Adults' understandings and experiences of capacity to consent to substance-involved sexual activity

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Keywords: Sexual consent; capacity; substance use; alcohol; drugs

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Abstract

Most research on capacity to consent to substance-involved sex has focused exclusively on the implications of alcohol with little attention given to other or additional psychoactive drugs. This study aimed to explore people's understanding and experiences of the capacity to consent to alcohol- and/or drug-involved sexual activity. UK adults ($N = 354$) completed an online mixed-methods survey on sexual consent during sober, alcohol- and/or drug-involved sex. Qualitative data were analyzed using thematic analysis. Themes for capacity to consent were: (1) 'There is no normative understanding of substance-involved sexual consent', (2) 'Moving beyond the binary of consciousness versus incapacitation' and (3) 'Substance-involved sexual decisions are viewed as irresponsible'. The findings illustrated that capacity to consent is nuanced and multidimensional, and that people's understandings and experiences of capacity to consent to substance-involved sex are not solely individual, but rather, they are also shaped by their environment. We call for a multidimensional view of capacity to consent, where a standard of 'unimpaired', rather than sober, is used and modeled by academics, legislators, and educators.

Keywords: Sexual consent; capacity; substance use; alcohol; drugs

Introduction

The prevalence of substance-involved sexual activity in the United Kingdom remains unclear, though evidence shows that both alcohol and drugs are used frequently in sexual contexts among the people who consume them (Desai et al., 2019; Lawn et al., 2019; Sumnall et al., 2007). Sexual activity following alcohol and other drug use has been associated with a range of sexual outcomes, both positive (e.g., feeling more sexually expressive; Palamar et al., 2014) and negative (e.g., sexual regret; Barnett et al., 2014; sexual violence; Fileborn et al., 2020). Alcohol is the most frequently used substance before sexual activity, followed by cannabis, MDMA/ecstasy, and cocaine (Lawn et al., 2019). The term 'substance' is used to refer collectively to all psychoactive drugs including alcohol and excluding caffeine and nicotine (World Health Organization, 2021). The term 'substance-involved sex' refers to the act of engaging in sexual activity while under the influence of one or more psychoactive drugs (Lawn et al., 2019, p.3). Although the term 'substances' will be used to refer collectively to all psychoactive drugs including alcohol, this paper will – as much as is possible - distinguish between alcohol and other drugs, reflecting the distinction often made in legal statute (e.g., Misuse of Drugs Act, 1971) and sexuality research (e.g., Torres et al., 2020).

Sexual consent

Sexual consent has previously been defined in many ways. First, as a cognitive activity, that is, a 'decision' made by individuals to have a sexual experience (Beres, 2007; Hickman & Muehlenhard, 1999). Sexual consent has also been conceptualized as an affective state, for example, a feeling of 'willingness' to engage in sexual activity (Hickman & Muehlenhard, 1999; Peterson & Muehlenhard, 2007). Sexual consent may also be defined by external elements: it involves people's ability to use verbal or non-verbal cues (Smith et al., 2021). It is also often described as something that is 'given' to another person or an implicit or explicit agreement to engage in sexual activity (Beres, 2007; Hickman & Muehlenhard, 1999). Recently, scholars have noted how sexual consent is socially mediated too: it is interlinked with dominant gender norms and sometimes made sense of through social interactions with peers (Jensen & Hunt, 2020).

We conceptualized sexual consent, at an individual level, as comprising internal (i.e., cognitive and affective states) and external (i.e., behavioral ability and action) dimensions (Figure 1). We view internal consent as present when an individual has 'given' consent at both a cognitive and affective level. For example, when they can make the decision to engage in, and experience a feeling of willingness for, sexual activity. For external consent to be present, a person should be able to communicate their consent using external cues (e.g., explicit, or implicit verbal or non-verbal cues; Marcantonio et al., 2020).

In line with the socio-ecological model (see Kilanowski, 2017, for an overview of the socio-ecological model), it is our view that personal beliefs about, and experiences of, sexual consent, are mediated by people's environments and the interactions of people with their environment (Jones et al., 2020). For this paper, the 'environment' is conceptualized as three nested layers: relationships; communities; society (see Figure 1). The individual-level of the social ecology model comprises people's beliefs about, and experiences of, sexual consent. The 'relational' level involves the relationships that influence people's understandings, and experiences, of sexual consent. A person's relationship to a sexual partner has been associated with their internal and external sexual consent (Willis et al., 2019; Willis et al., 2021; Willis & Jozkowski, 2019). The 'community' level explores the settings in which social and sexual relationships occur and where agreements to engage in sex are made. Recent evidence has shown that people sometimes infer sexual consent based on the social setting (Jozkowski & Willis, 2020) and that the interpretation of sexual consent cues is highly context-specific (Harrell et al., 2022). Finally, the 'societal' level looks at the broader social and structural factors that help to create a climate in which sexual consent is encouraged or inhibited. For example, gender norms privileging men have been argued to normalize sexual coercion in casual relationships - thus inhibiting sexual consent (Lewis et al., 2020).

[insert Figure 1 near here]

Implications of substance use for sexual consent

Substance use has implications for sexual consent at each level of the social ecology (Figure 1). First, at the individual-level, people can report internal consent when they are drunk and high (Marcantonio & Willis, 2022), however, substance use may have a deleterious effect on the internal

elements of sexual consent relative to when sober. For example, young adults have reported lower feelings of internal consent at both alcohol-involved (Jozkowski & Wiersma, 2015) and cannabis- and alcohol-involved sexual activity (Willis et al., 2021), compared to sober sexual events. Unfortunately, the measure of internal consent used in these studies did not differentiate between the affective (e.g., feelings of willingness, how safe and ready they feel) and cognitive (e.g., awareness or ability to make an informed decision) components of internal consent, meaning that it is unclear whether substance use differentially or similarly impacts these and whether they are differentially impacted upon by other or additional psychoactive substances.

Substance use may also have an impact on the external elements of sexual consent, such as people's behavioral ability and behavioral action. Looking first at general alcohol use, research has shown that 30-day alcohol use consumptions patterns are associated with people's external communication of sexual consent. Marcantonio et al (2022) found that people who engaged in 30-day binge-drinking (defined as >4 or 5 drinks in one sitting), compared to those who did not, relied less on active consent communication cues (e.g., verbally asking for consent or using behavioral signals, such as smiling) over the same period. Among young adults, alcohol is understood to increase feelings that are associated with, and are sometimes used to infer, sexual consent, such as romance or arousal. Subsequently, the authors of the aforementioned study argued that people who drank to a higher degree may have been more likely to misidentify alcohol-induced feelings as sexual consent rather than using more explicit active communication cues (Marcantonio et al., 2022). Unfortunately, the study looked at the association between 30-day binge drinking and sexual consent, rather than alcohol use at the level of the sexual event.

Research has explored how substance use at the time of a sexual experience impacts external sexual consent with evidence showing that people can feel that they are able to actively communicate their sexual consent whilst drunk or high (Marcantonio & Willis, 2022). However, substance use, as well as relational factors, may influence the degree to which people use different cues to communicate and determine sexual consent. For example, one study found that single young adults (i.e., not in a relationship with their sexual partner), who drank alcohol before their most recent sexual experience, compared to those who did not, used less direct nonverbal behaviors, such as taking off one's clothes,

and fewer initiation cues, to communicate their sexual consent (Jozkowski & Wiersma, 2015). Contrastingly, Willis et al., (2021) found no differences in the communication of sexual consent across sober, alcohol, cannabis, and alcohol-and-cannabis among people who were in a relationship with their sexual partner. Therefore, secondly, these studies highlight the relational nature of sexual consent. In particular, the latter findings suggested that for people in relationships, the external communication of sexual consent is stable across substance-involved and non-substance-involved sexual activity. For example, they may use greater nonverbal and indirect communication in general. Unfortunately, these studies did not speak to the extent to which people felt that their behavioral ability (rather than behavioral action) was influenced by their substance use. It is possible that some drugs, particularly at higher doses, produce behavioral effects that make verbally or non-verbally communicating a feeling of (un)willingness to another person difficult (Smith et al., 2021).

Third, sexual consent may be constrained in contexts where substance use takes place due to community norms. The social context in which substance use typically happens, such as in bars, nightclubs, parties, and festivals, is argued to reinforce and perpetuate the norms and social structures that underpin sexual violence (Fileborn, 2016). In these spaces, cross-gender interactions have been found to conform to hegemonic gender rules: men are aggressive initiators of sexual activity whilst women are expected to tolerate, or enjoy unwanted sexual attention (Connell, 2002; Hlavka, 2014). There is also global evidence that substance use is viewed to be part of the sexual consent 'process'. Young adults from North America, Europe, and South Africa have reported that (often a women's) acceptance of a substance, from a man, such as in a bar, is viewed by others as an implicit indicator that they are willing to engage in sexual activity (Jozkowski et al., 2018; Smith et al., 2021). This view of sexual activity and substance use as 'transactional' constrains women's autonomy in substance use contexts: women have reported feeling less able to express their unwillingness to engage in sexual activity once a substance has been accepted for 'free' (e.g., Jozkowski et al., 2018; McElrath, 2005). Fourth, societal beliefs about drugs and the people who consume likely have implications for sexual consent. Drug-taking - in particular, opiate (e.g., heroin), methamphetamine, and crack cocaine - is often constructed through discourses that reduce people's agency and autonomy, such as addiction and criminality discourses (Bright et al., 2008). These discourses have

been found to be drawn on by men to justify the sexual violation of women who drugs (e.g., Jessell et al., 2018; Smith et al., 2021).

Substance use and the capacity to consent

At the individual-level, substance use can negate people's capacity to consent to sexual experiences, yet, at a societal level, there is no academic or legal agreement on how intoxicated is "too intoxicated" to consent to sexual activity (Drounin et al., 2018; Muehlenhard et al., 2016). It is noteworthy though, that in England and Wales, the loss of capacity to consent can occur prior to the point of unconsciousness (see. R v Bree [2007] EWCA Cr.). Prevailing legal definitions of sexual consent note the importance of 'capacity' (e.g., Sexual Offences Act, 2003, s.74) but often fail to model what this 'looks like' in a tangible sense (Clough, 2018; Temkin & Ashworth, 2004). In line with the Mental Health Capacity Act, which notes that cognitive and communicative abilities are necessary to consider when assessing a person's capacity to consent in applied settings (e.g., medical; 2005; s.3), we define 'capacity to consent' as the cognitive abilities (part of internal consent) and behavioral abilities (part of external consent) that are needed to make and communicate decisions during sexual activity.

There is a large degree of subjectivity regarding how people understand and interpret what constitutes capacity to consent in substance use contexts. This likely stems from a lack of resources and information on capacity to consent (Gunby et al., 2013; Hunt et al., 2022). Many sexual consent social marketing campaigns emphasize affirmative consent and what that entails, but do not model what constitutes having the capacity to consent to sexual activity (see Beres, 2018). Concerningly, the evidence shows that some people hold the belief that if a person maintains consciousness during a sexual encounter, then this suggests that they had the capacity to consent to sexual experiences (Gunby et al., 2013); a belief which contrasts with the legal context in England and Wales (see Bree, 2007). Thus, there may be people who engage in substance-involved sexual activity without a complete understanding of what constitutes capacity to consent in these contexts from a legal perspective (Schumlich & Fisher, 2020). Evidencing this point, a recent qualitative study carried out by Jensen and Hunt (2020) showed that young women sometimes question their capacity to consent to sexual experiences following alcohol consumption, for example, in conversation with friends, but do

not always label these experiences as non-consensual. In the same study, young women who could not remember aspects of the sexual activity due to partial or total blackouts, often described them as 'regretted', rather than, sexual violence. Possibly, people make sense of these types of experiences considering the wider societal-level messages that are available to them. It is the case that in UK legal settings, an inability to remember the details of a sexual encounter has not always determined a complainant's lack of capacity to consent to sexual activity (Clough, 2018).

Most research to date has explored the implications of alcohol for people's understanding and experience of the capacity to consent. This research has shown that young adults hold differential beliefs about what it means to give consent to sexual activity after drinking alcohol (Marcantonio & Jozkowski, 2021) and believe that it is difficult to determine the validity of another person's sexual consent when that person has consumed alcohol (Hunt et al., 2022). In practice, young adults have been found to rely on factors, such as the number of units of alcohol consumed, as an indicator of someone else's capacity to consent (Baldwin-White, 2019). These indicators are likely drawn upon as they are used in other legal contexts (e.g., see Road Traffic Act, 1988; s.5). However, this method of assessment is likely to be limited due to the variable nature of alcohol intoxication. Subjective intoxication is influenced by both community-level and individual-level factors, including the context in which alcohol is consumed and a person's consumption practices (such as the rate of consumption and history of use, e.g., tolerance) and the concomitant physiological effects of the alcohol and other drugs (Hartogsohn, 2015). Moreover, interpreting someone else's drinking behavior may not be effective in the assessment of a person's capacity to consent to sexual experiences because people's estimates of another person's consumption are not always an accurate reflection of 'true' consumption (Drounin et al., 2018). Little research has had a primary focus on people's beliefs and experiences of the capacity to consent when other drugs have been consumed (irrespective of whether with or without alcohol).

Different psychoactive drugs – including alcohol - have differential effects on people's cognition, emotions, and behavior (Parrott, 2003). Thus, it is important to consider whether different drugs have a differential effect on people's capacity to consent. A recent systematic review and thematic synthesis of 21 studies found variable effects of drugs on people's capacity to consent to

sexual activity (Smith et al., 2021). People sometimes felt that drug-taking bore no impact on their ability to make sexual decisions, whilst others reported improved clarity over their decision-making - usually following cannabis and ecstasy use. Most commonly, however, a diminished capacity to consent was described. People felt less able to weigh up the risk and consequences of their behavior and partial and total blackouts were not uncommon. Some people also felt less able to use verbal communication due to intoxication. Whilst this systematic review provided insight into the effects of drug-taking on people's capacity to consent, sexual consent was often a secondary or incidental finding of the studies included. As such, a deliberate and in-depth exploration of this topic has not yet been carried out.

Summary and research questions

Emerging evidence shows that substance use has implications for the capacity to consent to sexual experiences (Drounin et al., 2018; Hunt et al., 2022; Smith et al., 2021), yet no empirical research has had the primary focus of exploring people's capacity to consent to sexual activity when drugs, with or without alcohol, have been consumed. Thus, the present study aimed to address this. This paper presents a subset of qualitative findings relevant to this aim, derived from a larger, online, mixed-methods study that explored people's understandings and experiences of sexual consent and how these were similar or different across sober, alcohol, and drug-involved sexual experiences and the demographic, situational, and psychosocial characteristics that were associated with sexual consent across these sexual events.

In this paper, we present qualitative data relevant to the following research questions:

1. What are people's understandings of the capacity to consent for alcohol- and/or drug-involved sexual activity?
2. How is capacity to consent experienced during alcohol- and/or drug-involved sexual activity?

Materials and Methods

Respondents and recruitment

A total of 354 people took part in the study. Respondents were recruited between July 2017 – April 2018 via social media (e.g., Facebook, Twitter, and Instagram), university email announcements, and by placing flyers in bars, nightclubs, cafes, leisure centres, and university campuses in the North of England. Most respondents accessed information about the study through their university ($N = 188$) or social media ($N = 142$).

The respondents were required to be living in the UK, between the ages of 18-40, have been sexually active within the last 4 weeks and have had at least one lifetime experience of either an alcohol- and/or drug-involved sexual activity.

People were asked to refrain from volunteering if they were currently accessing, or had previously accessed, treatment for substance use, or sex-related problems (e.g., compulsive sexual behaviour). Three screening measures were implemented in the body of the survey to screen for participant eligibility: The Alcohol Use Disorders Test screened for alcohol dependency (Babor et al., 2001) and a cut-off score ≥ 32 was used as this indicated severe dependency (Babor et al, 2001); The Drug Abuse Screening Test-10 (Skinner, 1982) screened for drug dependency and a cut-off score of ≥ 8 was used as this reflected a severe level of drug-related problems (Maisto, et al., 2000); finally, a modified version of the Sexual Addiction Screening Test-Revised (SAST-R; Carnes et al., 2010) screened for sexual addiction and/or strong preoccupation with sex. A cut-off score of >2 was used. These exclusion criteria were implemented for methodological reasons; for example, because people who experience drug dependency, compared to recreational drug users, report different motivations for substance use (Boys et al., 2001; Newton et al., 2009).

Study Overview

The Psychology Research Ethics Committee at [name of university redacted] approved the study. The study utilized a concurrent, mixed methods, retrospective study design (Cresswell et al., 2003; Johnson & Onwuebuzie, 2004). The study was presented online using Qualtrics© software.

Interested volunteers accessed the study through the study webpage which contained detailed information on what was involved and a link to take part, and access to free and confidential support for the topics covered by the survey (e.g., drug-taking, sexual violence, relationships). All respondents were required to consent to the study before being presented with the survey questions. The survey

was ordered thematically and by the degree of sensitivity of the questions, starting with those which were arguably least sensitive. The screening questions were embedded within relevant thematic blocks. If the respondents did not 'pass' the screening measures (N = 8) as they moved through each section of the study, they were shown a message to thank them for participation but informed that they were not eligible to continue and provided with a reminder of the links to support organisations.

First, people were asked demographic questions, followed by their substance use (e.g., history and current use) and general sexual behaviour (e.g., age at first sexual experience, 30-day sexual behaviour). The respondents were then invited to write about what they believed to be a consensual sexual experience. Next, participants completed a set of questions - producing detailed narrative (e.g., written descriptions about sexual consent communication) and numerical (e.g., quantitative ratings of sexual consent) information - for each of three events: their most recent sober, alcohol, and drug-involved sexual activity. These event-based question blocks were presented in a randomised order. Respondents were not required to have had all three types of sexual experience, but rather, to report on those that they had engaged in. A sexual experience constituted anything ranging from fondling through to penetrative vaginal and/ or anal sex with others. In the final part of the survey, respondents completed a battery of psychosocial questionnaires exploring their beliefs about sexual consent, sexual violence, and substance use, respectively. These questionnaires were presented in a randomised order.

The minimum number of questions possible in the survey was 261, and the maximum, 912; however, it was unlikely that any person would have to answer every question on the survey. No character or word limitations were applied to the qualitative responses. People's responses ranged from a single sentence to multiple pages of text.

Once the respondents had completed the survey, they were thanked for their participation and provided with a written debrief. Respondents who completed the survey were entered into a prize draw to win one of 80 x £10 Amazon vouchers. The median time spent completing the survey was 51 minutes (IQR = 31).

Relevant Measures

This section outlines the questions from which the descriptive and qualitative data presented in this paper are derived.

Age, race/ethnicity, and educational attainment

Respondents were asked about their age, their ethnicity, and their highest level of education, including any courses that they were currently undertaking. These questions were derived from the Office for National Statistics census survey questions (ONS, 2015).

Gender, sexual identity, and current relationships

Respondents were asked to complete closed questions on their sex assigned at birth: female, intersex, or male. They were also asked to report their gender identity (e.g., genderqueer, non-binary, woman, man) and sexual identity (e.g., bisexual, gay, lesbian, pansexual, straight) from a broad range of options. They were asked about their current relationship status with response options of single, dating, married, divorced/separated, or widowed and respondents were able to tick multiple responses for this question (e.g., dating and married).

Substance use history

Respondents were asked to report the average number of alcohol units that they consumed per week and per drinking occasion. Guidance was provided on what constituted a 'unit' of alcohol (see NHS, 2021). Respondents were also asked to report their lifetime, yearly, and 30-day drug use from a list of 24 commonly consumed illicit drugs (e.g., cannabis, cocaine, ecstasy/MDMA, ketamine). Respondents were also able to list any other drug that they had consumed which was not already stated in the list.

Understanding of sexual consent

Respondents were invited to complete an open-ended question about their understanding of sexual consent before completing detailed information about their sexual experience(s). This question asked people to, ". . . tell us in as much detail as possible, what you believe to be a consensual sexual experience? There is no correct answer. We want to understand more about what this term means to you"). Participants were told that a 'sexual experience', for this study, constituted anything ranging from fondling through to penetrative vaginal and/or anal sex with others.

Time since most recent sexual experience

Respondents were asked to report the time since their most recent sober, alcohol and drug-involved sexual experiences to the closest hour.

Alcohol use

Respondents were asked to estimate the total units of alcohol that they had drunk before the sexual experience. They were also asked whether they had consumed 6 or 8 units of alcohol at a rate of at least 4 units per hour (for people who identified as female or male, respectively; Office for National Statistics, 2018). This variable reflected 'binge-drinking' behavior and was measured categorically, "Yes (1)", "No (0)", "I think so" and "I don't know".

Drug-taking

Respondents reported the drugs that they had consumed at their most recent drug-involved sexual experience from a list of 24 commonly consumed illicit drugs (e.g., cannabis, cocaine, ecstasy/MDMA, ketamine). An 'other' option was included to list any other drug that they had consumed which was not already stated in the list.

Before, during, and the end of the sexual experience

Closed questions were presented to the participants asking them to provide contextual information about the sexual event, such as who sexual partners were (e.g., a person that they were friends with or in a relationship with) and where they were before and during the sexual experience (e.g., at their own or their partners' home, in a bar/club, at another person's home).

Respondents were then asked to describe in detail how the (sober, alcohol- or drug-involved) sexual experience started, what happened during, and how the sexual experience ended. The respondents were provided with examples of the types of information that they might want to report (e.g., what happened before, what each person did or said). People were also invited to share how they felt about the sexual experience afterwards. These questions were intended to provide insight into the broader context in which the sexual experience took place (e.g., at the community-level), the cognitive and affective state of the people at the time, and their own and others' behavioral abilities and actions in relation to the sexual experience.

Feelings of willingness and wantedness at alcohol and/or drug-involved sexual experiences

A series of open-ended questions explored how people communicated their own willingness and wantedness to a sexual partner, and how they knew that their sexual partner was willing and wanted the sexual experience, before and during the sexual experience. Although these questions focused more on the internal-affective component of sexual consent, some people's responses also provided insight into aspects of their own or their partner's capacity to consent (i.e., behavioral action).

Ability to consent to alcohol and/or drug-involved sexual experiences

A series of open-ended questions asked the participant why they felt that they, and how they knew that the other person, respectively, was or was not able to communicate their willingness before and during the sexual experience. These questions intended to gain insight into the respondents' perception of their own cognitive and behavioral ability to consent, and how they determined their sexual partner's cognitive and behavioral ability to consent.

Qualitative analysis

A Critical Realist (CR) position was adopted, acknowledging the materiality of physical and psychological experiences, and that reality is socially constructed through human activity (Sayer, 2000). In line with a CR framework, people's accounts of their sexual experiences were not viewed as a direct reflection of reality, but rather, a socially mediated reflection of reality; thus, this position (and the analysis resulting from it) aims to go beyond the individual-level of the social ecology to consider how culture and society may have shaped people's experiences and responses (see Braun & Clarke, 2021). The qualitative data were analyzed using Thematic Analysis (TA), guided by methodological frameworks proposed by Braun and Clarke (2006; 2019; 2021) and Attride-Stirling (2001). TA is theoretically unbounded and is well-suited for large datasets (Nowell et al., 2017). The overall goal of the analysis was to identify patterns of meaning relevant to the research questions and research area. The themes reported on are subsequently not determined by frequency, but rather salience and importance for the field of study (Braun & Clarke, 2019; 2021).

Braun and Clarke's (2006; 2019; 2021) guidance was drawn upon for the stages of data familiarization, coding, and theme formation. Attride-Stirling's (2001) guidance was drawn upon later to structure and present the data using Thematic Networks (i.e., illustrations that summarize the main

themes derived from the data; Attride-Stirling, 2001). The use of these web-like networks allowed for higher-level, abstract, concepts to be drawn out of the dataset (e.g., linkage to theoretical and conceptual concepts). Overall, six phases were followed in the analysis of the data: 1) data familiarization; this involved reading the data and jotting down initial thoughts; 2) generating codes to 'chunk' the data, using a mostly inductive and semantic approach (see 'Example quotes' and 'Example codes' in Table 1); 3) identifying themes and subthemes by clustering similar codes together (see 'Subthemes' and 'Theme' in Table 1); 4) reviewing the themes and subthemes and constructing thematic networks through which the themes could be depicted (for part of this thematic network, see Figure 2); 5) describing and exploring thematic networks (e.g., identifying connections between themes and subthemes within the network, see Figure 2); (6) interpreting the patterns in the data (i.e., in the final report).

All qualitative analysis was undertaken in NVivo version 11 and 12. From the final, large thematic network that was produced from all the study qualitative data, this paper focuses specifically on the themes and subthemes within this network that are most relevant to, and have implications for, people's capacity to consent to substance-involved sexual activity.

[Insert Table 1 and Figure 2 near here]

Results

Sample characteristics

The respondents were 23.4 years (*SD* = 6.09) on average and most identified as cis-gender women, heterosexual/straight, degree-level educated and White (British, Irish, or Other) - see Table 2. Most people were in a relationship at the time of survey completion, and on average, had been in that relationship for 2.9 years (*SD* = 4.05). The respondents reported drinking an average of 13.65 units per week (SD = 15.05) and, during a typical drinking occasion, 10.36 units of alcohol (SD = 6.89). Almost half of the respondents reported 30-day drug-taking and were subsequently considered 'current' drug takers (see Table 2). Of those people who reported 30-day drug use, they consumed drugs on an average of 8.94 days (SD = 9.61) in the last 30 days. The most common drug reported in

the past 30-days was cannabis followed by MDMA and cocaine. One in five people reported never having used drugs (see Table 2).

[insert Table 2 near here]

Characteristics of alcohol- and/or drug-involved sexual experiences

Time since the sexual experience

Of the substance-involved sexual experiences, alcohol-only experiences were the most recently engaged in. The median number of days since the reported alcohol-only experience was 13 days (IQR = 24.00), for an alcohol-and-drug experience, 30 days (IQR = 109.50), and for a drug-only experience, 60 days (IQR = 234.00).

Location before and during the sexual experience

Before sexual experiences involving alcohol (either drank on its own or in conjunction with another drug) respondents were often in a bar/nightclub setting (alcohol only; 50.7%; *n* = 116; alcohol-and-drug; 50.6%; *n* = 44). Lower proportions of people were at their own or their partner's home (alcohol only; 34.9%; *n* = 80; alcohol-and-drug; 20.7%) or someone else's home (alcohol only; 9.2%; *n* = 21; alcohol-and-drug; 17.2%; *n* = 15). Before drug-only sexual experiences, the respondents often reported being at their own home or the home of their partner (57.4%; *n* = 23), rather than in bars/nightclubs or someone else's home (10%; *n* = 4, respectively).

Most substance-involved sexual experiences occurred at the home of the respondent (alcohol only; 81.3%; *n* = 187; alcohol-and-drug; 67.8%; *n* = 59; drug only; 82.5%; *n* = 33). Much lower proportions of people reported that their sexual experience took place at the home of another person (alcohol only; 9.6%; *n* = 22; alcohol-and-drug; 19.5%; *n* = 17; drug only; 7.5%; *n* = 3).

Alcohol and drug use

At both alcohol- and alcohol-and-drug-involved sexual experiences, people reported consuming an average of 9.41 (*SD* = 5.79) and 9.56 (*SD* = 2.74) units of alcohol, respectively. A marginally greater proportion of people reported binge-drinking at alcohol-involved (46.1%; *n* = 107) relative to alcohol-and-drug-involved (40.2%; *n* = 35) sexual experiences.

At drug-only sexual experiences, cannabis was the most consumed drug. At alcohol-and-drug sexual experiences, cocaine was most reported, followed by MDMA and cannabis (see Table 3). The

use of more than one illicit drug (i.e., polyuse) was greater at alcohol-and-drug-involved (26.4%; *n* = 23) versus drug-only (10.0%; *n* = 6) sexual experiences.

[insert Table 3 near here]

Partner status

Most substance-involved sexual experiences took place between people who were in a relationship at the time of the sexual experience. The highest proportion of non-partners were reported at alcohol-and-drug-involved sex (non-partner; 46%; *n* = 39; partner; 54%; *n* = 47), followed by alcohol-only (non-partner; 35.2%; *n* = 77; partner; 64.8%; *n* = 151). Much lower proportions of non-partners were reported at drug-only sexual experiences (non-partner; 17.5%; *n* = 7; partner; 82.5%; *n* = 33).

Findings for Capacity to Consent

Three themes constructed from the data were relevant to capacity to consent (see Figure 2 for Thematic Map). The first theme, 'There is no normative understanding of substance-involved sexual consent', contained three subthemes: 'Substance use is perceived to complicate sexual consent', 'Some intoxication is acceptable but not *"too much"*' and '*Relationality influences understandings of sexual consent whilst drunk or high'*. The data from this theme demonstrated that there was no accepted, universal understanding amongst respondents about the point at which a person is 'too drunk or too high' to consent to substance-involved sex – potentially reflecting a lack of wider societal norms around whether and when sexual consent is possible, with capacity to consent being viewed as difficult to understand and interpret when people are consuming substances. The second theme, 'Moving beyond the binary of consciousness versus incapacitation', contained three subthemes: 'Sexual partners should be lucid', 'Sexual partners should understand the meaning of their decisions' and 'Capacity to consent can change during a sexual experience'. The data in this theme pointed to 'capacity' as a multidimensional and dynamic construct. The third theme, 'Substance-involved sexual decisions are viewed as irresponsible', contained two subthemes: 'Intoxicated decisions are viewed as 'bad' decisions' and 'Maintaining sobriety to avoid sexual regret'. The data in this theme showed that people often framed sexual decision-making following alcohol and drugs as

irresponsible and regretted in contrast to sober sexual decision-making which was typically framed as responsible and not regretted.

Theme 1: There is no normative understanding of substance-involved sexual consent

Substance use is perceived to complicate sexual consent

Substance use was described as 'complicating' or 'blurring' sexual consent by people in the study; illustrating this, one person wrote, "Although, under the influence of drugs or alcohol, the lines between consent often become blurred as inhibitions are lowered. In which case, I believe that in these situations, consent must be cautionary. . ." (25, cis-woman, straight). Another wrote, "You want to make sure you're not being pushy or pressuring but it's often harder to tell as we are all less sensitive to more subtle communications like body language and tone of voice when we're drunk" (24, cis-woman, straight). The viewpoint that consent was 'blurry' following substances appeared to be held strongly when both/all parties had (or were perceived to have) consumed a substance; one woman wrote, "when all parties are drugged up or drunk, the situation becomes more complicated" (18, cis-woman, bi+).

Some of the respondents expressed the belief that if both people were intoxicated to the same degree, then consent could be assumed. One man wrote, "[consensual sex is] If both people are at the same level of intoxication, be that sober or entirely twizzled . . ." (22, cis-man, straight). Possibly, some of the people in the study viewed intoxication status as the only imbalance of power between sexual partners without recognizing other factors that can also constrain or extend a person's freedom to consent following substance use.

Some intoxication is acceptable but not "too much"

Consensual sex was not typically viewed as something which needed to take place when all people were 'sober', for example, one person wrote, "An experience in which both parties are mostly sober (in control of their actions/aware of what they are doing)" (21, cis-woman, bi+). However, for those people who did align consent with a standard of sobriety (for example, "When both/all parties involved in the experience vocally agree to partake while sober"; 18, cis-woman, straight), this was at odds with the alcohol- or drug-involved sexual experiences that they reported as consensual in this

study. This suggested some discordance in people's understandings of sexual consent and their sexual consent practices.

"Sober *enough* [emphasis added]" (22, cis-woman, straight) was a recurring phrase across the dataset, which may have implied shared meaning. 'Sober enough' was framed as 'obvious' and 'simple', or something easily recognizable. To illustrate this, one woman wrote, "Some level of drunk or high is acceptable but not too much. I believe that any decent human being is capable of understanding how fucked is too fucked to consent" (18, cis-woman, bi+). The use of the phrase 'not too much' pointed to a belief that a particular 'level' of intoxication would negate consent, but, the fact that no participant stated a specific level of intoxication, shows that this cannot always be easily defined or described. Additionally, some people defined their substance-involved sexual experiences as consensual despite partial and total blackouts, an absence of memory, and being "pretty passed out" (32, cis-woman, bi+). Exemplifying this, people wrote things like, "I really don't remember at all. . . I was really smashed" (28, cis-man, bi+), "to be fully honest i cant fully remember" (20, cis-man, straight), and "It's a bit hazy. . . I was stoned" (36, cis-woman, bi+). Overall, these data suggested that there is no normative understanding of "how fucked is too fucked" to consent to sexual activity.

Relationality influences understandings of sexual consent whilst drunk or high

The relationship between sexual partners was noted by respondents as influencing how sexual consent was understood, determined, and communicated, at substance-involved sexual activity. A shared history of substance-involved sexual activity appeared to act as an implicit way through which people determined and communicated their sexual consent at substance-involved sexual activity. This is illustrated in the forthcoming two quotes. When describing how his partner knew he was willing to have the alcohol-involved sexual experiences, one man wrote, ". . . due to understanding my capacity to say at any point whether I wanted to stop. As well as the normality and familiarity of the experience with each other" (21, cis-man, straight). When describing how her partner knew she was willing to take part in the sexual activity, a woman wrote, "we had a sexual experience drunk prior to this one and had spoke about it beforehand" (19, cis-woman, lesbian). Both these extracts suggested that a history of intoxicated sexual activity with the partner is seen to be a sexual consent cue. Higher levels of drunkenness during sexual activity also appeared to be more understood as consensual if

sexual partners were known or regular. For example, one woman wrote, ". . . or for the person to have a good enough relationship with the person that if one was very drunk, know they would still be wanting to have sex" (22, cis-woman, straight). Implied across this data was a belief that people in relationships, or with a shared sexual history, can more accurately predict sexual consent with their partner across sexual contexts, and possibly, that this outweighs a standard of capacity to consent.

Being able to indicate a verbal or non-verbal 'yes' whilst under the influence of a substance was important to people's understanding of capacity (see Theme 2: Moving beyond the binary of consciousness versus incapacitation). What was interesting though, was that the type of communication perceived as required following substance use varied according to the type of sexual partner (known or unknown), suggesting that individual-level substance use, and relational factors, interact to influence people's external communication practices. Illustrating this, when describing what consensual sex meant to them, one person wrote, "An experience in which both parties are mostly sober (in control of their actions/aware of what they are doing) and are able to indicate either verbally or nonverbally if they are uncomfortable, obviously for random encounters a 100% positive, mostly sober, yes is needed" (21, cis-woman, lesbian).

There was also evidence that women may sometimes feel unable to express their unwillingness to engage in substance-involved sexual experiences with men partners due to feelings of obligation. For example, when describing the events leading up to a sexual experience with a man partner that she was dating, one woman wrote, ". . . plus I would have rather spent more of the night with the friends that I arrived with, but in the club I felt like I should stay with the man once I saw him" (19, cis-woman, straight). This quote in particular, illustrates how women may sometimes experience difficulty negotiating sexual boundaries with dating partners within public nightlife environments contexts.

Theme 2: Moving beyond the binary of consciousness versus incapacitation

Sexual partners should be lucid

Capacity to consent was sometimes written about in binary ways, for example, some people wrote about sexual partners needing to be 'conscious' and not 'incapacitated' during their substance-involved sexual activity. Illustrating this, one woman wrote, "obviously if someone's unconscious it's

a no go!" (40, cis-woman, bi+), another wrote, "If either party loses consciousness . . . the encounter ceases to be consensual" (39, cis-woman, bi+). These extracts suggested that a lack of capacity to consent may have only been recognized by people at the 'extreme' end of intoxication (i.e., incapacitation), rather than understood as something that could be lost before this point.

Other people, though, wrote about the drug effects before incapacitation that could indicate that a person may not have the capacity to consent with certain aspects of drug-taking noted, such as dissociating, or hallucinating. Illustrating this, one woman wrote, "consensual sex is not when someone is . . . clearly hallucinating/not in the zone" (19, cis-woman, bi+). Possibly then, it is these specific psychoactive effects of drug-taking that are understood by people to negate a person's capacity to consent to sexual activity.

People offered examples of how they could, or did, 'check-in' with a sexual partner to determine their capacity to consent; for example, by checking that they were able to hold a conversation, rather than simply agreeing or disagreeing to a question. One woman wrote, "Both parties need to be conscious and able to answer basic questions maybe 2x3 for example, not just like "are you okay?" with a yes/no answer" (23, cis-woman, straight). Another respondent, when describing how her partner knew she had the ability to consent to sex wrote, "we are both aware that we enjoy sex whilst a little bit boozy and as long as we are both . . . lucid and not drunk. . ." (25, cis-woman, straight). This suggested that being lucid during substance-involved sex was an important facet of capacity to consent to sexual activity.

A pattern identified within data was that substance-involved sexual experiences often involved – what appeared to be - aware and lucid sexual partners. People described knowing what was happening and engaging in conversations with a sexual partner before, and during, sexual activity as is shown in the following quotes. When answering questions about how they knew their partner was willing to have a sexual experience, one woman wrote, "We talked a lot all the way through. It's more important to do this when we're drunk. . ." (24, cis-woman, straight); and one man who had consumed cannabis wrote, "We asked each other what our boundaries were and what we wanted. . . " (20, cis-man, bi+). The first quote spoke to how ongoing verbal communication may sometimes be employed

by people during substance-involved sex, possibly, because it can help people to assess the nuances of another person's capacity to consent to sex relative to non-verbal communication.

Some environments and their norms may not be conducive to being able to 'check-in' with a (potential) sexual partner about their lucidity or capacity to consent to sex. Illustrating this, one man wrote:

> I have witnessed at a sex party someone having penetrative sex with someone who they had not spoken to before and without asking permission which is experienced as 'okay' within the context, however later the same group of people may stop someone from having penetrative sex with the same person who seems to be "going under" on GBL, not being fully conscious (38, cis-man, gay).

This experience reported by the man is also misaligned with some of the data reported in Theme 1, whereby consensual substance-involved sexual experiences were seen to require greater verbal communication, in particular, when a sexual partner was not known to the individual. Also illustrating that non-verbal sexual consent cues may be used more to interpret a person's willingness to consent to substance-involved sexual activity in a sex-party environment, another person wrote, "we were in the darkroom, everyone was dressed in fetish gear, and it was a very sexually-charged environment" (28, cis-man, Bi+). Here, it appears that the other person's willingness to have sex is being inferred by their presence in a sexualized environment.

There was also evidence that moving from a public to a private space may involve inferred, rather than explicit sexual consent, for example, one woman wrote, "after a few he started talking about going to my place which I agreed to. From that point on it was pretty much implied that we would have sex" (22, cis-woman, bi+). When sexual consent is understood to be something 'pre-agreed', sexual partners may be less likely to pay attention to cues that would indicate whether a person has capacity to consent in the moment. Subsequently, these data show that community-level factors, such as sexual consent norms in particular environments, may contradict understandings of sexual consent communication at the individual-level.

Having 'awareness' of what had taken, or what was taking, place during a sexual experience was also mentioned by people when describing what constituted consensual sexual activity, for

example, “Both parties must not be excessively intoxicated and aware of their own actions in order to consent” (23, cis-man, straight). Not all people though appeared to have ‘awareness’ before or during their ostensibly consensual substance-involved sexual experiences. Some people described having only partial recollection of their sexual experiences and were unable to remember how they, or the other person, indicated their sexual consent, for example, because they were cycling in and out of consciousness at the time. One woman who had drank alcohol wrote, “I have flashbacks of being on top of him, but I cannot remember anything further” (27, cis-woman, straight); another wrote, “I don't know, I can't remember. I was blind drunk. The Uni faculty paid for the drinks and they were blind drunk too. They probably had sex with someone and regretted it too” (28, cis-man, bi+). The fact that consensual substance-involved sex was often defined in terms of ‘awareness’ and ‘lucidity’, but that some people’s experiences did not fit with these definitions, suggested a disparity between how some people understood capacity to consent more generally versus how they understood and subsequently categorized their own experiences. There were also sexual experiences involving total blackouts where no detail about their sexual experience could be given. One woman wrote the following about an experience that took place after consuming alcohol and MDMA:

> Apparently, I was up for it at the time and the guy told me I was flirting with him beforehand at the bar. . . the next day we had a conversation about it. I couldn’t really understand how he thought I was able to consent. . . The guy said that he thought I was definitely up for it at the time but then stopped at some point during because he had realised that I was too drunk and stopped (26, cis-woman, gay).

This experience was reported as consensual by the woman despite some feeling that she was unable to give meaningful consent. Possibly, when capacity to consent has been lost, some people reconstruct their experiences considering how it is relayed to them and in the context of the consent norms within the environment. In the above extract, being told that she was ‘flirting’ and ‘up for it’ may have led to the experience being reported as consensual. In other cases, where people could not remember their sexual experiences in full, they appeared to make inferences about their ongoing sexual consent based on any memories they did have of the event, for example, “I remember prior and wanting it and assume that continued” (31, cis-woman, straight).

Understanding the meaning of decisions

Being able to make sexual decisions following substance use appeared to be understood as a feature of consensual sexual experiences. For example, one woman wrote, "when both my partner and I are both sober and able to make the choice to have sex" (25, cis-woman, straight). Extending this, was the emphasis placed on understanding the decision being made. One woman wrote, "where both parties have capacity to agree, and understand what they are consenting to" (26, cis-woman, bi+), and another wrote, ". . .Or if they're too drunk/high to understand what's going on" (23, cis-man, straight). 'Deciding' then did not always appear to constitute sexual consent in itself; a standard of 'understanding' was important to people too. This conceptualization of 'understanding', was also extended by people who noted the importance of having the ability to understand the outcomes associated with the sexual activity. One woman wrote, ". . . understanding of what that action involves and any possible consequences" (26, cis-woman, straight). Having the capacity to consent may therefore involve: first, being able to understand what is happening in the moment and, second, being able to consider future outcomes associated with sexual engagement.

Different substances were sometimes discussed as having differential effects on a person's understandings of sexual consent. Alcohol consumption was described by some people to have an increasingly negative effect on people's understandings of sexual consent. Illustrating this point, one woman wrote, "People have a much much lesser understanding of consent after consuming alcohol. Whereas I have never experienced anyone be too high [from cannabis] to understand consent, and they perhaps even have a better understanding of sex when high due to the intolerance to violence/pressuring/uncomfortability brought on by cannabis" (20, cis-woman, gay).

Capacity to consent can change during a sexual experience

The data showed that 'capacity' is a dynamic rather than static construct. The variable nature of intoxication sometimes led to changes in people's awareness, lucidity, and ability to understand decisions, over the course of a sexual experience. A participant who had smoked cannabis wrote, "I don't remember it well… I was pretty stoned…I think he wanted to do oral which I was happy to do. Then he gave me oral to orgasm. Then he had sex with me. By that point I was pretty passed out (32, cis-woman, bi+). This woman's description of her sexual experience suggested a transition from an

active and aware state (i.e., of 'doing' sex), to a more passive cognitive and physical one. Interestingly, despite reporting being close to incapacitation (i.e., 'pretty passed out'), this experience was reported as consensual by the woman. Echoing the point raised earlier, this may suggest that it is only at the point of incapacitation that some people judge their experiences to be non-consensual.

It is also possible that other contextual factors influence the extent to which people perceive their experience as consensual. For example, the extent to which they felt able to stop the sexual experience. One person wrote about how they had experienced being 'too drunk' to consent on numerous occasions but seemingly did not consider the experiences to be non-consensual because they felt able to stop the experience once they regained awareness, "although there have been occasions where I have been too drunk to give consent I have also always been able and allowed to stop the engagement when I realised what was happening" (20, cis-woman, straight). This quote demonstrates that, for some people, a loss of capacity on its own does not automatically determine a sexual experience to be non-consensual.

Also evidencing the point that substance use can change a person's cognitive and physical abilities throughout a sexual experience, harm-reduction strategies were sometimes used to prevent negative drug-related experiences during substance-involved sex. For example, stopping a sexual experience to take a water break due to physical concerns (e.g., overheating, dizziness) or waiting for the acute effects of drugs to wear off before continuing with a sexual experience. One man and woman, respectively, wrote, "stopped, had some water to help her dizziness" (19, cis-man, bi+), "he understood that i was . . . still high so also wanted to try to sleep the effects of the drugs off before we tried again" (21, cis-woman, bi+). Beyond reducing the physiological negative effects of drugs, these 'breaks' appeared to offer people an opportunity to discuss and recheck their own and their partner's capacity to consent. Interestingly, these practices were reported often in the context of drug-involved sexual experiences (with and without alcohol); typically, those which involved MDMA, ketamine and cocaine, but not sexual activity where alcohol or cannabis alone had been consumed. Overall, the data relevant in this paragraph demonstrated that people are employing their own safety practices in the context of substance-involved sexual activity to make them safer for all people involved.

Theme 3: Substance-involved sexual decisions are viewed as irresponsible

Intoxicated decisions are viewed as 'bad' decisions

Substance use was written about as something that could have an undue influence over people's sexual decision-making. One person wrote, ". . . nor under the influence of drugs/alcohol to the point where they would have not have otherwise had sex" (24, cis-woman, straight). Another woman wrote, "'Consensual' should probably mean 'nobody is intoxicated enough to make decisions they wouldn't make sober'" (20, cis-woman, bi+). These extracts suggested two things: first, that people believed that substance use can sometimes lead to people making decisions that they would not otherwise make; second, that substance-involved sexual activity should only be determined 'consensual' if the same decision (i.e., to have sex) would have been made sober. This latter position may, however, be too simplistic, because as one participant noted, some people use substances to, ". . . deliberately intoxicate themselves in order to engage in sexual relations they wouldn't normally feel brave enough to undertake while sober." (20, cis-woman, bi+). There was evidence of sexualized substance use in this study, for example, one woman wrote, "I drank alcohol to steady my nerves and to help me want to do it. It made me feel more relax and more willing" (19, cis-woman, straight). In this example, substance use appeared to be freely engaged in for the purposes of sexual activity, demonstrating that a person may make an informed choice about sexual engagement when sober which is then implemented when they are drunk or high.

Underlying the data in this subtheme was a belief that, sober, versus intoxicated, decision-making, is inherently better. Sober decisions were sometimes constructed as sensible and typical, whilst intoxicated decisions were framed as irresponsible, for example, one person wrote, "I remember telling them I wanted to but it was a bad idea because we had both been drinking" (18, cis-woman, straight). Another man described avoiding drug-taking – despite later consuming drugs – due to a need to stay 'level-headed'. He wrote, ". . . stay straight-headed as pre-sex was a serious conversation" (21, cis-man, straight). Possibly then, some people may have believed that abstaining from substance use can enable them to avoid making 'bad' decisions.

Contrasting the position that substance use always resulted in 'bad' decisions though, were those substance-involved sexual experiences in which people felt that they or their partner had made 'good' decisions. One person who had consumed alcohol and MDMA concurrently wrote, "We

weren't that high really and were perfectly capable of having a sensible conversation/making good decisions. We just both had a little buzz" (25, cis-woman, straight). Notable in this quote, was the participant's emphasis on their lower levels of intoxication, "weren't that high. . . little buzz". It could be interpreted then that at lower levels of intoxication, people do not feel that substance use impedes their decision-making compared to when sober, and subsequently, that they are likely to make decisions that are not perceived in a negative way by them. It was also the case that people made – what appeared to be - informed decisions when drunk and/or high such as avoiding penetrative vaginal sex due to a lack of contraception. For example, one woman wrote "I couldn't have sex because I had forgotten to take my pill, so I gave him a blowjob" (22, cis-woman, straight). This highlighted that substance use can co-occur with the ability to weigh up risk and consequence.

Maintaining sobriety to avoid 'sexual regret'

A pattern observed in the data was that women wrote about the importance of intoxicated sex not being 'regretted'; exemplifying this, one woman wrote, "The "correct state of mind" means to me, sober enough to not regret anything that happened" (18, cis-woman, straight). The language used by the woman implied a belief that people can avoid sexual regret if they maintain sobriety. It was not unusual for substance-involved sexual experiences to be reported as 'consensual' but to involve some regret, particularly, when women did not remember all of, or parts of, their sexual experience. One woman who had consumed alcohol wrote, "Slight regret as I couldn't remember all of the details" (31, cis-woman, straight). This is notable because having awareness appeared to be one of the central features of what it means to have 'consensual' sexual activity (see Theme 2: Moving beyond the binary of consciousness versus incapacitation). In other instances, women reported sexual experiences as consensual and regretted, when they had experienced pressure and coercion from another person. Following the consumption of cocaine and alcohol, one woman wrote:

> He started to touch me more than a friend would but at first I refused due to having started seeing somebody . . . He ignored me when I said it was a bad idea/wrong to do. I did fancy him, I had fancied him before this event…I suppose I lost my inhibitions and gave in to him eventually. I know I don't have to share my feelings but straight after the act I felt dirty, I felt like a betrayer and I was disappointed in myself for not sticking to what I said. I wished that I

had never gone out for drinks, taken Cocaine and I regret going back to the house to have more drinks. I still feel horrible about it now (21, cis-woman, straight).

The phrase 'I suppose I lost my inhibitions and gave into him eventually', suggested that the woman attributed the outcome of this experience (i.e., sexual contact) to her consumption of substance use, perhaps implying that, in the absence of alcohol and drug use, she felt that she would not have acted on her attractions or 'given in' to his initiations.

It is also possible that when intoxicated sexual decision-making becomes synonymous with 'regret', that there is an expectation that women will 'regret' decisions that they make when drunk or high, even when sexual experiences are not harmful. One young woman who had consumed alcohol, cocaine, and MDMA concurrently wrote, "good but socially pressured to feel embarrassed" (23, cis-woman, straight). This extract highlights how factors beyond the individual shape sexual interactions and outcomes.

Discussion

This paper had two primary research questions: (1) 'What are people's understandings of the capacity to consent to alcohol- and/or drug-involved sexual activity?' and (2) 'How is capacity to consent experienced during alcohol- and/or drug-involved sexual activity?'

Addressing research question 1, people's understandings of capacity to consent were multidimensional and dynamic, involving both internal cognitive (e.g., lucidity, understanding decisions being made) and external behavioral abilities (e.g., able to communicate a decision verbally). People tended to think that sexual consent was hard to determine following substance use, and overall, there appeared to be no normative understanding of what constitutes being 'too drunk or high' to consent to sexual activity. People's understandings of capacity to consent were also mediated by relationality, such as whether they knew the other person, whether they were in a relationship together, and whether they had a shared sexual history following alcohol/drugs. It was also the case that some people held misconceptions about substance-involved sexual consent, such as that consent could be assumed when two people were similarly intoxicated.

Addressing research question 2, most people demonstrated the capacity to consent during the alcohol- and drug-involved sexual experiences that they deemed consensual. In this study, people described sexual activity whereby – in our view - they were able to make the decision to have sex (internal cognitive ability) and were able to communicate that decision to others (external behavioral ability). This is in line with the definition of capacity to consent given in the Introduction and the participants' understandings of capacity to consent described in this study. Regarding sexual decision-making, our data showed that people sometimes framed sexual decision-making following substance use as irresponsible and regretted, in contrast to sober sexual decision-making which was typically framed as responsible and not regretted. Though the presence of capacity to consent was a common feature of many sexual experiences, there were experiences in which people experienced some loss of capacity during sexual experiences reported as consensual; these experiences were written about as harmless in some cases and harmful in others (e.g., embarrassing, questioning whether they gave consent). Finally, the data showed that both community-level (e.g., sexually charged environments; nightlife settings; public versus private locations) and relational-level (e.g., shared sexual history; familiarity with partner) factors influence how sexual consent is navigated when substances have been consumed. The following section discusses how the findings from this study relate to or extend prior research. Implications for theory and practice are also discussed.

Modelling capacity to consent as a multidimensional and dynamic construct

At the individual-level, sexual consent was understood to be 'blurry' when people had consumed alcohol or drugs, in particular, at intermediate levels of mutual intoxication where people were neither sober nor incapacitated. Across the sample, there did not appear to be any normative understanding about the point at which a person becomes too intoxicated to consent to sexual activity prior to the point of incapacitation. This finding is consistent with contemporary research on intoxication and sexual consent which has found that young adults often do not have a clear understanding of how to ensure that sexual consent has been given when sexual partners have been drinking alcohol (Baldwin-White, 2019; Hunt et al., 2022). Recognizing the interplay between people's experience and their environment, individual-level confusion about what constitutes capacity to consent to substance-involved sexual activity, in part, may stem from unclear legal statute and

educational models at the societal-level of the social ecology. In England and Wales no clear guidance is given on the point at which a person becomes 'too intoxicated' to consent to sexual activity following voluntary substance use (see Sexual Offences Act, 2003; Tempkin & Ashworth, 2008). It is also the case that social marketing sexual consent campaigns are sometimes incongruent with the legal context, for example, where they have aligned 'sexual consent' with 'sobriety' (see Beres, 2018).

Some people also held misconceptions about sexual consent and substance use, such as that sexual consent can be assumed when people are similarly intoxicated (recently termed 'intoxication parity'; Hunt et al., 2022). This viewpoint is problematic as it contradicts sexual violence statute; intoxication is not a legal defense for enacting sexual violence (see Sexual Offences Act, 2003). Nevertheless, men have been found to use the concept of intoxication parity strategically to protect themselves against claims of sexual harassment (Hunt et al., 2022). This viewpoint is also problematic as it ignores other power imbalances and the wider societal norms that might impede a person's ability to negotiate sexual consent (e.g., gendered sexual scripts; Hunt et al., 2022).

Drawing together the data from the present study, overall, capacity to consent appeared to be a multidimensional and dynamic construct comprising of several dimensions. These included, lucidity, that is, a person's ability to retain and recall information; understanding, which involves a person using information to come to a decision; ability to consider risks or consequences, that is, a person's ability to understand the likely physical, psychological, and emotional consequences of a decision; and ability to communicate behaviorally, for example, communicating a decision through verbal or non-verbal communication throughout the experience. The dimensions and definitions outlined align closely with the way that capacity to consent (including to sexual activity) has been assessed among people living with dementia. These models have long emphasized concepts such as 'understanding' and consideration for the risks and consequences of a decision (e.g., Grisso & Applebaum, 1998).

Drawing on the above findings and the models of capacity to consent used in other settings (e.g., Mental Capacity Act, 2005; Smith et al., 2021), Table 4 provides a starting point for what would ideally be considered by people when they are determining if a sexual partner has the capacity to

consent to substance involved sex. Further work is needed, though, to consider how this would be translated into a public health intervention.

[enter Table 4 near here]

Placing a greater emphasis on the dimensions of capacity to consent outlined in Table 4 in educational campaigns and material may enable people to move beyond the interpretation of a verbal or non-verbal act to determine ability to consent, to consider whether people's expressions of sexual consent are meaningful in the first instance. Positively, the framework outlined in Table 4 affords people sexual autonomy, as it does not assume that substance use, per se, denotes a lack of capacity (Mental Capacity Act, 2005). This may lead to heightened engagement among people who engage in substance use and sexual activity as it is not 'risk-framing' or abstinence-focused – both of which can lead to disengagement with educational material (Pound et al., 2016). Emphasizing decisional capacity in the context of substance use, rather than sobriety, is also more consistent with the legal context in England and Wales and many other countries (e.g., 'drunk consent is still consent'; Beres, 2018; Sexual Offences Act, 2003). Positively, there is some recent evidence that sexual consent educators are providing education which recognizes that sexual consent can be given at lower levels of alcohol intoxication and encourages people to think beyond the communication of sexual consent to converse with sexual partners about things that might indicate their capacity to consent, such as whether sexual partners are thinking clearly (Alcohol & Sexual Consent Project, 2022).

Recognizing the dynamic nature of a person's capacity to consent to sexual activity, there should also be continued efforts to promote substance use harm-reduction practices. This is because some of the harm reduction practices employed by people in the present study, such as stopping for water breaks, could also offer a space to reduce the likelihood of sexual harm because they open a space for people to recheck a partner's capacity and willingness and inform each other about the effects of drugs experienced; the latter of which may be useful information when considering a partner's ongoing capacity to consent. Sexual consent educators may consider embedding messages about sexual consent, such as, reminders to 'check-in about capacity' during substance-involved sex, alongside already existing drug-related harm reduction material. These types of messages are likely to be well-received among people who use substances, compared to sexual consent campaigns, which

position sexual consent as invalid after substance use (e.g., see Beres, 2018). That is, because harm-reduction strategies work best when they meet people's contexts and experiences (Platteau et al., 2020).

Using a standard of unimpaired, rather than 'sober'

The data from the present study showed that alcohol and drug use can co-exist with sexual consent. People wrote about feeling that they had made 'good decisions', being willing to have sexual experiences and using verbal and non-verbal communication cues to communicate their sexual consent. This data supports research showing that people experience internal and external consent at their substance-involved sexual activity (Willis & Jozkowski, 2021). Beyond clearer modelling of capacity to consent, we agree with calls made by other sexual consent researchers to employ a standard of 'unimpaired' rather than 'sober' consent, in public health messages (Willis & Jozkowski, 2021). Having a legal threshold for a quantity of substance use that would, in legal terms, automatically negate sexual consent, may not be beneficial for sexual violence statute because it does not account for variability in intoxication among individuals (Gunby et al., 2013). A prescribed limit may only serve to (a) further dismiss sexual violence which occurs 'below' the legal limit of consumption, and (b) criminalize some consensual intoxicated sex. Instead, a standard of 'unimpaired' could be added to legal statutes, for example, the section 75 list of rebuttable presumptions in the Sexual Offences Act (2003). If certain impairment symptoms were present, then this would indicate a level of intoxication that negated capacity. Based on the findings from this study, and previous academic literature (Abellard et al., 2016; Lichtenberg & Strezepek, 1990; Smith et al., 2021), the 'symptoms' that people wrote about as negating the capacity to consent included: an inability to retain or remember information, an inability to make and/or understand what at decision meant, including the risks or consequences associated with sexual engagement, and an inability to communicate a decision non/verbally. Evidence shows that educational campaigns surrounding sexual consent are often underpinned by legal frameworks (Brady et al., 2020). Thus, these socio-legal changes would likely feed into the development of more detailed and clear guidance surrounding substance use and sexual consent in educational settings too. For example, rather than aligning sexual

consent with being 'sober', social marketing sexual consent campaigns could illustrate the types of symptoms that might be indicative of a person's lack of capacity to consent.

Context matters: Relational, community, and societal-level factors influence how substance-involved sexual consent is navigated

Relational factors, including a person's relationship to their sexual partner and whether they had a shared sexual history, were shown to have implications for capacity to consent to substance-involved sexual activity. For example, prior consent to substance-involved sexual experiences with a sexual partner – sometimes in conjunction with other sexual consent communication cues - was viewed as a way that people could interpret or communicate sexual consent when drunk or high on other occasions with the same partner. This approach to sexual consent is not uncommon; having a history of a sexual relationship with a person is found to influence the extent to which people believe it is acceptable to assume sexual consent (Humphreys & Brousseau, 2010; Humphreys & Herold, 2007; Muehlenhard et al., 2016). At the start of a relationship, people tend to use more explicit sexual consent cues, but, overtime, consent becomes the standard, with consent assumed until sexual activity is refused (Muehlenhard et al., 2016). Relying solely on a shared history of sexual activity as an indicator of sexual consent is likely to be problematic, irrespective of substance use. That is, because sexual consent changes from one partnered sexual event to the next within the same person (Willis & Jozkowski, 2019). Assuming sexual consent due to sexual history with another person may also lead to people taking less precautions during substance-involved sexual activity (Humphreys, 2007), such as placing less priority on assessing a person's capacity to consent at the time. Possibly, these findings point to a need for continued efforts to challenge beliefs that sexual consent can be assumed within committed relationships: focus must remain on how able a person is to consent during a given sexual experience and not their prior actions (Finch & Munro, 2006). It is possible though, that sexual consent is sometimes determined by both a person's history of substance-involved sexual activity with the potential sexual partner, as well as the behavior and actions of a person in the moment. This approach to determining sexual consent was identified in the present study. Using a combination of 'in the moment' cues (i.e., as an indicator of assent), and historical behavior, may be useful when people have consumed substances. That is, because considering prior actions, such as whether a

person has previously accepted or refused a sexual behavior, may provide insight into the extent to which substance use is having an undue influence over their external expression of sexual consent.

There was some evidence that community-level factors had implications for capacity to consent to sexual activity, too. In contexts or environments in which non-verbal communication is normative - which, in this study, included chemsex, bar, sex party spaces - another person's capacity to consent may be more difficult to interpret. That is, because judging only the behavioral actions of another person who has consumed a substance may only be assessing their technical ability to express a preference (or lack thereof) and not other facets of capacity to consent, such as their ability to appreciate the risks and consequences of sexual engagement (Clough, 2019). In sexually driven public spaces where substance use occurs, people may feel that it is permissible to initiate sexual contact without explicit consent from another person due to broader assumptions about the sexual availability of people who are consuming substances in sexualized environments (Marcantonio et al., 2022; McKie et al., 2020; Smith et al., 2021). Based on the findings from the present study, and the previously cited literature, we argue that, in spaces where substance use and sex co-occur, sexual consent educators should promote and encourage the types of verbal communication that would allow people to effectively assess another person's capacity to consent. For example, these messages about substance use and sexual consent could be made visible in spaces where sex and substance use co-occur or typically begin (Gunby et al., 2019). These messages may encourage people to check-in with their sexual partners about how they might feel (emotionally, physically, psychologically) about engaging in sexual behavior now or later, or encouraging each other to consider the expression of consent considering previous behavior, for example, are they consenting to sexual activity that they have previously refused or expressed a dislike about? Reframing messages about risk and consequence as something that should (also) concern the person gaining and interpreting the consent of another person, may help to reduce the extent to which individuals who experience sexual harm internalize blame for unwanted or negative sexual outcomes.

An agreement to transition from a public (e.g., bar) to private (e.g., home) space was used to infer ongoing consent in the present study. This finding extends the work of Jozkowski and Willis (2020) and Willis and Jozkowski (2022) who have explored perceptions of sexual consent using

vignette studies. They found that the act of transitioning from a social to a private setting was understood as an indicator of a person's sexual consent and that perceptions of sexual consent were higher when one person had accepted a drink from the other. The results from the present study combined with those from past research suggest that the combination of substance use and transitioning to a private setting may heighten perceptions of another person's willingness to engage in sexual activity (Willis & Jozkowski, 2022). These findings highlight the nuances of sexual consent, specifically, that contextual factors may heighten the extent to which people are viewed to be sexually willing and available. Thus, context should not be excluded from sexual consent education.

Finally, participants did not explicitly write about societal-level impacts on their understandings or experiences of capacity to consent to substance-involved sexual activity. This is perhaps not surprising as, more generally, people tend to think of themselves, and the other people involved, as determining their own actions, rather than attributing influences from broader societal factors (Hunt et al., 2022); however, societal factors are likely to have impacted on participants' understandings and experiences. Based on the findings, for example, which demonstrated that women often blame their own substance use for negative sexual outcomes, and past research on substance use and sexual consent, we anticipate that gendered sexual scripts (Hunt et al., 2022), cultural narratives on substance use and the people who consume them (Jessell et al., 2018), and socio-legal and educational discourse on sexual consent (Gunby et al., 2013) all interact with how people come to understand and define their own substance-involved sexual experiences.

A balancing act: Protecting people from sexual harm and honoring their right to sexual autonomy

One of the most nuanced aspects of sexual consent and substance use is that people do not necessarily consider their sexual experiences to be non-consensual when they experience the symptoms that are associated with a loss of capacity. In at least some instances, people might report their experiences as consensual because they experienced feelings of willingness or a desire for sexual activity that involved a lack of capacity to consent. The data from the present study suggested, then, that affective versus cognitive internal dimensions of sexual consent may sometimes be conflicting following substance use. This is a finding that is reflected in the sexualities literature with populations who experience cognitive impairment. For example, people with dementia may experience sexual

want, desire, and willingness, and simultaneously, experience some loss of sexual consent capacity function (Hillman, 2017). As sexual consent educators, it is important to weigh up the need to protect people from harm with their right to sexual autonomy. It would, for example, be disempowering to determine that all sexual activity involving some loss of capacity – even where a feeling of willingness and external consent were present – is sexually unethical or immoral. Bianchi (2021) has noted how people with dementia are unable to consent to sexual activity in line with conventional consent frameworks. Thus, they have proposed the use of a new framework, whereby consent is not the determining factor of whether sexual behavior is ethical and permissible. In their framework, assent to sexual activity is required, that is, a person would need to express a feeling of willingness for the sexual behavior. Along with assent, Bianchi's model argues that at least one of the following elements should be fulfilled: (1) desire (e.g., which could be identified through a person initiating sexual contact); (2) pleasure (e.g., derives pleasure from sexual acts; which could be identified through ongoing assent); (3) happiness (e.g., a positive emotional condition; which could be identified through behavioral or verbal signals during and after sexual activity). Possibly, to prevent the over-criminalization and stigmatization of intoxicated sexual activity, where it is likely that some loss of capacity will be experienced by people, novel frameworks, such as that by Bianchi, – which move beyond consent - are needed. This perspective supports the viewpoint of sexuality researchers who argue that a sole focus on sexual consent may be inadequate to the prevention of sexual harm and promotion of ethical sexual behavior (e.g., Bianchi, 2022; Jeffrey, 2022).

Some people in the present study also reported sexually harmful outcomes following substance-involved sexual activity that they labelled as consensual, such as not remembering what had taken place or feeling that they had made decisions which they would not have made in the absence of intoxication. These negative outcomes could lead to feelings of sexual regret, shame, and self-blame, particularly, among women respondents. The finding that substance-involved sexual activity, specifically, experiencing altered judgment due to substance use, is associated with negative outcomes is widely evidenced in the literature (Jensen & Hunt, 2020; Johnson et al., 2020; Jozkowski et al., 2017). In the present study, sexual regret and self-blame were sometimes directed to the overconsumption of alcohol or drugs, which was viewed as having led to irresponsible individual-

level sexual decisions, for example, 'giving in' to sexual requests from men or viewing themselves as having given in to their own sexual arousal. Possibly, women made light of their experiences, and interpreted them based on the wider messages that are presented to them at the societal-level. For example, the threat of 'sexual regret' has commonly featured in women-focused public health messages surrounding sexual behavior, sexual violence, and substance use (Jensen & Hunt, 2020) and these messages have tended to encourage women to restrict and control their substance use to avoid harm (Day et al., 2003). Women may reproduce these wider gendered notions of responsibility and direct feelings of regret towards their own behavior, rather than, for example, holding a person who has used some degree of pressure or coercion accountable (Jensen & Hunt, 2020). It is also the case, that women may have blamed substance use for sexual behavior when they view that behavior to transgress societal expectations for them, for example, cultural narratives of heterosex encourage women to act in a sexually reserved manner (Jozkowski et al., 2017).

People in the present study also sometimes reported substance-involved sexual experiences as consensual whilst questioning their ability to consent due to memory loss. This finding aligns with past research which has shown that narratives of sexual regret are drawn upon by women when consent can be considered questionable (Johnson et al., 2020). In at least some instances, the narrative of sexual regret may allow sexual violence to go unaccounted for because women internalize blame to themselves, rather than attribute this to the person who enacted harm against them (Jensen & Hunt, 2020). Possibly, women draw on the 'regret' narrative to redefine/reshape their experiences in a way that does not require them to take up the label of 'victim'.

Study limitations and future directions

Our sample reflects a subpopulation of people who engaged in high levels of alcohol and drug-taking relative to England and Wales' population estimates (e.g., CSEW, 2019). Possibly, this group of people hold differential understandings and norms surrounding intoxication and sexual activity compared to people who do not engage in substance use frequently. The sample also consisted largely of cisgender and straight women, with low numbers of non-binary people, trans people, cisgender men, and people who identified as bisexual, gay/lesbian, pansexual or queer+. Thus, we should be cautious in generalizing the findings to these latter groups. In terms of ethnicity, the

sample was overwhelmingly White. Future research should aim for a more ethnically diverse sample when conducting research in this area.

From a methodological point of view, a few limitations warrant mentioning. First, it is possible that asking people to report on their most recent *consensual* sexual experiences led most people to report on sexual experiences that were clearly aligned with broader conceptualizations of consensual sex, such as, those in which communication was verbal and explicit (i.e., yes means yes; Beres, 2008) and intoxication symptoms were mild. Possibly, simply asking people about their most recent sexual experience would be less leading and would provide further insight into people's capacity to consent to substance-involved sex. Although the study asked people to report on their most recent sexual experiences, it is also possible that due to time, some people may have forgotten the specifics of their experiences and may have not accurately recalled the event. However, a large proportion of the sexual experiences reported took place <4 weeks prior to completing the survey and most people were able to recall the detail of the sexual experience in their qualitative responses. This perhaps suggested that the effects of time on recall were minimal. Future research could consider using experience sampling methodology [ESM] to overcome this limitation (e.g., Willis et al., 2021). We recognize that the use of fixed open-ended surveying provided less opportunity to follow-up new avenues of insight and clarify ambiguous phrasing with participants. Researchers may consider employing novel digital data collection methods, such as semi-structured instant messaging methods, which are more flexible than fixed surveys but afford similar benefits to participants (see Dawson et al., 2020). We recognize, though, that it can be often difficult to ensure that our interpretations of the data reflect the meaning that participants intended to convey. That is, because researchers' assumptions and positions will always influence how the data is interpreted (Braun & Clarke, 2019). Positively, the anonymous, online methodology employed in the present study likely facilitated both the size of the data corpus and the extent to which people felt able to share sensitive information (Braun et al., 2021).

For a more nuanced understanding of how intoxication impacts capacity to consent to sexual activity, future research would benefit from addressing the impact of substance use on each aspect of capacity mentioned in this study, for example, lucidity and awareness, understanding of decisions and

any risk and consequence, and the ability to communicate decisions. It is also the case that it was not always possible to disentangle the effects of specific drugs, such as cocaine and MDMA on people's capacity to consent. That is, because people often reported their drug use alongside alcohol consumption. Although this is a limitation of the present study, this pattern of consumption does reflect how these drugs are commonly used in the general population (Bravo et al., 2021).

Conclusion

Within this article, we argued that capacity to consent to sexual activity is a dynamic construct which comprises both internal cognitive abilities and external behavioral abilities. Reflecting this, many participants noted the importance of being aware and lucid, able to understand a decision, able to consider any risks or consequences, and able to communicate a decision non/verbally to others, for sexual activity to be consensual. Consistent with our broader conceptualization of sexual consent, our data also showed that people's understandings and experiences of capacity to consent to substance-involved sex are not solely individual, but rather, they are also shaped by their environment, notably, by their relationships to a sexual partner and the location in which sexual activity takes place (i.e., the relationship-level and community-level of the social ecology), as well as, more implicitly, understandings of wider societal legal statutes and gender norms. On this basis, we call for a multidimensional and dynamic view of capacity to consent to be adopted, and modelled, by academics, legislators, and educators. This should include employing a standard of 'unimpaired', rather than 'sober', consent to reflect people's experiences and the legal context in England and Wales. Though these changes would likely help with providing clarity over what constitutes capacity to consent to substance-involved sexual activity, going beyond contemporary models of sexual consent for substance-involved sex may be necessary if we are to balance the need to protect people from harm with their right to sexual autonomy.

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