



Drug use amongst Lesbian, Gay, Bisexual and Transgender young adults in Ireland.

Dr. Kiran Sarma, C. Psychol

Commissioned by
BeLonG To Youth Project

and funded by
The Department of Community Rural & Gaeltacht Affairs





Drug use amongst Lesbian, Gay, Bisexual and Transgender young adults in Ireland

Dr. Kiran Sarma, C. Psychol



Commissioned by *BeLonG To*
and funded by Pobal

BeLonG To

BeLonG To Youth Project works with Lesbian, Gay, Bisexual & Transgender (LGBT) young people in Ireland. It provides one-to-one and group support for LGBT young people, aged 14 –23 years, to allow them to safely engage with confidence building, personal development and peer support. It also affords young people a space where they can experience inclusion, acceptance, social justice, fun and safety. BeLonG To believe that youth work offers an ideal opportunity for LGBT youth to address their issues and concerns, while enabling them to participate as equal citizens in a society which often denies their rights. BeLonG To campaigns and lobbies on issues that affect LGBT young people and works to promote and support LGBT youth work in Ireland. The project is funded through the City of Dublin Youth Services Board by the Youth Affairs Section of the Department of Education and Science, by The Department of Community, Rural and Gaelteacht Affairs through the North Inner City Drugs Task Force, and by The HSE's National Office for Suicide Prevention. Further information is available at <http://www.belongto.org>.

Dr. Kiran Sarma

Dr. Kiran Sarma is a Lecturer in Psychology at the Department of Psychology, Mary Immaculate College, University of Limerick. He is a Chartered Psychologist with a PhD in Applied Psychology from University College Cork dealing with forensic-related issues. Kiran worked for An Garda Síochána between 2000 and 2004 as a Lecturer in Psychology and police researcher. He has published articles in a wide variety of areas relating to forensic psychology including hate crimes (against the LGBT community), suicide, police practice, drug tobacco and alcohol use amongst young people, victimization, repeat victimization, and group conflict (terrorism). Further information is available at <http://www.mic.ul.ie/psychology/Kiran.htm>.

Contents

	Page
Preface	4
Foreword	5
Executive Summary	6
Overview	
Key findings	
Summary of implications & recommendations	
Terminology	12
Section A: Introduction	13
Introduction	
Barriers to research in the area	
Explanations for drug use amongst the LGBT community	
Levels of drug use	
Consequences of drug taking	
Conclusion	
Section B: Methodology	19
Introduction	
Sample characteristics	
Representativeness of sample	
Ethics	
Section C: Findings	22
Overview of drug taking	
First time drug use	
Reasons for drug taking	
Polydrug use	
Financial cost of drug taking	
Problems associated with drug taking	
Alcohol and drug taking	
Service provision	
Miscellaneous issues	
Section D: Discussion and Recommendations	37
Introduction	
Review	
Recommendations	
References	46
Appendix	50

Preface

We would like to thank all those who participated in and supported this research.

Thank you to all the young people in Dublin, Cork, Dundalk, Limerick and Waterford who participated in one-to-one interviews and focus groups, and to all the respondents throughout the country who took time to share their experiences with us through our online survey. Their generous inputs have greatly enhanced our understanding of drug use amongst LGBT young people in Ireland.

Thank you also to Dave Roche from Gay Project Cork/UNITE; Bernie Quinn from Dundalk Outcomers; Dade Marcus from sOUTH youth group in Waterford and Damian Landy from Limerick Youth Service who kindly organised interviews and groups and supported the research process along the way.

Thank you to the research Advisory Committee who provided important direction and insights throughout the project. The Advisory Committee were:

Michael Barron, BeLonG To

David Carroll, The Gay Men's Health Project, HSE

Thomas Dunning, Drug & Alcohol Counsellor

Anthony Finn, Research Consultant

Petra Jäppinen, OUTHouse

Ciaran McKinney, Gay HIV Strategies/GLEN

Anna Quigley, Citywide Drugs Crisis Campaign

Almha Roche, BeLonG To

Paul Rudden, Chairperson, BeLonG To Management Committee

This research was made possible by funding and support from The Department of Community, Rural and Gaeltacht Affairs, The National Drugs Strategy Team and Pobal, for which we are very grateful.

Finally, we would like to thank Dr Kiran Sarma who did an expert and thorough job in carrying out this important research.

On behalf of BeLonG To Youth Project,

Michael Barron, National Development Coordinator

Almha Roche, Youth Worker

Foreword

As Chairperson of the NDST, I am happy to welcome the publication of this research report “Drug Use amongst Lesbian, Gay, Bisexual and Transgender Young Adults”. The research has been funded by the Dept. of Community, Rural and Gaeltacht Affairs and will play an essential part in informing the work of the BeLonG To Drugs Worker. This new position is being funded by the Drug Strategy Unit of the Dept of Community, Rural and Gaeltacht Affairs as part of the Emerging Needs Fund, with the support of the North Inner City Local Drug Task Force.

BeLonG To Youth Project should be commended for commissioning this piece of research to draw our attention to the need to include gay, lesbian, bisexual and transgender (LGBT) young people in our drug strategy. This research builds on the exciting and innovative work which BeLonG To have delivered over the past four years. In particular it builds on the ‘*So Gay*’ and ‘*Stop Homophobic Bullying*’ campaigns which highlighted LGBT youth identities and provided vital support to vulnerable young people throughout Ireland. In addition it complements BeLonG To’s extensive policy and lobbying work in the area of suicide prevention for LGBT young people.

The publication of this report is important for a number of reasons.

First, we must continue to develop our National Drug Strategy so that it is inclusive of all groups in our society and has the capacity to address the issue of drug use amongst all of these groups. Secondly, it is essential that the National Drug Strategy is evidence based and this is the first piece of research that provides us with specific information on drug use amongst LGBT young people in Ireland. The report indicates significant levels of drug use that are higher than amongst the general youth population and this gives us clear cause for concern. This is an exploratory piece of research which provides us with an initial evidence base on which we can build.

Thirdly, the report makes clear recommendations about the next steps in developing a response to drug use amongst LGBT young people by building links and practical cooperation between the organisations working with LGBT young people and the NDST and its Task Forces which are composed of a partnership of the statutory, voluntary and community sectors. We look forward to participating in the discussion on these recommendations.

Padraic White, Chairperson of the National Drugs Strategy Team

Executive Summary

Overview

Drug use amongst Ireland's teenage and young adult population has emerged as a growing concern for those involved in health, education, social welfare and criminal justice areas. Those working with young lesbian, gay, bisexual and transgender (LGBT) people, in particular, are concerned that anecdotal evidence points to particularly high levels of recreational drug taking amongst this section of the community deriving from an array of psychological, environmental, social and experiential risk factors.

A considerable amount of research has been conducted abroad that probes levels of drug taking and routes into drug use amongst the LGBT community. Yet there is a complete absence of comparable research here and we are left with a rather vague notion that there is a serious problem, rather than the type of sophisticated appreciation that emerges from systematic research that can be used to formulate policy and initiatives.

This study represents an initial step towards addressing this dearth of research. BeLonG To Youth Project, Ireland's only designated LGBT youth service, secured funding through Pobal to commission research with young LGBT people between the ages of 18 and 26 to determine a) the extent and causes of drug use amongst this client group b) the impact of drugs on young people and c) the type of service response that is appropriate to meet the needs of those who are currently using drugs or who may potentially begin to do so in the future. As a general aspiration, the research strives to provide evidence that can support the development of BeLonG To services for young LGBT drug users.

A three phase research methodology was employed. In Phase 1 interviews were held with 12 young LGBT drug users to record their personal experiences of drug use. A small number of interviews were also conducted with the staff at BeLonG To and other stakeholders to get a service-provider perspective. Themes emerging from these interviews were then explored further in a focus group setting (Phase 2) with 32 participants (in five focus group sessions). Themes emerging in Phase 1 and 2, together with themes emerging from international literature, were then incorporated

into an on-line questionnaire which was completed by 173 respondents between August and mid-October 2006.

Overview of findings

While recognising that alcohol is a drug, and that alcohol abuse is a growing problem within the LGBT community, for the purposes of this research it was excluded from our definition of 'drugs'. Thus when used in this report, the term 'drugs' refers to 'any psychoactive substance, excluding alcohol'.

Section C of this report provides detailed analyses of the on-line survey set in the context of testimonies recorded during focus groups and interviews. Headline findings from the survey include the following.

- 65 per cent of LGBT youth have had some experience of drug taking.
- 21 per cent have systematically used drugs (i.e. have done so on more than 60 occasions).
- 60 per cent had taken drugs over the 12 months preceding the survey.
- 40 per cent had used drugs in the preceding month and 29 per cent in the seven days leading up to the survey.
- 56 per cent of LGBT youth have some history of taking cannabis, 44 per cent poppers, 33 per cent ecstasy and 32 per cent cocaine.
- 89 per cent reported that they had been offered drugs at some point in the past.
- 65 per cent said that they had wanted to try drugs at some stage in their lives.
- 21 per cent of drug users either always or frequently mix their drugs on a night out (i.e. are polydrug users).
- 80 per cent of drug takers attributed their motivations for first trying drugs to curiosity. Eight per cent linked it to issues relating to their sexuality.
- 49 per cent of drug takers experienced blackouts resulting from drug taking.
- 46 per cent of drug takers had engaged in unprotected sexual intercourse attributed to drug taking.
- 11 per cent of drug users had been sexually assaulted while 'incapacitated due to drugs'.

These findings would tend to suggest that drug use is widespread amongst LGBT young people and is more prevalent than recorded in comparable studies probing drug taking within the youth population generally.

Summary of implications and recommendations

This research suggests that the problem is significant, impacts on young people in very real and often very negative ways, and is growing more serious in extent and nature. Minimising drug taking amongst LGBT youth, providing specific drug-related services sensitive to their needs, and doing so in a way that does not demonise an already marginalised and vulnerable section of the community, presents a major challenge for both Government and non-Governmental organisations.

Specific recommendations emerging from the research include the following:

The relative dearth of LGBT youth services around the county is lamentable and efforts must be made to support the formation of new Youth Projects and the continued evolution of groups currently emerging. The National Development Coordinator at BeLonG To should play a key role in providing this support and ensuring that such groups take cognisance of the drug-related needs of LGBT youth.

Given the vulnerable nature of the client base, and the sensitive issues involved, it is essential that projects are staffed by professionally trained youth workers and offer a safe and supportive environment for young people.

Peer-based education and outreach must play an integral aspect of LGBT youth services.

As a medium term aspiration a formal network of youth groups should be established, perhaps along the lines of the Swedish Federation for Lesbian, Gay, Bisexual and Transgender Rights (RFSL) and which has accreditation, quality assurance, funding and lobbying functions. Such a model is particularly important given the ethical and professional considerations inherent in working with young clients and individuals at risk of self-harm, substance abuse, victimisation, mental illness and suicide. Working together this network could formulate drug policy, training and a range of services that could be standardised across the country.

In the short-term existing LGBT youth service providers in Dublin, Cork, Waterford, Dundalk, Wexford and elsewhere should collectively agree a model of quality practice that can serve as a service guide to new and emerging projects.

It was noted by a number of LGBT stakeholders that the gay community in Ireland is currently without a national drugs policy. This needs to be addressed as a matter of urgency, perhaps through the LGBT National Network. In forming such a policy particular attention should be paid to youth issues – given that most recreational drug users first take drugs at an early age. BeLonG To, in consultation with LGBT youth groups around the country, should formulate a drugs policy that caters specifically for young people.

The appointment of a National Drugs Education and Policy Officer for LGBT youth should be secured to deliver on the recommendations presented below that pertain to education and awareness. This appointment would augment the services to be offered by the Drugs Education and Prevention youth worker to be appointed at BeLonG To in late 2006 – a post that will primarily fill needs in Dublin. The holder of the National Drugs Education and Policy Officer post, however, would have a wider remit and link-in with other service providers including GPs, youth workers, educators and the police. The post-holder would also design and pilot education programmes to be delivered on a local level by non-specialist LGBT youth workers and peer supporters.

In terms of specific service issues for LGBT youth groups, the following recommendations are offered:

- Primary drug prevention should be provided for those who have not yet taken drugs and should centre on education and awareness training that deals with deterrence, promoting alternatives to drug taking and strengthening of resistance skills and life skills. As noted above, the content and nature of this programme should be standardised across youth projects.
- Secondary drug prevention should be provided for those currently taking drugs. A key part of this service will be the development and implementation of outreach services into the gay community for those who take drugs, but are not currently seeking help for drug-related problems. Encouraging these drug users to access some aspect of the youth service will increase the likelihood that they will link-in with drug services should they feel the need to do so in the future. Again, services should focus on drug education and awareness, deterrence, life skills, resistance skills, harm reduction, HIV prevention and competence in risk taking.

- Existing procedures for referring clients to counseling services should be formalised at the earliest opportunity.
- Efforts must be made to promote awareness of LGBT issues amongst service providers including drug workers and medical practitioners.
- Efforts must be made to promote an awareness of LGBT identity amongst students in post-primary schools, building on the successful 'Stop Homophobic Bullying' and 'So Gay!' campaigns.
- Efforts must be made to promote awareness of LGBT identity amongst Irish society in general, a task that 80 per cent of our respondents felt would help reduce drug taking amongst LGBT youth.
- LGBT Youth groups should invite drug counsellors to provide occasional information sessions on drug issues and services. Derry's New Youth Project for Drugs takes this a step further in having client groups decide on the type of content to be covered by the counsellor and their experience is that this leads to better attendance at the subsequent course.
- Inclusion of drug-related information on gay websites and in the print media is important. Again Derry's New Youth Project for drugs is excellent in this regard. It provides a profile of all major illicit substances, including street names, forms, effects, risks, withdrawal symptoms, tolerance, risk minimisation and legality. It also provides contact details for different drug-related services in the city (see <http://www.nypdfoyle.com>). It would also be useful to provide similar information in LGBT publications.
- It is recommended that the research conducted here is built upon in the future. This research has illustrated that recreational drug use is widespread amongst LGBT youth. We know little, however, of other types of drug use including reliance on prescription medicine and drug addiction. Similar research is most certainly required that examines the life histories of these drug users. It is at least possible that such individuals spiralled very quickly into addiction as a result of negative life experiences.

- We also know little about drug taking amongst those under the age of 18, who were omitted from this research due to ethical considerations. Yet most drug use begins between the ages of 12 and 18, at a time when young LGBT people are particularly vulnerable. Research should probe motivations for drug taking amongst this age group, the types of drugs being taken, new trends in drug use, and the initiatives that can be effectively employed to minimise the extent of the problem.
- Finally, this research provided a snapshot of the extent and nature of recreational drug taking amongst LGBT youth today. It would be very useful indeed to replicate the study at set intervals in the future to track trends over time and ensure that policies and initiatives can be tailored to meet the changing needs of vulnerable young people.

Terminology

Drugs

The term 'drug' is used here to refer to any psychoactive substance, excluding alcohol.

Drug use

The term drug use and drug taking are used interchangeably throughout the report and refer to 'any aspect of the drug taking process' (Bryan et al, 2000, p. ix).

Problem drug use

Problem drug use refers to the use of drugs in 'a manner that results in physical or mental harm or loss of social well-being for the individual, for other individuals, or for society at large' (Bryan et al, 2000, p. ix).

Recreational drug use

Recreational drug use refers to 'the use of psychoactive substances to 'have fun"', normally in nightlife settings (EMCDAA, 2002, p. 1).

The 'scene'

The 'scene' refers to the gay social scene.

Section A: Introduction

Introduction

There has been growing concern in recent years that levels of recreational drug use amongst teenagers and young adults in Ireland is having serious social, psychological and physical health consequences. Particular concern has been expressed in relation to drug taking amongst young lesbian, gay, bisexual and transgender (LGBT) people with youth workers noting that anecdotal evidence points to increasing levels of problem substance abuse. This resonates with anecdotal evidence from the LGBT community in general (i.e. of all ages) and with empirical research from abroad which consistently reports higher levels of drug taking amongst gay men and lesbians than those who identify as heterosexual.

It is generally accepted that drug use often first occurs, and later becomes habitual, as a result of a desire to 'escape' from some negative aspect of the drug takers life. The reality is that many of those who identify as lesbian, gay, bisexual and transgender live with such 'negative aspects' on a daily basis, most visibly in the form of marginalisation, isolation, bullying, harassment, family and peer rejection and fear. Commentators have suggested that these and other negative experiences contribute to the relatively high levels of drug taking within the LGBT community (McKiernan & Peterson, 1989).

LGBT youth are particularly vulnerable in this regard. One recent survey of LGBT young people in Ireland, for instance, found that half of school-goers surveyed reported that they had been bullied in the three months preceding the survey's administration, a prevalence figure far exceeding that reported in the general post-primary student population (Minton et al, 2006; see also Baron, 2006). Echoes of this were reported in surveys of post-primary teachers with more than 80 per cent stating that they were aware of homophobic bullying in their schools (see Norman, 2004 & Norman & Galvin, 2006).

LGBT youth find it exceptionally difficult to deal with such experiences alone. They dwell on past negative events, such as bullying or rejection, and suffer intense fear of what the future may bring. Those in rural areas, who are less likely to have access to support networks, are particularly vulnerable in this regard.

It is unsurprising therefore that LGBT youth are particularly predisposed to suffering from depression, anxiety disorders and other mental illnesses. International research has found that depression is far more widespread amongst LGBT youth than their heterosexual peers (Youthnet, 2004) and there are echoes of this at home, with 11 per cent of LGBT school-goers reporting taking anti-depressants at some stage in the past (Minton et al, 2006).

Youth workers are concerned that high levels of mental ill health have left LGBT youth vulnerable to self harm and suicide. This fear was largely confirmed in a recent survey reporting that 15 per cent of LGBT youth had attempted suicide in the past and 21 per cent had admitted to 'self-harm' behaviour (Minton et al, 2006). Such findings lend support to growing concern amongst youth workers that low self esteem, fear of rejection, bullying, and prevailing feelings of isolation are becoming manifest in suicide and self harm amongst LGBT youth (National Strategy for Action on Suicide Prevention, 2005; Belong To, 2005).

Drug use set against this context raises particular concerns. First, when psychoactive non-prescription drugs are taken by someone suffering from a mental illness, the illness invariably becomes more severe and more difficult to treat. On another level, drugs can, on their own, 'trigger' the onset of a mental illness when the drug-taker has a predisposition towards a particular clinical disorder (NYU, 2006). For example, in someone with no prior history of schizophrenia, but a psycho-physiological predisposition towards the illness, chronic use of cannabis, or infrequent use of ecstasy or LSD, can trigger the onset of that illness.

Drug taking may also reduce inhibitions and promote increased levels of risk-taking behaviour associated with unprotected sexual behaviour, sharing of drug-delivery mechanisms and polydrug use. Similarly, those under the influence of drugs may place less emphasis on personal security and be more vulnerable to physical and/or sexual victimisation.

Third, evidence would tend to suggest that while drug consumption levels decrease with age amongst the general population, amongst the LGBT community levels remain high at all ages – potentially due to less dramatic age-related role changes over their lifetimes. Similarly while levels tend to be lower amongst females than males in the heterosexual population, no such difference has emerged in research on the LGBT community.

Barriers to research in the area

Before reviewing some of the studies in the area it is pertinent to note the not insignificant conceptual and methodological problems that hamper attempts to conduct such research. In addition to the barriers to research encountered by almost all researchers investigating sensitive topics, studies attempting to understand the gay and lesbian community face obstacles specific to that target population. The primary problem is that it is almost impossible to recruit a representative sample. There are two principal difficulties here. First, a significant proportion of gay men and lesbians are 'hidden' from researchers, are unwilling to publicly disclose their sexuality, and do not engage with service providers or representative groups (Herek, 1992; Berk, Boyd & Hamner, 1992; GLEN, 1995). Second, those who are 'visible' and accessible to researchers may be those most likely to be engaged in drug use, possibly due to greater exposure to environmental and cultural risk factors, and thus creating a skewing effect in prevalence-of-use statistics.

Even within the gay community itself, there are specific sample sub-populations that are difficult to include in research. Certainly 'young LGBT people' is one such population - at least some of whom fear stigmatisation, are uncomfortable with their sexual identity and may not be 'out', and thus do not visit gay-friendly venues or engage with service providers.

Finally, it is particularly difficult to conduct research on drug use amongst the LGBT community, which combines both the problems associated with investigating a sometimes 'hidden' community and those associated with examining illegal behaviour (Paul et al, 1991). Most of the international studies in the area have recruited participants at gay venues where drug use levels may be unrepresentatively high and ability to accurately report/recall behaviours, attitudes and experiences is low and thus we are uncertain just how valid reported findings are in terms of the gay community in general (Greenwood et al, 2001). This is not to say that valid research is not possible, but rather that we must take cognisance of these barriers in the design, implementation and interpreting of research.

Explanations for drug use amongst the GLBT community

While useful to some extent, traditional causal models of drug use may be of only partial utility in understanding drug taking amongst the LGBT community, which may experience many specific stressors that relate, directly or indirectly, to their sexuality. Being part of a marginalised community, an attempt to escape from negative personal experiences relating to homophobia, fear of 'coming out', conflicts in self identity, reduced family support, fear of HIV and other sexually transmitted diseases, underlying feelings of depression and social isolation and normative influences within the gay sub-culture may all play some role here (see for instance McKirnan & Peterson, 1989).

In psychological terms, one key predisposition would appear to derive from difficulties incorporating 'homosexuality' into personal identity and the damage this has on self-esteem. Cultural stigmatisation of homosexuality creates negative prejudices, even amongst the gay community itself. It is suspected that as a result some young gay men and lesbians often fail to fully accept their sexual identities and thus have personal vulnerabilities, insecurities and a dominant fear of rejection (Pachankis & Goldfried, in press). This is manifest as inadequacies with being homosexual, deflated self-esteem, a lack of self-confidence and social anxiety. Drugs and alcohol, it is increasingly accepted, allow individuals to artificially circumvent their personal insecurities, bolstering their self esteem and thus allowing them to interact socially and sexually in society (Ghindia & Kola, 1996; Lau et al, 2004). This can often lead to deterioration in ability to function in social gatherings without a drug-induced affect (i.e. psychological dependence on drugs), with normal social skills falling into disuse (Bacon, 1973). It seems reasonable to assume that young gay men and lesbians are particularly at risk of this identity-formation/self-esteem predisposition.

Others have intimated that drug taking is normalised within gay culture and there is certainly some evidence in the international literature to support this assertion (Bochow, 1998). It would appear that this reflects attempts to enhance atmosphere and experience at gay events (Lau et al, 1998) and reduce tension prior to and during social gatherings (McKiernan & Peterson, 1989).

Levels of drug use

Research from abroad tends to suggest that gay men and lesbians are between two and five times more likely to take drugs than the general population (Murnane et al, 2000; Dyter & Lockley, 2003; Lau et al, 2004; Thiede et al, 2003). In the USA 52 per

cent of gay men stated that they had used drugs, 17 per cent frequently (Stall et al, 2001). In Australia 62 per cent of young LGBT people had used cannabis, 30 per cent speed, ecstasy or LSD and 11 per cent had injected drugs (with some admitting to sharing injecting equipment) (Hillier et al, 1998).

In North West Lanchashire 43 per cent of gay men stated that they used drugs 'frequently', a prevalence rate six times that of the general population (HPU, 1998). Comparable levels of drug taking were reported in Weatherburn et al's (2000) *National Sex Survey* of gay men in England. A similar survey conducted in Ireland in 2000 found that 55 per cent of gay men had used drugs in the 12 months preceding the research (Carroll et al, 2002).

McKiernan and Peterson (1989) note that while drug use amongst the general population tended to be lower amongst females than males and declines with age, neither of these trends occur amongst the LGBT community, where the sex-role stereotype was not adhered to and age-related role changes do not as readily occur.

Lau et al (2004) found that participants took a variety of different drugs during a night out, 'varying the type, timing and sequence to achieve a desired effect at specific times during the night' (p. 19). For instance, some reported alternating ecstasy and Gamma hydroxy butyrate (GHB), with the former creating an 'upper' and latter a 'downer'. Similarly cannabis, in its various forms, was used as 'to mellow out' the high resulting from ecstasy use. Others reported taking cocaine the day after to deal with the depressive symptoms of the ecstasy come-down.

With the exception of the *Vital Statistics Ireland* report, no comparable research on drug taking amongst the LGBT community has been conducted in Ireland, nor is there any qualitative data dealing with experiences of use or routes into use. Such research would aid in the identification of user networks and environments and psychological, group-dynamic and experiential antecedents to use. Moreover, findings could aid in the formulation of harm-reduction education programmes and provide focus and direction to policy makers and agencies working with the LGBT community.

Consequences of drug taking

In terms of the consequences of drug use, one of the main concerns is that certain types of drug use can lead to high-risk sexual behaviour (Lau et al, 2004). While the relationship between the two behaviours is likely to be complex, it would appear that drugs lower inhibitions about sexual contact and unsafe sexual intercourse and increases the likelihood of having multiple sexual partners (Greenwood et al, 2001). Obviously this has serious ramifications for sexual health and the transmission of sexually transmitted diseases amongst the population as a whole.

As noted earlier, the potentially serious mental health problems that can be triggered by drug taking is also of particular concern. Research has consistently linked use of a range of hard and soft drugs with irritability, sleep disturbance, severe anxiety, paranoia, depression and schizophrenia (NYU, 2006). Commentators have suggested that this has contributed to high levels of suicide amongst the LGBT community (Saunders & Valente, 1987) which is again in line with anecdotal evidence as reported by BeLonG To and others working with LGBT youth in Ireland. Drug taking is also linked to a range of other potentially problematic outcomes including hampered performance in educational and vocational settings, involvement in criminal behaviour, strain on interpersonal relationships and in particular with family members and partners.

Drug use amongst young LGBT people is of particular concern. The social impact of use is likely to be higher, with underperformance in second and third level education potentially irreversible and with knock-on effects (Miller & Plant, 1999). Young drug users are also more vulnerable to victimisation, particularly sexual exploitation, and there is an increased likelihood of involvement in criminal behaviour (Tyler et al, 2004). Finally, there is a physical impact with drugs triggering psychological imbalances at a time when the young person is often most vulnerable (CAMH, 2006).

Conclusion

There is a dearth of research on the extent and nature of drug use amongst young LGBT adults in Ireland (and indeed pathways into drug taking). Yet the value of such research is considerable. International best practice would tend to suggest that understanding the causes and consequences of use can inform and focus government policy and lead to the emergence of effective interventions.

Section B: Methodology

Introduction

The study had three core components. Phase 1 and 2 adopted a qualitative approach and sought to record the real-life experiences and attitudes of LGBT youth through a series of interviews (Phase 1) and, subsequently, focus groups (Phase 2). 12 young people were interviewed and 32 participated in focus groups over a three month period. In the main participants were recruited through LGBT youth projects and groups across the country with peer-referrals and recommendations leading to a snowball effect (often referred to as 'snowball sampling').

Following transcription of recorded interviews and focus groups, and thematic analysis of this data, and taking cognisance of the international literature and recommendations from the Research Advisory Group, a questionnaire was designed and administered on-line between August and September 2006 (Phase 3). The questionnaire contained 34 items: Eleven dealing with background information; fourteen with alcohol and drug consumption during the respondent's life; six with alcohol and drug consumption on the respondent's last night out and; two dealing with drug-related service provision issues. Pre-test instructions stressed the confidential nature of the research and gave an approximate time required to complete the questionnaire. Post-test instructions provided respondents with contact details for BeLonG To.

The questionnaire was hosted by a web survey service provider. Websites for a number of LGBT representative groups publicised the survey and provided links to the survey site. Based on pilot testing, the questionnaire took between four and 15 minutes to complete depending on the number of applicable questions that each respondent was required to answer. For instance, a respondent who reported having never taken drugs would have been able to complete the questionnaire within five minutes but others who had experience of both drug and alcohol consumption would have required more time. Minimum quotas for gay, lesbian, bisexual and transgender respondent's were reached after three weeks and in total the survey was 'live' for 10 weeks (see Appendix 1 for a copy of the questionnaire).

Sample characteristics

198 respondents completed the on-line survey. Of these 18 reported that they were 'straight' (and did not identify as transgender) and a further seven were either above or below the target age range of 18-26. This sub-group of 25 respondents were excluded from further analyses leaving a core sample of 173.

Of this cohort 84 per cent (n=144) were Male and 16 per cent (n=28) Female. Three per cent (n=6) identified as transgender. Seventy-four per cent stated that they were gay (n=124), 10 per cent lesbian (n=17), 11 per cent bisexual (n=19) and 4 per cent (n=7) were 'unsure' of their sexuality.¹ The average age of our sample was 22 (SD=4).

The majority (68%, n=115) of respondents resided in Dublin during the testing period with less than 10 respondents participating from any other county – a sample characteristic that may reflect a number of factors including greater access to broadband and internet services in urban areas, more frequent accessing of gay websites by city-based LGBT youth (who are more likely to socialise in that environment), the presence of the questionnaire on two prominent websites that are largely accessed by Dublin-based youths (www.belongto.org and www.queerid.com), and promotion of the survey through word of mouth.

Seventy-six per cent (n=128) of respondents were employed. A third (33%, n=55) were in a relationship at the time of the survey. Just over three quarters (76%, n=128) of respondents were "out" with either all or some of their family and 92 per cent (n=155) were "out" with either all or some of their friends. Seventy-six per cent (n=129) socialise on the gay 'scene' either 'always' (25%) or sometimes (51%).

Representativeness of sample and predictive utility of the research

The weaknesses and fortes of on-line surveys have been discussed at length elsewhere (Couper, 2000; Manfreda et al, 2002). Suffice it to note here that given the difficulties associated with recruiting LGBT youth for survey research, the on-line approach offers a useful mechanism for survey administration.

¹ Where total sample numbers in this report fall below the 173, the shortfall is due to non-responses (i.e. respondents electing not to provide an answer to the item).

There is currently no credible and definitive 'profile' of the LGBT community in Ireland and it is therefore not possible to make an assessment of the representativeness of the sample employed here. All that can be said with confidence here is that as an exploratory study and first foray in the area the survey sample size was sufficient to provide a good snapshot of drug taking by LGBT youth and that the qualitative stages provide a real-world overview of the lives of drug takers.

Finally, the relatively small numbers of lesbian, bisexual and transgender youth participating in the survey means that it is not possible to provide comparisons of drug taking behaviour across different sub-samples and thus results provided below are based on the full respondent pool.

Ethics

This research conforms to the Psychological Society of Ireland and British Psychological Society's Codes of Ethics. *Informed Consent* forms detailing the aims and objectives of the study were provided to each focus group and interview participant and contact details for BeLonG To were provided should any participant wish to discuss any aspect of the research or negative consequence arising from it. These contact details were also provided to web-survey respondents through a pop-up box that appeared at the end of the questionnaire.

Digital recordings of focus groups and interviews were held on a secure IT system and names of participants were changed during transcription to ensure confidentiality and anonymity. Testimonies reproduced in this document have been vetted to ensure that those quoted cannot be identified from the content.

Section C: Findings

Overview of Drug Taking

The overall picture emerging from the research is that drug taking by LGBT youth is widespread. As illustrated below, the vast majority have taken drugs at some stage in their lives and for many drugs have become part of the routine of socialising. Others report frequently taking large quantities and mixing drug types.

Of the 173 survey respondents, 150 answered the series of questions relating to drug and alcohol taking and percentage figures provided here are based on this sub-sample.² Of this group, 89 per cent (n=134) reported that they had been offered drugs at some point in the past and 65 per cent (n=97) said that they had wanted to try drugs at some stage in their lives.

Sixty-five per cent (n=98) of young LGBT youth have had some experience of drug taking with 21 per cent (n=31) having systematically done so - using drugs on more than 60 occasions. Approximately one in five (19%, n=29) had taken drugs on fewer than six occasions and could be labelled 'experimenters'.

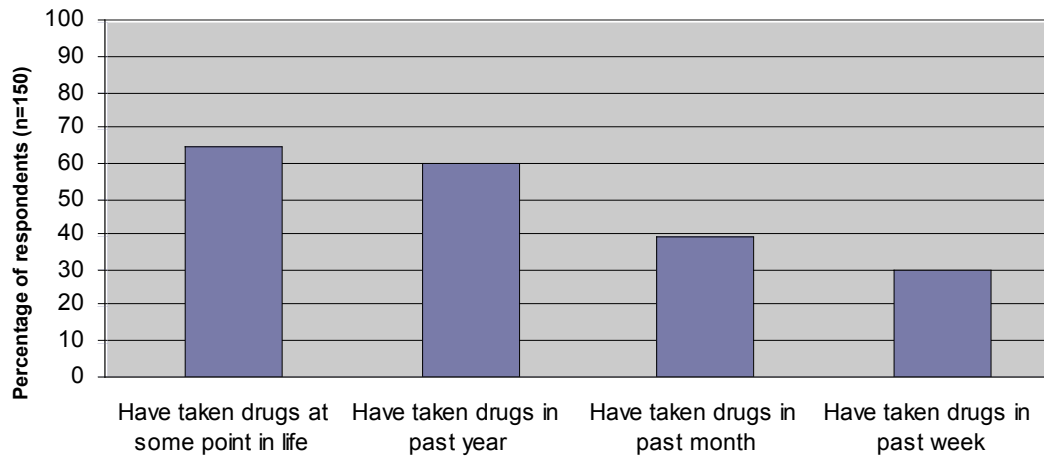
Most of our sample (60%, n=90) had taken drugs over the preceding 12 months with a significant minority (8%, n=12) having done so on more than 60 occasions in that period. Forty per cent (n=60) had used drugs in the past month and 29 per cent (n=44) in the seven days leading up to the survey.

Table 1: Headline findings from the BeLonG To web survey

	%
Had been offered drugs	89
Had wanted to try drugs at some stage in the past	65
Have taken drugs	65
Systematically take drugs	21
Have taken drugs in preceding 12 months	60
Have taken drugs in preceding month	40
Have taken drugs in preceding seven days	29
Have taken cannabis	56
Have taken poppers	44
Have taken ecstasy	33
Have taken cocaine	32

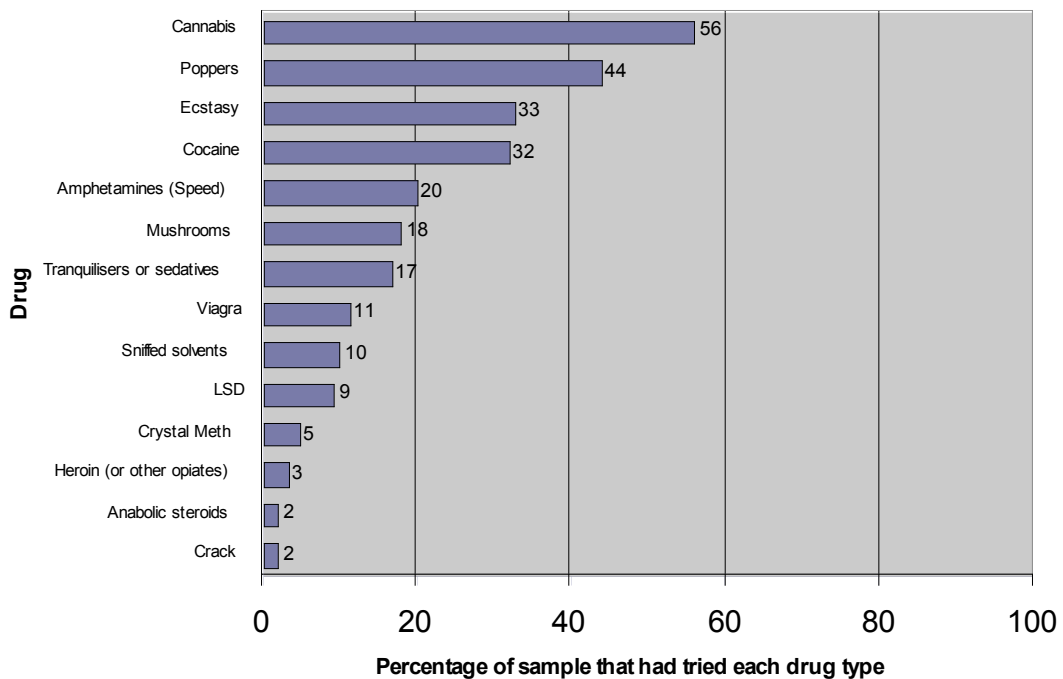
² That 23 respondents elected not to answer this set of questions is understandable given the sensitive nature of the subject being probed.

Figure 1: Overview of drug taking experience 'ever', over past year, month and week.



Participants were asked to identify the types of drugs they had taken in the past. Somewhat predictably, cannabis was the drug most likely to have been taken with 56 per cent (n=84) of our sample having tried the drug at some period in their lives. Poppers (44%, n=66), ecstasy (33%, n=49) and cocaine (32%, n=48) were also prevalent in the report statistics (see Figure 2).

Figure 2: Percentage of respondents who had tried each type of drug at some stage in their lives.



When asked specifically about the last night out during which they took drugs, 39 per cent (n=58) of our sample had used cannabis, 17 per cent (n=25) ecstasy and 11 per cent (n=17) cocaine.

These findings are largely in line with testimony provided by focus group and interview participants, most of whom had some experience of drug taking, and a number of whom took drugs systematically. As with the survey results, cannabis, ecstasy, cocaine and poppers were the most common drugs taken and most of our participants reported moderate levels of drug taking typically characterised by occasional drug use during nights out. In the main this cohort tended to use drugs when they were offered by friends, but were unlikely to actually approach a dealer to purchase them. They were also unlikely to take more than two ecstasy tablets during a night out and tended to place greater emphasis on alcohol. Seán provides a typical example of this level of drug taking.

Seán: Well I suppose I would be more likely to take them [ecstasy] after a few drinks and just before going to the club. I wouldn't have to go looking for them... to a dealer or anything... but one of my group would always have enough for us all... so I'd take a couple over the course of the night. That would only be sometimes... a lot of the time I just wouldn't bother 'cause we wouldn't have any and couldn't be bothered looking for a dealer.

Others, however, reported alarming levels of drug taking. Peter and Mark's 'last night out' illustrates the typical night out for drug use at the high end of the spectrum.

Peter: Well, this is what happened the last night out. I went over to a drug dealer, his name is Anthony, and I asked him for three [ecstasy tablets]. I gave him the money and he said come back in a while for them. Then I went over to another drug dealer and I said that "Anthony said he would come back to me, but I don't want to wait, so will you give them to me now and Anthony will give them to you when he gets back?" He gave me three. Then Anthony came back and gave me his three. I took them all in one go.

Interviewer: All six?

Peter: Yeah.

Mark: I suppose I would normally drink some beer and smoke some grass. Then I would go out around seven o'clock and take ecstasy. I'd probably buy 20 pills and I might take 10 during the night and back at a party, and I'd give away the others or save them for the next night.

Interviewer: What about your last night out?

Mark: It was two weeks ago... I can't remember all the details... I went up to a friend's house, had a few drinks, did a bit of Coke... €30 worth of Coke (five lines)... went to the [named club] did five yokes (Es), and then I can't remember. The yokes were five euro each. And then I remember waking up at a friend's house.

Clare reported similarly high levels of drug taking on a night out.

Clare: I went on pills [ecstasy] after 15 [years old]. I couldn't go out without taking them. Then I started taking a lot more. I used to hate the comedown during the night, so I'd have to take three just to get myself back up again.

Interviewer: So how many would you take in a night?

Clare: Six I suppose on that night. But it could go on for three days and then I'd need about 20.

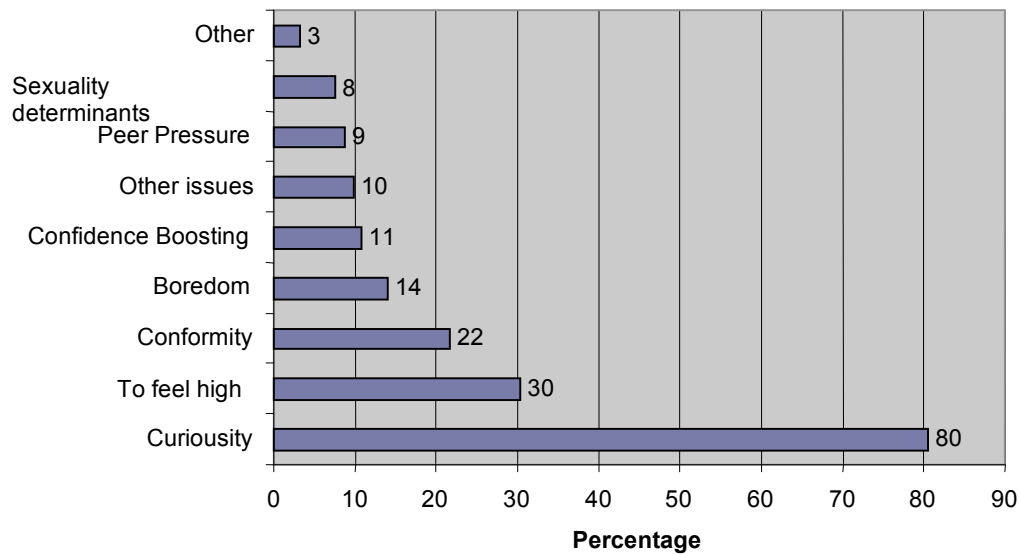
Reasons for first-time drug use

Those who had taken drugs in the past were asked a series of questions relating to the first time they had done so. Fifty-six per cent (n=51) had been under 18 years of age when they had first tried drugs and 18 per cent (n=17) under 15 years old. Cannabis (78%) and ecstasy (9%) were the most common drugs taken during this first encounter.

When asked to describe the reasons for taking drugs on this occasion, curiosity (80%, n=74), a desire to feel high (30%, n=28), a desire to 'be like others' (22%, n=20) and to overcome feelings of boredom (14%, n=13) were the most common explanations. Eleven per cent (n=10) linked their first experience of drugs with a need to bolster their self confidence and eight per cent (n=7) blamed 'issues to do with their sexuality' (see Figure 3).

Most had been given these drugs by a friend (75%, n=65) and one in five (20%, n=17) had obtained them through a 'dealer'. Sixty-five per cent had consumed more than six units of alcohol on that occasion and just 16 per cent (n=14) had not consumed alcohol.

Figure 3: Motivations for taking drugs on the first occasion based on all those who had taken drugs at some stage in their lives (n=98).



Echoes of these findings were found in the testimonies of interview and focus group participants. Seán, like many of our other participants, first experimented with cannabis, which later proved to be a gateway drug for further experiences with other substances.

Seán: I remember being with a girlfriend and she was way more advanced than I was and she used to have mostly cannabis... and we'd smoke it.

Interviewer: What age were you then?

Seán: 15 I think.

Interviewer: Where would you smoke?

Seán: Well we would go to her place and we would smoke in their garden sometimes... later we took Es when we could get them... we used to buy petrol in a coke a cola bottle sometimes and sniff that too.

Peter provides similar testimony.

Peter: My friend smoked cannabis regularly, so I started taking it with her. Every weekend. I still like cannabis. It is definitely a gateway drug though. I moved to pills and then Coke.

Seán and Mark both linked their first experiences with drugs to boredom and curiosity.

Interviewer: And thinking back now, why do you think you were so willing to take drugs?

Seán: Well... I was curious. And I was bored with everything. School and family and that. It was an outlet. It was something to do in the evenings.

Mark: I was just bored. We had heard of solvents word of mouth and we would have drunk Toilet Duck if we thought we could have got high on it.

Another respondent, Luke, linked his drug taking to the fact that others in his social network had adopted this as a normative behaviour – a network that was comprised of both gay and straight men and women.

Luke: I just fell in with people who do take drugs. I suppose it was peer pressure. But it could have happened in either scene [straight or gay]. And in our group that go out, we have both straight and gay men and some women – their girlfriends.

For others, however, experiences directly or indirectly related to being gay appear to have led to drug taking. Peter, for instance, was bullied in school and feels that this may have led to his drug taking.

Peter: I went to an all-boys school. I was bullied a lot. Not physical, but name calling. I got used to it. I don't know if it affected me at all to be honest.

Interviewer: What was the first memory you had of being bullied?

Peter: I was six or seven and I was being teased at that stage. I think maybe it did impact on me later and maybe it did mean that I wanted to escape from it through drugs. Maybe it did. I just don't know.

Mark had a similar explanation for his drug use.

Mark: It was also hard being gay and growing up in a rural area. Particularly for someone like me who is prone to introspection and depression. It was depressing. You are going to use drugs and alcohol more than you would if you were in a healthier environment. You would be called names and people made jokes when you are younger.

Reasons for sustained drug taking

Interview and focus group participants were asked to comment about some of the causal factors that led to sustained drug taking – as opposed to motivations for first time drug use. In the main these explanations centred on positive first experiences of drugs that led to habitual recreational drug use and the normative and widespread

use of and access to drugs that has resulted in high drug taking in Irish society in general. Factors relating directly or indirectly to sexuality were identified in very few instances - although two such accounts were narrated by Mark and Thomas.

Mark: I was attacked one night by some guys. I was terrified for about a year afterwards and wouldn't leave the house. I drank and took a lot of drugs at that time. I wouldn't leave my house and eventually moved to Dublin.

Interviewer: And do you think that the experience got you further involved in drugs?

Mark: Yeah. It did.

Thomas had a particularly tragic story to tell.

Thomas: When I moved I worked for a while as a house boy.

Interviewer: Explain that to me.

Thomas: Well it's the same as a rent boy, but I was over 18 – but I looked a lot younger. I didn't stand on corners either, I was advertised through an internet service. I used a lot of drugs at that time.

Interviewer: Why

Thomas: To numb myself. I would do three each week [clients] and it wasn't always sexual. But it did damage me and I did use drugs to numb me from what I was doing. Ecstasy, cocaine, a lot of cocaine, grass and hash... It would make you feel awful about yourself... I would end up back in strange houses... One time in Dublin I woke up naked on a bed and there were seven people in the room and it was mortifying. I can't remember what happened.

Others reported taking drugs to boost their confidence when going out on the scene, particularly during the initial period after coming out.

Peter: Yes it gives me more confidence. It really does.

Interviewer: Why is that?

Peter: Well coming out on the Gay scene was difficult for me. I was scared. Just being around other gay people... Ecstasy helped me. Obviously I wasn't me on it, but if I didn't have it I would just hang my head. It's different now. Then I lacked confidence. I couldn't have a good night without them.

Interviewer: What would go wrong for you if you didn't have them?

Peter: I wouldn't talk to people. I wouldn't, am... be dancing. I would just stay in the corner all night.

Polydrug use

Twenty-one per cent (n=19) of those who reported a history of drug taking stated that they would “frequently or always” take more than one type of drug on a night out. A further 30 per cent (n=26) have engaged in polydrug use on occasion. When asked about their last night out, for instance, of those subjects who reported taking drugs, 27 per cent (n=24) stated that they had taken more than one type of drug with combinations of ecstasy, cocaine and cannabis being most common. This was illustrated by Fergal and Sharon’s descriptions of a night of polydrug use during which they described the combinations of drugs they would sometimes take and the order in which they would do so.

Fergal: There are some combinations I would go for and some that I would not. If I was in a pub, for instance, I would do coke and take ecstasy later at a club or party. You couldn’t take ecstasy in a local pub ‘cause everyone would know and you’d get barred. So in that case, coke first and ecstasy later. I’d smoke [cannabis] at any time really.

Sharon: I couldn’t do coke unless I had some ecstasy first. Coke puts me in a place that I don’t like. I don’t like myself. But if I had taken a few yokes [ecstasy] first and I saw someone doing lines I would definitely want it then.

Most, however, were largely unconcerned with the order in which they take drugs on a night out.

Financial cost of drug taking

Fifty-six per cent (n=49) of those who had taken drugs reported that they would normally pay for them. The financial burden of drug taking on ‘the scene’ is evident from Paul’s description of the costs involved.

Paul: I budget myself on a night out. I know that I’ll be dividing drugs between myself and two of my friends and I know that I’ll be with them and going back to one of their houses.

Interviewer: So how much would you budget for?

Paul: €100 or €150, but it shoots up to €200 if I’ve just got paid. Vodka, cigs, taxis, money for drugs. Alcohol €50, drugs €40, rest taxi and so on. The most I’ve done in a night is six E’s. I’ve done €100 of coke as well. I don’t really like it, it is too greedy. People show their true colours when they are on Coke. I only take it at home with friends because people who see you taking it just want it.

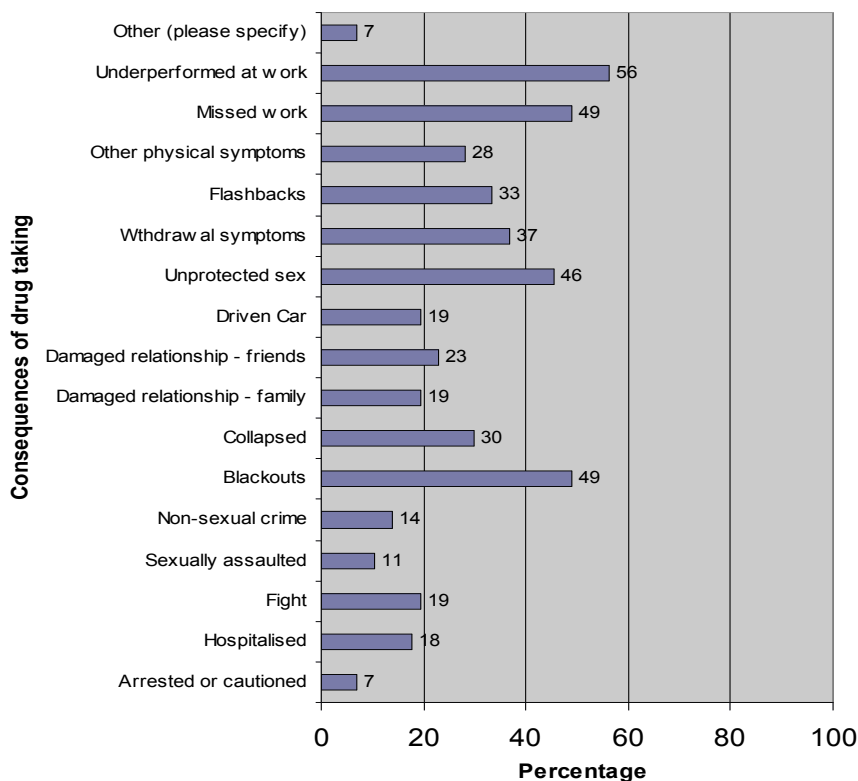
Mark provided a similar account of the financial burden that can accompany recreational drug use.

Mark: I would spend half my wages on drugs. After rent and drugs I would have about €190 left to live on for two weeks. On a Friday night I would drink double vodkas and take pills... go to parties and buy more drugs. It would definitely be more than €100 on drugs and €80 on alcohol. That would include 20 pills, 10 of which I would take over the course of the night. I'd give the others away or save them for the next night.

Problems associated with drug taking

Those who had taken drugs in the past were asked about negative experiences arising 'directly or indirectly' from drug taking. Just 57 subjects were willing to answer this question and the small sub-sample size means that percentage results provided below should be viewed tentatively. This said, the range of side-effects and experiences reported by LGBT drug takers makes for dramatic reading. As illustrated in Figure 4, almost half (49%, n=28) experienced blackouts, 46 per cent had engaged in unprotected sexual intercourse (n=26) and 11 per cent had been sexually assaulted while 'incapacitated due to drugs'. Data for additional physical side-effects and experiences relating to every day life are provided in Figure 4.

Figure 4: Consequences of drug taking as reported by drug takers (n=57)



During interviews and focus groups some participants readily acknowledged the problems associated with their drug use, but others claimed to have little or no negative side effects. Yet on further discussion it was clear that such side effects were felt but largely dismissed as being trivial.

Peter: I am very health conscious, I eat properly, I'm skinny, so I'm careful. It doesn't affect me.

Interviewer: Do you feel any side effects to it at all?

Peter: No.

Interviewer: What about sleeplessness, restlessness, irritability and so on?

Peter: No. Although I remember once taking a yoke [ecstasy tablet] and I didn't know what was going on. I was offered half a one and I took it. I can't remember anything. I went to work an hour later, collapsed at my desk and woke the next morning. My body just switched off...

Others did suffer some consequences, but in the main were not deterred from future drug taking.

Seán: I would be in bits the next day. They call it come downs. Your skin feels different and you feel fragile and you get depressed about stupid little things. You think back and say "Oh God, I made a show of myself again". Depression. I would get really depressed. Depressed about stupid things. Things that happened from the night before. Other things. Just thinking, thinking, thinking, thinking.

Peter: When I smoke I get paranoid. People would phone and I'd be like "what are you ringing me for". Stupid paranoia things. Anxiety as well... Then sometimes, if I took more than a few pills, I'd have blackouts. I woke up in a junkie's house one morning... I was out for three days after that night. I couldn't move.

The issue of safe sex was also discussed during the interviews and focus groups and the testimony provided below illustrates the potential for drugs to reduce inhibitions and expose young people to high risk sexual behaviour.

Mark: Yeah. It's kind of funny when you're on ecstasy because you are aware of what you are doing, but not aware at the same time. You remember everything, even though you don't know at the time what exactly you are doing. I woke up next to a stranger twice. I don't think I had sex, but I don't know... It does pose a problem for safe sex and I know

people who it has happened to. It doesn't bother me much because in my group of friends... we look after each other.

Mark had a particularly serious experience.

Mark: It happened once out in [Dublin]. I was 20, I had been out with a few friends. I got very drunk and taken two ecstasy pills as I was leaving the pub and walking down the laneway. I went to the next pub and I remember sitting at the table and my friend saying to me "are you all right". Next thing I remember is going to the toilet and then I blacked out. When I work up there was a man having sex with me in the toilet. I think I must have been getting sick over the toilet when it happened. I pulled away. I had always been so careful in relation to safe sex, but I had no control.

Interviewer: Did you report the incident to the Gardaí?

Mark: They would have laughed in my face because of the drugs and drink they would have said it was my own fault.

Alcohol and drug taking

One of the key themes emerging from the focus groups and interviews is that LGBT youth perceive alcohol to be as much of a problem on the gay scene as drugs. Indeed, reported volumes of alcohol consumption amongst our survey sample was extremely high. The average intake during a night out socialising is 10 units of alcohol, which equates to five pints of beer, 10 glasses of wine, 10 measures of spirits or eight bottles of alcopops. All the evidence points to a culture of weekend binge drinking.

Many of the interviewees and focus group participants argued strongly that alcohol was a drug and should be discussed as one (as noted earlier, for the purposes of this study we separated the two).

Tom: Well alcohol. You see it is actually far worse. It's easier to get and it's harder to say no to. I can say 'no' to drugs and not be hassled, but if I spent the night drinking 7up I wouldn't be invited the next time. I was found unconscious one night when I was young and was taken to hospital and had my stomach pumped. I think that parents are very innocent sometimes about their own children and alcohol. It's hard to imagine that I used to drink so much spirits that time.

Predictably, for many of those interviewed alcohol became an essential means of creating artificial social courage that enabled them to enter the gay scene in the first instance and interact therein with confidence.

Seán: The first time I ever went to a gay club I had a lot of alcohol [laughs]. I suppose it sort of builds up your courage. I think it was more important when I was younger though. I didn't connect as much [with people].

In terms of the relationship between drugs and alcohol, two dominant points were made by interview and focus group participants. The first is that in many cases the disinhibiting affects of alcohol can lead to drug taking and thus constitutes a 'gateway' substance. According to Tom, for instance,

Tom: The first time I took drugs I was pissed [drunk].

Interviewer: What age were you?

Tom: Fourteen. We were drinking tinnies [cans of beer] and this girl I knew produced a splif and... well maybe I would have said "no" if I was sober, but I'd have tried anything at that stage.

On further analyses of the data, it emerged that those who take drugs tend to consume more alcohol when out than those who do not take drugs. There was no linear relationship, however, between the actual levels of drugs taken and volumes of alcohol consumed – that is, amongst those who take drugs, higher levels of drug taking do not appear to relate to higher levels of alcohol consumption (or visa versa).

Service provision

The on-line survey probed the perceived efficacy of a number of measures that could potentially lead to reductions in levels of drug use. Eighty-three per cent, for instance, felt that more drugs-related education in 2nd level schools would be useful and 90 per cent (n=119) felt that more education in society would help. Almost three quarters (74%, n=95) felt that LGBT youth would benefit from community-specific awareness training and 70 per cent (n=92) believed that greater efforts by the Gardaí in controlling supply and distribution could lead to reduced availability and thus reduced consumption. Interestingly, despite the lack of evidence in this research that experiences of marginalisation play a major role in LGBT drug taking, eighty per cent (n=106) of our respondents felt that greater awareness in Irish society of LGBT issues would lead to reduced levels of drug taking amongst this community. This

would tend to suggest that while LGBT youth may not perceive a *direct* link between alienation and drug taking, they feel that *indirectly* at least, a lack of knowledge amongst Irish society of LGBT issues in some way plays a role.

Approximately 60 per cent (n=78) of respondents believed that national and regional drug workers would be useful, with a large sub-sample (25%, n=33) unsure as to the efficacy of such an initiative.

Additional initiatives were identified during the focus groups and interviews. Access to 'gay-friendly' GPs, for instance, was identified by a number of participants as a very useful service improvement. The problem, it would appear, is two-fold. First, LGBT youth are largely unwilling to attend their family GP for advice, testing, or treatment when such a consultation may involve disclosure of their sexuality. It is even more difficult when drug taking has led to the attendance. On a second level, a number of gay men in particular reported attending GPs during which they disclosed their sexuality and which, they felt, led to the GP becoming uncomfortable and largely unresponsive. This appears to be particularly pertinent when attending for STD testing in rural areas.

Others felt that additional LGBT youth projects should be formed that provide an outreach service and information on drug taking. It was stressed that while such services are provided by BeLonG To in Dublin and the Cork Gay Men's Health Project (through Unite), similar programmes are largely unavailable to those in other areas. The option of attending mainstream youth projects as an alternative service was greeted with a lack of enthusiasm with many interviewees feeling that they simply would not 'fit in' or be accepted in this setting. It was also noted that peer support played a major role in drugs awareness and that this was best offered in the context of a LGBT specialist group.

The on-line survey also asked respondents to state 'how likely' it is that they would discuss drugs with family, friends and drug workers. Ninety-two per cent stated that it was 'likely' that they would discuss drug taking with friends. Forty-two per cent said they would do so with a LGBT drug worker, 40 per cent with a family member and 36 per cent with a 'drug worker available to the entire community'. These findings support the efficacy of including peer-based education and facilitation in LGBT youth settings.

Table 2: The perceived efficacy of potential initiatives in reducing drug taking in Irish society.

	Useful	Neither	Not Useful	n
More education in 2 nd -level education	83	9	8	133
More education in society in general	90	5	5	132
Specific awareness for LGBT youth	74	16	11	129
Greater police effort	70	11	18	131
Dedicated national LGBT drug worker	59	25	15	130
Dedicated regional LGBT drug workers	60	24	16	131
Increased awareness in relation to LGBT issues	80	9	11	132

Some of our participants lamented the absence of high-quality informative gay publications (either in print or on-line). There was a feeling that those currently available focus on social events on ‘the scene’ and provide little information on more serious issues. Seán stressed that “we need more [information] about the problems. I’ve seen publications like this in Spain and in other places abroad. You can go into shops and get a free gay newspaper that deals with everything you could want to know”. Another participant felt that gay representative groups should use the mainstream media to reach gay audiences that do not purchase gay magazines or browse gay websites. It was felt that gay youth who are not ‘out’ would be able to purchase mainstream papers and read such content without fear of being prematurely ‘outed’.

The importance of education in second-level education was stressed by all our participants. Most could not recall any such education being provided and there was universal agreement that drugs-related issues should be included in the national curriculum at all levels. Some suggested that second level teachers should receive in-service training on signs and symptoms of drug taking and LGBT awareness training.

Miscellaneous issues

While this research was primarily concerned with recreational drug use, from time to time information emerged about more serious drug taking. One of our interviewees, for instance, was addicted to prescription drugs, first taken while being treated for a mental health problem. Indeed, 23 per cent (n=34) of our respondents reported taking prescription drugs for non-medicinal purposes at some stage during their lives. The list of substances used varies quite widely but includes zanax, valium, temazapan, ponstin, and viagra.

Also of interest here was a discussion that occurred during one focus group and that centred on expectations of drug use beyond the age of 26. The discussants noted that drug taking decreased amongst the “straight” community after this age and resulting from the moderating impact of marriage and starting a family. Darren articulates this argument succinctly.

Darren: if I was a straight man and married... I could have done drugs in college but by the time I got married and had kids and that, I'd have to stop. That's just the way that social network works you see... Its harder for a gay man... marriage isn't really an option, adoption isn't really an option... so it means that the incentive to stop experimenting isn't always there. People on the gay scene just keep going.

The applicability of international research to Irish situation was also discussed and it was widely felt that quite distinct differences exist between the gay community here and abroad. Most importantly participants felt that there was much greater integration of social networks in Ireland as evidenced by groups comprised of both gay and straight people. This, they felt, meant that drug taking was less of a ‘gay scene problem’ and more of a problem in Irish society in general. In fact some of our participants felt that addressing drug taking amongst the gay community further alienated LGBT youth and could contribute to their vilification and argued strongly that any initiatives should target drug taking amongst gay and straight young people.

Finally, some insight was provided into drug taking environments. Results of the on-line survey were in line with testimonies provided during the focus groups and interviews. Those who had experience of drug use identified night clubs (65%, n=57), ‘at a friends home’ (58%, n=51), in their own homes (42%, n=37) and pubs (40%, n=35) as the most common drug taking settings.

Section D: Discussion

Introduction

In this section further consideration is given to the findings outlined above. In particular it deals with the extent of drug use, set in a comparative context, and explores some probable explanations for the high levels of drug use reported by LGBT youth. It also discusses the implications of findings relating to motivations for taking drugs, problems associated with drug taking and service provision. Finally a series of recommendations arising from the research process are presented and discussed.

Extent of drug use

Headline statistics relating to prevalence of drug use amongst the on-line sample suggest that 65 per cent of LGBT youth have taken drugs at some stage in their lives, 60 per cent have done so in the 12 months preceding the survey, and 40 per cent in the “last month”. Fifty-six per cent had some experience of taking cannabis, 33 per cent ecstasy, and 32 per cent cocaine.

Table 3 sets these findings in a comparative context by drawing on prevalence of drug use statistics from a series of recent studies, both at home and abroad. It is important to note that the surveys cited - Eurobarometer (2004), National Advisory Committee on Drugs (2006) and the current study - all varied in sample size, sample profile and methodology and caution is required when comparing results from each. The NACD (2006) survey is likely to be a low-end estimate of the true figure as data was gathered during face-to-face interviews while the Eurobarometer was based on a telephone survey and may more accurately reflect the true prevalence of drug use. In any case it is clear that levels of drug taking amongst our sample was significantly higher than amongst all other samples included in the table. Based on this cursory comparison, therefore, it would appear that LGBT youth are more likely to have experience of drug taking than the population as a whole, with the difference in prevalence rates likely to range from between 10 and 40 per cent.

While this difference is less marked than reported in similar studies abroad, where LGBT respondents were two to four times more likely to have taken drugs than the general population, it is important to acknowledge that prevalence rates for drug

Table 3: Prevalence of drug use as reported in 2 comparable studies and including the current research.

Reference	Eurobarometer 2004		NACD & DAIRU 2006	BeLonG To 2006
Date of Fieldwork/Survey	2004		2002/2003	2006
Location	All EU	Ireland	Ireland	Ireland
Age	15-24		15-24	18-26
Sample Size	7659	500	893	178
Item	%	%	%	%
Have used drugs at some stage in life	43	55	24.9	65
Have used in last 12 months	NA	NA	12.7	60
Have used in last month	14	22	6.9	40
Have taken Cannabis	33	33	22.8	56
Have taken Cocaine	NA	NA	4.9	32
Have taken Ecstasy	NA	NA	7.7	33

taking in Ireland is one of the highest in Europe and thus the difference between drug taking within the gay ‘community’ and general population is within anticipated ratios.

It is also possible that the LGBT and heterosexual youth identities in Ireland are simply more similar than in other countries. Indeed this research suggested that LGBT youth tend to socialise in ‘mixed’ social groups comprised of both gay and ‘straight’ young people and take drugs in this setting. It is rational to argue that both groups share some key predictors of drug use and that this is manifest as similar levels of drug taking.

The fact remains, however, that prevalence of drug taking is significantly higher amongst LGBT youth than the general youth population. What is at the heart of this variation? First, eight per cent of our respondents partially attributed their *first-experience* of drug taking to “issues to do with their sexuality”, a largely LGBT-specific contributor. Second, it is possible that young gay people experience the ‘normal’ motivations towards drug use (curiosity, a desire to feel high, conformity pressures and a desire to boost confidence) but simply do so on a more potent level and resulting from a greater need to ‘fit in’, a lack of confidence on the ‘scene’, a desire to escape reality and a deflated self esteem. Third, it is at least possible that these determinants in some way interact with one another leading to a cluster of determinants that together create the major predisposition towards drug use. Without further research, involving large sample sizes and utilising questionnaire designed to identify predictive models through regression analysis, however, these suggestions

cannot be explored and a definitive explanation for the discordance in drug prevalence statistics will remain elusive.

Explanations for drug taking

Traditional explanations for *systematic* (on-going) drug taking within the LGBT community were by and large rejected by interviewees and focus group participants. 'Raves', they argued, were rare and the 'dance' scene is apparently in decline. While some do regularly take drugs in pubs and clubs, most drug taking appears to be occurring in private houses and the beginning and end of the night out – and with gay and straight friends.

They accepted that peer pressure issues to do with their sexuality may have played a role in their first encounter with drugs, but stressed that it played no part in on-going drug taking. Similarly they agreed that some LGBT youth may take drugs to boost their confidence during first and early encounters with the gay scene, but felt that this was of little importance thereafter. Overall they felt that their motivations for taking drugs were comparable to motivations amongst the heterosexual community and revolved around a desire to "have a good time".

Yet perhaps the most important finding here is that a relatively small but significant minority of LGBT youth (8%) report that 'something to do with their sexuality' played a role in their *first experience* of drug taking. Thus almost one in ten LGBT drug users first experimented with drugs because of some form of fear, or other negative psychological state, that was linked to their personal and sexual identity. In many ways it is this eight per cent of young gay men and lesbians who are most in need of a service response that provides more productive ways of dealing with insecurity, isolation and fear than experimentation or systematic drug use.

Types of drugs taken

Cannabis, poppers, ecstasy and cocaine were the drugs of choice amongst the research participants. This is in line with international research and studies of the general population. Worthy of consideration is the 44 per cent of LGBT youth who had taken poppers in the past and 32 per cent who had taken cocaine (just one per cent less than had taken ecstasy).

Poppers are liquid chemicals (amyl or butyl nitrate) that are usually sold in small bottles and the vapours from which are inhaled through the nose. Once in the blood

stream blood pressure drops and heart rate increases leading to a 'high' that lasts approximately five minutes. During this time drug takers report enjoying music more and, for some, intensified sexual experience. Others feel dizzy, nauseous and can blackout. When ingested in liquid form it is highly poisonous.

Poppers are legal in Ireland and can be purchased at health stores and sex shops. There is anecdotal evidence that they are increasingly being used by young teenagers who experiment with solvents and stimulants, and recent research from the UK reported that seven per cent of 11 to 15 year olds had used poppers at some stage in their lives – a doubling in prevalence rate since 1999 (Institute for Public Policy Research, 2006).

Use of cocaine by young people in Ireland has been on the increase year-on-year since the late 1990s. In 2001 Maycock reported increased visibility and use of cocaine here, particularly amongst recreational drug users and in night clubs and pubs (Maycock, 2001). SLÁN (2002) reported that almost twice as many males had used the drug in 2002 as had done so in 1998 and amongst females the prevalence rate had more than trebled. There is also evidence that cocaine plays a prominent role in the polydrug use culture in Ireland (Maycock, 2001). These findings are certainly in line with the current study which found that cocaine was a drug of choice on the 'scene'.

Why is cocaine use so widespread? According to those interviewed during this research, cocaine is increasingly easy to purchase, and in some areas is now in greater supply than cannabis. The cost of cocaine has also decreased dramatically and can now be ingested for between €5 and €10 a line, meaning that it is affordable for those in lower paid or temporary employment. Finally, interviewees and focus group participants felt that cocaine had developed a reputation as being non-addictive and low-risk - in comparison to ecstasy, for instance, which had been directly implicated in a number of sudden deaths of drug takers and led to others engaging in self-harm behaviour (jumping from windows for example). Most participants rejected the suggestion that cocaine had become associated with the LGBT drug 'scene', arguing that it formed an integral part of drug taking amongst all drug taking networks.

Problems associated with drug taking

A range of side-effects to drug use were reported by our interviewees and survey respondents. In terms of physiological problems, more than one third of drug users had collapsed (30%), experienced flashbacks (33%) or withdrawal symptoms (37%). Almost half of drug users had blackouts (49%) and 18 per cent had been hospitalised. Yet when problems associated with drug taking were discussed with interviewees and focus group participants, those who had a history of drug taking were largely unconcerned with the potentially serious physiological consequences of drug use. It is not that they were unaware of the potential risks involved – they very clearly were – but that they felt that the risks were justifiable given the ‘fun’ they experienced when ‘high’. This has important implications for service provision as it raises the question: Just how effective is educating recreational drug takers about the risks associated with drug use?

Almost half of those taking drugs (46%) had ‘unprotected sex’ attributed directly to ‘being on drugs’ – obviously a serious concern for those working in sexual health promotion roles. More than one in ten (11%) had been sexually assaulted ‘while incapacitated due to drugs’ and Mark’s account of losing consciousness in the toilet of a pub and waking up to “a man having sex with [him] in the toilet” was disturbing and tragic – all the more so given his unwillingness to report the incident to the Gardaí and thus inability to have redress through the criminal justice system.

Finally, drugs are clearly very detrimental to the working lives of LGBT youth with 56 per cent of drug takers having underperformed at work and 49 per cent missing work. The long term implications here are unclear, but the possibility that drug takers are irreparably damaging their career potential cannot be dismissed.

Service Provision

A question surrounds the usefulness of providing a specific drugs-related service for the LGBT community. Certainly some of our research participants felt that this would only serve to further demonise an already marginalised community and felt that in-service training for existing drug workers and improved access were a preferable endeavour. Others, however, were broadly supportive of a specialised service that would be offered through outreach centres and youth projects.

International experience is that multi-faceted service provision offers the best chance of dealing with problem drug taking. That is, on some level LGBT community workers or representative groups need to secure a specialised service where such a service is justified by client demands. Where such a service may not be merited, at the very least efforts must be made to promote drug education and awareness through LGBT awareness officers that work both within the LGBT network of voluntary representative groups and with existing drug services and educators to ensure awareness of LGBT issues. Developing a tradition of referrals between LGBT youth workers, drug workers, counsellors and the education system is of great importance and will ensure the cross fertilisation of ideas and sharing of expertise.

Eighty per cent of our respondents felt that greater awareness in Irish society of LGBT issues would lead to reduced levels of drug taking amongst this community. This would tend to suggest that while LGBT youth may not perceive a direct link between alienation and drug taking, they feel that, *indirectly* at least, a lack of knowledge amongst Irish society of LGBT issues in some way plays a role. The nuances of this distinction are difficult to understand and additional research dealing with this issue is desirable.

The efficacy of including peer-based education and facilitation in LGBT youth work was evident from the 92 per cent of survey respondents who stated that they would discuss drug taking with a 'friend'. It is imperative that youth projects, and emerging youth groups, take cognisance of this in responding to drug use.

Finally, most of our interviewees and focus group participants felt that the various service providers require further in-service training on LGBT issues. Included in this target audience are local and regional drug task forces, educators and medical practitioners.

Recommendations arising from the research

The relative dearth of LGBT youth services around the county is lamentable and efforts must be made to support the formation of new Youth Projects and the continued evolution of groups currently emerging. The National Development Coordinator at BeLonG To should play a key role in providing this support and ensuring that such groups take cognisance of the drug-related needs of LGBT youth.

Given the vulnerable nature of the client base, and the sensitive issues involved, it is essential that projects are staffed by professionally trained youth workers and offer a safe and supportive environment for young people.

Peer-based education and outreach must play an integral aspect of LGBT youth services.

As a medium-term aspiration a formal network of youth groups should be established, perhaps along the lines of the Swedish Federation for Lesbian, Gay, Bisexual and Transgender Rights (RFSL) and which has accreditation, quality assurance, funding and lobbying functions. Such a model is particularly important given the ethical and professional considerations inherent in working with young clients and individuals at risk of self-harm, substance abuse, victimisation, mental illness and suicide. Working together this network could formulate drug policy, training and a range of services that could be standardised across the country.

In the short-term, existing LGBT youth service providers in Dublin, Cork, Waterford, Dundalk, Wexford and elsewhere should collectively agree a model of quality practice that can serve as a service guide to new and emerging projects.

It was noted by a number of LGBT stakeholders that the gay community in Ireland is currently without a national drugs policy. This needs to be addressed as a matter of urgency, perhaps through the LGBT National Network. In forming such a policy particular attention should be paid to youth issues – given that most recreational drug users first take drugs at an early age. BeLonG To, in consultation with LGBT youth groups around the country, should formulate a drugs policy that caters specifically for young people.

The appointment of a National Drugs Education and Policy Officer for LGBT youth should be secured to deliver on the recommendations presented below that pertain to education and awareness. This appointment would augment the services to be offered by the Drugs Education and Prevention youth worker to be appointed at BeLonG To in late 2006 – a post that will primarily fill needs in Dublin. The holder of the National Drugs Education and Policy Officer post, however, would have a wider remit and link-in with other service providers including GPs, youth workers, educators and the Gardaí. The post-holder would also design and pilot education programmes

to be delivered on a local level by non-specialist LGBT youth workers and peer supporters.

In terms of specific service issues for LGBT youth groups, the following recommendations are offered:

- Primary drug prevention should be provided for those who have yet to take drugs and should centre on education and awareness training that deals with deterrence, promoting alternatives to drug taking and strengthening of resistance skills and life skills. As noted above, the content and nature of this programme should be standardised across youth projects.
- Secondary drug prevention should be provided for those currently taking drugs. A key part of this service will be the development and implementation of outreach services into the gay community for those who take drugs, but are not currently seeking help for drug-related problems. Encouraging these drug users to access some aspect of the youth service will increase the likelihood that they will link-in with drug services should they feel the need to do so in the future. Again, services should focus on drug education and awareness, deterrence, life skills, resistance skills, harm reduction, HIV prevention and competence in risk taking.
- Existing procedures for referring clients to counselling services should be formalised at the earliest opportunity.
- Efforts must be made to promote awareness of LGBT issues amongst service providers including drug workers and medical practitioners.
- Efforts must be made to promote an awareness of LGBT identity amongst students in post-primary schools, building on the successful 'Stop Homophobic Bullying' and 'So Gay!' campaigns.
- Efforts must be made to promote awareness of LGBT identity amongst Irish society in general, a task that 80 per cent of our respondents felt would help reduce drug taking amongst LGBT youth.

- LGBT Youth groups should invite drug counsellors to provide occasional information sessions on drug issues and services. Derry's New Youth Project for Drugs takes this a step further in having client groups decide on the type of content to be covered by the counsellor and their experience is that this leads to better attendance at the subsequent course.
- Inclusion of drug-related information on gay websites and in the print media is important. Again Derry's New Youth Project for drugs is excellent in this regard. It provides a profile of all major illicit substances, including street names, forms, effects, risks, withdrawal symptoms, tolerance, risk minimisation and legality. It also provides contact details for different drug-related services in the city (see <http://www.nypdfoyle.com>). It would also be useful to provide similar information in LGBT publications.
- It is recommended that the research conducted here is built upon in the future. This research has illustrated that recreational drug use is widespread amongst LGBT youth. We know little, however, of other types of drug use including reliance on prescription medicine and drug addiction. Similar research is most certainly required that examines the life histories of these drug users. It is at least possible that such individuals spiralled very quickly into addiction as a result of negative life experiences.
- We also know little about drug taking amongst those under the age of 18, who were omitted from this research due to ethical considerations. Yet most drug use first begins between the ages of 12 and 18, at a time when young LGBT people are particularly vulnerable. Research should probe motivations for drug taking amongst this age group, the types of drugs being taken, new trends in drug use, and the initiatives that can be effectively employed to minimise the extent of the problem.
- Finally, this research provided a snapshot of the extent and nature of recreational drug taking amongst LGBT youth today. It would be very useful indeed to replicate the study at set intervals in the future to track trends over time and ensure policies and initiatives can be tailored to meet the changing needs of vulnerable young people.

References

- Bacon, M. (1973). The process of addiction, *J. Stud. Alcohol*, 34, 1-27.
- Barron, M. (2006). Addressing Homophobic Bullying in Irish Schools. Paper presented at the *Lesbian and Gay Youth in Education Seminar*, The Children's Research Centre, Trinity College Dublin, September 2006.
- Becker, J & Roe, S. (2005). *Drug use amongst vulnerable groups of young people: Findings from the 2003 Crime and Justice Survey*. Home Office Report No. 254.
- BeLonG To. (2005). *Submission to National Strategy for Action on Suicide Prevention*. Dublin: BeLonG To.
- Berk, R. A., Boyd, E. A., & Hamner, K. M. (1992). Thinking more clearly about hate-motivated crimes. In G. M. Herek & K. T. Berrill (Eds.). *Hate crimes: Confronting violence against lesbians and gay men* (pp. 123-146). London: Sage Publications.
- Bochow, M. (1998). Are younger age and drug use risk factors for German gay men? *The 12th World AIDS Conference*, Geneva, 28 June–3 July.
- Bryan, A., Moran, R., Farrell, E., & O'Brien, M. (2000). *Drug-related knowledge, attitudes and beliefs in Ireland: Report of a nation-wide survey*. Dublin: Health Research Board.
- CAMH. (2006). *Youth, Drugs and Mental Health: A resource for professionals*. Toronto: Centre for addiction and mental health.
- Carroll, D., Foley, B., Hickson, F., O'Connor, J., Quinlan, M., Sheehan, B., Watters, R., & Weatherburn, P. (2002). *Vital Statistics Ireland: Findings from the All-Ireland Gay Men's Sex Survey, 2000*. Dublin: Sigma Research.
- Couper, M. P. (2000). Web surveys: A review of issues and approaches. *Public Opinion Quarterly*, 64(4), 464-494.
- Dyter, R & Lockley, P.(2003) *Drug misuse amongst people from the lesbian, gay and bisexual community: A Scoping Study*. Report of the Tackling Drugs Chaging Lives initiative, accessed 07/2006 from <http://213.121.214.244/Home>.
- EMCDA. (2002). *Recreational drug use – a key EU focus*. Lisbon: EMCDA Bi-Monthly Publications.
- Eurobarometer. (2004). *Young people and drugs*. Flash Eurobarometer: European Union.
- Ghindia, D.J. & Kola, L.A. (1996). Co-factors affecting substance abuse among homosexual men: an investigation within a midwestern gay community, *Drug Alcohol Depend.* 41, pp. 167–177.

- GLEN. (1995). *Poverty – Lesbians and gay men: The economic and social effects of discrimination*. Dublin: Combat Poverty Agency.
- Greenwood, G. L., White, E. W., Page-Shafer, K., Bein, E., Osmond, D., Paul, J., & Stall, R. (2001). Correlates of heavy substance use among young gay and bisexual men: The San Francisco Young Men's Health Study, *Drug and Alcohol Dependence*, 61, 2, 105-112.
- Health Promotion Unit. (1998). *Drugline*. Lancashire: Lancashire and North West Lancashire Health Promotion Unit.
- Herek, G. M. (1992). Violence and victimisation overview. In G. M. Herek & K. T. Berrill (Eds.). *Hate Crimes: Confronting Violence Against Lesbians and Gay Men* (pp. 11-45). London: Sage Publications.
- Hillier, L., Dempsey, D., Harrison, L., Beale, L., Matthews, L., & Rosenthal, D. (1998). *Writing Themselves In: A national report on the sexuality, health and well-being of same-sex attracted young people*. Melbourne: National Centre in HIV Social Research.
- Institute of Public Policy Research. (2006). Today's Teenagers abusing 'legal' drugs like glue, stimulants and booze. Accessed 1/10/2006 from <http://www.ippr.org/pressreleases/?id=2414>.
- Lau, C., Murray, J., Sutdhibhasilp, N., Maharaj, R., Cedano, J., Ho, P., Opal, S., & Gray, T. (2004). *Party Drugs in Toronto's Gay Dance Club Scene: Issues for HIV prevention for gay men*. Toronto: Aids Committee of Toronto.
- Manfreda, K. L., Batagelj, Z., & Vehovar, V. (2002). Design of Web Survey Questionnaires: Three basic experiments, *Journal of Computer Mediated Communication*, 7(3). Accessed 08/2006 from <http://jcmc.indiana.edu/vol7/issue3/vehovar.html>
- Mayock, P. (2001). Cocaine Use in Ireland: an exploratory study. In Moran et al (Eds.). *A Collection of Papers on Drug Issues in Ireland*. Dublin: Health Research Board
- McKirnan, D.J. & Peterson, P.L. (1989). Alcohol and drug use among homosexual men and women: epidemiology and population characteristics, *Addict. Behav.* 14, 545–553.
- Miller, P., & Plant, M. (1999). Truancy and perceived school performance: An alcohol and drugs study of UK teenagers. *Alcohol and Alcoholism*, 34 (6), 886-893.
- Minton, S. J., Dahl, T., O' Moore, A. M., & Tuck, D. (2006). *A report on an exploratory survey of the experiences of homophobic bullying amongst lesbian, gay, bisexual, and transgendered young people in the republic of Ireland*. Dublin: Anti-bullying centre, TCD.
- Murnane, A., Smith, A., Crompton, L., Snow, P., & Munroe, G. (2000). *Beyond perceptions: A report on alcohol and other drug use among gay, lesbian, bisexual and queer communities in Victoria*. Victoria: The ALSO foundation.

- NACD & DAIRU. (2006). *Drug use in Ireland & Northern Ireland: First results (revised) from the 2002/2003 Drug Prevalence Survey, Bulletin 1*. Dublin: NACD.
- National Strategy for Action on Suicide Prevention. (2005). *Reach Out: National Strategy for Action on Suicide Prevention*. Dublin: Health Service Executive.
- Norman, J. (2004) *A Survey of Teachers on Homophobic Bullying in Irish Second-Level Schools*. Dublin: Dublin City University
- Norman, J. & Galvin, M. (2006). *Straight Talk: An Investigation of Attitudes and Experiences of Homophobic Bullying in Second-Level Schools*. Dublin: Department of Education and Science Gender Equality Unit.
- NYU. (2006). *Policies on substance abuse and alcoholic beverages 2005-2006*. New York: New York University.
- Pachankis, J., & Goldfried, M. (in press). Social anxiety in young gay men. *Journal of Anxiety Disorders*.
- Paul, J.P., Stall, R. & Bloomfield, K.A. (1991). Gay and alcoholic, *Alcohol Health Res.* 15, pp. 151–160
- Roe, S. (2005). *Drug misuse declared: Findings from the 2004/2005 British Crime Survey*. Home Office Statistics Bulletin, 16/05.
- Saunders, J.M., & Valente, S.M. (1987). Suicide risk among gay men and lesbians: a review, *Death Stud.* 11, 1-23.
- SLÁN. (2002). *A Survey of Lifestyle, Attitudes and Nutrition and the Irish Health Behaviour in School Aged Children*. Galway: Centre for Health Promotion Studies.
- Stall R., Paul J.P., Greenwood G., Pollack L.M., Bein E., Crosby G.M., Mills T.C., Binson D., Coates T.J., & Catania J.A. (2010). Alcohol use, drug use and alcohol-related problems among men who have sex with men: The urban men's health study, *Addiction*, 96 (11),1589-1601.
- Thiede, H., Valleroy, L., MacKellar, D., Celentano, D., Ford, W., Hagan, H., Koblin, B, LaLota, M., McFarland, W., Shehan, D., & Torian, L. (2003). Regional patterns and correlates of substance use among men who have sex with men in 7 US urban areas, *American Journal of Public Health*, 93, 11, 1915-1921.
- Tyler, K., Whitbeck, K., Hoyt, D., & Cauce, A. (2004). Risk factors for sexual victimisation among male and female homeless and runaway youth, *Journal of Interpersonal Violence*, 19 (5), 503-520.
- Weatherburn, P., Stephens, M., Reid, D., Hickson, F., Henderson, L., & Brown, D. (2000). *Vital Statistics: Findings from the National Gay Men's Survey, 1999*. London: Sigma Research.

YouthNet. (2004). *ShOut: Research into the Needs of Young People in Northern Ireland who Identify as Lesbian, Gay, Bisexual and/or Transgender*. Belfast: YouthNet.

Appendix A: The BeLonG To Questionnaire

Many thanks for agreeing to take part in this questionnaire, which is anonymous and completely confidential (your i.p. address is not recorded during this session). The questionnaire takes approximately 10 minutes to complete! Please note that for the purposes of this study the term 'drug' refers to *mood altering substances excluding alcohol*.

Before we start please provide the following background information.

1. Do you identify as

Male Female

2. Do you identify as

Transgender Not Transgender

3. What age are you

4. Which of the following best describes your sexual orientation?

Gay
Lesbian
Bisexual
Straight
Other
Unsure

5. In which county do you currently live

6. What type of location is this?

City
Large town
(over 10,000 inhabitants)
Small town
(between 1000 and 10,00 inhabitants)
Village
Rural

7. Are you employed?

Yes No

8. Are you in a relationship?

Yes No

The next set of questions deal with your social networks and being 'out'

9. In terms of your network of friends, is this network best described as

Mostly GLBorT
Mostly Straight
A mix of both GLBorT and Straight

10. Are you "out"

	YES	NO	With some of them	N/A
To your family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
To your friends	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

11. Do you socialise on 'the scene' (i.e. do you attend gay bars, clubs and other events)

Always Sometimes Rarely Never

12. Do you use GLBorT websites?

Frequently Sometimes Rarely Never



This section of the questionnaire deals with alcohol and drug taking in general

13. On average, how many units of alcohol would you consume
(1 unit=a half pint of beer, a small glass of wine or a pub measure of spirit. An alcopop will contain approximately 1.3 units of alcohol)

Each day _____
 At the weekend _____
 Each week _____
 When socialising (e.g. on a day or night out) _____

14. On how many occasions, if any, have you taken drugs?

In the past week _____
 In the past 30 days _____
 In the past year _____
 In your lifetime _____

15. Have you ever used prescription drugs (i.e. drugs normally prescribed for medicinal purposes but taken by you for non-medicinal purposes)?

Yes No [If 'No', go to q. 16].

If so, please list the drugs here _____

16. What would you do if you were offered drugs (please select all that apply)?

I would take them
 I would say no straight away
 I would feel under pressure to accept
 I would report them to the Gardaí

17. Have you ever been offered drugs?

Yes No [if 'No', please go to q. 19]

18. If so, where were you offered the drugs (please select all that apply)?

At home
 At a friends home
 In school
 At a Club
 In a pub
 At a concert
 On the Street
 In another public place
 Other (PLEASE SPECIFY) _____

19. Have you ever wanted to try drugs?

Yes No

20. On how many occasions in the past have you used the following drugs?

I have never taken drugs [Please go to q. 36]

	Never	Number
Cocaine	<input type="radio"/>	_____
Cannabis	<input type="radio"/>	_____
Ecstasy	<input type="radio"/>	_____
Mushrooms	<input type="radio"/>	_____
LSD	<input type="radio"/>	_____
Crack	<input type="radio"/>	_____
Crystal Meth	<input type="radio"/>	_____
Sniffed solvents	<input type="radio"/>	_____
Poppers	<input type="radio"/>	_____
Heroin (or other opiates)	<input type="radio"/>	_____
Tranquilisers or sedatives (other than on medical advice)	<input type="radio"/>	_____
Viagra (other than on medical advice)	<input type="radio"/>	_____
Amphetamines (Speed)	<input type="radio"/>	_____
Anabolic steroids	<input type="radio"/>	_____
Other drugs not listed above (please specify)	<input type="radio"/>	_____

21. From whom would you normally get your drugs (please select all that apply)?

A friend
 A 'dealer'
 A stranger (not a dealer)
 Other (please specify) _____

22. Would you normally pay for these?

Yes No

23. If you do take drugs, would you sometimes take more than one type of drug on a night out?

Never Seldom Frequently Always

24. Where would you normally take drugs (please select all that apply)?

At home
 At a friends home
 In school
 At a Club
 In a pub
 At a concert
 On the Street
 In another public place
 Other (PLEASE SPECIFY) _____

25. Have you ever had any of the following experiences that arose directly or indirectly from drug taking (please select all that apply)?

- Blackouts
- Collapsed
- Flashbacks
- Experienced withdrawal symptoms
- Had other physical symptoms (such as convulsions, palpitations, bleeding etc.)
- Been hospitalised
- Deterioration in relationship with friends
- Deterioration in relationship with family
- Missed work
- Underperformed at work
- Been in a fight or scuffle
- Been arrested or cautioned by a member of the Gardaí
- Driven a car or other vehicle whilst under the influence of drugs
- Engaged in unprotected sexual intercourse
- Been sexually assaulted whilst incapacitated
- Been subjected to a non-sexual crime
- Other

Please specify _____

26. What age were you when you first took a drug?

Age _____

27. What was the first drug you tried (please select one only)?

- Cocaine
- Cannabis
- Ecstasy
- Mushrooms
- LSD
- Crack

- Crystal Meth
- Sniffed solvents
- Poppers
- Heroin (or other opiates)
- Tranquilisers or sedatives (other than on medical advice)
- Viagra (other than on medical advice)
- Amphetamines (Speed)
- Anabolic steroids
- Other drugs not listed above (please specify)

28. Which of the following describes why you took this drug (please select all that apply)?

- Because I was curious
- I wanted to feel high
- Others in the group pressurised me to take them
- I just wanted to be the same as others in the group
- I was bored
- Because of issues relating to my sexuality
- Because of other issues
- To increase my confidence
- Other reasons (please specify)

29. How would you best describe the group in which you would normally take drugs (please select one answer only)?

- Mostly GLBoT
- Mostly Straight
- A mixture of GLBoT or Straight

This section of the Questionnaire deals with the last time took drugs

30. When did you last take drugs (please select one answer only)?

- Within the last week
- Within the last month
- Within the last 3 months
- Within the last 6 months
- Within the last 12 months
- Longer than 12 months ago

31. On that occasion where did you take them (please select all that apply)?

- At home
- At a friends home
- At a Club
- In School
- In a pub
- At a concert
- On the Street
- In another public place
- PLEASE SPECIFY _____

32. Which drugs did you take on that occasion (please select all that apply)?

	Taken	Number
Cocaine	<input type="checkbox"/>	___
Cannabis	<input type="checkbox"/>	___
Ecstasy	<input type="checkbox"/>	___
Mushrooms	<input type="checkbox"/>	___
LSD	<input type="checkbox"/>	___
Crack	<input type="checkbox"/>	___
Crystal Meth	<input type="checkbox"/>	___
Sniffed solvents	<input type="checkbox"/>	___
Poppers	<input type="checkbox"/>	___
Heroin (or other opiates)	<input type="checkbox"/>	___
Tranquilisers or sedatives (other than on medical advice)	<input type="checkbox"/>	___
Viagra (other than on medical advice)	<input type="checkbox"/>	___
Amphetamines (Speed)	<input type="checkbox"/>	___
Anabolic steroids	<input type="checkbox"/>	___
Other drugs not listed above (please specify)	<input type="checkbox"/>	_____

33. From whom did you get these drugs (select all that apply)?

- A friend
 - A 'dealer'
 - A stranger (not a dealer)
 - Other
- Please specify _____

34. How many units of alcohol did you consume on that night?
(1 unit=a half pint of beer, a small glass of wine or a pub measure of spirit. An alcopop will contain approximately 1.3 units of alcohol)

35. Did you have any of the following experiences that arose directly or indirectly from drug taking that night (please select all that apply)?

- Blackouts
- Collapsed
- Flashbacks
- Experienced withdrawal symptoms
- Had other physical symptoms (such as convulsions, palpitations, bleeding etc).
- Been hospitalised
- Deterioration in relationship with friends
- Deterioration in relationship with family
- Missed work
- Underperformed at work
- Been in a fight or scuffle
- Been arrested or cautioned by a member of the Gardaí
- Driven a car or other vehicle whilst under the influence of drugs
- Engaged in unprotected sexual intercourse
- Been sexually victimised whilst incapacitated
- Been subjected to a non-sexual crime

This final section of the Questionnaire deals with service issues

36. How likely is it that you would discuss issues relating to drug taking with the following people (please select all that apply)?

	Very Likely	Likely	Neither	Unlikely	Very Unlikely
Friends	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
A GLBandT drug worker	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
A drug worker available to the entire community	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

37. Please suggest how useful the following initiatives might be in terms of minimising drug taking in Irish society (please select all that apply)?

	Very Useful	Useful	Neither	Not Useful	Definitely Not Useful
More education around drug issues in 2 nd Level Education	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
More education around drug issues in society in general	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Specific drug awareness education for young GLBandT youth	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Greater police effort to combat drug supply and distribution	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
A dedicated national GLBandT drug worker	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dedicated regional GLBandT drug workers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Increased awareness amongst young people in general in relation to GLBT issues	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>