“It’s not rocket science, what I do”: Self-directed harm reduction strategies among drug using ethno-racially diverse gay and bisexual men

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A B S T R A C T

Background: Research on harm reduction has typically focused on broad-based or organisational strategies such as needle exchange and opiate substitute programmes. Less attention has been paid to the self-directed harm reduction practices of substance users themselves. Few studies have focused on sexual minority populations such as gay and bisexual men and fewer still on the marginalised groups that constitute these populations. This paper identifies self-directed harm reduction strategies among substance using ethno-racially diverse gay and bisexual men.

Methods: This article presents findings from the Party Drugs Study in Toronto's gay dance club scene, a community-based qualitative study in Toronto, Canada. We present a thematic analysis of interviews with 43 gay and bisexual men from diverse ethno-racial backgrounds about their substance use in the gay dance club scene.

Findings: We identify five self-directed harm reduction strategies: rationing, controlling or avoiding mixing, controlling quality, maintaining a healthy lifestyle, and following guidelines during substance use.

Conclusions: We discuss our findings in relation to prior research and to critical theory. We suggest that drug users’ awareness of possible harm, and their personal investment in harm reduction, constitute a viable platform from which community-based and public health organisations may promote and strengthen harm reduction among gay and bisexual men from ethno-racially diverse backgrounds.

Introduction

While there has been particular attention paid to substance use among lesbian, gay, bisexual, and transgendered populations (e.g., Hughes & Eliason, 2002; Rosario, Hunter, & Gwadz, 1997; Stall & Purcell, 2000), research on substance use practices among ethno-racially diverse gay and bisexual men remains rather sparse. Some research on the broader ethno-racial male population attempts to distinguish rates of drug use among particular ethno-racial groups (e.g., Ompad, Galea, Fuller, Edwards, & Vlahov, 2005) or to distinguish comparable or greater rates of use among gay and bisexual men within these groups (e.g., Operario et al., 2006).

From a public health perspective, research suggesting greater rates of substance use among gay and bisexual men is worrisome given the purported association between substance use and HIV risk and seroconversion (Burcham et al., 1989; Chesney, Barrett & Stall, 1998; Penkower et al., 1991; although see Aguinaldo & Myers, 2008, for a critical perspective on this body of research). A small body of research has identified similar statistical associations between substance use and HIV risk within gay and bisexual Latino (Dolezal, Carballo-Dieguez, Nieves-Rosa & Diaz, 2000), Black (Wilton, 2008), and Asian (Operario et al., 2006) populations. Such findings have prompted heated debates about appropriate policy...
and programme responses related to drug use. While abstinence-premised interventions appear to remain the primary approach in North America, harm reduction has emerged as a viable option, at least in Canada (albeit with some resistance).

There is sufficient evidence to warrant the adoption of harm reduction as a policy framework for responding to illicit substance use (Ritter & Cameron, 2006). While vast in its scope, harm reduction programming as it applies to illicit substance use generally involves needle exchange and opiate substitution programmes, in addition to condom distribution and the provision of health promotion information related to substance use and sexual health. The primary objective of these interventions is to achieve immediate and pragmatic goals to reduce the harms of drug use and increase protective factors rather than eliminating drug use (although the latter is still an option for users who are motivated or determined to give up drugs). While needle exchange and opiate substitution programmes attend to reducing the harm from injection drug use, condom distribution addresses the sexual risks that drugs users may face. Such harm reduction strategies are typically directed by health services organisations. However, as Drumm, McBride, Metsch, Neugeld, and Sawatsky (2005) claim, “using existing strengths of drug users is an effective treatment approach […] more work needs to be done to understand health care skills that users may already possess” (p. 609). Such self-directed harm reduction strategies can offer another tool on which public health practitioners may capitalise. Unfortunately, there is only a small body of research that identifies self-directed harm reduction strategies among substance users.

Existing research has mainly focused on the self-directed harm reduction strategies of ecstasy users. According to Shewan, Dalgarno, and Reith (2000), ecstasy users in their study were aware of the adverse effects of their use and planned their use accordingly. In particular, monitoring their mindset and selecting an appropriate context for using ecstasy (i.e., “set and setting”) played a substantial role in managing risks associated with use. Hansen, Maycock, and Lower (2001) identified a number of ‘risk reduction techniques’ such as rationing one’s use, peer monitoring (for physical or psychological effects), and choosing to use drugs only during positive mood states. Similar findings were offered from a more recent study by Panagopoulos and Ricciardelli (2005) who found that ecstasy users in their study implemented psychological, drug-specific, behavioural, and peer-related strategies to manage the risk of their use. Psychological strategies included limiting use when in a psychologically vulnerable state (e.g., depressed), while drug-specific strategies involved careful pacing of use, prohibiting polydrug use, inspecting ecstasy tablets before use, and purchasing from known and ‘trusted’ dealers. Specific behavioural and peer-related strategies involved the consumption of water or other non-alcoholic beverages to hydrate the body, or the use of ecstasy only with ‘experienced’ users. Jacinto, Duterte, Sales and Murphy (2008) found similar results regarding users’ reliance on ‘trusted’ dealers.

Similar findings have been found across a (limited) range of study populations. Drumm et al. (2005) found that street involved drug users “do not passively accept the health consequences of use, but rather actively engage in behaviours that attempt to ameliorate damage to their health as well as behaviours specifically designed to improve their health” (p. 608). So-called ‘self-care strategies’ included improving nutrition, increasing physical activity, addressing medical concerns (e.g., over the counter treatments, home remedies, etc.), substance use regulation, and reducing sexual risk. Drumm et al. argued that these strategies indicated substance users’ “substantial knowledge about health issues and considerable commitment to manage health risks while at the same time continuing to be chronic drug users” (p. 622). Preliminary data suggested that pregnant women may also implement self-care practices for their drug use (Baker & Carson, 1999; Flavin, 2002). Interestingly, harm reduction practices of gay men are not well addressed in the literature. Only one of the aforementioned studies on self-directed harm reduction practices reported the inclusion of gay men in their sample.

Some research has explored the drug use practices of gay men in Sydney, Australia and found that lay expertise, shared among peers and ‘network nannies’, produced a community folk pharmacology (e.g., Southgate & Hopwood, 2001). Dowsett, Keys and Wain (2005) identified gay community norms that encourage acceptable, controlled drug use and argue that they be harnessed for harm reduction purposes. However, none of these studies reported the inclusion of participants or users from specific ethno-racial backgrounds. This is particularly problematic given the reported prevalence of substance use among gay and bisexual men from various racialized groups, and its associated health risks. The present study addresses this gap.

In this article, we identify the self-directed harm reduction strategies of substance-using gay and bisexual men from ethno-racially diverse backgrounds. All participants in our study identified as either gay or bisexual and that is the terminology we use in this article. Our study contributes to a broader understanding of substance use among ethno-racially diverse gay and bisexual men in two ways. First, it challenges the popular notion of substance users and (specifically non-white substance users) as weak in constitution, lacking self-control, and needing a higher form of rationality (see, Lupton, 1995). Instead, it views substance users as knowledgeable about their use, aware of the risks involved, and keen or able to make informed decisions and choices when given the opportunity. Second, it contributes to the growing body of literature that suggests harm reduction (self-directed or otherwise) is a viable option for public health interventions (Myers, Aggleton, & Kippax, 2004). This affords us the opportunity to make recommendations for the content of education and prevention materials and programming and provides context for dissemination and outreach.

Methods

The current paper is based on an analysis of face-to-face semi-structured interviews conducted for the Party Drugs Study in Toronto’s gay dance club scene (Husbands et al., 2004). The Party Drugs Study was a community-based research project initiated and implemented by five community-based AIDS service organisations (ASOs) in Toronto, Canada. It was designed to address community and ASO concerns related to the use of party drugs in Toronto’s gay dance club scene and the possible implications for HIV prevention efforts. Overall, the Party Drugs Study sought to understand gay and bisexual men’s interpretations of their experiences and participation in the gay dance scene, with a focus on sex and drug use. Snowball and targeted sampling techniques (Watters & Biernacki, 1989) were used to recruit gay and bisexual men in the dance scene. Ethics approval was granted by McMaster University Research Ethics Board.

Seventy-seven participants were recruited for the study through the distribution of advertising materials (i.e., fliers and cards) at gay dance clubs, social events, and ASOs as well as research advertisements in gay publications and websites. Three members of the study team conducted the interviews, which typically lasted 60–90 min each. Screening confirmed that participants self-identified as gay or bisexual men who had (1) gone to a gay dance club in Toronto in the last 3 months; (2) used party drugs (i.e., ecstasy, ketamine, GHB, crystal meth, etc.) in the last 3 months; and (3) identified with an ethno-racial background consistent with the populations served by the main study partners.

The interview included questions about respondents’ participation in the gay dance club scene, drug use in the club environment,
Participants identified five self-directed harm reduction strategies: rationing, application of rules related to mixing, controlling quality, maintaining a healthy lifestyle, and following guidelines during substance use. We describe these in turn.

**Rationing**

The most widespread strategy through which participants minimized the risks of their substance use was, simply, to ration their use—that is, to limit or regulate the quantity and/or frequency of use in a particular setting or over a given time period. Limiting how much one uses in a particular setting involved the restriction of substance use to a specifiable amount deemed acceptable to the participant: “I only limit myself to one vial of K an evening or one E tablet or whatever” (Paul). For many participants, self-restriction was based on “know[ing] my limits and my levels” (Dave). For other participants, the ‘limit’ was defined by the threshold at which they experienced adverse effects. Implicit within much of the participants’ responses was an expectation of ‘informed use.’ Many participants stated what was, to them, widely known rules of appropriate amounts of substance use to which they adhered.

The second method of rationing substance use involved regulating how often one uses, typically reducing the number of occasions when they use substances over time:

I don’t know if I’ve completely come to the point where I said you know just stop, but I’ve certainly come to the point where I’ve said I need to slow down and just do it if I want to do it on the occasion, but not like going out every weekend like I used to every other weekend. (Neil)

Many participants also expressed due concern to avoid interference of day-after effects with work or other responsibilities:

I time my drug very carefully. I measure my drug use very carefully so I will kind of minimise the day after effect. (Michael)

Others limited their use for fear of addiction:

There’s times I know I could do it [crystal] every night. But I’ve seen other people like who do it constantly, constantly and I don’t want to end up like them. (Tom)

**Rules for selecting and mixing substances**

Participants described strategies to reduce the harms they associated with using party drugs that involved rules or guidelines about which drugs they would use, how they would take these drugs, and which drugs they would use at the same time. A variety of respondents described avoiding or selecting specific party drugs in order to minimise harm. Physical harms were stated as the reason to avoid specific party drugs. Frederick describes:

I would never do it [GHB] in my life because people have overdosed so bad that they die or they have heart palpations or they go into seizure or, so I, I’m scared for that.

Other respondents had a longer list of positive characteristics associated with their drug of choice:

Interviewer: Yeah, why did you choose mushrooms?

Frank: They’re affordable. They’re natural. They don’t leave you sketchy or tweaked out and once you’re tired and you just had it, you can just go to sleep as opposed to the other drugs when you’re tired and you’ve had, all you seem to want is more drugs or you can’t go to sleep and you start sketching out.

Sometimes the preferred drugs were described in terms of their lesser harms compared to other party drugs. For example,

I know special K does brain damage to you right . . . I know pot, pot’s not going to fuck me up that much you know, just you get hungry you know”. (Don)

Participants also described their preferred form of drug use as a harm reduction strategy, such as avoiding injection drug use or snorting over ingesting pills.
I would just never, never inject myself with anything, never do stuff up. Like powder, I did it once. I would never do it again. (Doug)

Another practice described by participants to minimise harm involved following a set of rules or guidelines about which drugs they would use at the same time. The two main ways of applying this strategy were not mixing drugs, and instituting guidelines about avoiding or selecting specific drug combinations to reduce harm.

Refraining from mixing drugs involves limiting use to one drug at a time. For example, Carl states, “I don’t mix alcohol with for example GHB or drugs that I know that they’re not supposed to be mixed because you know I don’t want to take that risk.” Some respondents were explicit about the specific combinations they avoided in order to minimise their harm.

Well I don’t really mix a lot. Like you know, if I’m smoking pot, I could. Okay, if I’m on E, if I’m on acid, I can smoke pot and drink beer. If I’m on E, I can still smoke pot and drink beer. If I’m on K, all I can do is drink water. (Paul)

Many participants described ‘common knowledge’ about mixing rules in order to avoid harm. One respondent was clear about the difference between his knowledge and actions:

Well ecstasy, there’s, they say that if you drink with it, you can have an adverse. That’s the only thing I’ve really read that stuck out with me. But I still have a couple of drinks with it. (Scott)

Controlling quality

A third strategy that participants implemented to minimise the potential harms of their drug use was to ensure, as best they could, the quality of the drugs they used. Participants reported a number of interrelated practices that entailed obtaining drugs from a ‘reliable source,’ using drugs that have been (safely) used by others or have been deemed ‘safe’ through a form of assessment and evaluation (e.g., trial and error).

Participants reported their reliance on trusted drug dealers to provide ‘safe’ recreational drugs. They scrutinized not only what drugs they used, but from whom they purchased these drugs and reported developing a relationship with drug dealers from whom they know provide safe and clean substances:

Know your sources, your dealers well. Have an established relationship with a dealer who usually provides good products or safe products. Then, you know, I guess, that’s reducing the risk if you’re getting, when you’re using drugs. (Corey)

Participants perceived these drug dealers to take greater care and consideration about the drugs they sell and the advice they provide to users. These more trustworthy drug dealers were contrasted with those who are less discerning about the drugs they sell:

The worse E trips have actually come from, from those people but the better ones, and if I can use in quotations “better”, have come from a supplier that I’ve been with for a certain period of time. Some suppliers will actually tell they’ve used a bit of their E and what we’ll do. Usually I’ll go with their advice. (Max)

In sum, participants sought quality control by evaluating and selecting trustworthy sources to procure safe, clean recreational drugs.

Participants also attempted to manage the quality of their drugs through reliance on peer networks. Some participants reported using substances, sometimes from unknown sources, simply because these drugs were offered by trusted networks. Peer networks offer ‘reviews’ of drugs currently in circulation and some participants suggested utilising peer-networks as a valuable source of information about a variety of topics. When peer reviews were not available, participants would then attempt to judge quality of drugs through careful inspection and evaluation:

Well, I guess, the whole colour variation thing, I find that, first, look at the pill and see how it’s pressed, right. See if it’s burned, you know. Make sure it’s not like, you know, falling apart in your hand. (Max)

Well ecstasy, there’s, they say that if you drink with it, you can have an adverse. That’s the only thing I’ve really read that stuck out with me. But I still have a couple of drinks with it. (Scott)

I take one. But if it’s something that I’m not experienced with you’re supposed to take half to see what the high is like. Whether or not it’s a good high or a bad high. Cause if it’s a bad high then no use doing that. But if it’s a good high then I take the other half and then, you know, let it go, see how the night’s going. (George)

Participants were obviously mindful of the quality of the drugs they consumed. Whereas poor quality drugs were said to increase the harmful effects of substance use, good quality drugs, by contrast, reduced these harmful effects. Participants reported a number of practices to ensure drug quality: procuring drugs from a trusted dealer utilising knowledge gained from peer networks, and carefully inspecting, testing, and evaluating drugs from known sources.

Maintaining a healthy lifestyle

Another strategy commonly highlighted by participants to minimise the harms they associated with drug use was to maintain a healthy lifestyle. The components of this healthy lifestyle commonly involved: eating, resting and exercise; drinking water; and taking vitamins and other supplements. Maintenance of this daily lifestyle was seen to counter the negative effects of party drugs. As Carl describes,

Sometimes. I do, I do [try and maintain my regular routine]. I did try to rest for, for a whole day. I try to eat the best, the best that I can and that’s it.

Eating was seen as an important practice. Participants mentioned ‘eating well’ when describing their healthy routine, while others cited eating something before taking any drugs as a means to minimise harm from their drug use. Participants also mentioned sleep habits as a component of this healthy lifestyle package. Drinking “a lot of water” (Patrick) was mentioned by several participants. Vitamins were also a component of this healthy lifestyle package. As Martin describes,

But to minimise any other risks, I take a lot of vitamins. I’m always popping vitamins and drinking tons of water. So I’m not
dehydrated and get sick and you know, the common cold affect afterwards.

Three participants described their use of 5-Hydroxytryptophan (5HTP) as a practice they employed to minimise their risk when they take party drugs. 5HTP is a non-prescription dietary supplement which is used as an antidepressant and was described as part of the package of a healthy lifestyle for these participants:

I’ll do, you know the, the 5HTP, the melatonin, you know, and that’s about it. Drink lots of water. It’s not rocket science, what I do. (Michael)

Following guidelines during use

A final strategy through which participants minimised the harms of their drug use was by adhering to guidelines during the course of their use. Water consumption was reported by an overwhelming number of participants. Typically club drug use occurred within events or environments that involved extended periods of dancing or other activity. Drug use may lead one to disattend to the undue stress such activity may cause. Participants reported the consumption of water mainly to avoid dehydration that may result from these activities. They articulated a general imperative to monitor for the signs of dehydration and rehydrate themselves accordingly. Water consumption, particularly during substance use, was often reported as a widely known practice for harm reduction:

The risk with overheating, definitely. Trying to keep myself hydrated. I think the statistics or the recommendation is like, a bottle of water for every, I don’t know if it’s every hour or two hours, again, for ecstasy. (Brian)

Here also, participants attempted to minimise harm using drugs within the context of peer relations. By peers, participants referred to those who they may trust or who are known to have particular experience with the drugs used on that occasion. Participants reported that peer networks were vital for ensuring a safe context where the harmful effects of drugs could be managed by knowledgeable and experienced users. Peer networks were reported to be helpful in managing violent to catatonic reactions to drug use. Having this type of network created a social environment wherein the drug user could ‘trust’ peers to intervene if an episode of drug use turns problematic:

And I try to have people who I trust around me, who know, who know some things about drugs and who, like, if something happens, like, if I start having like, a seizure or something, they will know, they won’t panic and be like, “Oh, my God! I have no idea what to do!”. (Mark)

Finally, participants reported a number of ‘prosaic’ guidelines to manage possible harms during the time of use. For example, one participant reported continually sucking on candies and cough drops in order to avoid throat irritation and loss of voice during the night. As Mark states, “[w]ith ecstasy I have to like, put something in my mouth or I’ll start chewing my tongue”. Another remained vigilant to “always watch our drinks” (Doug) presumably to prevent their drinks from being maliciously contaminated.

Discussion

The gay and bisexual men from racialized communities who participated in this study reported a range of self-directed harm reduction practices to manage the potential ill effects of their substance use. They reported rationing or limiting their use, carefully selecting the types or combinations of drugs used, attending to the quality of drugs used and from whom ‘quality’ drugs are obtained, maintaining a healthy lifestyle more broadly to offset the ill effects that may occur from drug use, and adhering to a fixed set of guidelines during use. Participants reported these very pragmatic strategies in order to avoid such harms as overdosing, ‘bad highs,’ missing work, dehydration, or other consequences after use. While a few participants clarified the difference between harm reduction practices they knew of and their actual practices, on the whole, they did not explore the efficacy or limitations of those practices. While the success or efficacy of these practices is unclear, this research suggests that ethno-racially diverse gay and bisexual men have available to them a range of repertoires that may potentially avert the ill effects of party drug use; these are similar to self-care practices found among other groups of substance using gay and bisexual men (e.g., Dowsett et al., 2005; Southgate & Hopwood, 2001).

An overwhelming number of respondents cited consuming water as a guideline they follow during drug use occasions. This is a practice recommended by harm reduction practitioners that conduct outreach at dance club events in Toronto. This could indicate that these harm reduction messages have been taken up by gay and bisexual men. However, ‘expert’ knowledge is often inspired from past experiences as well as ‘common sense’ practices (Holt & Treloar, 2008). In addition, health promotion messages that appeal to elements of popular culture are also likely to have influenced our respondents’ self-care practices.

The harm reduction practices were embedded within the larger context of the party drug scene described by our respondents. The results of the Party Drug Study showed how drug use enhanced the quality of the dance club experience. Drug use facilitated and was facilitated by other compelling experiences, such as music, dancing, and the “energy” that permeated the dance club atmosphere. Party drugs were also associated with boosting confidence, overcoming alienation and promoting confidence to fit into the scene. A more detailed discussion of these findings can be found in the Party Drugs report (Husbands et al., 2004).

Our findings about harm reduction practices of ethno-racially diverse gay and bisexual men offer three interrelated contributions: first, to the body of literature on self-directed harm reduction techniques among substance users; second, to a critical contribution to public health literature on substance users more generally; and third, to evidenced-based health promotion.

A small body of research has examined the harm reduction strategies that users themselves employ to minimise the harms they associated with using drugs. Our findings contribute to this work, which shows that certain populations of users exhibit signs of controlled and informed drug use. Qualitative research on ecstasy users in Australia (Hansen et al., 2001; Panagopoulos & Ricciardelli, 2005), Scotland (Shewan et al., 2000), and the US (Jacinto et al., 2008) have described similar strategies such as rationing use and quality control methods employed to minimise harm reported in our sample. Several studies call for further investigation into polydrug use and cross-cultural research to rule out the possibility that ecstasy user ‘types’ were limiting their findings. Our results show that these previously identified harm reductions strategies are relevant even when polydrug use is present. The research conducted so far, including our study, has been unable to evaluate the efficacy of these self-directed harm reduction strategies, the extent to which they are informed by the evidence that harm reduction professionals may recommend, and the facilitators or barriers towards implementation. What this study does demonstrate is a general receptiveness of some gay and bisexual party drug users to attend to the potential harms of their use and a willingness to incorporate concrete practices to reduce those harms. Such recep-
tiveness should be harnessed productively in health promotion. Future research may further examine the "safety and care that might go unregistered in the current punitive political environment" (Race, 2008), the extent to which current harm reduction programmes respond, support or build on the self-care practices of their participants, and also the limitations of relying on drugs users' self-care practices. Another avenue for research would be to investigate possible differences in the content or prevalence of self-directed strategies across various target populations, and the effectiveness of harm reduction programmes at reaching these populations.

Critical social scientists have challenged the implicit assumptions embedded within public health discourse on substance use. This perspective has shown how public health reproduces the ideologies of the state and brands those who do not conform to these ideologies as 'at risk' or 'sick' (Petersen & Lupton, 1996). From this perspective, substance users are assumed to be in need of intervention because they are said to have failed to conform to Western cultural pre-occupation with individualism and self-regulation. According to much public health discourse, drug use (excessive or otherwise) causes the user to lose self-control resulting in ill health and social disruption (Hammersley & Reid, 2002). Substance users are characterised as weak in constitution and morally corrupt (Lupton, 1995). Such characterisations are most evident in current efforts to link the disinhibitory effects of substance use with risky sex or HIV transmission among gay men (Leigh & Stall, 1993; Ostrow, 2000; Shopfatt & Froshch, 2000). These efforts implicate those who use substances in some way behave without full cognitive capacity as a result of their use and are thus dangerous to themselves or to the public. Public health interventions are designed, typically, to (re)establish substance users' self-control largely by promoting abstinence (e.g., 'just say no').

Previous research has challenged these constructions of the substance user. For example, Myers, Aguinaldo, et al. (2004) following others (e.g., Weatherburn & Project SIGMA, 1992) identified a range of pragmatic uses that substances play in the sexual lives of gay and bisexual men. Substance use may be used as a 'social lubricant' to meet potential partners, initiate sex, and even accomplish sexual acts, which suggests that gay and bisexual men use drugs wilfully and strategically. The Party Drugs Study explored how drug use facilitates a sense of belonging and community among gay and bisexual men in the club scene (Husbands et al., 2004). Our findings suggest that, among ethno-racially diverse gay and bisexual men, substance users are aware of their risks and report a repertoire of practices to manage those risks. These findings suggest that at least some substance users can be 'in control' of their use and that a harm reduction perspective (Myers, Aggleton, et al., 2004) is a viable alternative.

Our perspective implies the construction of substance users within the domain of neo-liberal subjectivity which is useful for reducing stigma and marginalisation. However, in agreement with Moore and Fraser (2006) we do this while recognising that notions of 'agency', 'empowerment' and 'responsible drug use' may have little impact if they are not accompanied by policy and practice that "attempts to address the political economic conditions that contribute to the marginalisation of drug users" (p. 3041). While putting forward that substance users can be self-regulating and in control, we recognise that this type of substance use is only possible within a social and political context that allows for these kinds of choices to be made. Put another way, our findings provide insight into the specific choices substance users may consider to reduce the risks of their use, but interventions must also address the social spaces to allow for these choices to be made.

Our findings indicate that ethno-racially diverse men currently have an investment in harm reduction. While we acknowledge that there are limitations to relying on self-care practices, they can provide a language and point of engagement for harm reduction practice and programmes among this group. The Party Drugs Study suggests that a harm reduction framework in health promotion practice and policy should employ a social determinants of health approach which takes into account the social context in which substance use occurs among gay and bisexual men (Husbands et al., 2004). Outreach and other interventions should treat substance users as capable and informed, and should attempt to build upon existing capacities of participants. Education methods that make use of peer networks and that emphasise pragmatic or everyday activities are recommended. A number of these principles already inform programmes among drug using communities; an example of this is the TRIP project which has been providing health info to "Toronto party people" since 1995 (www.tripproject.ca). Examples of harm reduction programmes directed at gay and bisexual men are Seattle Counseling Service's Project NEON (www.projectneon.org) and the AIDS Committee of Toronto's "Hi! My Name Is Tina" campaign (www.nameistina.com). While these programmes are focused on the use of crystal methamphetamine in this community and include abstinence as part of their harm reduction philosophy, they also employ a harm reduction approach based on the social determinants of health that supports evidence-informed choice among programme participants. Our research points towards the investment that ethno-racially diverse men have in harm reduction.

Public health interventions directed towards these populations have a role in helping gay and bisexual men strengthen and build on their investment and resiliencies.

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Conflict of interest

None

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