction problems. When asked to explain why, men frequently compared their own drinking or drug use patterns to those of others that they considered to be addicted. Thus, if they did not drink during the day, or if they could go for periods without alcohol, they were not alcoholic.

Would you consider yourself to be alcoholic at the moment?

No. [...] I'd say an alcoholic is somebody who when they get up has a drink [...] my problem is, not knowing when I've had enough [...] sometimes I can [stop] and actually if I'm on my own and I'm in London [...] you know you go see everybody and then you leave Compton Street and you go I'll just pop into Bar Code and have look and have one there, oh I'll go to G.A.Y. Late Bar and before you know it its 4 o'clock in the morning and I'm pissed and I've got my shopping with me.

[aged 45, diagnosed with HIV, alcohol]

This respondent does not necessarily associate his problem with alcohol, but rather with the facilitating or enabling role of the commercial gay scene in his excessive drinking. The problem is social, one of identity and behaviour, of drinking in the wrong way rather than addiction. Social norms were instrumental in men's construction of their problem in other ways. The following respondent talks about the fact that his long-term recreational drug use goes unchallenged by the community within which he lives.

[I've] taken drugs for 20 years now [...] it hasn't seemed to affected my life hugely. I seem to be in a good position, enough money, all that kind of thing [...] But I just wonder, I don't know how dependent I am on them, do you see what I mean? It's like, there's nothing in society that says that that's acceptable in a way but maybe it should be... you know its not ... its not like drinking, if you drink for that time no one cares [...] There's no rules are there?

[aged 34, last test negative, alcohol & cocaine]

Again, the following respondent effectively compares what he feels is his predicament (which is exacerbated by social and cultural factors) with the notion of being addicted to alcohol.

[I'm not an alcoholic because I don't need an] 'eye opener'. I'm not physically addicted to alcohol. I don't have withdrawals [...] I'm not having DT's or shakes. [Doctor said I am] on the cusp of [...] drinking dangerously. That's why I'm here [taking part in this study]. Not that I'm here for any therapy but I just thought it would be useful to talk about, you know, as a gay man who drinks too much but where... and I've seen so much on the scene of men getting trolled you know, we all have [laughs]. It's part of the culture, unfortunately.

[aged 43, last test negative, alcohol]

As the majority of men lived out their problematic relationship with alcohol within a culture that strongly reinforced it, the kind of problems that might lead an individual to seek help were not so obvious. While the majority of the men did not think of themselves as having an addiction, in recognising that they had a problematic relationship with alcohol or drugs, they were at odds with

their social and cultural surroundings. It should not be surprising therefore that few had sought help for their substance use problems.

Some, however, had discussed their alcohol and drug use while seeking help with other problems. For example, men had addressed their substance use through help-seeking around health-related problems. The following respondent talks of approaching his GP concerned about his memory loss.

I can remember they did brain scans on me. They took it quite seriously because I remember going to [named hospital] and them sticking all these things all over my head and you know measuring my brainwaves, sort of thing, and they didn't find anything. And I remember the doctor saying an explanation which made sense was alcohol, about alcohol and how it can effect your short-term memory [...] whereas your long-term memory [is not so affected] and so again I couldn't remember what I'd done the night before.

[aged 45, diagnosed with HIV, alcohol]

Others addressed their substance use in ongoing therapy, recognising it as part of a larger problem.

I've had like various forms of therapy for years. [...] It's never been specifically for drug and alcohol use. [...] I had depression for three years – on anti-depressants for three years – came off of those and I've had psychotherapy and [CBT] and sometimes there's a part of it like with cognitive it was very much about triggers [to alcohol and drug use]. But it made me a bit more aware of what was going on and even sometimes, even sometimes I go, 'Ok, I know why I'm drinking so much and going out because some things going on in my [life]' [...] If you know what you're doing you know there's reason behind it, you don't feel as guilty the next day. I can kind of see what happened there so I'm not going to beat myself up about it.

[aged 34, last test negative, alcohol & cocaine]

Others found that a benefit of counselling for other problems was that they could control their drug or alcohol use better. The following respondent used a counselling service connected to his work for stress and suicidal thoughts.

I found [the counselling] really very useful the way I work in my head [...] And I knew what my problem was and I felt I could sort it which is why I'd gone in really depressed and quite suicidal and then by the end of the six sessions, not only was I not depressed and back to my normal. [...] I mean [counsellor] was a really decent person because he helped – he worked toward my strengths. [...] I feel I'm in control [of alcohol use] and I go home tonight now and not drink and I'm really pleased with myself for not doing that.

[aged 29, last test negative, alcohol]

Some men found that when they approached providers that dealt specifically with substance use, the remit was not wide enough. Thus they found it unhelpful.

There was an incident in February this year and was referred again to psychiatric support. And they decided that I wasn't really suffering from depression but I did have an alcohol abuse problem. That I should see an alcohol counsellor. [...] So I did. But they sort of brought up a whole lot of other issues. And [the counsellor] quite categorically said 'I'm not here to talk about other issues. I'm here to talk about your substance abuse and alcohol'. So I sort of said to him, 'But it's part of a big picture!' [...] And he said, 'Well that's not in my remit. That's not what I'm here for. I'm here to support you getting off the alcohol'.

[aged 38, last test negative, alcohol]

Some men had tried 12-step abstinence programmes. However, all but one felt that the intervention was not suited to them. Some did not feel that the level of their dependency merited such an intervention.

I've been to [AA] meetings and things [but they weren't useful] because I weren't as bad as a lot of them [...] living on whiskey and they were saying I usually drink 4 bottles of vodka a day and [...] I mean I've never been like that [and] some of them haven't had a drink for 18 years and stand up and we all clap.

[aged 57, last test negative, alcohol]

Others felt that AA interventions dominated participants' social and emotional life too much.

I went to AA. And didn't really like it. [Everybody] smoked. That seemed to be the thing to do. And I didn't really bond with anyone. [...] Everybody seemed to know each other and it was like a clique and it was their alternative. It was, 'Oh I'll see you at such and such a place tomorrow'. Their social life was actually AA. [...] So I need to find alternatives to try and get off the alcohol.
[aged 38, last test negative, alcohol]

Allied to this was the sense that 12-step interventions replace one sort of addiction (alcohol or drugs) with another.

I did go to lots of meetings and things, lots of AA meetings during that time and I felt worse. It was a purely personal thing but for most of the people, or a lot of the people that I met, it seemed to be working for them but it was like they'd replaced one thing with another thing [...] filling the void in their lives with AA meetings [...] I felt that I wasn't looking for something to replace [...] maybe according to their definitions I could be considered to be alcoholic then that would also make most of my friends, all of my family and a lot of the people I know, alcoholics as well.
[aged 35, last test negative, alcohol]

The sense of complete personal surrender involved in AA interventions was considered by some to be inappropriate. Others were suspicious of their quasi-religious connotations.

I don't know much about [12-step] actually but what I do know about it I think is a bit too rigid [...] almost militaristic sort of, spiritual stuff so its, its that kind of, its got some connotations of strict religious stuff somehow for me [...] I don't really like that kind of cut and dry, black and white approach to things really.
[aged 49, last test negative, alcohol]

We asked men whether, if they were to access a service, it would be important to them that the service was gay-run or gay-friendly. The majority of those who gave us an opinion said that they would prefer any service they used to be so. For some, this was because they feared heterosexist attitudes from non-gay services.

I think also there's an experience of being gay which people have if they're gay. And that the language you're speaking is the same. So a doctor isn't talking to you constantly about how is it affecting your family life. And will it impact on the kids? [...] I think it would be more efficient. More effective. And more pleasant.
[aged 40, last test negative, alcohol]

Others talked about any service provider having to understand underlying societal or structural factors that may increase gay men's tendency towards problematic substance use.

If I were to decide that I wanted to go and start seeking help in whatever form, it would be important for me that that therapist be gay. I'd prefer that, and I'd prefer if the service was gay-related. You know it was geared towards particular needs. Gay-led. [...] because I think there are particular issues, like homophobia for instance which may have an influence in that person's drinking.
[aged 52, last test negative, alcohol]

For the majority, a gay or gay-friendly service was important precisely because their substance use was generally bound up with their gay social and sexual life.

Although homosexuality or sexuality in general is not necessarily defining part of, or you don't have to make it a defining part of yourself, it leads into everything that you do. It bleeds into all the relationships that you have with other people. It bleeds into how you conduct yourself on a day-to-day basis. And for you to have to go to, if I was going to Alcoholics Anonymous or where alcohol also was involved in every part, because that's what it would need to be if I was to use those services, that I wouldn't be able to talk about alcohol abuse without it becoming involved with sexuality in some way.
[aged 25, last test negative, alcohol]

The following respondent feels that his use of a particular drug was bound up with a set of social, economic and sexual circumstances particular to him as a (young) gay man.

I would prefer it [to see a gay service] definitely. Just because, like say for example maybe a couple of months ago when I was hanging around with those people and doing the ketamine and I thought that I couldn't get myself out of it, I don't think I'd feel comfortable sitting down and telling people about that particular drug [...] or about working in a gay bar, that's like how I got involved in it. I think that would feel like I was being a bit judged more than I would do at a gay, lesbian and gay or whatever [organisation].

[aged 22, last test negative, alcohol & ketamine]

Because, drug or alcohol use (and the control of it) was bound up with specifically gay social norms, it was seen as important that a service was completely familiar with this.

I think it would be [important to have a gay or gay-friendly service] in the sense that because I find myself more inclined to drinking with my gay friends. And because my gay friends tend to drink more [...] than my straight friends.

[aged 39, last test negative, alcohol]

Overall then, help for problems with substance use came from a variety of sources. However, other community members were far more prominent in helping men deal with substance use problems than were mainstream alcohol or drugs services. Where gay substance use services would sit in relation to these two options remains to be seen.

6.3 SUMMARY

Although a minority of the men we interviewed considered themselves chemically addicted, the majority had developed a dependency on substances that was heavily mediated by their gay social and sexual networks and norms. Substance use was bound up with gay identity in many ways. This has a profound influence both on tactics for control or abstinence, patterns of help-seeking and indeed the way any services could best be configured.

For those men with chemical addiction or dependency, in order to give up or abstain, major changes to personal and social life are usually needed. Therefore, mainstream substance abuse services, AA, twelve-step and clinical interventions are more or less appropriate depending on the man and his problems. However, such services need to be alive not only to specific factors that may exacerbate problematic substance use among gay men (such as dealing with homophobia) but also to the extent to which these men's gay social and sexual lives can be constructed around alcohol and drugs.

For other men, the problem was less chemical addiction than a socially mediated dependency. That is, their social and sexual expression is informed by substance use which, for a range of reasons has begun to make them unhappy and has started to interfere with their capacity to function (work, self-care, socialising, etc.). In this situation men experience a dissonance with one's social and intimate world. Therefore, the response to this problem needs to be one which engages with this reality while trying to reduce the harm caused. For this reason, services should seek to address what substance use enables (or disables) rather than the substance use in and of itself. For example, the problem is not alcohol, or even alcohol use, but the pervasive anxiety or discomfort it can be used to alleviate, including the lack of social skills and confidence to speak to someone. Similarly, services which take abstinence as a pre-specified goal are unlikely to be appropriate for many men. There may therefore be a need to consider specific service models for gay men experiencing these problems.

7 Conclusions and recommendations

We have described the motivation, context and outcomes of alcohol and drug use among a group of gay men and bisexual men who identified themselves as being concerned about their use. While they clearly do not represent all substance using MSM in the UK we believe the reasons for their use and the problems they face are not peculiar to this sample. Rather than seeing these as men with a problem, we view the issues we have described as being potential problems for most substance using gay men. They are certainly issues that more men will experience in the future, and they are the outcome of social problems arising within a culture of widespread and normative substance use rather than the failures of individuals.

For those men in our study who could identify a 'cause' to their problematic alcohol or drug use, it was usually associated with social factors or incidents related to their intimate relationships. Therefore when thinking about interventions to reduce substance use harm, it is vital to take into account the particularities of gay men's intimate and social lives. It is also, of course, necessary to understand *how* gay men use alcohol and other mood-altering substances and we hope this current study contributes towards that understanding.

We note that generating quantitative evidence for sexuality differences in substance use and problems has been severely hampered by the omission of a sexuality question from government sponsored surveys, especially in the British Crime Survey. Instead gay organisations have been left to 'fend for themselves' in terms of research capacity, policy response and services with regard to substance use, a service ghettoisation that is slowly ending. This situation will start to improve from 2009 when a sexual identity question developed by the Office for National Statistics is introduced.

In terms of policy, we believe it is important that the Home Office review and extend the aims and targets of the National Drug Strategy to better reflect harms associated with 'club drugs' as well as opiates, and to acknowledge gay men as a specific population vulnerable to drug-related harm. This would be facilitated by extending or adapting the Drug Harm Index. The number of men diagnosed with HIV who are both MSM and IDU (collated by the HPA) could be an easy move in this direction.

There is a strong case for the Home Office and the Department of Health to consider the performance of current service models for problematic substance users who are members of sexual minorities. This is in terms of the number of access points for substance use services as well as the nature of the services themselves. An almost exclusive focus on access to treatment through the criminal justice system means non-offending users are disadvantaged in access. We think this might particularly disadvantage gay men. We have noted above how the nature of substance misuse is intimately tied to the structure and quality of people's interpersonal relationships. Therefore sexuality is bound up with the context in which problems develop, the way in which they are perceived, the sources of help and support available and the performance of services and interventions when they are encountered.

Home Office equalities mechanisms for the delivery of the national drugs and alcohol strategy need to be extended to take account of sexuality. Influence in applying this at local level might be brought through the Drugs Action Teams which include a variety of community perspectives.

Community-based health promotion for gay and bisexual men could make significant inroads into the harms associated with substance use among their population of concern, not least because of the large gulf between need and current service provision. Countering the norms of substance use

on the commercial gay scene and in gay social networks is a tall order, especially with the increase in gay targeted alcohol advertising. Providing an awareness of an alternative to automatic substance use might be more achievable than reversing a determined hedonistic culture.

Finally there is, of course, enormous scope for developing and delivering services for men experiencing problems with substance use. The lives of men for whom drugs are problematic are very varied, therefore a range of interventions are called for. However, all will require a recognition of the acceptability of seeking and accessing substance use services. Acknowledging the problems and how common they are is a first step.

References

- Adams J, McCreanor T, Braun V (2007) Alcohol and gay men: consumption, promotion and policy responses. In V Clarke and E Peel (eds) *Out in Psychology*. London, Wiley and Sons.
- Bonell C, Weatherburn P, Rhodes T, Hickson F, Keogh P, Elford J (2008) Editorial: Addressing gay men's use of methamphetamine and other substances. *Addiction Research & Theory*, 16(5): 417-420.
- Bux D (1996) The epidemiology of problem drinking in gay men and lesbians: a critical review. *Clinical Psychology Review*, 16(4): 277-298.
- Cabaj RP (1996) Substance abuse in gay men, lesbians and bisexuals. In RP Cabaj and TS Stein (Eds) *Textbook of homosexuality and mental health*. Washington DC, American Psychiatric Association.
- Celentano DD, Valleroy LA, Sifakis F, MacKellar DA, Halton J, Thiede H (2006) Associations between substance use and sexual risk among very young men who have sex with men. *Sexually Transmitted Diseases*, 33(4): 265-271.
- Chesney MA, Barrett DC, Stall R (1998) Histories of substance use and risk behavior: Precursors to HIV sero-conversion in homosexual men. *American Journal of Public Health*, 88(1): 113-116.
- Clutterbuck DJ, Gorman D, McMillan A, Lewis R, Macintyre CCA (2001) Substance use and unsafe sex amongst homosexual men in Edinburgh. *AIDS Care*, 13(4): 527-535.
- Cochran SD, Ackerman D, Mays VM, Ross MV (2004) Prevalence of non medical drug use and dependence among homosexually active men and women in the US population. *Addiction*, 99(8): 989-998.
- Cochran BN, Cauce AM (2005) Characteristics of lesbian gay bisexual and transgender individuals entering substance abuse treatment. *Journal of Substance Abuse Treatment*, 30(2): 135-146.
- Colfax GN, Mansergh G, Guzman R, Vittinghoff E, Marks G, Rader M, Buchbinder S (2001) Drug use and sexual risk among gay and bisexual men who attend circuit parties: A venue based comparison. *Journal of Acquired Immune Deficiency Syndromes*, 28(4): 373-379.
- Colfax G, Vittinghoff E, Husnik M, McKirnan D, Buchbinder S, Koblin B, Celum C, Chesney M, Huang Y, Mayer K, Bozeman S, Judson F, Bryant K, Coates T (2004) Substance use and sexual risk: A participant and episode level analysis among a cohort of men who have sex with men. *American Journal of Epidemiology*, 159(10): 1002-1012.
- Crosby GM, Stall RD, Paul JP, Barrett DC (1998) Alcohol and drug use patterns have declined between generations of younger gay-bisexual men in San Francisco. *Drug and Alcohol Dependence*, 52(3): 177-182.
- Darrow WW, Biersteker S, Geiss T, Chevalier K, Clark J, Marrero Y, Mills V, Obiaja K (2005) Risky sexual behaviours associated with recreational drug use among men who have sex with men in international resort areas: challenges and opportunities. *Journal of Urban Health*, 82(4): 601-609.
- Drumright LN, Little S, Styrahtdee S, Slyman D, Araneta M, Malcarne V, Daar E, Gorbach P (2006) Unprotected anal intercourse and substance use among men who have sex with men with recent HIV infection. *Journal of Acquired Immune Deficiency Syndrome*, 43(3): 344-350.
- Eisenberg M, Wechsler H (2003) Social influence on substance-use behaviours of gay, lesbian and bisexual college students: findings from a national study. *Social Science and Medicine*, 57(10): 1913-1923.

- Halkitis PN, Parsons JT, Wilton L (2003) An exploratory study of contextual and situational factors related to methamphetamine use among gay and bisexual men in New York City. *Journal of Drug Issues*, 33 (2): 413-432.
- Hayaki J, Anderson B, Stein M (2006) Sexual risk behaviours among substance users: Relationship to impulsivity. *Psychology of Addictive Behaviours*, 20(3): 328-332.
- Heffernan K (1998) The nature and predictors of substance use among lesbians. *Addictive Behaviors*, 23(4): 517-528.
- Hickson F, Weatherburn P, Reid D, Jessup K, Hammond G (2006) *Consuming passions: findings from the United Kingdom Gay Men's Sex Survey 2005*. London, Sigma Research.
 www.sigmaresearch.org.uk/go.php/reports/report2007c/
- Hirshfield S, Remien RH, Humberstone M, Walavalkar I, Chiasson MA (2004) Substance use and high risk among men who have sex with men: a national online study in the USA. *AIDS Care*, 16(8): 1036-1047.
- Hollaran PR, Novak AH (1989) Support choices and abstinence in gay/lesbian and heterosexual alcoholics. *Alcoholism Treatment Quarterly*, 6(2): 71-83.
- Hughes TL, Eliason M (2002) Substance use and abuse in lesbian, gay, bisexual and transgender populations. *Journal of Primary Prevention* 22(3): 263-298.
- Ibanez G, Purcell D, Stall R, Parsons J, Gomez C (2005) Sexual risk, substance use and psychological distress in HIV-positive gay and bisexual men who also inject drugs. *AIDS*, 19(supplement 1): S49-S55.
- Kalichman SC, Heckman T, Kelly JA (1996) Sensation seeking as an explanation for the association between substance use and HIV-related risky sexual behaviour. *Archives of Sexual Behaviour*, 25(2): 141-154.
- Lyons T, Chandra G, Goldstein J (2006) Stimulant use and risk behaviour: the influence of peer support group participation. *AIDS Education and Prevention*, 18(5): 461-73.
- McKirnan DJ, Peterson PL (1988) Stress expectancies and vulnerability to substance abuse: a test of a model among homosexual men. *Journal of Abnormal Psychology*, 97(4): 461-466.
- McKirnan DJ, Venable PA, Ostrow DG, Hope B (2001) Expectancies of sexual 'escape' and sexual risk among drug and alcohol-involved gay and bisexual men. *Journal of Substance Abuse*, 13(1): 137-154.
- Meyer IH (1995) Minority stress and mental health in gay men. *Journal of Health and Social Behaviour*, 36(1): 38-56.
- Minichiello V, Marino R, Khan MA, Browne J (2003) Alcohol and drug use in Australian male sex workers: its relationship to the safety outcome of the sex encounter. *AIDS Care*, 15(4): 549-561.
- Myers T, Aguinaldo JP, Dakers D, Fischer B, Bullock S, Milson P, Calzavara L (2004) How drug using men who have sex with men account for substance use during sexual behaviours: questioning assumptions of HIV prevention and research. *Addiction Research and Theory*, 12(3): 213-229.
- Ostrow DG, Beltran ED, Joseph JG, DiFrancesco W, Wesch J, Chmiel JS (1993) Recreational drugs and sexual behaviour in the Chicago MACS / CCS cohort of homosexually active men. *Journal of Substance Abuse*, 5(4): 311-325.
- Parsons JT, Vicioso K, Kutnick A, Punzalan JC, Halkitis PN, Velasquez MM (2004) Alcohol use and stigmatized sexual practices of HIV seropositive gay and bisexual men. *Addictive Behaviors*, 29(5): 1045-1051.

- Paul JP, Stall R, Davis F (1993) Sexual risk for HIV transmission among gay bisexual men in substance abuse treatment. *AIDS Education and Prevention*, 5(1): 11-24.
- Purcell DW, Parsons JT, Halkitis PN, Mizuno Y, Woods W (2001) Substance use and sexual transmission risk behavior of HIV-positive men who have sex with men. *Journal of Substance Abuse* 13(1): 185-200.
- Reback CJ, Larkins S, Shoptaw S (2003) Methamphetamine abuse as a barrier to HIV medication adherence among gay and bisexual men. *AIDS Care*, 15(6): 775-785.
- Redback, CJ, Larkins, S, Shoptaw S (2004) Changes in the meaning of sexual risk behaviours among gay and bisexual male methamphetamine abusers before and after drug treatment. *AIDS and Behaviour*, 8(1): 87-98.
- Remien RH, Goetz R, Rabkin, JG Williams JBW, Bradbury M, Ehrhardt AA, Gorman JA (1995) Remission of substance use disorders: gay men in the first decade of AIDS. *Journal of Studies on Alcohol*, 56(2): 226-232.
- Rhodes T, Stimpson GV (1994) What is the relationship between drug taking and sexual risk? Social relations and social research. *Sociology of Health and Illness*, 16(2): 209-228.
- Wright-Deaguero L, Rhodes F, Weir B, Deren S, Cotter L, Wood MM, Rourke KM, Shedlin MG, Trotter RT, Carlson RG, Lambert EY, Kochems LM, Stark MJ, Falck RS (1999) Understanding HIV risks of chronic drug-using men who have sex with men. *AIDS Care*: 11(6): 629-648.
- Rosario M, Scrimshaw EW, Hunter J, Gwadz M (2002) Gay-related stress and emotional distress among gay, lesbian and bisexual youths: a longitudinal examination. *Journal of Consulting and Clinical psychology*, 70(4): 967-975.
- Rosario M, Scrimshaw EW, Hunter J (2004) Predictors of substance use over time among gay, lesbian and bisexual youths: An examination of three hypotheses. *Addictive Behaviors*, 29(8): 1623-1631.
- Rusch M, Lampinen TM, Schilder A, Hogg RS (2004) Unprotected anal intercourse associated with recreational drug use among young men who have sex with men depends on partner type and intercourse role. *Sexually Transmitted Diseases*, 31(8): 492-498.
- Stall R, Paul JP, Greenwood G, Pollack LM, Bein E, Crosby GM, Mills TC, Binson D, Coates TJ, Catania JA (2001) Alcohol use, drug use and alcohol-related problems among men who have sex with men: The Urban Health Study. *Addiction*, 96(11): 1589-1601.
- Stueve A, O Donnell L, Duran R, San Doval A, Geier J (2002) Being high and taking sexual risks: findings from a multi-site survey of urban young men who have sex with men. *AIDS Education and Prevention*, 14(6): 482-95.
- Thiede H, Valleroy L, MacKellar DA, Celentano DD, Ford WL, Hagan H, Koblin BA, LaLota M, McFarland W, Shehan DA, Torian LV (2003) Regional patterns and correlates of substance use among young gay men who have sex with men in 7 US urban areas. *American Journal of Public Health*, 93(11): 1915-21.
- Williamson IR (2000) Internalized homophobia and health issues affecting lesbians and gay men. *Health Education Research*, 15(1): 97-107.

