

A Quantitative Exploration of Dance Drug Use:

The New Pattern of Drug Use of the 1990s

Alasdair John MacGregor Forsyth

Thesis submitted for the degree of PhD,

University of Glasgow,

Faculty of Social Sciences,

Department of Sociology,

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Abstract

Since the late 1980s there has been a great deal of public concern about a new form of drug use. This concern has arisen from the practice of people using drugs as an adjunct to dancing at events commonly known as 'raves'. This dance drug phenomenon is most closely associated with a drug called 'ecstasy' (usually 3,4-Methylenedioxy-N-methamphetamine or MDMA). It is usually assumed that many of the hundreds of thousands of young people who attend raves use ecstasy. Beyond this assumption however, little is known about the patterns of drug use among 'ravers'. This thesis will examine in detail the relationships between the 'rave scene' and changing patterns of drug use. This was done using data from 135 dance drug scene event attendees (ravers) collected during detailed interviews conducted by the author. It was found that drug use related to dance events was not restricted to MDMA, but included a variety of other substances used in different settings. The implications of this complex form of drug use are discussed and potential future trends in illicit substance use are identified.

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“And their music lead thousands to experiment with T” – *the Rutles*, 1978.

NOTES

1. The fieldwork for this thesis was undertaken while the author was employed at University of Glasgow's Criminology Research Unit a research centre within the Department of Sociology, on Chief Scientists' Office grant number K/OPR/2/2/D125, held by Professor Jason Ditton and Dr Iain Smith.

2. This thesis was written up while the author was employed at the University of Glasgow's Centre for Drug Misuse Research a research centre within the Department of Sociology. The Centre for Drug Misuse Research is funded by the Chief Scientists' Office of the Scottish Office Department of Health. The views reported in this thesis do not necessarily reflect those of the Scottish Office.

3. The data in this thesis has provided the basis for the following three published papers:

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FORSYTH, A. J. M. (1996) Places and Patterns of Drug Use on the Scottish Dance Scene. *Addiction*, 91, 511 - 521.

FORSYTH, A. J. M. (1996) Are Raves Drug Supermarkets? *International Journal of Drug Policy*, 7, 51 - 56.

DECLARATION

I certify that the substance of this thesis has not already been submitted for any degree and is not currently being submitted for any other degrees.

I certify that to the best of my knowledge any help received in preparing this and all sources used have been acknowledged.

ALASDAIR J. M. FORSYTH

INTRODUCTION

Since the late 1980s, there has been a great deal of public concern about a new form of drug use. This concern has arisen from the practice of people using drugs as an adjunct to dancing at events commonly known as 'raves'. This dance drug phenomenon is most closely associated with a drug called ecstasy. Until now there has been little empirical research into dance drug use. It is usually assumed that many of those who attend raves use ecstasy. Beyond this assumption however, little is known about the patterns of drug use among 'ravers' and the importance of dance events in shaping these patterns. This thesis sheds light on these gaps in our knowledge of this most important new style of drug use in the 1990s.

It is the main aim of this study to see which drugs are used by participants in the dance drug scene and to measure the extent of their use. It is intended to identify which drugs are associated with the dance drug scene (and which are not) and to examine any relationships that might exist between these drugs and attendance at raves. It is also intended to look at the drug use of ravers in other settings unconnected with the dance scene. For these reasons, a quantitative approach was adopted to measure the extent of drug use among ravers and to statistically verify any relationships found between drugs and dance music style.

Since legislation was first passed making the possession or supply of specific drugs illegal in Great Britain, the use of these substances has become associated with deviant subcultures. The first such association was between dancing to jazz music at night-clubs and cocaine use during the period from 1916 (when drugs were first controlled in the UK) until the mid-1920s. Successive drug using subcultures have been

characterised by links with other deviant or minority activities such as styles of music and dancing at night-clubs. As such, each of these subcultures have embraced drug use and other minority recreational activities among their defining norms and values. Drug subcultures and their associated shared value-sets, norms, behaviours and beliefs are usually referred to as (drug) scenes.

Since the Second World War a succession of new fashionable scenes has emerged, each with its own music and drug styles. These have included, the beats (cannabis), mods (amphetamines and barbiturates), hippies (LSD) and punks (glue and heroin). The extent and nature of drug use in each of these scenes has not been well researched, perhaps because of the relatively small numbers of participants involved. Despite this, the role of drug use by these groups has been important in that it has served to further 'demonise' drug users as 'outsiders' in the eyes of the general public, especially since each subculture was inevitably accompanied by a media-fuelled 'moral panic'.

The drug scene that has featured as the analogous moral panic of the 1990s has been 'christened' the 'rave scene' by the media. Also known as the dance (drug) scene, a term preferred by its participants, this style has been associated with the use of drugs, particularly ecstasy (usually, MDMA). This scene differs from the others in two key ways. Firstly, the central role played by drug use in its formation and development, without the advent of the widespread use of ecstasy, the rave scene would certainly never have started and it seems unlikely that it could survive if drugs were removed from it. Secondly, the magnitude of this dance scene is much greater than anything previously witnessed. The number of participants in the dance drug scene is usually estimated in millions rather than thousands. 'Raving' (participating in the dance drug scene) might better be described as a mainstream recreational activity, rather than a deviant subculture. Equally importantly the dance scene appears to involve people

from all social backgrounds rather than the usual drug user stereotype of young, unemployed, lower class, disaffected males.

In common with earlier drugs and music associations, to date little research had been undertaken into drug use in the rave scene. The funding of scientific research has been almost exclusively targeted at the much smaller numbers of people involved in problem or injecting drug use. This has abdicated reporting of more widespread forms of drug use, such as dance drug use, to the media, especially the tabloids. For these reasons it was felt that patterns of recreational drug use were an under-researched area. The advent of the rave scene presented an opportunity to explore the relationship between a current dance/music culture and drug use. This thesis aims to explore patterns of drug use in the dance drug scene. There is an undoubted need to quantify drug use by ravers (dance drug event attendees), especially with the added risks of substance use in combination with strenuous physical activity (dancing). Also the frequency of use and types of drug taken by dance drug event attendees requires investigation to ascertain whether these people are likely to become the problem drug users of the future. This might be especially important if involvement with the dance scene can lead to the use of drugs in other settings or to involvement in criminal drug dealing subcultures which do not have a share in the values of rave culture. Though cross-sectional and limited to a relatively small specific group of dance drug event attendees, this thesis breaks new ground by quantifying drug use in the dance scene and exploring the relationships between dance music events and drugs.

In the opening chapter the sociological and pharmacological literature concerning the dance drug scene is reviewed. One difficulty immediately encountered here was an imbalance between the amount of literature published in these two disciplines. In several instances, existing sociological publications began by commenting on "the

paucity” of such material available. This is in part due to the recency of the dance drug phenomenon. However, some useful comparative material was found in articles relating to previous dance, music and drug scenes. In contrast there has been a great deal of pharmacological research into the substances used as dance drugs, such as MDMA. Additional relevant information was obtained from medical (i.e. neurological, psychological, psychiatric and bio-chemical) sources. Particular attention was paid to any research on the drug ecstasy (or MDMA). In order to understand the nature of the dance drug scene, a review of the literature concerned with this substance was deemed necessary. The advent of MDMA coincided with the creation of dance music styles (e.g. ‘house’ or ‘techno’) and the drug played a pivotal role in the creation of the rave scene. This chapter details the history of MDMA until the convergence of its non-medical use with dance music. The chapter goes on to document the evolution of the dance drug scene through various stages of development until its present status as the mainstream youth culture of the 1990s. As such, this opening chapter sets the stage on which the empirical research conducted in this thesis was undertaken.

The chapter that follows details the research methods used in this thesis. A description is given of how a sample of dance drug users was recruited and data collected. Several difficulties that were encountered due to the sensitive nature of the research topic are explained. Initially a period of participant observation in the dance scene was undertaken. This primarily served as a ‘reconnaissance’ of the relevant issues to be addressed. This observation helped identify a target population and assisted in the design of the research instrument. The recruitment of the sample using key informant and snowballing methodologies is described. The relative strengths and weaknesses of these recruitment methodologies are discussed. This recruitment phase also made use of fliers, the medium most often used to transmit information about the dance scene.

An example of a recruitment flier used by this thesis is given in Appendix I. A structured, mainly quantitative, questionnaire was designed and administered in a one to one setting. This instrument also included a short self-complete section. The questionnaire is contained in Appendix II. All data collected were prepared for quantitative statistical analysis using the SPSS for Windows™ on PC computer.

Chapter 3 profiles the sample of dance drug users interviewed. The types of persons involved are described in terms of demographics and drug use. These findings are compared to both other dance drug (ecstasy) using groups and other samples of Scottish drug users. The differences and similarities between this sample and all other drug user samples are discussed in terms methodologies used (e.g. sample recruitment) and patterns of drug use. A discussion is made as to where these drug users might lie on the recreational to problem drug use continuum. The implications of these differences are discussed in the context of the advent of the dance drug scene.

Chapter 4 explores the nature of dance events themselves. A variety of dancing behaviours, such as frequency of attendance, duration of attendance, time spent dancing and style of music preferred when dancing, are examined. The settings in which these behaviours take place and their potential hazards are detailed. Motivating and deterrent factors that might influence participation in the scene are discussed.

Drugs use among participants in the dance scene is explored in detail in Chapter 5. In this chapter the location where respondents used each drug is analysed. This chapter is not confined to focusing on drug use at dance events, but also on respondents' use in other settings. This is done to help to categorise which drugs can be described as 'dance drugs' and which cannot. All drugs used by respondents are categorised into three types: drugs which are usually used at dance events (primary dance drugs), drugs sometimes used at dance events but are more often used elsewhere (secondary dance

drugs) and drugs which are seldom used at dance events (non-dance drugs). Finally, analyses are conducted to test for the existence of any statistical relationships between drug use and the dancing behaviours detailed in Chapter 4.

Having established a link between certain drugs and the dance scene, Chapter 6 investigates whether this relationship exists (at least in part) because of drug availability at dance venues. This chapter explores patterns of drug dealing among respondents, in terms of where drugs are obtained, where they are used, if they have to be paid for, at what cost and who they are obtained from. Availability of drugs at dance events is compared with availability elsewhere. Numbers of respondents obtaining drugs before attending a dance event (being sorted) is compared with the numbers who obtain drugs at the actual event, either to be used there and then (in house) or later elsewhere (take-aways). Although obtaining drugs at dance drug events is unique to drug dealing among ravers, this chapter goes on to explore other sources of dance drugs (outwith dance events) and patterns of obtaining other drugs. The way in which dance drug users obtain drugs is compared with the way other groups obtain drugs and the implications of a possible convergence between these scenes discussed.

Chapter 7 returns to ecstasy, the drug that was the catalyst for the whole scene. Amid concerns that ecstasy quality has changed, which has in turn affected the scene itself, respondents were asked to describe this drug in detail. A self-complete section of the questionnaire invited respondents to draw and describe the appearance and effects of three doses of ecstasy. These were their first, last and most often used 'brand' of ecstasy (assuming they had used it). It is detailed how the drug is no longer believed to be only MDMA, but has become confused or identified with other drugs commonly used in the dance scene. Whether this perception is true or not is seen as less important than that users believe that it is, and that ecstasy is not (just) MDMA of varying

quality. The implications that this belief may have on continued use, the patterns of drug dealing and increasing the likelihood that ravers will go on to use other substances are discussed. The differing perceived effects of this drug are described and compared with respondents' motivations for participation in the scene. A case is made for describing ecstasy as a new type of illicit compound drug. This new concept drug is designed for its alleged effects and its ecstasy label (dictating setting of use) rather than merely being seen as a single substance the nature of which may vary only by cost or purity.

In the concluding chapter the main findings of this work are summarised. The various aspects of the dance drug scene explored in previous chapters are brought together and the implications of these are discussed. The findings of this thesis are viewed in the wider context of the scene's impact on society as a whole. Finally, new avenues for research in this field are identified. The dance drug scene is at the forefront of drug trends and fashion; its rapidly evolving nature was apparent (even if somewhat subjectively) during the months of fieldwork. Many new drug issues were uncovered in the course of this research which require future investigation.

CHAPTER 1

STORMING EDEN: GENESIS OF THE DANCE DRUG (RAVE)

SCENE

Introduction

The dance drug scene evolved in Britain during the late 1980s. This was not an entirely spontaneously occurring phenomenon, but the product of the merging of several subcultures. As it grew, the dance drug scene was to acquire characteristics from many diverse aspects of youth culture that had previously been quite discrete. Though drug culture and dance culture were the scene's primary roots, other youth subcultures previously remote from drug use became associated with the dance drug scene. Aspects of youth culture as diverse as football and mainstream high street fashion added to the dance drug scene. However, despite these later additions, the genesis of dance drug scene occurred when its two unique ingredients, the drug 'ecstasy' and 'house music', fused during the late 1980s. This chapter will review the current literature relevant to the dance drug scene, but will focus on these two main elements.

Previous dance music and drug use subcultures

The association between dance music and drug use is not new. Dancing under the influence of psychoactive drugs has been a widespread phenomena throughout history and cross-culturally. In traditional societies, such dancing has been used to help reach visionary states in religious ceremonies. These ethnic trance dances and musical styles include those of the whirling dervishes of Turkey, the joujouka players of Morocco and

the mantra chanting of far eastern religious groups (Lyttle and Montague, 1992). Such dancing is often accompanied by continuous drum beats or chanting (as in rave music), the use of hallucinogenic or stimulant drugs, or by both music and drugs.

In the western world during the twentieth century, several forms of music and dance have been linked with drug use. Music and dance subcultures associated with drug use include: reggae associated with cannabis, country and western with alcohol, 'mods' with amphetamine or barbiturates and 'punk' with glue sniffing (Mignon, 1993). Kohn (1992) describes cocaine's association with the jazz clubs that played the dance music of the early twentieth century. The history of cocaine use then and the legislative reaction that followed has many parallels with the dance drug scene of the 1990s. These parallels are exemplified by a newspaper cartoon in the *Daily Express* (1992) which depicts a couple entering a night-club called The Dope Dance Club, passing death dressed as the doorman, with the legend reading "The Shadow of Death". The Scottish media dubbed raving as the "Dance of Death" in the 1990s (*Daily Record*, 1992; *Evening Times*, 1995a). In the 1950s it was cannabis not cocaine that became the drug of the ('be-bop jazz') night-club scene (Kohn, 1992; Mignon, 1993). Lyttle and Montague (1992) detail a more recent night-club scene where cocaine was again used to enhance dancing during the *Saturday Night Fever* era of 'disco' in the 1970s.

Sometimes drugs have been used to enhance music or dancing, but conversely at other times music or dancing has been used to enhance drug experiences. The phenomenon of drug parties being greatly enhanced by appropriate music is observed in Jay Stevens's book *Storming Heaven: LSD and the American Dream* (Stevens, 1987). This book details the 'acid test' parties of Ken Kesey of the mid-1960s in the USA. At these events it was noted that "once the music stops it becomes very dull". The music was provided by a group called the Warlocks, who later became the Grateful Dead,

who's fans have since been associated with MDMA use (Beck, 1990). Like the dance drug scene of today, these events were usually accompanied by sophisticated psychedelic light shows. At around the same time in the UK, drugs were being used to prolong and enhance dancing. Amphetamine was the drug of choice among British music and dance cultures of the 1960s and 1970s (Petridis, 1996b). This was particularly the case in the 'Northern Soul Scene' centred in clubs such as *The Wigan Casino* (Collin, 1997). As will be explained in this chapter, the dance drug culture of the 1990s exhibits all the above features that either enhance the drug experience or the dance experience.

Although the current dance drug scene has much in common with previous subcultures detailed above, it differs from all of these in two key ways. Firstly, the key role played by drug use in its origins. The advent of one drug, MDMA, can be deemed as responsible for the whole scene. Even today, when ecstasy use is no longer an essential element of the scene, it would seem unlikely to continue were drugs removed from it (Headon, 1996). The second unique factor has been the scale of this drug use. Raving has been called a mainstream social activity rather than merely a deviant sub-culture. As such, those participating in the dance drug scene are likely to come from a wider range of backgrounds and lifestyles than persons involved in other forms of drug use which have been much researched in Scotland.

The need for dance drug research

In attempting to review current literature pertaining to dance drug use, any researcher will immediately be struck by an apparent lack of such material in scientific publications. This is in part due to the recency of the scene and the drug that was said to be responsible for its initiation - ecstasy. This is evidenced by the number of

publications which have begun by stating the "paucity" of ecstasy research available to date (e.g. Davis et al, 1987; Peroutka, 1990; James, 1991; Solowij et al, 1991). It is therefore unsurprising that the one thing all these authors have in common is their belief that there is a need for more research in this field.

This lack of information about non-medical ecstasy use, and more particularly drug use in the dance scene, seems to have been caused not only by the recency of ecstasy use (and therefore also the dance drug phenomenon) but also by official disinterest with this style of drug use. Henderson (1996) points to research funding and policy attention being directed at problematic drug using groups such as injectors rather than dance drug users. This is despite such drug users being much fewer in number in the population than dance drug users. To draw an analogy with another mainly 'weekend recreational drug', alcohol, it is as if policy and research were driven by concerns with the minority of alcoholics rather than those of the majority of occasional users. It is known from the alcohol field that the cost to society incurred by 'social drinkers' is greater than that caused by 'problem drinkers' because of their much greater numbers in the population (Saunders, 1984). Despite an acknowledged unprecedented increase in the levels of drug use among young people since the late 1980s (Balding 1994; Measham et al, 1994; Loretto, 1995; Barnard et al, 1996; Border and Norton, 1996; Miller and Plant 1996), to date official interest in non-problematic drug use is no more than at the level of other "youth statistics such as joyriding" (Henderson, 1996).

In studies that have attempted to measure the prevalence of drug use, there has been a reliance on the use of data from official sources. Such sources include the police, forensics, death statistics, drug agencies, psychiatric services and hospital accident and emergency units. The individuals who appear in such statistics are unlikely to be representative of dance drug users. If drug use is measured only from official statistics

or samples of problematic drug users, then a distorted picture of drug use will be obtained. For example, studies which have identified ecstasy as a drug which is injected by intravenous drug users will give a false impression of the nature of ecstasy use (Green et al, 1995). Injection is clearly not a dance floor activity. Also, among intravenous drug use samples, individuals can be found who inject alcohol (Haw 1985; Lavelle et al, 1991; Forsyth et al, 1991; McGinty, 1997), again clearly not the norm amongst users.

As far as assessing dance drug related harm, again the main problem identified has been the lack of published research (Grob et al, 1990; James, 1991; Newcombe, 1991a). In view of the supposed large numbers of dance drug users, this need is now greatest for empirical studies in the dance event setting. There is a need to establish what drugs are actually being used, in what doses, how often, where and why, before any implications of this new form of drug use can be made.

Returning to the issue of the recency of the main drug involved in the dance drug scene, MDMA use has only become widespread since the mid-nineteen eighties. This is much more recent than the widespread use of drugs such as opiates, cocaine or benzodiazapines. This in itself means that our understanding of this drug and its effects are relatively limited (which in turn has limited understanding of dance drug use). The scheduling of MDMA as having no medical applications has only served to further limit scientific knowledge of this substance. Results obtained in laboratory animal studies may not be applicable to human subjects and the medical techniques used, even in human experiments, have proved to be inconclusive (see Steele et al, 1994 for review). For these reasons the most promising route into meaningful ecstasy research would appear to be from the dance drug scene. Conversely, no exploration of the dance drug scene is possible without first reviewing ecstasy use.

The creation of ecstasy

Ecstasy is a name originally given to the drug 3,4-Methylenedioxy-N-methamphetamine or MDMA. This substance was synthesised, by the German pharmaceutical company, E. Merck, in 1914. Merck patented MDMA (patent number 274,350) allegedly for use as an appetite suppressant in the German army during World War I (James, 1991). Its use was soon discontinued, reputedly because of side effects that were unwanted by the military. This early use of MDMA has even become part of the folk-lore of today's ecstasy culture, giving rise to speculation about the reasons behind the Christmas peace mutinies during that conflict. Merck also synthesised a related drug, 3,4-methylenedioxy-N-amphetamine (MDA) at around the same time. Both of these substances are members of a large family of compounds called the phenethylamines. MDA is a close chemical cousin of MDMA and it was to play an important supporting role throughout the history of the dance drug scene (as will be confirmed in subsequent chapters). After World War I these drugs appeared to have vanished from the pharmacopoeia.

Although synthesised by the US Army in 1953 (as experimental agent EA-1457), and then in Poland by Biniecki and Krajewski in 1960 (Kaplan et al, 1989), MDMA did not reappear until the late 1960s. It was then that Californian chemist Alexander Shulgin synthesised MDMA in his laboratory. Shulgin has synthesised and tested 179 different phenethylamines and many other psychoactive drugs (Shulgin and Shulgin, 1991). He has been dubbed the 'father of ecstasy', in much the same way as Albert Hoffman was dubbed the 'father of LSD' (Saunders 1993a). Shulgin himself prefers the word 'stepfather' as he only rediscovered MDMA. He 'christened' the drug as 'ADAM' (from MDMA) a name still used to refer to ecstasy today.

When Shulgin synthesised MDMA it was not yet a controlled drug. When MDA was scheduled as an illegal substance under American drug control laws, MDMA began to be used as a recreational drug. Between 1967 and 1970, MDA was a part of the 1960s' psychedelic drug culture of the Haight-Ashbury area of San Francisco. It was known 'on the street' as 'Mellow Drug of America' (from the initials MDA) and 'love drug' because of its reputation for sensuous and easily managed euphoria (Beck, 1990). In 1970 MDA was placed in Schedule I of the Controlled Substances Act (CSA). This schedule indicates a substance with no therapeutic potential. MDMA was unknown as a street drug at this time and so was not scheduled. Following the scheduling of MDA in the USA, MDMA soon appeared on the street as a legal alternative, but its use was limited to a small number of enthusiasts until the 1980s. Also by the mid-1970s a small number of Californian psychotherapists had begun to use MDMA as a therapeutic tool.

As detailed in Beck (1990), MDMA use began to draw attention from the authorities as its popularity 'on the street' increased during the early 1980s. The 'original' groups of producer chemists were based in California (Beck and Rosenbaum, 1994) and Boston (Collin, 1997) in mid-1970s America. These were small scale operations or 'bucket labs', which produced MDMA of variable quality to an elite group of self therapeutic oriented users. Unreliable quality and periodic 'droughts' led to one MDMA distributor in Texas establishing a new producer group. In line with the new monetary ethos of the 1980s (and in contrast the egalitarianism of the 1960s West Coast hippies), the 'Texas Group' was more profit oriented. They allegedly produced more MDMA in 18 months than all previous networks combined had done throughout history (Beck, 1990). The Texas Group used commercial tactics, including open sales in the bars of Dallas and Austin, pyramid selling, free phone, mail order service, poster

advertising campaigns and the use of credit card purchase, all trappings of 1980's 'yuppie culture'. A respondent of Beck (1990), one of the original Californian producer group, claimed that it may have been another ten years before the authorities had scheduled MDMA were it not for the marketing tactics of the Texas Group.

One other factor that hastened the media and legal attention given to MDMA, was its new name - ecstasy. Reputedly, one Los Angeles distributor gave the name ecstasy to MDMA as a marketing ploy. The distributor had wished to name the drug "empathy" as this was more descriptive of the drug's true nature, but thought that ecstasy would sell better (Eisner, 1989). The empathy producing qualities of MDMA had previously been noted by Shulgin and colleagues; Nichols (1986) had wanted to name the whole class of drugs with MDMA type properties "empathogens", but did not like a word that contained the term "pathogen" (as this might infer illness inducing). Nichols opted to call this class of drugs "entactogens" from the Greek meaning touching within.

Naming MDMA as ecstasy was indeed a good marketing ploy. The word ecstasy became synonymous with MDMA, replacing all its other pseudonyms. However, this new name was also quickly 'bought up' by the American media. There was an explosion of media coverage of ecstasy in the USA during 1984 and 1985. This coverage culminated in an episode of the popular television program, the *Phil Donahue Show*. The show's presenter was to introduce the programme about ecstasy by implying that the drug was a threat to national security, suggesting that if the Iranian leader, Ayatollah Khomeini, was to land on American soil he would be welcomed by the population if they were on ecstasy. This chat show also featured the future head of the National Institute on Drug Abuse (NIDA), brain surgeon Dr Charles Schuster. Schuster commented on recent unpublished research that indicated that MDMA's chemical cousin MDA could cause brain damage in rats (Ricurate et al,

1985). The inference of potential harmful effects from MDMA use was from that point onwards set in the minds of those who wished to make it illegal (Rosenbaum and Dolbin, 1991).

The media's fascination with the name ecstasy was to persist after MDMA use was to become more prevalent in the UK some years later. The British media also provided similar advertising opportunities (Farrell, 1989) which may have bolstered sales of the drug. It has been suggested that were the drug simply known as MDMA it may never have become so popular (Edwards, 1989; Beck, 1990). The name's sexual connotations were perhaps in part responsible for the scheduling of MDMA. Such connotations may have linked its effects further with those of the drug MDA, the so-called love drug. This is a somewhat unjustified association as studies in both clinical and dance scene settings have indicated that MDMA use may actually decrease human sexual activity (Buffum and Moser, 1986; Henderson 1996).

American legislative response to ecstasy use

The publicity resulting from ecstasy's more widespread use led to the authorities taking an interest in controlling the drug. Both the World Health Organisation (WHO) and the US Drug Enforcement Agency (DEA) first expressed such interest in the drug in 1984. When the DEA proposed controlling this 'street drug' in Schedule I of the CSA (no therapeutic uses), to their surprise, there was an immediate counter action by a group of psychiatrists and researchers who had been using the drug. The ensuing conflict between those who wished MDMA placed in Schedule I and those who believed it was of great therapeutic use and scientific interest provided national media interest in ecstasy across the USA. The effect of this was an exponential increase in demand for the drug. One producer was reported to have increased sales from 10,000

doses per year in 1976 to 30,000 doses per month in 1985 (Beck, 1990). Sales continued to increase and became greatest immediately before the drug was eventually scheduled.

To resolve the MDMA controversy, two US federal law hearings were to be held in mid-1985. These were influenced by two other events. Firstly, the WHO stated that MDMA should be controlled internationally as Schedule I; secondly, the citing of the as yet unpublished study by Ricurate et al (1985) associating high dose MDA use with neurotoxicity in rats. On 1st July 1985, ten days before the first hearing was due to begin, the DEA invoked the emergency scheduling powers of the Comprehensive Crime Control Act 1984 (CCCA). This effectively placed MDMA in Schedule I. The act was specifically introduced to counteract the production of designer drugs such as the fentanyl analogues, the production of which peaked about the same time as MDMA (Morell, 1990). The act defines a designer drug as “a substance other than a controlled substance that has a chemical structure similar to that of a controlled substance in Schedule I or II or that was specifically designed to produce an effect similar to that of a controlled substance in Schedules I or II”. In the case of MDMA such a definition was possible because of its similar chemical structure to MDA and reputed similar effects (love drug and ecstasy). It has however been stated that such decisions are open to question. Chemical structures and pharmacological effects which may look similar to legislators may look dissimilar to a chemist or psychotherapist (Baum, 1985). Or as Shulgin (1986) put it, “the chemist sees the carbon chain, the pharmacologist sees the stimulant and the policeman sees the drug laws”. In other words, to assume that MDMA will have similar neurotoxic effects to MDA is rather like assuming that drinking methanol would make a good low alcohol alternative to ethanol containing beverages. A comparative review of the literature on MDA and

MDMA from that time indicates both similarities and differences between these two discrete drugs (Climko et al, 1987).

The timing of this legislation was also bad for the proponents of MDMA. A true designer drug (as defined by the DEA) called MPPP, an analogue of Meperidine (DemerolTM), which contained a toxic impurity called MPTP, had recently been indicated as causing Parkinson's disease in some previously healthy drug users (Baum, 1985; Tyler, 1988). This precipitated a panic, whereby designer drugs cause Parkinson's disease; ecstasy is a designer drug, therefore ecstasy causes Parkinson's disease. Also the possibility of loss of neurotransmitters in the spinal fluid of rats who had been exposed to MDA precipitated an ecstasy drains the spinal fluid panic (Beck, 1989). This rumour was fuelled by the action of researchers who had drained the spinal fluid of MDMA users to look for the presence or absence of neurotransmitters.

During the hearings which followed the scheduling of MDMA, arguments for and against reconsideration were put forward. These arguments have continued in the USA into the 1990s (Beck and Rosenbaum, 1991). Attempts have been made aiming to remove MDMA from Schedule I, perhaps towards controlling the drug in a way that would allow further experimental and therapeutic use, for example placing it in Schedule III.

Three forms of argument have been put forward in favour of liberalising the controls on MDMA use. Firstly, that the basis on which it was scheduled was invalid. MDMA is not a designer drug and therefore the DEA's emergency powers should not have been used. The term 'designer drug' has been incorrectly used to refer to MDMA and its close relatives such as MDA (Baum, 1985; Kirsch, 1986; Edwards 1989). This confusion may arise from the notion that MDMA is a synthetic combination of two other types of drugs, hallucinogens and amphetamines. If this were the case, then in the

broadest sense any synthetic drug may be considered a designer drug. In this way, many pharmaceutical drugs could be described as designer drugs. For example, Bost (1988) points to 36 different benzodiazapines being marketed in the USA alone, each different benzodiazapine having subtly designed differences in action. Clearly a more rigorous definition of the term designer drug is necessary before ecstasy can specifically be identified as one. Smith and Seymour (1985) contend that MDMA is not a designer drug. These authors quote the definition of such a substance preferred by the DEA; that is Donald R. Wesson MD's definition of a designer drug, "wherein the defined psychoactive properties of a scheduled drug have been retained, but the molecular structure has been altered in order to avoid prosecution under the Controlled Substances Act". MDMA does not fit this definition, as it was invented before such drug control policies existed and has its own unique structure and effects. Also many drugs such as benzodiazapines would, albeit surreptitiously, have been designed to retain the effects but alter the structure of the drug to circumvent the patent laws. Nonetheless, this confusion between MDMA and genuine designer drugs such as the analogues of phencyclidine (PCC), fentanyl (3-MF or 'china white') and meperidine (MPPP and its toxic derivative MPTP) was in part responsible for its scheduling (Beck and Morgan, 1986). Ironically, the scheduling of MDMA resulted in the designing of other substances to be marketed as ecstasy to circumvent that particular piece of drug legislation. Notable amongst those was MDMA ethyl analogue MDEA or 3,4-Methylenedioxy-N-ethamphetamine (Dowling et al, 1987; Beck, 1990).

Baum (1985) quotes Gary L. Henderson, who coined the phrase 'designer drug'. Henderson feels that a true designer drug is designed for effects, legality, undetectability, potency and appearance. In short the "entire packaging and marketing concept" rather than simply creative chemistry. This definition of designer

drug as a marketing concept may in fact now be more appropriate when referring to the use of MDMA in the UK in the 1990s (as will be demonstrated in Chapter 7).

Secondly, the emphasis placed on the research by Ricurate et al (1985) had set a number of precedents. This action set a precedent of a drug being controlled because of its potential for harmful side effects, rather than the number of persons using it on the street (Baum 1985). This raised cause for concern in the medical community, as most (if not all) drugs which are used medicinally are dangerous, have unwanted side effects and in many cases, such as tranquillisers, are also addictive (Riedlinger, 1985; Naysmith, 1989). Furthermore, this was done even though MDMA had not yet proven to be harmful to humans.

Thirdly, MDMA required further research. The American academic community was so concerned at the impact of the MDMA controversy that a whole edition of the *Journal of Psychoactive Drugs* was devoted to the topic (Seymour et al, 1986). Citing the example of LSD, researchers have expressed concern that the potential of this relatively new substance would not be realised (Beck, 1989). The need for caution has been expressed when discovering such substances to prevent them from becoming street drugs and in turn Schedule I controlled drugs, unavailable for further research (Holsten and Schieser, 1986). It has been contended that the criminalisation of ecstasy use succeeded in preventing its use in therapy, but did little to deter street use. Such laws have never succeeded in eliminating the street use of other Schedule I drugs, such as cannabis or LSD (Rosenbaum and Dolbin, 1991). Coupled with the media attention surrounding the scheduling debate, the DEA's action had only increased the likelihood of MDMA becoming just another problematic street drug. Ultimately, the fear is that too little clinical research has been done to anticipate the outcome of widespread use of ecstasy as a street drug. This was particularly unfortunate as it had been claimed

that MDMA had already proven to be a useful tool in psychotherapy (Wolfson, 1986) and may have other therapeutic uses (Riedlinger, 1985). Case reports had been produced which detailed the ability of MDMA to break down defensive barriers, induce personal communication and induce feelings of empathy (Wolfson, 1986). Psychotherapists, especially in California, were concerned at having to suddenly terminate courses of treatment because of the imposition of the CCCA. Those who claimed that MDMA was successful in psychotherapy lobbied for the law to be changed to allow its continued use (Leverant, 1986). The apparent lack of harm or negative side effects, plus greater success potential as compared with other drugs used in psychotherapy, has been cited as a reason for continued therapeutic use of MDMA. Psychotherapist George Greer has been described as the pioneer of the psychotherapeutic use of MDMA, in the same way as Alexander Shulgin was the pioneer of its chemistry (Seymour, 1986). In a study of 29 of his patients, Greer (1986) reported no serious side effects directly attributable to the use of MDMA.

Therapeutic use of MDMA has continued into the 1990s in Switzerland. Swiss psychotherapists were given permission to use MDMA and other psychedelic drugs (including other dance drugs, such as LSD) in December 1985, shortly after MDMA use by therapists was discontinued in the USA. Though many Swiss patients have been treated with MDMA, reports of successful therapy remain largely anecdotal (Saunders, 1993a).

Ecstasy American style

The scheduling of MDMA had a profound effect on the pattern of recreational use of MDMA in the USA. Prior to scheduling, two forms of recreational user (as opposed to medical or scientific user) had been identified. Firstly, the original American West

Coast users. Secondly, night-clubbers in what was called the Texas “X” scene. Since the scheduling of MDMA other groups of user have been identified. However, there has been neither widespread use amongst the drug using ‘under-class’, nor the emergence of a mainstream ecstasy based dance drug culture.

The West Coast scene

The first recreational users of MDMA were from America’s West Coast. Typically these users were middle-aged professionals with a history of psychedelic drug use in the 1960s. They were often linked with either the Californian ‘yuppie scene’ or the ‘New Age movement’. MDMA was usually taken as amateur psychotherapy by the former group and as an aid to spiritual awareness by the latter. As will be seen in later chapters, the patterns of MDMA use by both these groups cannot be said to have much in common with the hedonistic motivations of ecstasy users in the dance drug scene.

The use of MDMA by ‘yuppie’ professionals in the San Francisco/Bay Area of California was examined in the *Exploring Ecstasy Study* (Rosenbaum et al, 1989). Many of the respondents in this study were quoted as using MDMA as a method of taking “time out” from their hectic business routines. Sessions on MDMA are described as being similar to a sort of holiday that only lasts a few hours, such as a “picnic with no food” and even as “two years of psychotherapy in one afternoon”. Users were identified as planning their MDMA use well in advance of a session, by synchronising several appointment books to find a free weekend for “ADAM”. The investigators used these ethnographic findings to challenge the stereotype of drug users as addicts. Suppliers of ecstasy to this group of professional users were non-profit

motivated. This is witnessed by reports of droughts during times of peak demand, namely the summer vacation period and the festive season (Beck, 1990).

The Exploring Ecstasy study also identified MDMA use among New Age seekers (Watson and Beck, 1991). The New Age movement has been strongly associated with MDMA. Indeed, this movement and other religious cults, such as the Rajneshees of Oregon, are believed to have been responsible for much of the initial distribution of MDMA throughout the world (Watson and Beck, 1991). Such individuals claimed to use MDMA as an adjunct to achieving spirituality, meditation or therapy rather than for hedonistic pleasure. For the 'New Age seeker', MDMA use was seen as part of their 'work' in their quest for spirituality. New-agers were generally against drug use, other than psychedelics which had alleged religious significance. One such user is quoted as describing MDMA use as "a Eucharist, a communion" (Watson and Beck, 1991). For these reasons, those who used MDMA and other drugs, such as cocaine, for hedonistic reasons were seen by New Age users as sacrilegious abusers of this gift from God. These differences in set and setting for MDMA use are reflected in the New-agers choice of name for the drug, ADAM, rather than ecstasy. This was because the name ecstasy was seen by them as more appropriate to MDMA users seeking thrills, rather than an aid to spiritual enlightenment (Beck, 1990). Throughout its history across the globe MDMA terminology has consistently had religious connotations. Pseudonyms and brand names for MDMA and its chemical cousins have included, adam, eve, eden, eternity, passion, trance, and zen. Also, MDMA orientated subcultures have conspicuously adopted religious imagery and icons (Rose, 1991). These have been 'borrowed' from both Orthodox Christian and eastern religions as well as shamanistic tribal traditions associated with psychedelic drug use. However

only among New Age MDMA users may this have been seen as anything more than a marketing exercise.

The Texas 'X' scene

The establishment of the Texas MDMA producers resulted in the formation of the second group of American MDMA users, the 'Texas X scene'. This group was similar to their Californian counterparts in that they also tended to be mainly upwardly mobile professionals. Ecstasy became known as the 'yuppie drug'. In the mid-1980s, the increase in production by the Texas group of MDMA producers and their advanced marketing techniques resulted in a rapid localised explosion of ecstasy use in the Dallas area. The setting of MDMA use was no longer in private, but by contrast took place in the open, at night-clubs. Indeed one poster was seen to advertise ecstasy as "good to dance to" (Beck, 1990). Adherents to this scene referred to nights out as going "X-ing" (Beck, 1986). The content of interviews by Beck (1990), of participants in the Dallas X scene, will be familiar to those involved in researching the UK rave culture or 'E scene' (see also Collin, 1997). Ecstasy users in Dallas during 1984 and 1985 typically went out all night to clubs with flashing lights and very loud music. Consumption of alcohol and food was kept to a minimum. Soft drinks were consumed to keep cool during prolonged periods of partying. Such dance events were typified by crowded bars with little alcohol being consumed and everyone being very friendly and touching each other. The Dallas X scene was quite different from patterns of use elsewhere in America. This was the case even although the participants in the X scene were often from similar social backgrounds (yuppie or gay) to MDMA users elsewhere (e.g. the Bay Area of California).

The Dallas X scene did not survive MDMA being criminalised. The Texan users were mainly from conservative backgrounds and more fearful of punishment by the law than say the Californian users. Indeed, some of these Texans maintain that they were never illegal drug users and did not see ecstasy as a drug during the time of the X scene (Beck and Rosenbaum, 1994). Many consumers of MDMA were deterred from continued use by its scheduling, which was passed during the strongly anti-drug climate of the 'Reaganite' 'just say no' era. Also, during a time of recession, criminalisation had priced ecstasy out of the reach of many users. Finally, most of the Texas Group of MDMA producers retired. An offshoot of the Texas Group did attempt to market the then still legal ethyl analogue of MDMA, Methylenedioxyethamphetamine (MDEA or MDE), under the name of "EVE" (Dowling et al, 1987; Beck, 1990). However, the apparently similar, but milder, effects of EVE, were not so popular with users. Eventually, MDEA and other analogues of MDMA were made illegal by US congress passing the 'Designer Drug Bill' shortly after their appearance. Those who dared to keep producing these phenethylamine drugs now had to do so with the added threat of heavy legal penalties. This led to producers giving up manufacturing less popular substitutes and resuming MDMA production (Beck, 1990).

After the scheduling of MDMA, patterns of underground ecstasy use in the USA continued. Other groups became been identified with ecstasy scenes. These included students, gays, 'deadheads' (fans of the 1960s 'acid rock' group the Grateful Dead), and by the end of the 1980s attendees at 'acid house' parties (Beck, 1990). Peroutka (1987) conducted a survey of Stanford University undergraduates. Of 369 students anonymously polled, 143 (38.8%) admitted to having used ecstasy at least once.

Despite the diversity of groups using MDMA, the drug remained relatively 'hidden' from American drug agencies or drug research. Epidemiological studies of MDMA use were acknowledged as facing two problems. Firstly, the diverse and dispersed nature of its users meant no single particular group could easily be targeted for research. This also meant that general population studies would be unlikely to yield many MDMA users. Secondly, the (anecdotal) reports that ecstasy did not cause harm. If true, then MDMA users would be unlikely to end up in treatment. Newmeyer (1986) examined accident and emergency (AE) incidents in 1984 and 1985 (the zenith of legal ecstasy production). Of over 90,000 AE incidents in 1984 and 48,000 such incidents in the first half of 1985, less than 20 incidents mentioned MDMA. The comparable figures for cannabis, opiates, amphetamine, LSD and PCP were all in four or five figures. Also, laboratory reports from ecstasy seizures revealed that the market was relatively pure. This suggests demand for ecstasy was not outstripping supply, which would probably have resulted in market pollution (adulteration) filling the shortage. Newmeyer concluded that MDMA use was still comparatively uncommon in America, perhaps only being used by a "number of cognoscenti". However, the possibility is expressed that, as with LSD in the 1960s, MDMA use may "trickle down" to a larger number of "less sophisticated persons", with a corresponding increase in ecstasy related problems.

One reason cited as to why MDMA use in the USA remained unproblematic was in the way it was distributed. MDMA distribution in the USA has been characterised by 'sidelining' users (Rosenbaum and Dolbin, 1991). These were mainly middle class professionals, with little financial incentive to deal in drugs. These people had no need to involve themselves with the traditional drug dealers of the inner cities. In turn, the

drug using underclass of America's inner cities had little access to MDMA. Therefore, demand for MDMA remained low among such groups.

In the late 1980s the European phenomena of acid house crossed the Atlantic. The cult, imported from the UK, largely failed to catch on in the USA and such parties in the San Francisco Bay Area were noted as having an absence of ecstasy use (Beck, 1990). Seymour and Smith (1991) stated that "drug dealers see MDMA as a relatively short fashion drug that does not have the kick of heroin cocaine and other 'popular' drugs". They concluded that hallucinogenic drugs were "no longer at the center of a counter- or subculture as they were in the 1960s". Seymour and Smith believed that hallucinogen use in America is primarily concerned with the quest for spirituality or self-therapeutic use. Such use even included MDMA being used to assist in achieving abstinence from addictive drugs, such as heroin and cocaine. In short, ecstasy use in the USA during the 1980s was not related to dance music or popular culture. The exception to this was the Texas X scene, which with hindsight may be seen as an early manifestation of dance drug culture.

The European 'E' scene

MDMA use was almost unknown in Britain during the controversy surrounding its scheduling in the USA. Before the advent of the dance drug scene, the only record of ecstasy use in the UK came from some sparse anecdotal press reports (e.g. "Police Warn of Pin-striped Pusher Peddling Death. Hallucinogenic Tablets Seized in South Wales, Pushed in City Club", *South Wales Echo*, 1986; "Cocktail of Death", *Evening Times*, 1987, "Yuppie Ecstasy Hits the Street", *The Observer*, 1988). The initial British ecstasy users appeared to fit the American typology. Ecstasy use was the preserve of a clique of "beautiful people", being described as a "yuppie drug" or "a gay

thing” (Dorn et al, 1991). Articles about ecstasy then were most often published in style magazines such as *ID* and *The Face* (notably Naysmith, 1985). At this time the British tabloid press were said to be more interested in the traditional folk devils of heroin and crack cocaine than in a drug which was doubtless being used in their own press rooms (Naysmyth, 1986). The advent of the acid house and rave scenes, with their attendant media hypes, were soon to proletarianise MDMA (Tyler, 1988). Ecstasy use was to become synonymous with the dance drug scene.

With the exceptions of the Dallas X scene and the limited introduction of acid or rave parties, American MDMA use was not associated with dance events. Indeed, Beck (1986) stated that it was a misnomer to call ecstasy a “party drug”. This was in contrast to the pattern of ecstasy use in Britain. Henry (1992) described ecstasy as “almost exclusively as a dance drug”. Another difference between British and American ecstasy use is in demographics. In the USA the typical MDMA user was identified as middle aged, middle class, professional and part of an ‘underground’ subculture (Rosenbaum et al, 1989). In contrast, the typical British user has been identified, as youthful, mainly working class and part of a mass popular culture (Newcombe, 1991a). As a consequence of this cultural divide, it has been said that the American literature about MDMA users is of little relevance in understanding UK users (Pearson et al, 1991). In short, the British ecstasy experience has had as much in common with that of its American counterpart as the kinds of music listened to by respective users while under the drug’s influence; that is the novel sounds of acid house and ‘techno’ rave music frenetically danced to by British users compared with the pre-existing forms of music statically listened to by Californian MDMA users (e.g. Beethoven, Mahler and Bach) (Beck, 1990).

The Ibiza connection: The advent of dance drug music

Although ecstasy was not associated with the dance scene in the USA, the dance music associated with British ecstasy use had its origins in that country. In 1983 an innovative DJ named Frankie Knuckles created a new form of music which was called 'house' after the Chicago night-club, the *Warehouse*, in which he worked (World in Action, 1988; Collin 1997). Although house music became popular at the same time as ecstasy use in the USA (often at similar venues, e.g. gay night-clubs), both developed separately. Ecstasy was most popular with white middle class (often middle-aged) users in the southern and western states, while dancing to house music was initially restricted to poorer young black participants in the cities of America's north-east. Together with the related music styles called techno and 'acid jazz' from Detroit, and 'garage' music from New York, house music crossed the Atlantic during the late 1980s. It was only then that the dance drug scene began.

A style known as 'acid house' emerged from the Chicago house scene in 1987 (Cosgrove, 1988). At this point the term acid referred to the stealing (sampling) of other people's music by mixing it into an original music track. In black American subculture the slang term 'acid' was used to mean theft, derived from the older slang term of 'getting burned' (being the victim of theft). Unusually, this style of music mixing most often used a sampler (computer rather than instrumentally generated). This innovation distinguished acid house from other 'traditional' forms of black American dance 'street' music. During the mid-1980s, other music styles such as 'hip hop' had pioneered mixing techniques using record decks. In 1987, a DJ known simply as Pierre recorded a dance record entitled "Acid-Trax". This was released on the Chicago based *Trax* record-label and credited to a non-existent group called *Phuture*. This record became available on import in the UK and was popular at the 'warehouse

parties' of London. Warehouse parties had become popular in London following the abolition of the Greater London Council or GLC (Rose, 1991). The warehouse party scene grew out of *red-wedge* and other leftist music groups as a reaction to Thatcherism and the demise of suitable dance venues following the GLC's abolition. Industrial venues such as old warehouses and airport hangers were seen as being pre-Thatcherite (yuppie culture), free from the increasing surveillance becoming the norm at discos or football stadiums (Melechi and Redhead, 1988).

Dance music, such as acid house, techno and garage had also become popular in Europe. The Spanish holiday island of Ibiza (Eivissa) in the Balearics was one such place. By 1986, before the arrival of acid house, Ibiza had become known as "ecstasy island" (Kaplan et al, 1989). Several theories have been proposed as to why it was on Ibiza that ecstasy and house music met. One connection may have been made via the New Age movement (Beck, 1990). Ibiza had been known as a 'Mecca' for hippies returning to America from treks to Asia since the 1960s. Many of these people decided to stay in Ibiza and had later adopted the New Age philosophy. Another possibility was a direct connection with the Dallas X scene being formed by Ibiza town's 'yuppie set' (Beck, 1990). It is also possible that at some of the *Warehouse* club revellers of Chicago and Detroit revellers had begun using MDMA as a cheaper alternative to cocaine (Kaplan et al, 1989). This practice then crossed to the internationally renowned clubs of Ibiza. No matter which, if any, of these scenarios is true, the synergy between the new music and MDMA was to provide the impetus for the establishment of dance drug culture. How the connection between the drug and the music was made is not precisely known, but it most likely happened in the elitist clubs near Ibiza town, sometime in the mid-1980s. Newcombe (1991a) cites one user who, in referring to the Ibiza connection said that they should like to meet the person who

first brought ecstasy and house music together “and shake their hand”. Since this time Ibiza has remained a focus of house music and dance drug use (M8, 1997)

Reputedly, the house music of the island of Ibiza was ‘discovered’ by three young working class British DJs, Danny Rampling, Paul Oakenfield and Nicky Holloway. These DJs were on holiday from London in the summer of 1987 (Rose, 1991). Like other British tourists who went on holiday to Ibiza, they stayed at the popular ‘British resort’ of San Antonio, on the other side of the island from Ibiza town. San Antonio, was a downmarket mass tourism destination, synonymous with the *Club 18-30* holiday company and regarded as the home of the archetypal ‘lager lout’. Though only a few miles away, Ibiza town contrasted sharply with San Antonio. Ibiza town was of a more sophisticated cosmopolitan nature than the mass tourism resorts that had been developed on the island in the 1970s. On returning to London these DJs, who were veterans of the London warehouse scene, created their own ‘Balearic’ house style of music. Thereafter, British ‘clubbers’ adopted the style and drugs of the chic venues of Ibiza town. Most notably amongst Ibiza’s clubs was an open-air venue called *Amnesia* at San Rafel just outside Ibiza town. This club was where resident DJ, Alfredo, had first played the new music, including Phuture’s Acid Trax to Rampling, Oakenfield and Holloway. The new music was reportedly being played in UK clubs by the autumn of 1987. An example of one of these events, taking place after-hours in a Manchester night-club with a DJ after returning home from Ibiza, is detailed by Reitveld (1991). In November of that year, DJ Danny Rampling opened a club in London called *Shoom*. This club embraced the Balearic house music subculture, using the hippie and the ‘smiley face’ (☺) as logos. The latter logo was to become notorious in the iconography of acid house. *Shoom* used dry ice and strobe lights that were to become an integral part of the dance drug culture. In that club “shooming” was described as “the state

ecstasy dancers aspire to” (Reitveld, 1991). The other DJs, Paul Oakenfield and Nicky Holloway, opened similar influential clubs, named *Spectrum* and *Trip* respectively. The style spread to other clubs as the term acid house took hold. London and in particular Manchester (the ‘Madchester scene’) became centres of the new youth culture. A subculture of conspicuous consumerism began to grow, centred on expensive drugs (ecstasy), expensive Mediterranean clothes and expensive (and exclusive) parties in clubs or at secret warehouse venues (Q, 1989). The secret nature of acid venues precipitated new forms of street advertising and design (Rose, 1991). Fliers featuring the coded iconography of acid house, such as the smiley face or Mediterranean religious idolatry (ecstasy) were employed to advertise parties at short notice. As with the new music, this was only possible through recent developments in technology. The advent of the Apple Mac computer meant that fliers with sophisticated art-work could be mass produced in time to publicise secret venues that night. This mirrored an earlier advance in technology, the Xerox photocopier, which allowed the mass production of unsophisticated hand-bills to advertise secret ‘punk gigs’ ten years earlier. Illicit (‘pirate’) radio stations became central in the promotion of the music and its venues (Q, 1989). The early acid scene coincided with the ‘Lawson Boom’ years of Thatcherism and its upwardly mobile participants could be described as ‘Thatcher’s children’, materialistic and unloved without the help of an empathetic drug called ecstasy (Redhead, 1993).

The new music was loud, with a back-beat upwards of 120 beats per minute. This was complemented with appropriate psychedelic light shows. The use of drugs, dancing, music and light shows can be seen as complementary to one another in a form of synergy. The different types of drugs used in the dance drug scene can also be seen as being complementary or synergistic with each other. Dancing to acid house music has

been described as a “trance dance” Lyttle and Montague (1992). During this the dancer achieves an ecstatic or trance like state through moving to certain frequencies of sound, especially the sub-sonic bass rhythms produced by a continuous beat. Drugs are used to assist in the achievement of the trance dance state rather than merely for the direct effects of the drugs themselves. Rather than conventional pieces of music, house involves the DJ rather than singers or musicians as the central character. The DJ continuously mixes the tracks throughout the dance event without verbal interruption. Lyrics are uncommon, which means the music is less restricted by national or linguistic boundaries. This is analogous to another ‘international language’ - football, which like house music involves crowds of young people influenced by trans-European movements. Where instruments are involved in this new music these are electronic keyboards and not the guitar and drums of rock music (‘rawk’). Acid house itself was characterised by the use of the Roland TR303 synthesiser, which was at the forefront of technology at that point in time. What the DJ plays is mostly the new music, but often contains nostalgic snatches of older (songs or instrumental) tracks mixed in. These mixes were allegedly called acid mixes, because of the practice of ‘acid burning’ or stealing pieces of other people’s music, hence ‘acid house music’. However, unlike in Chicago, the slang term ‘acid’ had only referred to the drug LSD in British subculture. Before long both partygoers and media had corrupted the term acid house. The ‘Es’ (for ecstasy) had both metaphorically and literally become a part of the ‘aceid’ scene. Acid house reached its peak in the parties and clubs of London and Manchester during the summer of 1988 (Melechi and Redhead, 1988). This became nostalgically known amongst its participants as the ‘second summer of love’. Ironically the so called ‘first summer of love’ had been centred on the San Francisco Bay Area of California in 1967, about the time Shulgin had synthesised MDMA, when

the music was associated with LSD use. Nineteen eighty-eight was a time where the chic cognoscenti could enjoy dancing with ecstasy, unmolested by the police, the media, mainstream commercialisation or criminals.

The supply of ecstasy in the acid house scene was not from established organised crime drug dealing groups. Instead, the ecstasy dealer at that time was characterised by Dorn et al (1992) as “trading charities”. These are individuals or groups who sell drugs for ideological motives rather than profit. The acid scene was particularly conducive to this form of dealing because of its underground nature and association with particular groups (e.g. gays). In this respect, ecstasy in the acid house scene was similar to that of the USA.

The British legislative reaction to the dance drug scene

In November 1988, the UK media had discovered that drugs were used at acid house parties. In the popular press, acid (or aceed) read - ecstasy and acid house read - ecstasy test, like the ‘acid tests’ of Ken Kesey in 1960s America (Stevens, 1987). A media based moral panic ensued (Davies and Ditton, 1990).

The term moral panic was coined in and is best illustrated by the book *Folk Devils and Moral Panics*, by Stanley Cohen (1972). This book describes the UK media reaction to a previous youth movement, the mods and rockers of the 1960s. In both the 1960s and 1980s, headlines of the time reflected the media’s desire to make copy from reporting the youth culture, whilst taking a moral stand against it. The moral panic over acid house that occurred in November 1988 was directly comparable to that described by Cohen over 20 years earlier. In the month during which the acid panic peaked, headlines included “Roof falls in on Acid House craze” (*Daily Express*, 1988), “Drug Deals at the ‘Acid’ Disco: I’m shocked says Wet Wet Wet man” *Daily Record*,

1988a), "The Acid Menace: Police probe drug discos" (*Daily Record*, 1988b). The Ibiza connection easily linked 'acid house fans' with the other great media cause célèbre of the times, the lager lout. Both groups were identified as young, white middle class and affluent. It has been argued that highlighting these affluent deviants was a policy the Thatcher Government used to contradict claims that the rising crime rate during the 1980s was associated with the worsening social conditions of poverty in the UK and hence Conservative Government policy (Melechi and Redhead, 1988). Xenophobic media coverage was also quick to point out this latest drug craze had its origins in the USA or Ibiza. Acid house was portrayed as just another invasion of foreign influences that was going to corrupt British youth. The moral panic which ensued was a classically British phenomena (Cosgrove, 1988). Folk devils and innocent victims were soon identified "Acid Kids Lured to Holland" (*Daily Mirror*, 1988). Perhaps the most significant headline that month was *the Sun's* "Acid fiends spike page 3 girl's drink" (*the Sun*, 1988). This article was referring to a claim that Spaniards in Ibiza were spiking English girls' drinks with LSD with intent to rape. This front-page story could have come straight from the media 'cocaine panics' of 1916 and 1922. These early drug panics were to prove to be the origin of all British drug control policy. Earlier this century, the 'foreign devils', who the press reported were drugging British girls for sex, were from the British Chinese community (Kohn, 1992), a story that was to be repeated with black 'be-bop' musicians and cannabis during the 1950s. What the press had so far failed to notice about the drugs being used at acid house parties was that being synthetic they could be manufactured in Britain. This did not fit the usual maritime metaphors of the great British drug panic. Such metaphors, including 'floods', 'tides' and 'waves' of drugs, 'pouring' into a Britain 'awash', 'sinking' or 'swamped' with drugs from abroad, had been applied in the past to drugs

such as heroin or cocaine. These latest 'folk devils' could easily become home grown. Perhaps unsurprisingly, the acid house scare was soon to be replaced by a more traditional crack cocaine scare in early 1989 (Davies and Ditton, 1990; Bean 1993).

Acid house came to the attention of the press and public in November 1988, largely because of a record at No. 3 in the BBC Radio 1 pop charts. This record entitled "We call it Acid", by a group called *D-Mob* (named after a Carnaby Street dance club), reached notoriety and was reputed to have been deliberately kept off the Number 1 slot in a similar fashion to the *Sex Pistols* punk anthem, "God Save the Queen", eleven years earlier. Another record released at the same time as *D-Mob's*, entitled "Acid Man" by *Jolly Roger*, was banned by the BBC, as were all records containing the word 'acid' (*World in Action*, 1988; *Daily Record*, 1988c). Ironically this track could still be heard on pirate radio. Ecstasy, a drug little known to drug problem agencies and the general public alike, was advertised in a similar fashion to that which happened in the USA prior to the MDMA hearings three years earlier. There were increasingly lurid media claims about the dance drugs. Some of these had been borrowed from the American MDMA coverage, for example, "Acid eats the Brain Loose", *The Guardian Weekend Magazine*, November 1988 (Pye, 1988). This represented a transatlantic corruption of the ecstasy drains the spinal fluid panic. Another was the story "Acid drove Pink Floyd star up the Wall" (*News of the World*, 1988). This story referred to a guitarist named Syd Barrett, formerly in the group *Pink Floyd* who, according to the newspaper, had used "the acid drug LSD" in the 1960s leaving him permanently brain damaged. The overall accuracy of this story can be judged by the fact that Barrett had left the group ten years before they recorded the album *The Wall* referred to in the headline. This pattern of media misinformation prompted the first action by drug researchers to provide information about dance drugs (Newcombe, 1988).

At the time of acid house, MDMA and its chemical cousins were already illegal in the UK. There had been no need for an American style legislative debate in the UK. All substances which contain a methoxy or dimethoxyphenethylamine structures had been made illegal following their discovery in an English Midlands illicit methamphetamine laboratory in 1977 (Shapiro, 1992). An amendment to the Misuse of Drugs Act 1971 made all such drugs illegal to stay one jump ahead of the illicit chemist. MDMA, MDEA, MDA and LSD (acid) were all already controlled in the UK as Schedule I (having no medicinal use) and Class A (a maximum life sentence). Therefore all the drugs that were associated with acid house already carried the most severe of existing controls. The media coverage of acid house and the ensuing moral panic precipitated the need for national and local government to be seen taking action against this menace. As the drugs involved were already as illegal as they could possibly be made, the authorities were presented with a dilemma. A new legislative target was found - the party. The then Conservative MP for Luton South (home of the Whitbread brewing chain), Graham Bright, pushed the 'Entertainment (Increased Penalties) Bill' through parliament in 1989. This 'Bright Bill' had the seemingly absurd aim of punishment by up to six months' imprisonment and a fine of up to £20,000 for organising a party without a licence from the local authority. Newcombe, (1991a) details this apparent official "overreaction". Other laws invoked against party organisers and club owners have included those concerned with, public order, pollution, health and safety, food and hygiene and the Misuse of Drugs Act. This culminated with the jailing of a 26 year-old acid party organiser for 10 years. The defendant had allegedly known that drugs would be used at a party he had held on a Thames river boat (*Daily Record*, 1989a). The police who raided this party claimed that they found the boat "littered with drugs". The supporters of the Bright Bill became engaged in conflict with

supporters of the 'right to party'. The ensuing debate about proscribing the setting of ecstasy's use, rather than the criminalisation of the drug itself, mirrored the MDMA scheduling controversy of America in 1985. Indeed, much of the debate again took place in the public arena. In Britain the top chat show, hosted by Jonathan Ross, also played an important part in forming public attitudes. In one episode of that show, party organiser and 'Thatcherite' entrepreneur, Tony Colsten-Hayter, represented his Right to Party Movement. This movement had little chance of success, but the programme did mark a watershed in youth culture. Colsten-Hayter's performance was likened to a parody of the infamous Sex Pistols interview on the *Bill Grundy Show* in 1976 which had heralded in the punk era (Reitveld, 1991). The Jonathan Ross program, in the presence of punk journalist Paul Morley, confirmed the arrival of a new paradigm in youth culture. The summer of 1989 was the zenith of the illegal rave, characterised by thousands of people travelling through the night to ad-hoc open air venues, notably fields near the M25 London orbital motorway (Q, 1989).

Expansion of the dance drug scene

Cosgrove (1989) described acid house as the largest underground youth movement in the UK since punk. The acid scene, with its secret venues and use of illicit substances, has been likened to the 'speakeasies' of the USA during the era of alcohol prohibition (Redhead, 1991). However, by late 1989 the dance scene had been transformed, Cosgrove (1989) details the fall of acid house. Two things were chiefly responsible for the transformation of the acid house subculture into a mainstream youth culture called 'rave'.

Firstly, the 'Bright Bill'. This legislation eventually all but ended the underground warehouse parties. By the early 1990s, only a few illegal party organisations continued

to operate. An example of such was the Glasgow group *Desert Storm*, an ironic name reflecting their time of origin during the Gulf War. Such underground groups' fortunes were largely dependent on local government licensing policies. For example, a Glasgow 2am club curfew introduced in mid-1993 can only have benefited the illegal party organisers. Chapter 4 of this thesis will detail the kind of venues popular with the dance drug users in Glasgow during the mid-1990s.

Secondly, the commercialisation of the acid scene. As with previous youth movements, acid house clothing was created by manufacturers for sale in high street shops. Also, established town centre discos saw the potential of this new generation of dancers. Mainstream clubs began running acid nights. Large-scale parties (raves), which were licensed as such by the appropriate local authorities, began to take place. These events, perhaps involving thousands of people, were often sponsored by big business interests and run for profit by entertainment companies. Even many of the pirate radio stations which had backed the acid house scene, such as London's Kiss-FM, 'went legitimate' and obtained broadcasting licences. Despite these changes, all the styles of music, DJs, art, design, fliers, lights, dancing and drugs were retained by this mainstream dance drug culture. Consequently during the early 1990s the dance drugs came out of the underground drug subculture to become a part of mainstream youth culture. The consumerist nature of rave absorbed elements from other youth subcultures including facets of both the previously distinct sports and music 'youth tribes' (Newcombe, 1992a). At this point many of the original UK ecstasy users became disenchanted with the dance drug scene and left. The exclusive nature of the early house parties (detailed by *Q*, 1989 and Rietveld, 1991) had been replaced by a form of mainstream mass entertainment. Newcombe (1991a) described the dance drug scene as having changed from one of "being seen with the in crowd" to one of "being

out of it in a crowd”. In the 1990s, the letter ‘E’ (for ecstasy) replaced the smiley face as the pre-eminent icon of the dance drug scene. McDermott et al (1992c) describe rave as “possibly the biggest youth subculture that Britain had ever seen, a subculture intimately bound up with the use of ecstasy”. Chapter 3 of this thesis will examine the demographics of dance drug event attendees (ravers).

In 1991 another moral panic specific to ecstasy use at raves began. As with the ecstasy panic in the USA, the interest was such that it generated a special edition of a drugs journal, *The Journal of Psychoactive Drugs*, in the USA in 1986 and *Druglink, The Ecstasy Papers* (Ashton, 1992) in the UK in 1992. The moral panic that had first attacked the warehouse party had followed the dance into the high street clubs. Some commentators suggested that the question of legislation was now centred on youth entertainment itself rather any specific associated ‘folk devils’, such as ecstasy or drugs in general (Redhead, 1991). The rave itself could be seen as the addictive drug in this panic. Indeed, some reports spoke of ravers spending most of their free time and cash travelling around the county to raves (James, 1991). By the early 1990s, the dance scene and the drug scene had merged so closely that the two terms had become virtually indivisible. Chapter 5 of this thesis will investigate the types of drugs that are used at dance events.

The ‘free’ marketing of a drug scene

The mass marketing of the rave culture in turn precipitated a change in the supply of ecstasy from ‘trading charities’ to more organised drug dealing groups (Dorn et al, 1991). In the 1990s manufacturers began to locate offshore, to circumvent legislation or because of cheaper production costs than was possible in the UK. An article in *The Economist* (1993) detailed the eastward movement of ecstasy laboratories, first to the

Netherlands (where MDMA analogues were still legal) then behind the recently opened Iron Curtain, to countries such as Hungary or Latvia (to maximise profits). The result of all this movement and economising was a reduction in drug quality. By 1993 international MDMA trafficking appeared little different to that of other illegal drugs.

The moving of the dance drug scene into mainstream clubs, encouraged traditional criminal drug dealers to become involved in ecstasy supply. These gangs were attracted by the profits to be made in the expanding market, rather than any ideological motives related to the properties of the drug itself. As demand outstripped supply, these profit oriented dealers filled the gap with poor quality or impostor drugs (Sawyer, 1992). Many of the original ecstasy users, noting the declining quality of the drug, became disenchanted and ceased using (Howes, 1990; Saunders, 1993a). Club door security could deter trading charities, but not organised criminals. Violence associated with this form of dealing now appeared at the traditionally peaceful rave (Newcombe 1991a). Club security-staff were themselves ideally placed to become drug dealers on behalf of these suppliers (Newcombe 1992c). This, in part, led to the use of other drugs also becoming popular at raves. Chapter 6 of this thesis will investigate whether dance drug users buy drugs at raves or whether they buy them elsewhere, perhaps from sources where other 'harder' drugs are also available.

After the rave scene was forced into licensed venues, 'dance drugs' now included other substances such as amphetamines and ketamine (James, 1991; Lifeline, 1992a; Marcus, 1996). Amphetamines had been used in many previous dance scenes, but illicit ketamine use can be regarded as a new phenomenon in Scotland (Dalgarno and Shewan, 1996). Ketamine is a Benzylamine, an anaesthetic drug chemically related to phencyclidine (PCP). Ketamine use had earlier been noted among American MDMA users (Siegel, 1986; Kirn, 1991; Jansen, 1997). One of the first reports of ketamine use

in Scotland (by a Royal Marine) was shortly after the Gulf War, where it was allegedly to be administered as a battlefield analgesic (*Evening Times*, 1992; *Sunday Post*, 1992). Despite the advent of these 'new' rave drugs, ecstasy, "the drug which used to contain MDMA" (Newcombe, 1992c), remained the prototypical dance drug (Henderson 1993b). Chapter 5 will test whether these drugs have become as popular on the dance floors of Glasgow by the mid-1990s.

However, by the 1990s, ecstasy itself began to change. A multitude of new brand names for different types of the drug emerged. These included, 'manchester uniteds' (reflecting the linkage between football and the dance scene), 'M25' (referring to the motorway, which provided access to the illegal parties of the summer of 1989, such as those run by Colsten-Hayter's Sunrise Industries), 'scuds', 'sadam husseins' and 'B52s'. These latter three varieties appeared during the Gulf War, an event at philosophical odds with the rave culture in much the same way as Vietnam was to the first summer of love twenty years previously. As will be described in greater detail in Chapter 7, more often these names described the uses (e.g. dancing) or effects (e.g. drugs) of particular brands. Such marketing techniques were not new, this being how the name ecstasy originated. Nasmyth (1986) noted the careful marketing of brands of ecstasy or other new substances, perhaps with superior effects, at a time before the advent of the acid house (dance drug) scene.

It is not surprising that drug users should show brand preference. Stevens (1987) details how LSD manufactured by Augustus Owsley (a 'technical adviser' with the Grateful Dead in the 1960s) had by word of mouth obtained a good reputation among users in the USA. When it was alleged that other manufacturers were distributing their LSD by claiming it was his, he began injecting his product with coloured dye. Feedback from consumers attributed differing subjective effects to each of the

coloured batches. As an experiment, Owsley divided up equally the same batch of LSD, colouring each sub-division differently, then waited for a response. Different colours were alleged to have different effects. These included being “mellow” or “speedy” and in the case of one batch, being cut with strychnine.

By the 1990s brands of ecstasy had begun to appear which also allegedly contained other substances, often to modify the drugs effects, rather than as deliberate adulteration or deception. These have included ‘snowballs’ (allegedly containing heroin or synthetic heroin called MPPP, though they in fact contained MDA; Lifeline, 1993a; Lifeline, 1993b) and various pills which allegedly contained other drugs popular on the dance scene such as amphetamine, LSD or ketamine. For those seeking pure MDMA (ADAM), brand names inferring the drug itself were created, such as sADAM Hussein or MaDMAN. Whether these alleged contents are based on fact is impossible to determine, given that the same pill may have different names and different pills may have the same name varying over time and geography with new more fashionable brands constantly evolving. The marketing of ecstasy now resembled the definition of designer drug given by Gary L Henderson (Baum, 1985).

Risks and hazards of dance drug use

The potential for drug adulteration detailed above is just one of a number of risks which have become associated with the dance drug scene. Many of these risks are common to previous groups of drug users such as legal status, associated criminality, drug toxicity, potential for addiction and general health consequences. However, the dance setting has given rise to new hazards that may or may not be related to drug use. For example, regular prolonged vigorous dancing may have health consequences (whether under the influence of drugs or not) which may be either positive or negative

dependent on the individual; likewise the environmental conditions at dance events, such as temperature, access to refreshments, infections and noise. Participation in the scene may also incur social consequences relating to personal finances, criminality, employment and sexual behaviour.

At the extreme there has been a number of deaths associated with dance drug use. Though usually reported in the media as ecstasy deaths, there is considerable doubt over whether these deaths were in fact (solely) caused by MDMA, other drugs, or dancing behaviour (Grob, 1997). Each of these deaths (from press reports, approximately 50 in the UK between 1988 and 1996) received disproportionate media coverage as compared with other related drug deaths, and precipitated campaigns against dance drug use. Notable among these deaths were Claire Leighton (“Disco Dolly Killed by Love Drug”, *Daily Record*, 1989b), Leah Betts (“Ecstasy taker killed by water”, *Glasgow Herald*, 1995b) and three fatalities at a rave venue in Ayr, Scotland, called Hanger 13 (“Hanger 13 and the dance with Death”, *Glasgow Herald*, 1995a). An article about drug deaths in a Glasgow newspaper at the beginning of 1996 illustrates this point (“JUST ONE PILL - THAT’S ENOUGH TO KILL” *Evening Times*, 1996a). This reported on a girl who had become ill after taking ecstasy at a New Year party in England, a local drug addict death the same day and final total of 101 drug (addict) deaths in the local region in the previous year. More than twice as much column space was devoted to the English girl’s plight than to the combined local stories. The news-worthiness of death or serious harm associated with the dance drug scene appears to lie in the scarcity of such occurrences. Saunders (1993b) estimates the chances of death from ecstasy use to be about the same as taking five rides at a fun fair or playing ten games of football. This assumes about two million ecstasy users in the UK, with 15 alleged MDMA deaths over the previous two years. Saunders

estimates that other widespread recreational activities carry greater risks. These include a 33-fold greater chance of dying on the road and an equal likelihood of being killed horse-riding. Another way of assessing the risk of death from dance drug use is by making comparisons with other drugs. Abbot and Concar (1992) compare figures of drug deaths recorded by the Home Office in 1990. In that year MDMA is reported to have caused five deaths in Britain, amphetamine two, cocaine four, and LSD none (as was also the case with cannabis). This compares with 153 fatalities attributed to either heroin or morphine and an estimated 30,000 deaths from alcohol and 110,000 deaths from tobacco per annum. However, the authors point out that it is the long-term effects of alcohol and tobacco that are responsible for their higher death toll. It may therefore be possible that many more deaths associated with dance drugs will emerge after chronic long-term use. Of course this was also said about LSD in the 1960s, and fears about that drug, including long term brain damage and split chromosomes, have proven to be unfounded (Tyler, 1988; Beck, 1989). In the USA, MDMA deaths are so low (under ten per year) as to not even be recorded in the official figures by DAWN (Drug Abuse Warning Network). The low number of deaths associated with dance drugs, such as ecstasy, creates problems for future research. Fewer deaths mean less chance of understanding the mechanism behind those deaths that do occur. The rarity of these tragedies makes it difficult to partial out the relative roles played in each by dance drugs, other drugs, drug education, dancing behaviours and other factors. In Chapter 4 of this thesis, the environmental conditions in which raving takes place and the behaviour patterns of their attendees will be examined to highlight the risks faced by dance drug users other than those presented by the drugs themselves.

Reports of deaths associated with ecstasy (MDMA and MDEA) were first recorded in the USA prior to the advent of the dance drug scene. The first such report in the scientific literature was that by Dowling et al (1987). Dowling identified five deaths related to these substances. In two of these fatalities (both from cardiovascular causes) the presence of MDEA was detected in the blood. In one case the deceased only thought he had taken MDMA. In the remaining three cases MDMA was detected in the blood. The first of these deaths was by electrocution, allegedly by suicide whilst under the influence of the drug. The second such fatality was from asthma, the deceased having a history of that condition. The third case, a healthy 18 year old female, appeared to be from MDMA intoxication itself. By 1990 the total of (sudden) deaths solely attributed to MDMA in the USA had risen to two (Dowling, 1990). Given the extent of ecstasy use in the USA throughout the 1980s, this would appear to indicate that ecstasy use outwith a dance culture setting is extremely unlikely to cause many fatalities.

At this point deaths related to ecstasy became more frequently reported in the UK. Unlike the few American fatalities above, these deaths occurred almost exclusively in a dance setting (Newcombe, 1994a). Unlike other drug fatalities, these dance drug deaths do not appear to have been dose related. Henry et al (1992) detail one clinically documented case that recorded plasma levels of 7.72 mg/litre of MDMA after 'overdosing' on 42 ecstasy tablets, yet the patient only suffered a hangover. The same paper details deaths from only one tablet or with plasma levels of only 0.11 mg/litre of MDMA. Clearly other factors are at work in these cases.

Several of the fatalities labelled ecstasy deaths by the media have been identified as being caused by the deceased overheating. Indeed, death from coagulaopathy and hyperthermia (heat-stroke) associated with MDMA use has been clinically diagnosed.

Case reports of death or serious illness from these causes have been documented in patients in whom the presence of MDMA was detected (Chadwick et al, 1991; Campkin and Davies, 1992). Deaths from coagulaopathy and hyperthermia are caused by internal bleeding. This occurs because at high temperatures excessive blood clotting takes place. This is not harmful in itself, but it hinders internal clotting resulting in bleeding. Henry et al (1992) identified seven such cases in the UK during 1990 to 1992. All the deceased had body temperatures recorded at over 40 degrees Celsius. In each case analytical procedures confirmed the presence of MDMA. The authors also identify five non-fatal cases of severe reaction to MDMA ingestion. They conclude that such cases may at least in part be caused by the conditions under which MDMA is commonly taken. These include use in hot crowded dance clubs, with insufficient opportunity for fluid replacement, accompanied by vigorous exercise (which is perhaps an effect of the drug itself). It is speculated that metabolic myopathy may have been the cause of severe reactions in some individual ecstasy users.

One case of near fatal hyperthermia (41.7 degrees Celsius) has been recorded in the American literature (Hayner and McKinney, 1986; Brown and Osterloh, 1987). This did not involve vigorous physical activity in a hot environment. It has been suggested that the increased levels of 5-HT in the brain produced by MDMA may be responsible for this overheating. Speculation is that excess 5-HT may prevent the hypothalamus from being able to regulate body temperature in hot conditions (Abbott and Concar, 1992). The problem with these cases is in assessing whether the heat-stroke was due to the effect of MDMA itself or (at least in part) due to the environment in which it was taken. Simply being in hot overcrowded clubs may produce ill health by itself (James, 1991; Cook, 1997). The presence of MDMA may be masking the true cause of death, either other drugs or the effects of raving regardless of what drugs have been ingested.

The media's fixation with the word ecstasy may in part have been responsible for the role of other drugs in rave deaths being largely ignored. A local Glasgow example of this concerns four cases of intra-cerebral haemorrhage which were reported to have been associated with ecstasy use (Harries and De Silva, 1992). However, this report did not mention whether any of these patients had been tested for the presence of MDMA. In fact no toxicological confirmation had been conducted (Ditton 1994). Only one of these patients admitted to using ecstasy (with amphetamine), two claimed their drinks had been 'spiked' (with ecstasy) and the remaining patient was identified as having only used amphetamine on the basis of an anonymous phone call. Moreover, the authors cite only previous literature on intra-cerebral haemorrhage, which link the condition to the use of amphetamine, not MDMA. Despite this paper being discredited, the Scottish media continued to carry the ecstasy causes strokes message (*Daily Record*, 1996a) rather than concentrating on amphetamine in cases where both were used by the patient. Even in well publicised ecstasy deaths such as Leah Betts and the Hanger 13 cases, both eye-witness reports and toxicological analysis revealed that the deceased had taken other drugs, such as alcohol, cannabis and amphetamine.

The ambiguities above highlight the need for caution when examining anecdotal reports of harm related to a new form of drug use. Returning to the example of LSD use in 1960s America, it was noted that, in the years following the initial LSD moral panic and scheduling, reported harm caused by the drug ('bad trips') appeared to decline (Bunce, 1979). This decline could not be supported by changes in the use of the drug itself. In other words the harm associated with a drug may be seen as a social phenomenon rather than as a direct result of its pharmacological properties. While ecstasy remains in the public eye, cases of associated ill health would seem likely to

continue. Should ecstasy lose its high media profile, the number of such cases would be likely to fall, all other factors remaining equal.

Drug policy, agencies and the dance scene

The advent of the dance drug scene has presented new challenges in the treatment of drug problems. Both the type of drugs being used and the potential client group are quite different to what drug agencies were used to dealing with. As will be detailed in Chapter 3, the dance drug users of the 1990s have little in common with the mainly intravenous opiate using criminals of the 1980s (though these persons still predominate in treatment).

Initially, few dance drug users, other than problem drug users who also used dance drugs, were in contact with any form of drug agency. Then drug workers, particularly in the Northwest of England, began attempting to reach ecstasy users by outreach work (McDermott et al, 1992c). Attendance at night-clubs and raves was found to be quite different from the traditional 'street' outreach work used to contact opiate injectors. A noisy club where someone is partying (whether with ecstasy or alcohol) is hardly the best place to initiate a counselling session with someone who does not believe they have any drug problems. Participant observation at dance events enabled drug workers to conduct informal interviews with dance drug users and find out their needs. Two things became apparent (McDermott et al, 1992a). Firstly, most users did not see their use as problematic (requiring help at a drug centre), but they did want more information about the drugs they were using. Secondly, the new users believed that existing drug services were aimed at 'junkie' opiate injectors and had little relevance to them. The problem for agencies became defined as how to reach this group and provide them with information in time to prevent many of them coming to

any harm from their drug use. To meet the needs of these users, several initiatives were undertaken to provide them with information about ecstasy. One such initiative was *Chill Out*, an information leaflet produced by the Mersey Drug Training and Information Centre, Liverpool (MTDIC, 1992). This initiative took advantage of the style and iconography of the rave scene discussed above. From their previous two years of participant observation at raves, the MTDIC had noted the habit of ravers collecting glossy night-club and illegal rave fliers, often pinning them on their bedroom walls (McDermott et al, 1992c). Taking the form of a glossy night-club flier, the dance drug information leaflet, *Chill Out*, was distributed in places where dance drug users congregate before raves. That is in cafes, clothes or record shops and not drug projects (McDermott et al, 1992a). It was hoped that this information flier would be collected and read by rave goers, rather than simply left lying around unread or on the club floor as would be likely with another 'just say no' type leaflet. The success of the *Chill Out* method was exploited in this thesis by production of a study recruitment flier that will be detailed in Chapter 2. Other initiatives have included advice from Manchester's Lifeline Project's cartoon character *Peanut Pete* (a comic dance drug user) and also their *Big Blue Book of Dance Drugs* (Lifeline, 1992a). One not unexpected pitfall of this 'user friendly' approach has been sensationalist media coverage. The press has attacked such 'harm minimisation' strategy, because of its use of the glossy iconography of the dance scene, saying it encourages drug use. In the case of *Chill Out*, this media campaign was carried to the extent that drug workers were threatened with public incitement to violence by a national daily tabloid ("What a Dope" *Daily Star*, 1992). This editorial stated "storm the place (MTDIC) and dump all 20,000 copies of this pernicious pamphlet in the Mersey. Followed by Mr O'Hare". The

eventual outcome of this press criticism of the MDTIC was that project funds were placed in jeopardy (McDermott et al, 1992b).

Despite the credibility problem of dance drug users believing that drug projects were only for 'junkies', by the early 1990s the first 'casualties' of the new drug use era had begun to appear at agencies (Fraser et al, 1991). Their reported health problems were quite different from those of opiate users, usually psychological rather than physical in nature. Such problems included paranoia, flashbacks, depression, anxiety, or simply feeling 'cabbaged' (mentally fatigued). These problems were reminiscent of those experienced in the 1960s associated with LSD and amphetamine use then. Today, it is difficult to gauge to what extent these problems are the same as in the 1960s or are new, caused either by dancing behaviour or ecstasy.

One of the main concerns of drug agencies has been that today's recreational dance drug users, may be tomorrow's problem drug users. It is even possible that encouraging dance drug users to attend drug projects might actually accelerate this process. This could happen if ravers came into contact with heroin users or injectors for the first time at opiate/benzodiazapine orientated agencies. To insure against this possibility, some drug projects have striven to keep these groups apart. Manchester's Lifeline agency gives dance drug users three golden rules: i) never inject, ii) never use heroin, iii) never smoke rock cocaine (crack) (Lifeline, 1992a). However, there is some evidence of heroin and crack use amongst ravers (Gilman, 1993). This has created new dilemmas for agencies about how to deal with such clients. The use of cocaine, in particular, seemed to have increased at dance clubs by the early 1990s. However, this phenomenon seems to be restricted more to the veterans of the 1988 acid house scene than new drug users (James, 1994). Many of these older clubbers may have been no stranger to cocaine use prior to the advent of ecstasy. That said, these persons have by

now graduated to the higher echelons of the club scene (e.g. DJs) and their changing drug use has been blamed for changes in dance music and atmosphere, both being described as 'harder' (as with chosen drugs reputation) by James (1994). As raves are now often held in licensed clubs, there have also been reports of increased alcohol use with dance drugs (Sawyer, 1992).

By 1993 it had been acknowledged in Scotland that no gulf existed between the so-called dance drugs and those drugs being used by problem drug users. The drug temazepam, in particular, was seen as being used in clubs as a cheaper alternative to ecstasy as well as an aid to come off dance drugs and induce sleep. In a response to this situation a leaflet, *Jelly Time*, was produced to highlight the dangers of temazepam use (McDermott and McBride, 1993). Although this leaflet used the cartoon format of *Peanut Pete*, a radical new approach lay behind its production. The *Jelly Time* leaflet was produced by a group known as *Crew 2000* as part of a peer education initiative. *Crew 2000* is a group of young adults involved in the Edinburgh dance scene. Their aim is to provide ravers with the information they need without the direct involvement of drug agencies who may be viewed as being distant from the dance drug scene. In Chapters 3 and 5, the use of hard drugs by dance drug scene participants will be discussed further.

Another change, brought about by the arrival of dance drug users at agencies, has been the nature of their legal problems. Dance drug users were thought to be suffering the backlash of years of drugs being cited in court cases as mitigation by agencies (Gilman, 1991). In other words, opiate users often contacted drug agencies when legal problems arose which were associated with acquisitive or violent crime. These legal difficulties were allegedly committed either in order to feed an addiction or were caused by drug intoxication. The role of the drug agency was to present these clients as 'victims' of

'evil' drugs and 'non-addicted' drug dealers, in order that the courts would deal with them leniently. 'The drugs made me do it' has become an acceptable excuse which has been extensively utilised by opiate using criminals to explain their anti-social behaviours. This explanation absolves the criminal of responsibility for his/her actions (whether drug related or not) when explaining these actions to non-users, such as drug researchers, agencies, families, social workers, police, lawyers, judges, jurors and prison staff. By extending this logic, if drug 'addicted' burglars, shoplifters, muggers, robbers and murders are the victims, then who are the villains? Unfortunately, non-addicted, non-violent, honest drug users, such as ravers, are left to carry the burden of responsibility for these crimes. However, unlike the petty offending of daily opiate users, 'ravers' legal problems are of a much greater magnitude. In the extreme, commonplace charitable acts among empathetic dance drug users, such as sharing ecstasy with a loved one, could theoretically result in life imprisonment. When the main problem presented by one client group (i.e. the criminalisation of dance drug users by application of the Misuse of Drugs Act) is at odds with the interests of another client group (drug addiction amongst criminals), agencies are presented with yet another dilemma. Lifeline's Mark Gilman, (1991) resolves this by stating that "Drug user dealing may be seen as victimless crime, but by no stretch of the imagination could this be extended to burglary".

Concerns over drug use at night-clubs has led to many dance venues losing or being threatened with revocation of their licences. In response, some clubs have employed drug workers to monitor activities at their rave events (Newcombe, 1991b & 1992b). Such work has identified a relatively low incidence of problems (e.g. disorder, overt drug taking, ill health) at such events, as compared with other (alcohol orientated)

dance scenes, such as discos. The final chapter of this thesis will discuss the implications of this new form of drug use to agencies and policy makers.

Problems requiring investigation

Having reviewed the literature relevant to the dance drug scene, this chapter has outlined current knowledge of this topic. Several gaps in this knowledge have been noted which require further research. Clearly there is a need to identify and quantify patterns of drug use in the dance scene and to explore what the implications of these might be. In order to meet these objectives, data were collected from a sample Glasgow dance drug scene participants (ravers). Chapters 3 to 7 of this thesis will present data that sheds light on the following problems:

- What are the characteristics of participants in the Glasgow dance drug scene and how do they compare with other drug using groups?
- What are dance settings like and what behaviours, other than drug use, does raving (dancing at these) involve?
- Which drugs are related to involvement in the dance scene and which are not?
- Are dance events centres of drug selling; if not from where and how do dance event attendees obtain their supplies?
- Do dance drug users consume ecstasy in the belief that it is MDMA or is it the drug's effects, associated with the dance scene, that they are 'buying'?

The next chapter will describe the methods employed in conducting this research, the results of which will be reported in subsequent chapters of this thesis.

CHAPTER 2

STEPPIN' OUT: METHODS OF DATA COLLECTION AND ANALYSIS

Introduction

The aim of this thesis is to identify and quantify patterns of drug use in the Glasgow dance drug (rave) scene. In order to achieve this aim the methods below were employed:

- **Initial period of field observation.** A reconnaissance of the dance drug scene.
- **Structured questionnaire.** An instrument designed from a review of the relevant literature and from field observation.
- **Piloting.** Questionnaire piloted with users and non-users of dance drugs.
- **Key informants.** Persons contacted during observation phase, whose specialist knowledge of the dance drug scene allowed them to act as finders of potential respondents.
- **Publicity flier.** A technique used to assist in sample recruitment utilising the information technology of the dance scene.
- **Sampling Strategy.** Multi-site access to create 'networks' or snowballs of respondents and the monitoring of these for quality control.
- **Interviewing of respondents.** Data collection carried out in private by one to one interviews.
- **Quantitative analyses:** using descriptive and inferential statistical techniques, on appropriate micro-computer package.

These methodologies were chosen because from the literature described in Chapter 1 it was clear that there had been little empirical research carried out in the dance drug scene. Much of what little scientific research that has been undertaken is qualitative (notably that of Sheila Henderson, 1992, 1993a, 1993b, 1993c, 1996), whereas this study adopted a mainly quantitative approach. The paucity of research generally in this area is perhaps a result of the fact that only a few dance drug users are in contact with drug agencies. Not only does this give the impression of there being no problems requiring investigation, but it also means that there has been little opportunity (or will) for researchers to undertake even the most basic 'head counting' exercises of dance drug users. This has led to the understanding of the scene by outsiders being limited to media or other anecdotal accounts.

Plan of investigation

To explore patterns of drug use in the dance (rave) scene it was intended to recruit and interview a sample of dance event attendees. Entry criterion for inclusion in this sample was simply any participation in the Glasgow dance drug scene. Despite the limitations of time and resources (detailed later in this section) it was hoped to be able to recruit more than one hundred such respondents. These persons would be interviewed irrespective of any prior knowledge about their drug use. This (blind) interviewing method was chosen to maximise the likelihood that the eventual sample would include as wide a range of drug use patterns as might be found within the local dance scene, including non-users (controls). This was done in preference to targeting certain types of drug user, such as heavy ecstasy users. Had this been done, it would have produced a biased distribution of drug use among dance drug event attendees. In practice no respondent had a lifetime free from illegal drug experience, though this

varied in the extreme from once ever (childhood) use of psilocybin mushrooms to current daily use of opiates.

There are two problems that make it difficult for the researcher to recruit respondents from the dance drug scene:

i) Much of what raving (participation at dance drug events) involves is illegal. Most of the drugs used are illegal, especially the so-called dance drugs. Many dance events are also illegal or unlicensed by the appropriate local authority. In short, both dancing and drugs are to some degree secret activities. This was acutely so at the time of data collection (December 1993 to August 1994). Following several much publicised deaths, a moral panic ensued in which both the drugs (particularly ecstasy) and the dance scene were under attack from the press, politicians and police (*Daily Record*, 1993a & 1994a; *Evening Times*, 1994a). This served to drive such activities further 'underground' and make dance drug users a difficult to reach group.

ii) Unlike other drug using groups, the dance drug users were not appearing in official statistics. Unlike the heroin users of the 1980s, dance drug users were not usually visible at drug problem agencies, hospitals, prisons or needle exchanges (Gilman, 1991; McDermott et al, 1992a). Also the relative novelty of the scene meant that there were no established meeting points for such people other than the dances themselves. For these reasons the dance drug users can be described as a hidden population, that is, a population without a retrievable sampling frame.

One method that has proven to be a powerful research tool, which can overcome the difficulties presented by hidden or hard to reach populations, is 'snowballing'. An example where the snowballing method has been used to obtain a sample of 'invisible' non-deviant drug users is research undertaken by Cohen (1989). Working in Amsterdam, Cohen created 'snowball chains' of cocaine users by getting respondents

to nominate other potential interviewees from among their peer group. In this way cocaine users who were hidden from the official statistics were contacted. The sample Cohen recruited was found to differ from the low social class deviant drug users who might have been obtained had it been treatment based.

In the present study, it was intended to recruit respondents via a combination of purposive snowballing and using key contacts active in the dance drug scene, that is, employing a few individuals to act as recruiters of respondents. The use of key informants does not in the strictest sense produce a true snowball. Instead of a snowball, where a chain develops from one user to the next, this method produces networks of individuals who were in the social orbit of each key contact. A diagrammatic representation of this method (as shown later in Figure 2: 1) reveals a side-ways spread of new recruits from the key contact rather than a downward line from one new contact to the next new contact. However, using this method also left some scope for downward (snowball) chains to develop from finders to recruits to persons contacted by recruits. Bearing in mind these qualifications, the term network (rather than snowball) chain will be used to describe the associations between finders and respondents in this thesis. The advantages of using this key informant approach is that it allows a great variety of differing respondents to be recruited quickly and ensures against some of the biases found in downward chain referral (Griffiths et al, 1993). Suitable key contacts should be people who 'worked' in the dance drug scene and had access to a large number of different types of dance drug event attendees. Persons such as DJs, electronic musicians, youth workers or drug dealers would make ideal recruiters for this study.

It was not intended to produce a definitive sample that could be described as representative of the Scottish dance scene. However, as will be detailed later in this

section, during fieldwork every attempt was made to increase the representativeness of those surveyed within the particular dance scene population from which they were recruited. Prior to commencing fieldwork, it had been estimated that half a million people were using the drug ecstasy at night-clubs in the UK each weekend (*Economist*, 1993). If this is true then it implies around 50,000 such users in Scotland. With the addition of occasional ecstasy users, users of other dance drugs and non-users who attend dance drug events, it is clear that the number of people involved with the scene is very large; so large that any attempt to obtain a truly representative sample of the Scottish dance drug scene, by snowballing or by key informants, would require a large number of entry points (more entry points than there are respondents in this sample). Such a large number of potential respondents would also indicate a diverse typology of dance drug users. In other words, a question such as "what is a typical ecstasy user like?" may be on a par with the question "what is a typical alcohol user like?" The alcohol/ecstasy analogy may be extended to one between dance drug event attendees and public house patrons.

Instead, an intensive method of investigation looking at one group of dance drug users was envisaged. This method has previously been successfully employed by Hammersley et al (1990) to obtain a sample of new and hidden (problem) drug users in Glasgow. In such definable groups, users can be directly compared with their peers in context. This method overcomes problems with unrelated small groups of drug users (snowballs) in which differences in drug use may be due to the context of the scenes in which they were taken. This problem is illustrated by the possibility that different drugs may be used as dance drugs in different populations, dependent on local fashion, availability or social norms of the group. This is especially the case when drug use is associated with the rapidly evolving world of youth fashion as in the dance drug scene.

For example, James (1994) details a changing pattern of dance drug use in England, where cocaine rather than temazepam (as in Scotland) is identified as a potential route into problem drug use.

It was decided to obtain the sample from within a small geographical area known as the West End in Glasgow. There were two reasons for this:

i) This is an area with a lay reputation for dance drug use (the 'West End Scene'). The styles of what might be termed as rave fashion (record shops, fashion stores etc.) are more obvious in this area than in other parts of the city. There are several dance venues in the area, which is also close to the city centre and its night-clubs. Illegal rave parties were also known to take place at locations in the West End, including disused railway tunnels (literally underground parties), warehouses and old tenements. The organisers of Glasgow's leading illegal rave party group live in the area, as do several well-known DJs. An example of this area's emerging reputation is to be found in a November 1988 flier for a city centre night club (referred to as club *Saturn* in later chapters) which states "THE WEST END POSSE BRING YOU A FRIDAY NIGHT ACID HOUSE CLUB, **ecstasy fridays can u feel it**".

ii) In the past, official statistics (Haw, 1985) indicated that this area had the highest levels of drug use in the city prior to the advent of widespread problematic drug use in the early 1980s. Despite this, in the years which followed, relatively few problem drug users (opiate and benzodiazapine injectors) have been recorded as being resident in this area (Haw, 1985; Frischer, 1995). Such users were more typically resident in deprived housing estates. More recently, the Scottish Crime survey 1993 indicated that areas such as the West End (inner city, non-deprived) had the highest levels of drug use in Scotland (Hammersley, 1994). Again, only the so-called problem drugs were more commonly found in other types of area, that is in the most deprived housing estates.

Furthermore, the 1991 census data indicated that the West End had a high proportion of persons in the 15 to 34 year old age group (McLoone, 1994), the likely age range of most dance drug users.' Fieldwork in such an area would seem likely to uncover a large number of dance drug users, without the sample being contaminated by problem drug users who may only use dance drugs occasionally.

Field observation

To serve as a reconnaissance, a period of field observation of the West End dance drug scene was undertaken. This phase of research was intended to familiarise the author with the dance drug scene and therefore identify topics for research to be included in the interview schedule. Another function of this fieldwork was to contact persons who might act as key informants in the recruitment phase of the study. This method of familiarisation was important for studying this style of drug use because, as detailed in Chapter 1, there was little scientific literature describing the scene at that time. In contrast, popular magazines such as *M8*, *Eternity*, *Mixmag* and *DJ* were purchased and found to contain much information (even if these were somewhat anecdotal). By observing the dance scene in this fashion, issues concerning drug use in the dance scene were identified which could be incorporated in the questionnaire. This period of initial exposure also provided a sketch of the sort of persons who might become future respondents. Field observations were begun two months prior to commencing interviews. This was done in advance of any interviewing to maximise the chances of the author retaining anonymity. This was deemed important so dance drug event attendees would not modify their behaviour in the presence of a researcher. Despite this, at the second dance event attended, a party-goer (who later became respondent #005) approached the author and said "so you're the guy from Glasgow

University with the big arrow pointing at his head". During this phase of the research several night-clubs, raves and house parties were attended by the author (who had never been to such events before this study). Included in these were events held in city centre night-clubs (including respondents' most popular clubs *Saturn*, *Pluto* and *Ariel* detailed in Chapter 4), licensed raves (in and out of town), an illegal rave in a disused railway tunnel and DJayed parties in people's homes. These were attended both with and without the company of persons who later became key informants. As previously found by Morrison (1988), this combination of participant observation and key contacts also proved useful in allaying respondents' fears concerning confidentiality and that the researcher was not a police informer.

Structured questionnaire

Directly observing the dance scene greatly assisted in constructing the research instrument to be used in this study. This was a structured questionnaire that was developed in order to obtain quantitative data. The formats used were derived from existing drug questionnaires to make results from this study comparable with other Scottish drug research. The questionnaire was designed to measure all aspects of the dance scene covering all the areas listed below:

- **Demographic questions.** These included both standard (e.g. age, sex, income and occupational social class) and non-standard items (e.g. lifestyle, gender-orientation, spending and criminal activity).
- **Dance scene questions.** These were designed to measure involvement with dance culture and detailed many aspects of dancing behaviours (e.g. duration of activity and preferred style of dance music).

- **Questions about dance events.** These enquired about the venues which respondents had attended (e.g. type of event and if there was free water available).
- **Drug use questions.** These asked about the use of sixteen specific categories of drugs and up to three other drugs not listed. These were in a format that has often been used in previous Scottish drug research to measure levels of drug involvement (e.g. frequency of use and dosage). These questions were structured in such a way as to be directly comparable to those already asked about frequency and cost of dance event attendance.
- **Questions about circumstances of drug use.** These were open-ended questions which asked for the setting where each drug was last used and about how each drug was obtained (e.g. where from and at what cost).
- **Ecstasy drawing sheet.** A self-complete section inviting respondents to describe the drug most closely associated with the dance scene. This was self-complete because it involved respondents actually drawing the appearance of each tablet as well as describing its appearance and effects. All other questions were asked and recorded by the interviewer.

Some of these questions were pre-coded, such as those with 'yes' or 'no' answers and those with a limited number of responses (e.g. respondents' housing tenure). Most questions in this study were open-ended. These were either questions with structured replies, such as the number of days last year when alcohol was consumed (range 0 to 365) or truly open-ended questions which had to be post-coded. Examples of these include questions asking for respondents' favourite type of music or what it is they like about dance events, if anything.

Piloting

The questionnaire was piloted to screen for any mistakes, omissions or unnecessary questions and check that there were no practical difficulties in administration, such as it being too long. Suitable subjects for a short pilot study were found in Edinburgh, so as not to contaminate the Glasgow dance drug scene. These were four members of a 'peer coalition' drug using group who were well known ecstasy users and two persons who held DJayed parties in their house and who used drugs other than ecstasy. It soon became apparent that few changes were required of the questionnaire, the main change being there was no need to ask the price of each ecstasy tablet in the self-complete section since this was invariably fifteen pounds.

Key informants

Though the key informants took no part in interviewing any of the respondents which they recruited, this method is similar to that known as privileged access interviewing (PAI). Using key informants to recruit potential respondents, as in this study, is governed by similar methodological and practical issues to those of PAI studies (see Griffiths et al, 1993, for review). These issues include finding suitable key informants, respondents' representativeness and monitoring of sample development, which will each be discussed later in this chapter.

Identification of key informants was made during field observation in the dance scene. Fourteen key contacts were made, each of whom functioned as recruiters. Hereafter these individuals are referred to as finders and are given an alphabetical code name. For example, the most successful of these was finder *P*. Each finder generated a network of respondents, which could vary in length and complexity depending on his or her success rate of recruitment. These networks were each given their finder's code

letter (e.g. finder *C*'s network is called network *C*). These networks are shown in Figure 2: 1. From this, it can be seen that some respondents were recruited directly from the finder (key informant method), and others indirectly via other respondents (snowballing). As shown in Figure 2: 1, four of these finders were in fact pairs of individuals, who worked together as a team (e.g. *A* & *D*). Only one finder (*D*, $n = 2$) was personally known to the author prior to the onset of research (though finder *P* was known by reputation). Among finders, it transpired that *P* knew *B* and *F* knew *D* prior to fieldwork, though most met at least one other finder for the first time during the course of the study.

Finders had an age range between 18 and 43 years. Six were female, seven male and one a mixed team. Each finder was qualified to access different entry points into the West End dance drug scene. This can be illustrated by taking the six finders who recruited the most respondents as examples (networks $N > 10$). Finder *P* was the flat-mate of an internationally famous DJ whose local celebrity status allowed access to a wide range of dance scene participants. Finders *A* & *D* were psychiatrists with a keen interest in dance drugs. Finder *B* was an electronic musician, who also organised illegal 'crustie' raves and ran a pirate radio station. Finder *S* was a youth worker who ran (legal) raves at a youth club. Finder *C* was involved in the dance scene through art, the media and organising parties. Finally, finders *F* & *E* had conducted a student project into ecstasy use. All six main finders were themselves active in the dance scene. Each finder was paid £5.00 'bounty' per respondent.

Publicity flier

In order to recruit a wide range of potential respondents, these finders were given publicity fliers about the study. Fliers are advertising hand-bills which are given out free to publicise events or places (see Chapter 1). The intention was that finders would go to dance events armed with these and give them to anybody who might be interested in taking part in the study. The idea for using such fliers, rather than business cards, came from the work the Mersey Drug Training and Information Centre, Liverpool (MTDIC). Taking the form of a glossy club flier, a drug information leaflet *Chill Out*, was successfully distributed by the MTDIC (McDermott et al, 1992b). This method contacted ravers by using the iconography of the dance drug culture itself (see Chapter 1). Fliers have always been the dominant publicity medium for raves, night-clubs, illegal parties and dance music acts (Rose, 1991; Beddard and Parkes, 1995).

The advent of desk-top publishing at the same time as ecstasy and the dance drug scene has wedded fliers into the culture. Fliers are designed with attractive, often drug-related, imagery to encourage ravers to keep and collect them. In this way, the information on the flier is retained rather than forgotten as may inevitably be the case with verbal communications during a night dancing on drugs. By adopting this method it was hoped that potential respondents would be attracted to the study through it appearing 'rave friendly'. Also if they kept my flier it might keep them motivated and remind them of interview appointment dates. A flier was commissioned by the author and produced by a graphic artist known to be capable of producing such material. The study's flier was in day-glo bright colours and contained a map of how to get to the university and a contact telephone number. The flier also had drug related imagery such as smiley faces, doves (a brand of ecstasy, see Chapter 7) and the letter "E", in perhaps a more overt fashion than many clubs would have used by the mid-1990s. Even the name of the university building in which interviewing took place, the Adam Smith Building, was used in this. The name 'Adam' is a nickname for the drug ecstasy. Four versions of this flier, each with a seasonal theme, were designed as the location of interview and contact phone numbers for the study changed. The winter version of this flier is shown in Appendix I (both sides, not in day-glo colour). It is impossible to measure the impact of this method on recruitment, but the fact that this flier was observed on the walls and mantelpieces of respondents' bedrooms (as a part of their flier collection) indicates some degree of success. After interview respondents were also given a 'souvenir' flier to encourage snowball development.

Sampling strategy

Initially finders brought respondents to the university for interview. As a momentum developed, more than one potential respondent began to arrive at the same time, usually unaccompanied by their finder. If there were not sufficient persons available to act as interviewers, extra respondents were turned away. At one point the author's diary was fully booked with potential interviewees for two weeks in advance. Booking was then restricted to no more than two weeks in the future, as it was feared respondents might forget their appointment time. The number of potential respondents lost because of this unexpected problem is not known. Mid-way through recruitment ($n = 73$), it became no longer possible to interview on campus. From this point onwards, the time and place of interview was arranged over the telephone by the author. This slowed the recruitment process to a more manageable rate, but may also have resulted in the loss of some potential respondents who would have preferred to be interviewed on campus.

Sample monitoring and quality control

Though successful in obtaining a sample of dance drug users, these methods have a potential bias, in that results obtained may be limited to the specific group contacted. However, the sampling of naturally occurring drug using units may not always be a disadvantage when making population inferences (Kaplan et al, 1987). There may have been greater biases had this sample been obtained via drug agencies, or many unrelated small networks. A diagrammatic representation of the recruitment of this sample is given in Figure 2: 1. In this figure respondents are represented by male or female symbols with their subject number (order of interview) contained inside. These are connected to finders, represented by rectangles, in a family tree fashion, similar to that

produced by Wright et al (1991) in their sample of non-arrested burglars in St Louis USA and that produced by Ditton et al (1996) for Glaswegian cocaine users. Arrows leading off from some respondents and finders indicate known overlaps between different networks.

The composition of the main networks ($n = 10+$) is shown in Table 2: 1 below. During fieldwork, Table 2: 1 was continuously updated to monitor the development of the overall sample. This was done as a quality control measure to ensure that the sample would not become biased or unrepresentative of West End dance drug users. This is particularly important given the differing numbers of respondents that each finder was likely to bring. The headings in Table 2: 1 were the criteria used to ensure against such problems developing. From this it was possible to spot if any of the finders were bringing bias into the sample (e.g. only recruiting male respondents).

Table 2: 1, Profile of Main Networks

FINDER / NETWORK	SEX (% male)	AGE mean/range	SOC. CLASS mean mode	OCCUPATION (% in each)	OVERLAP (Networks)
<i>P</i> (<i>n</i> = 43)	67.4	25.9 18 - 41	IIIN II	work 14.0 study 16.3 benefit 58.1 other 11.7	<i>A & D</i> <i>B</i> <i>S</i> <i>C</i> <i>F & E</i> OTHER
<i>A & D</i> (<i>n</i> = 15)	46.7	23.1 18 - 31	IIIN II	work 46.7 study 20.0 benefit 13.3 other 20.0	<i>P</i> <i>C</i> OTHER
<i>B</i> (<i>n</i> = 15)	66.7	20.6 16 - 26	IIIM IV	work 0 study 46.7 benefit 46.7 other 6.7	<i>P</i> <i>F & E</i>
<i>S</i> (<i>n</i> = 13)	76.9	19.3 14 - 43	IV IV	work 7.7 study 23.1 benefit 53.8 other 15.4	<i>P</i> <i>F & E</i>
<i>C</i> (<i>n</i> = 13)	53.8	25.7 22 - 33	IIIN II	work 30.8 study 38.5 benefit 15.4 other 15.4	<i>P</i> <i>A & D</i>
<i>F & E</i> (<i>n</i> = 10)	40.0	28.0 22 - 37	IIIN II	work 40.0 study 0 benefit 30.0 other 30.0	<i>P</i> <i>B</i> <i>S</i>
OTHERS (<i>n</i> = 26)	65.4	23.6 18 - 44	IIIN II	work 15.4 study 38.5 benefit 34.6 other 11.5	<i>P</i> <i>A & D</i>
TOTAL	62.2	24.7 14 - 44	IIIN II	work 19.3 study 26.0 benefit 40.7 other 14.1	

There are two potential sources of bias common to both the method described above and other forms of snowballing. The first such bias is often known as ‘island models’ (Rapoport, 1957). The West End of Glasgow is quite distinct from other parts of the city and as such social networks of individuals living there are likely to be confined to or at least concentrated in this geographical area. If this applies to dance drug users, then few recruits made by the West End based key informants should live, or more importantly be part of social networks, in other localities. Given the social aspects of dance drug use it was expected that participants in the local scene would often be well known to each other, regardless of their demographic backgrounds. Indeed, as will be shown in Chapter 4, respondents often cited social reasons such as meeting people, as the thing they liked best about the dance scene.

In practice this research indicated that West End dance drug attendees did resemble an island group. As will be elaborated in Chapter 3, very few respondents lived far from the target area. Within the sample there was a great deal of overlap between respondents from different finders or networks. Table 2: 1 details such overlaps for all the main finders’ networks (those with more than ten respondents). In this table the eight smaller networks (*U*, *A & S*, *X*, *F*, *P & F*, *A*, *L* and *D*) are listed together as ‘OTHERS’.

In Table 2: 1 it can be seen that there were many examples of overlap between these acquaintance circles (networks). This included connections between individuals who were currently acquainted, but also persons who became acquainted after they had been interviewed. Examples of this, respondent #028 from network *U*, being an ex-partner of #055 from network *P* or that #007 (network *P*) became the partner of #108 (network *F & E*) some time after they were interviewed. That so many overlaps between networks were found indicates a high degree of extended peer group

interconnections within the West End scene. Indeed, finder *F* complained that many of the dance drug scene attendees which she asked had already been recruited by finder *P* (this even though neither of these finders were aware of the other prior to involvement in this research). Whether their common nominees were as a result of 'force field bias' (Rapoport, 1957), that is they both knew the most prominent characters on the scene, is not known.

The second source of potential bias with snowballing and key informant recruitment methods is that finders might tend to nominate people like themselves for interview. This has previously been shown to be the case in studies using a chain referral snowballing method. In such studies respondents tended to nominate their partners or siblings who had similar social if not drug using characteristics (Cohen, 1989). When the author found any look-alike chains generating they were terminated. These were recognised by continuously monitoring each network's development, to ensure, for example, that a chain of students did not develop. It was hoped that using key informants with access to many types of dance drug user would help to overcome this. This method would certainly overcome problems associated with 'social distance bias' (Rapoport, 1957). This bias involves having too many respondents who were their finders' partners or siblings.

The social characteristics given in Table 2: 1 were continuously checked to see if any look-alike chains were being generated. For example, a chain composed of respondents on benefit from an unemployment finder or an all-female chain, would seem likely to be introducing look-alike bias into the sample. As can be seen in Table 2: 1 this was not usually the case. The social characteristics of each network broadly overlapped. The exceptions to this were networks *B* and *S*, which appeared to be younger, more male and more working class than other networks. In the case of network *B*, a snowball

chain of (young) students was developing (though the finder was recruiting many non-students). In network *S* the finder was recruiting only males (though his recruits snowballed some female respondents). For these reasons these networks were terminated to ensure against biasing the overall sample profile. It should be noted that, despite these concerns both these networks did have some older, female or more middle class respondents (which assisted in deciding the optimal time when to terminate these networks). It may also be the case that the lower occupational classes of respondents from these networks was caused by their youth (having not yet reached their full occupational potential) rather than because of a true class difference. This tendency, for older drug users to snowball to younger ones, has been noted previously in a study of Dutch heroin users (Kaplan et al, 1987). All main networks had respondents from both sexes, an age range of ten or more years and respondents from a variety of social class and occupational backgrounds. There were two exceptions to this. Firstly, network *F & E* had no students. This was surprising (though perhaps fortunately so) given that their involvement with the scene was through student research. Secondly, finder *B*'s network had no employed respondents (unfortunately living up to his crustie stereotype).

In fact all networks showed a great deal of diversity. This was especially so with the finder *P*'s network. For example, on one (not atypical) occasion finder *P* brought two respondents, #057 and #058 together to the University together for interview. One of these was an unemployed 24 year old male, who 'worked' as a DJ and lived in a deprived area, the other was a 37 year old female solicitor, who lived in a affluent area. This is one of many examples of unusual peer associations found during the recruitment phase of this study. It is suspected that the disparate (bohemian) nature of

the local West End dance drug culture may have greatly assisted in producing such a diverse group of respondents by this method with the resources available.

One final potential source of bias lies in the inevitability that different finders will be able to recruit different numbers of respondents. The network generated by finder *P* was more than twice as large as any other network and so his respondents may have biased the eventual sample profile (whether they were acquainted with respondents recruited by other finders or not). With 43 members, finder *P*'s network had a sufficient number of respondents to allow statistical comparisons with the remainder of the sample. Such comparisons would test whether his respondents were different to those recruited by other finders in any systematic way (i.e. whether there was a finder *P* effect). When *P*'s recruits were compared with respondents recruited by other finders no significant differences were found in terms of sex, social class, being employed, being a student, living in a deprived area or on any income variables. There was a difference in unemployment, with 26.5% more of *P*'s respondents claiming to be unemployed ($X^2 = 7.91, df = 1, p < 0.01$). This discrepancy is most likely explicable by finder *P* being the first finder to bring in recruits. Respondents in the initial rush of recruits were typically unemployed people, who had fewer time constraints about when they could be interviewed. Finder *P*'s respondents were also slightly older (2.7 years, $t = 2.69, p < 0.01$). This age difference is not significant when respondents from the networks *B* and *S*, which were terminated because of young age group look-alikes, are excluded (1.2 years, $t = 1.24$).

When recruitment of the sample was completed, the respondents exhibited a great deal of diversity. This was true not only across the sample as a whole but also within individual finder networks. Such a diverse sample maximises the likelihood of

representative coverage of the target population and minimises the biases inherent in the snowballing and key access recruitment methods used.

Data collection

Data were collected from a sample of 135 respondents, who were interviewed between December 1st 1993 and August 31st 1994. The majority of the respondents ($n = 73$) were interviewed in offices at the University of Glasgow. The remainder were interviewed in their homes ($n = 29$), at a youth club in which raves were often held ($n = 10$), in the rooms used by the local health trust ($n = 22$) and in a private office ($n = 1$). Ninety-one (67.4%) interviews were undertaken by the author. The remainder were conducted by part-time researchers, employed by the University of Glasgow, who were trained in the use of the questionnaire by the author. Their assistance was particularly useful when more than one potential respondent arrived for interview at the same time. The author also 'sat-in' on all (during training) or part of many of the part-time workers' interviews. Only five respondents never (knowingly) met the author during fieldwork (#072, #080, #112, #120 and #121).

Interviews were conducted in private. The structured instrument was administered to each respondent. As well as questions relating to this thesis, the interview schedule also contained many questions relating to a Scottish Office Study of the socio-psychiatric consequences of MDMA use. An example of the questionnaire, as relevant to this thesis, is given in Appendix II. Interviews were conducted in private in a face to face, one to one basis. All participants were assured of confidentiality. Respondents' answers were recorded on the questionnaire by the interviewer, the exception to this being a self-complete section at the end of the schedule, which took approximately five minutes to complete. The mean duration of the whole interview was 103 minutes. This

total included time spent on questions asked on behalf of the Scottish Office ecstasy study (Ditton, forthcoming), which are not reported on in this thesis nor shown in Appendix II. Each respondent was paid £5.00 to cover travelling expenses. This money was from the Scottish Office study budget as was that used to pay bounty money to finders. After nine months, data collection was completed.

Quantitative data analyses

A coding frame was constructed from the answers (which were already not pre-coded) on the questionnaire. Numerical answers were coded as continuous variables with provision for missing data, don't know answers, refusals and mean substitutions, where appropriate. Verbal open-ended answers were reduced into categorical variables. All data were coded and entered directly from the questionnaire on to a PC computer spreadsheet. All statistical analyses were conducted using the SPSS for WindowsTM package (Nie et al, 1983). This package was also used to clean and logically validate the data before quantitative analyses were begun. Methods of data analysis included descriptive statistics (e.g. frequencies) uni-variant inferential statistics (e.g. *t*-tests) and multi-variant techniques (e.g. regression). Coding, data entry, cleaning and analyses were conducted by the author alone. The following five chapters will describe the results produced by these analyses.

CHAPTER 3

DIFFERENT CLASS: A PROFILE OF GLASGOW WEST END

DANCE DRUG USERS

Introduction

This chapter will report the demographics and levels of drug use of the eventual sample that was recruited using the methods detailed in the previous chapter. Specifically,

- The basic demographics of this sample will be summarised.
- Levels of drug use will be reported.
- Comparisons will be made between these respondents and those from other Scottish drug using samples, in terms of both demographics and patterns of drug use.
- Finally, this Glasgow dance drug scene sample is compared to other dance drug using research samples obtained elsewhere.

Any differences found between the dance drug scene sample and other groups of drug users will be explained in relation to, what is commonly termed, 'problematic' versus 'recreational' patterns of drug use.

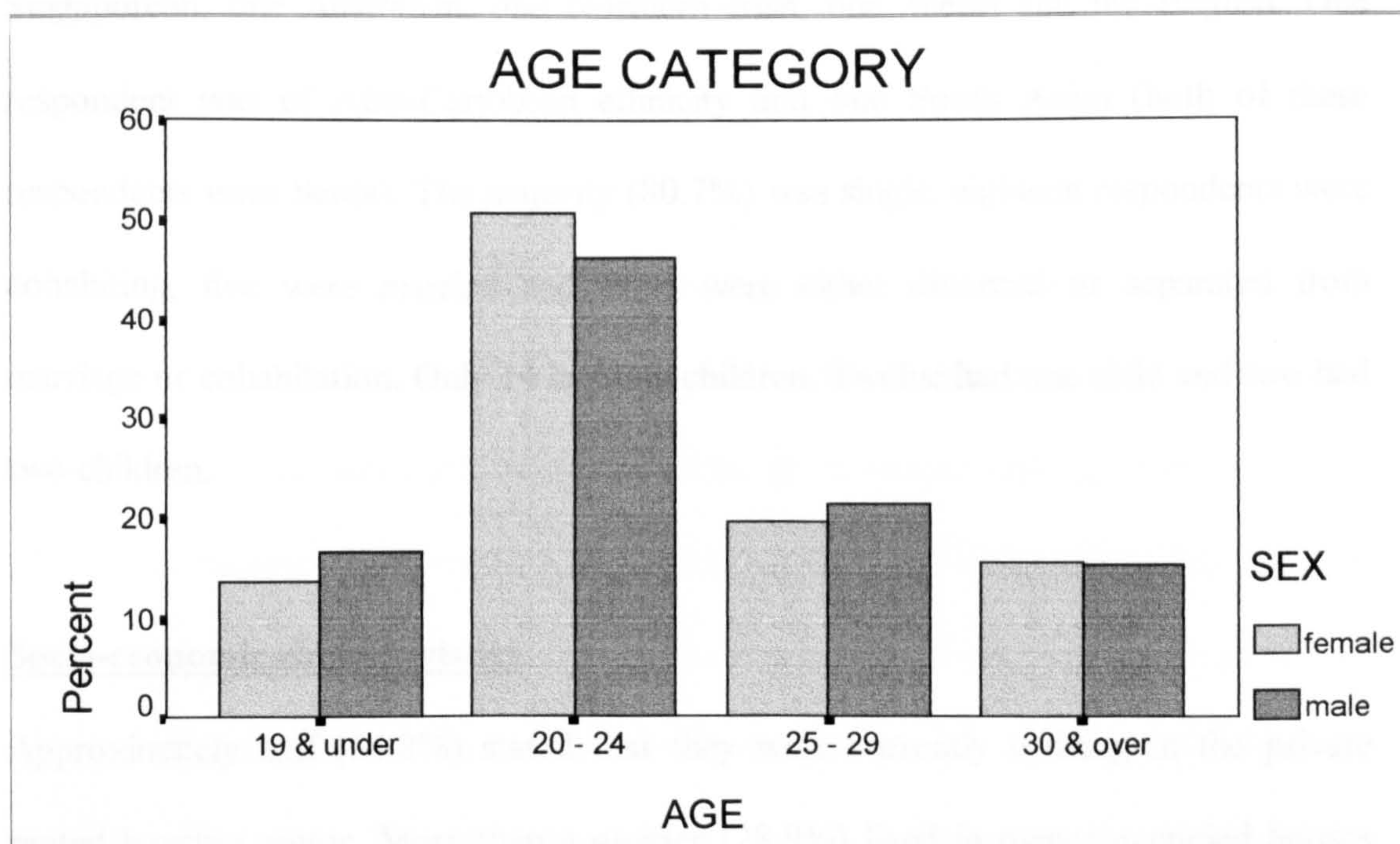
Demographic Profile

Basic demographics

The 135 respondents recruited had a mean age of 24.1 years (range 14 to 44). Twenty-one respondents were aged under 20 (15.6%), another 21 were aged 30 or

over, the remaining 93 (68.9%) were in their twenties. The age profile of the sample is shown in Figure 3: 1 below.

Figure 3:1, Age and Gender of Respondents



As can be seen in Figure 3:1, almost half the sample (48.1%) were in the 20 to 24 age group. Eighty-four (62.2%) respondents were male. From this figure, it can also be seen that the sex of these respondents did not vary by age group.

Respondents' current age was compared with the advent of the dance drug scene. From Chapter 1, it can be assumed that the onset of the acid house scene in Glasgow was some time during 1988. Sixty-two (45.9%) respondents were aged 18 or over (age of legal entry to licensed night-clubs) by the end of 1988, the remaining 73 would be younger than this when the scene began. The differences between this younger group of respondents who grew up, came of age (and began drug use) after the advent

of the dance drug scene and the older group who did not will be elaborated on in the next two chapters.

Almost all of the sample were white (98.5%). Of these whites, fifteen (11.1%) described themselves as being non-Scots. These included one American, one Singaporean, one Australian, one Northern Irish, one Welsh and ten English. One respondent was of Afro-Caribbean ethnicity and one South Asian (both of these respondents were Scots). The majority (80.7%) was single, eighteen respondents were cohabiting, five were married and three were either divorced or separated from marriage or cohabitation. Only 14 had any children. Twelve had one child and two had two children.

Socio-economic characteristics

Approximately half (54.8%) stated that they were currently residing in the private rented housing sector. More than a quarter (28.9%) lived in owner occupied houses and 14.8% lived in either local authority or housing association accommodation (council housing). Almost two thirds (64.4%) of respondents lived in their own home, 12.6% lived in a friend's or partner's home and 20.0% of the sample lived in their parental home.

Only 19.3% of respondents were currently in full-time employment. To these could be added 5.2% who were currently on government employment training programmes. Two-fifths of the sample (40.7%) were currently unemployed and another 3.0% were either in receipt of sick benefit or were disabled. More than one quarter was in full time education, comprising 23.0% who were attending university or college and 3.0% who attended secondary school. Eight respondents had other employment status (e.g. house-person or full-time drug dealer).

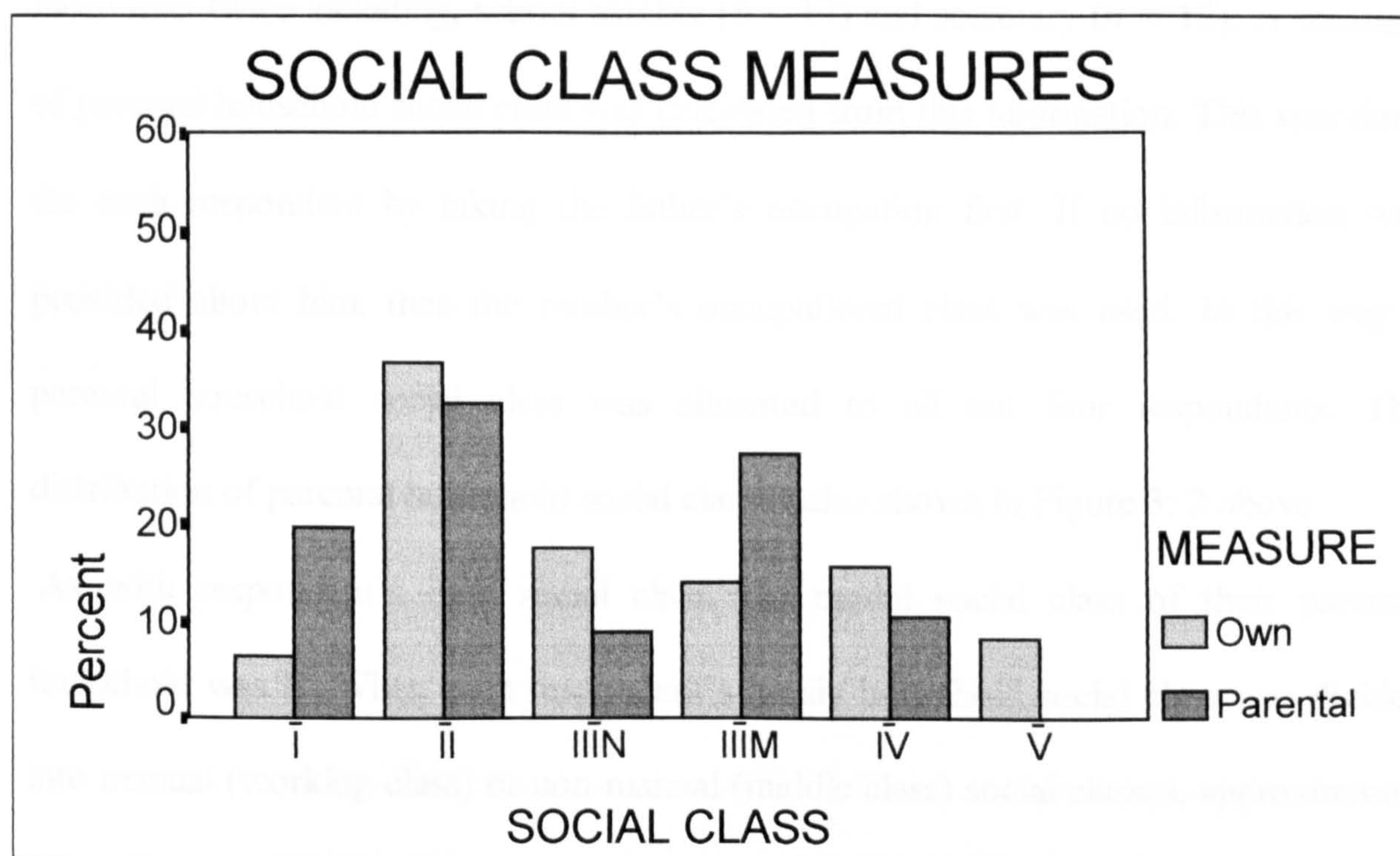
The mean numbers of Ordinary/Standard Grades and Higher Grades obtained by the sample were 5.7 and 2.9 respectively (these figures include those with none, such as those still at school and yet to sit). In total, 108 respondents were either currently in or had been in further education (i.e. 82.4% of the sample when the four respondents who were still at school are excluded). Twenty-eight respondents had successfully obtained a degree. Thirteen were either still studying for a degree or had sat a degree course but had not yet successfully graduated.

Of those who were currently in work only one occupation, advice worker ($n = 5$), was cited by more than two respondents. Of those not currently in full time employment 64 had previously been in full time employment. This figure comprises 46 (83.6%) of those currently unemployed, nine students and nine others. The range of previous jobs was equally varied, with only shop assistant ($n = 5$), chef (4) and retail manager (3) being cited by more than two respondents. This apparently high level of unemployment in the sample masks a large number of respondents (26.7% of the whole sample) who were working on the side. The range of jobs done on the side by these 36 otherwise unemployed respondents probably reflects opportunities in this 'grey-economy'. Half of these were in the service sector, such as bar worker ($n = 4$) and kitchen hand (3). However, half of the respondents working on the side were employed in jobs in the dance drug scene (excluding licensed trade employees and drug dealers). Nine respondents said they worked on the side as a DJ (one other respondent DJayed full time and one was a former DJ). Nine respondents had other dance scene jobs on the side, such as lighting operator, party organiser, press officer, (electronic) musician, band manager and vocalist. Clearly the dance drug scene can be seen as an employment opportunity for some people and has been identified as an ideal line of work to do whilst continuing to claim benefits (*Mixmag*, 1997). That so many

respondents should be working in the scene is unsurprising, given the aims of this thesis and methods of sample recruitment employed. An analogy may be drawn with research into other recreational activities. For example, in a study of football culture recruited through (sports) clubs, it would be unusual if some respondents were not involved in the game. Respondents in such a study might include persons working as trainers, grounds staff, agents, and especially players (part-timers, professionals and amateurs).

All jobs mentioned by respondents, including part-time work, previous work and work on the side, were allocated to a social class. The Registrar General's system of occupational classification was used (OPCS, 1991) to measure each respondent's social class. This was calculated by taking respondents' current job first. If the respondent was not currently working (either full time or in government sponsored training) then their previous occupation was taken. If the respondent had only ever worked on the side then this job was used. In this way 80.3% respondents were successfully allocated to a social class. The distribution of respondents (own) social class is show in Figure 3: 2 below.

Figure 3: 2, Respondents Own and Parental Social Class



From Figure 3: 2, it can be seen that the modal social class was II (36.8%). When each respondent was classified as being in either a non-manual social class (I to IIIN) or manual social class (IIIM to V), a majority of the sample (61.3%) can be described as non-manual social class (i.e. middle class). The remaining 38.7% of respondents can be described as manual social class (working class).

As the sample was of relatively young age, with many in full-time education, it is possible that the above social classes may not accurately reflect full employment potential (i.e. true social class). To check for this possibility, respondent's parental social class was also measured. When asked to provide their parents' main lifetime occupations, 94.8% of the sample provided sufficient information about their father and 81.5% their mother. Of the fathers' occupations given, ten jobs were cited by more than two respondents, including building company owner ($n = 8$) and university lecturer/professor (6). Interestingly, one respondent gave his father's occupation as

national radio DJ. A similar pattern was found with mothers' jobs, seven being cited more than twice including, school teacher ($n = 17$) and secretary ($n = 12$). A measure of parental household social class was calculated from this information. This was done for each respondent by taking the father's occupation first. If no information was provided about him, then the mother's occupational class was used. In this way a parental household social class was allocated to all but four respondents. The distribution of parental household social class is also shown in Figure 3: 2 above.

As with respondent's own social class, the modal social class of their parental household was II. When each respondent's family household social class was divided into manual (working class) or non-manual (middle class) social classes, approximately the same proportions of non-manual (61.8%) and manual (38.2%) classes were obtained. It is concluded that, despite the unusual diversity of respondents' occupations their own social class accurately reflects their true status.

Respondents were also asked about their income. As might be expected this varied greatly according to their employment status. Seven discrete sources of income were recorded, plus an 'other' income category; details of these are shown in Table 3: 1 below.

Table 3: 1, Respondents' Sources of Income

SOURCE	No. in RECEIPT	MEAN/WEEK	RANGE
Full-time work	26	£116.85	£10.00 - £400.00
Part-time work	17	£33.18	£9.00 - £80.00
Work on-side	41	£45.20	£4.00 - £300.00
Student grant/loan	28	£42.75	£4.00 - £125.00
State Benefit	72	£42.44	£7.00 - £84.00
Acquisitive Crime	8	£30.75	£1.00 - £70.00
Drug Dealing	17	£92.06	£8.00 - £500.00
Other	40	£43.43	£1.00 - £250.00
TOTAL	135	£107.82	£0.00 - £590.00

Three respondents stated that they currently received no income. Many respondents received income from more than one source. For example, part-time employees tended to also be students. One respondent (#042) refused to say how much he earned from drug dealing. In calculating his total income, his drug income was mean substituted to £92.06 pounds per week, though it is strongly suspected he earned considerably more than this. Other income includes allowances from parents, gifts and investments. From Table 3: 1 it is clear that drug takers in this sample do not typically fund their use from acquisitive crime (other than working on the side or drug dealing).

Another statistic commonly used to measure affluence is car ownership. Only nineteen respondents were currently car owners, though others stated they had owned a vehicle in the past. This finding is not unexpected, as car ownership in the West End and similar areas is low (McLoone, 1994) because of ready access to city centre facilities and the deterrent effect of parking difficulties.

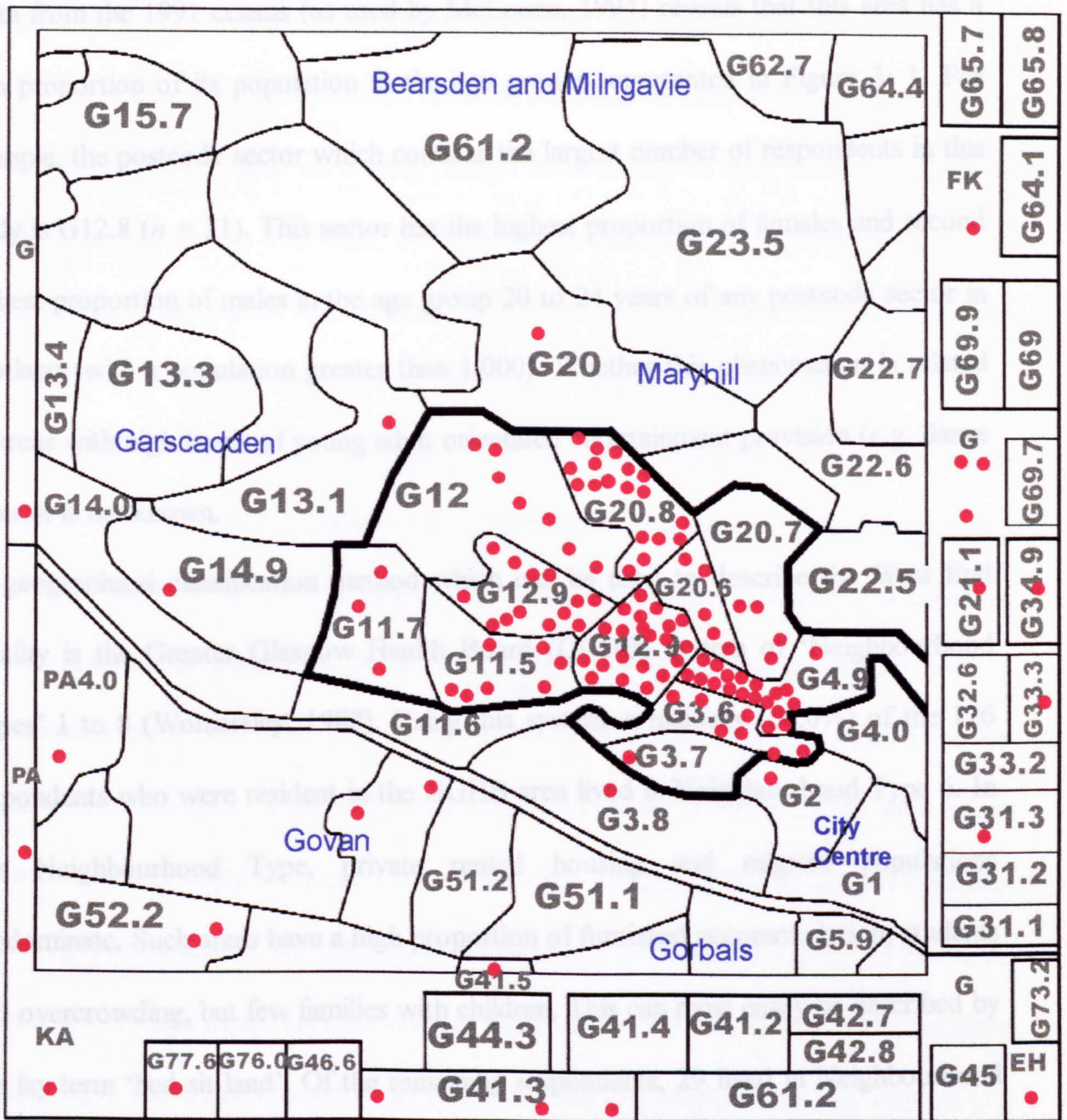
Criminal activity

The above income pattern was confirmed by examining data on respondents' criminal activities. Respondents were asked whether they had ever done any of a list of twelve criminal activities (fare fraud, driving without a license, bicycle theft, robbery, insurance fraud, vandalism, shoplifting, weapons, accepting stolen goods, fighting, sex work and drug dealing) and if they had done each in the past year. Of these items, only failure to pay full ticket fare on public transport (63.7%) and selling drugs for financial gain (51.1%) had been committed by a majority of respondents in the past year. In contrast only 30.4% had shoplifted (usually items such as CDs for personal use) and two respondents had done a robbery (mugging) in the past year. Only three respondents had ever worked in the sex industry, all male. One respondent (#133, who had not used any illegal drugs for seven years) was still doing sex work as a pornographic film dealer. The drug dealers in this sample will be examined in greater detail in Chapter 6.

Area of residence

As detailed in the previous chapter, this research was undertaken in the area known as the West End of Glasgow. It might therefore be expected that, as participants in the West End dance scene, many respondents should also be residents of this area. When respondents' home addresses were examined, 79.3% were in the West End, that is, in the area covered by the postcodes G3, G4.9, G11, G12, and G20.6-8. The remainder either lived close by (in G2.3, G13, G14, G21, G51), had previously resided in the West End of Glasgow or they spent much time in the area working or socialising. The distribution of subjects across the West End is shown in Figure 3: 3.

Figure 3.3 Map of Respondents Area of Residence



Type 8, defined as poor 'inner city' (including most respondents who lived in council houses) and 22 lived in Neighbourhood Type 3, defined as (first-time buyer) private flats and town houses. Only six respondents lived in any other Neighbourhood Type. It is noteworthy that no respondents lived in Neighbourhood Types 7, peripheral 'scheme' (a term analogous to the American 'project'). It is in these Glasgow council housing schemes where much previous drug research in Glasgow has indicated high levels of often problematic drug use (Haw, 1985; Hammersley, 1994; Frischer 1995).

Data from the 1991 census (as used by McLoone, 1994) reveals that this area has a high proportion of its population in the age groups represented in Figure 3: 1. For example, the postcode sector which contains the largest number of respondents in this study is G12.8 ($n = 21$). This sector has the highest proportion of females and second highest proportion of males in the age group 20 to 24 years of any postcode sector in Scotland (with a population greater than 1,000). Whether this phenomenon is related to areas with high levels of young adult orientated entertainment provision (e.g. dance venues) is not known.

A geographical classification method which can be used to describe the West End locality is the Greater Glasgow Health Board (GGHB) system of 'Neighbourhood Types' 1 to 8 (Womersley, 1988). Using this system, a majority (54.0%) of the 126 respondents who were resident in the GGHB area lived in Neighbourhood Type 6. In this Neighbourhood Type, private rented housing and migrant populations predominate. Such areas have a high proportion of furnished accommodation, students and overcrowding, but few families with children. This can most easily be described by the lay term 'bed-sit land'. Of the remaining respondents, 29 lived in Neighbourhood Type 8, defined as poor 'inner city' (including most respondents who lived in council houses) and 22 lived in Neighbourhood Type 3, defined as (first-time buyer) private flats and town houses. Only six respondents lived in any other Neighbourhood Type. It is noteworthy that no respondents lived in Neighbourhood Types 7, peripheral 'scheme' (a term analogous to the American 'project'). It is in these Glasgow council housing schemes where much previous drug research in Glasgow has indicated high levels of often problematic drug use (Haw, 1985; Hammersley, 1994; Frischer 1995).

From their basic demographics and the type of area in which they lived (both characterised by students, unemployed graduates, first-time buyers, immigrants and child-less couples), few respondents could be described as settled. This is borne out by respondents having spent an average length of residence at their current address of only 70 months (range 1 to 360). This short-term residence was most obvious among those living in the private rented sector who had only lived at their current address for a mean of 27 months, compared with 120 in other sectors ($t = 6.66, p < 0.001$).

To account for this short-term transitional nature of residence, it was decided to examine in which area respondents had lived in most until age 16 years. This revealed that respondents came from a much wider range of backgrounds than was apparent from their current addresses. Some respondents (9.6%) had not previously lived in Scotland. Only 20.0% of the sample had lived most of their lives up to age 16 in the West End of Glasgow, as defined by the postcodes above. Another 23.2% were native to other parts of Glasgow, such as the middle class suburbs of Eastwood and Bearsden ($n = 7$). The remaining half (48.2%) of the sample were from other parts of Scotland. Defined by Health Board area these were: Lanarkshire ($n = 15$), Lothian (12), Ayrshire (10), Argyll and Clyde (9), Highland (6), Grampian (5), Forth Valley (3), Tayside (3), Fife (1) and the Western Isles (1).

Many, if not most, of the respondents in this study could be described as being in a transitory life stage, usually between parental home and their own permanent home or between school and lifetime occupation. It seems certain that the 'non-nine till five' lifestyle of many of these respondents is conducive to rave (night-club) attendance, which in turn may influence the pattern of their drug use. This pattern of drug use will next be examined.

Drug Use Profile

Measuring levels of drug use

An inventory designed to record levels of drug use was presented to each respondent. This asked about sixteen specific categories of drugs and also whether they had taken any other drugs not listed. Space for data from up to three additional other drugs was provided. The sixteen drug categories were: alcohol, tobacco, cannabis, heroin, buprenorphine (TemgesicTM), dihydrocodeine, temazepam, diazepam, solvents, cocaine, amphetamines, LSD, psilocybin mushrooms, nitrites, ketamine and ecstasy.

Respondents were first asked whether they had ever in their lifetime used each of these drugs. For each drug which respondents had used, they were then asked how many days in the previous week, month and year they had used it. Next they were asked to state the dose of each drug on the last day that they used it. This measure of last dose was asked in preference to an estimate of typical dose in order to minimise the opportunities for respondents to misrepresent. Respondents were then asked what age they were when they first used each drug that they had lifetime experience of. Finally, they were asked if they had ever injected any of these drugs. These questions were intended to quantify each respondent's level of involvement with drugs. That is, how much and how often they used each drug. It was hoped that such questions would make it possible to differentiate between drugs with a problematic or 'habitual' pattern of use and drugs with a recreational or 'something for the weekend' pattern of use, in at least quantitative terms.

This instrument design has been used elsewhere (Hammersley et al, 1990; Lavelle et al, 1991), making data from this study directly comparable with these previous

Glasgow drug use samples. This method of recording drug use was found to be very 'user friendly' with the dance scene group because their drug use (excluding alcohol, tobacco and cannabis) was often related to specific dates, events, holidays or weekends. In other samples where this instrument has been used, respondents' recall may have been more effected by the chaotic or habitual nature of their drug use, which often made periods of abstinence more memorable than patterns of use.

From this drug inventory it was intended to show which drugs are used by dance drug scene participants and which drugs are not. This would demonstrate whether dance drug users are single substance users or poly-drug users. This is important because, as explained in Chapter 1, there has been a tendency to assume that dance drug event attendees only use MDMA. Indeed the terms raver and ecstasy user have been treated as if they were interchangeable. Table 3: 2 summarises the levels of use of each drug category.

Table 3: 2, Levels of Drug Use in the Dance Drug Sample

DRUG	EVER USED (%)	USED LAST YEAR (%)	CURRENT DAYS/YEAR	LAST DOSE
Alcohol	134 (99.3)	129 (95.6)	125.7	9.6 units
Tobacco	127 (94.1)	111 (86.2)	290.4	11.8 cigarettes
Cannabis	132 (97.8)	129 (95.6)	220.3	4.0 joints
Heroin	29 (21.5)	15 (11.1)	14.3	0.2 gms.
Buprenorphine	21 (15.6)	8 (5.9)	3.8	2.0 pills
Dihydrocodeine	41 (30.4)	26 (19.3)	21.2	3.8 pills
Temazepam	70 (51.9)	53 (39.3)	27.8	3.4 capsules
Diazepam	52 (38.5)	35 (25.9)	10.7	3.8 pills
Solvents	39 (28.9)	8 (5.9)	3.5	0.8 containers
Cocaine	95 (70.4)	79 (58.5)	10.1	0.3 gms.
Amphetamine	126 (93.3)	104 (77.0)	15.3	0.8 gms.
Psilocybin	110 (81.5)	63 (46.7)	2.9	89.5 mushrooms
LSD	124 (91.9)	106 (78.5)	16.9	1.3 tabs
Nitrites	115 (85.2)	69 (50.7)	7.1	6.7 sniffs
Ketamine	20 (14.8)	10 (7.4)	3.0	0.5 gms.
Ecstasy	123 (91.1)	118 (87.4)	23.7	1.3 pills
Others	53 (39.3)	33 (23.9)	12.5	-

Notes: Dose for each drug as follows: Alcohol = 1 unit / 8 gms. absolute alcohol; tobacco = 1 unit / cigarette; Cannabis = 1 unit / joint or 0.23 gms. resin; Heroin, Cocaine, Amphetamine and Ketamine = 1 unit / 1 gm; Buprenorphine, Dihydrocodeine, Temazepam, Diazepam, LSD and Ecstasy = 1 unit / tablet or capsule; Solvents = 1 unit / can or tube; Psilocybin = 1 unit / mushroom; Nitrites = 1 unit / sniff.

Which drugs are being used by dance event attendees?

From Table 3: 2, it is clear that drugs with certain types of effects were more commonly used than drugs with other effects. In terms of lifetime use, all hallucinogens and illicit stimulants (cocaine, amphetamine, psilocybin, LSD and ecstasy) had been used by at least 70% of respondents. In contrast, all illicit depressants (heroin, buprenorphine, dihydrocodeine, diazepam and solvents) had a lifetime use by only 30% or less of this dance drug sample. The sole exception to this pattern was the benzodiazepine, temazepam. This finding confirms the belief that temazepam has intruded into the Scottish dance drug scene and the concerns that it may act as an epidemiological bridge to 'problem' drug use (McDermott and McBride, 1993). Although this sample is defined as an illegal dance drug-using group, it is noteworthy that alcohol, tobacco and cannabis are by far the substances most frequently used. These were used so frequently by respondents that they will be described in this thesis as 'ubiquitous drugs', being used at dance scene events only because they are used everywhere else as well (this will be elaborated on in Chapter 5).

Are dance drug users single substance or poly-drug users?

A total of 51 different discrete drugs had been used by the Glaswegian Dance Drug sample. The mean number of drugs used by respondents was 10.7, range 3 to 18 (maximum allowed 19). Drugs used included all 16 categories provided plus a variety of 'other' additional substances. These 'others' were dipipanone ($n = 12$), opium (11), methadone (10), morphine (5), 'zonks' (5), barbiturates (4), codeine (4), chloroform (3), mescaline (3), nutmeg (3), anti-depressants (2), chlordiazepoxide (2), methaqualone (2), nitrazepam (2), prothiaden (2), beta blockers (1), broom (1), chlorpromazine (1), 'crack' (1), cyclizine (1), DOM (1), ephedrine (1), ether (1), GHB

(1), 'ice' (1), khat (1), lorazepam (1), 'magic' datura apples (1), meptazinol (1), morning glory (1), nitrous oxide (1), pethidine (1), "slimming pills" (1), synthetic ergot (1), and triazolam (1). This extensive range of drugs, including stimulants, opiates, hallucinogens, depressants and anaesthetics indicates a tendency amongst this group to experiment with different substances. In no sense could this dance drug group be classified as users of a single substance (e.g. MDMA). Forsyth (1996 unpublished internet book) details incidence of drug use from this study and from nine others in which drug data was collected by the author (O'Docherty and Davies, 1988; Coggans and Davies, 1988; Hammersley et al, 1988; Rahman et al, 1989, Hammersley et al, 1991; Lavelle et al, 1991; Lavelle et al, 1991a; Forsyth et al, 1991; Forsyth et al, 1992; Forsyth et al, 1993; Barnard et al, 1996). Of these ten drug-using samples the dance scene group used the greatest range of substances, a total of 67 different drugs (including compounds). Incidence of drug use in the nine other studies ranged between 18 and 60 different substances. These findings suggest that the dance drug users could indeed be described as 'poly-drug users'.

Does drug use among dance event attendees vary demographically?

The large number of different drugs used by the dance scene sample may be as a result of their varied demographics. That is, people from different backgrounds who attend dance events may use different drugs. For example, working class respondents may be more likely to use opiates. To test for intra-dance scene sample variations, the levels of drug use detailed above were compared across the sample's basic demographics, that is age, gender and social class.

Age differences in patterns of drug use

Table 3: 3 compares drug use with the age categories defined in Figure 3: 1. The Mantel-Haenszel test (M^2) for linear associations was used to test for differences in lifetime drug use here in preference to chi-square (X^2), as this test takes into account the ordinal nature of this data. It was suspected that lifetime experience of drug use would increase with age. However, as can be seen in Table 3: 3, this incremental pattern reached statistical significance with three drugs: heroin ($M^2 = 10.7$, $df = 1$, $p = 0.01$), cocaine ($M^2 = 17.4$, $df = 1$, $p < 0.0001$) and ketamine ($M^2 = 5.2$, $df = 1$, $p < 0.05$). Whether the greater lifetime use of these ('hard') drugs among older dance drug scene participants is due to them being more likely to have been part of other drug scenes (perhaps in the past) or whether, in time, younger respondents will graduate to using these substances is not known. Also from Table 3: 3, it can be seen that there were few differences in drug use frequency across age categories. Heroin was again an exception ($F = 19.1$, $df = 3$, $p < 0.0001$, by one-way analysis of variance), with older users using more frequently. When dosage was compared across age groups a different pattern was found. Younger users tended to consume drugs in greater quantities. This reached statistical significance for linearity with temazepam ($F = 4.6$, $df = 1$, $p < 0.01$) and amphetamine ($F = 3.9$, $df = 1$, $p < 0.01$).

Table 3: 3, Drug Use and Age Compared

AGE GROUP	% EVER USED				DAYS/YEAR			
	<20	20-24	25-29	>30	<20	20-24	25-29	>30
Alcohol	100	98.5	100	100	96.3	139.0	111.9	136.0
Tobacco	95.2	95.4	92.9	90.5	295.2	288.0	305.3	272.9
Cannabis	100	98.5	96.4	95.2	171.7	228.1	265.4	188.7 *
Heroin	9.5	15.4	25.0	47.6 **	1.0	8.1	2.3	70.0 ***
Buprenorphine	19.0	12.3	7.1	33.3	4.5	5.7	1.0	1.5
Dihydrocodeine	33.3	21.5	35.7	47.6	8.9	9.0	3.5	76.8
Temazepam	76.2	44.6	50.0	52.4	77.7	16.7	8.8	5.7 *
Diazepam	61.9	27.7	42.9	42.9	12.3	10.7	7.3	11.8
Solvents	42.9	23.1	32.1	28.6	3.0	4.0	3.5	0.0
Cocaine	47.6	61.5	89.3	95.2 ***	4.4	9.7	7.1	18.8
Amphetamine	95.2	89.2	96.4	100	12.7	18.0	15.7	7.0
Psilocybin	76.2	80.0	85.7	85.7	2.4	3.2	2.6	2.7
LSD	95.2	92.3	89.3	90.5	16.7	19.4	10.5	16.5
Nitrites	90.5	81.5	96.4	76.2	10.6	6.7	5.4	4.8
Ketamine	4.8	12.3	17.9	28.6 *	2.0	1.3	2.0	10.5
Ecstasy	95.2	90.8	89.3	90.5	25.9	26.3	14.1	26.4
Others	23.8	36.9	46.4	52.4	7.0	3.9	3.1	26.5 **

Note * $p < 0.05$, ** $p < 0.01$, $p < 0.001$.

Table 3: 3, Drug Use and Age Compared (continued)

AGE GROUP DRUG	LAST DOSE			
	<20	20-24	25-29	>30
Alcohol	11.4	9.1	8.6	10.8
Tobacco	10.6	11.2	11.9	15.3
Cannabis	5.8	3.3	4.4	3.8 *
Heroin	0.2	0.1	0.1	0.2
Buprenorphine	1.3	2.0	2.0	2.5
Dihydrocodeine	7.1	2.5	2.1	4.8 **
Temazepam	6.4	2.9	2.5	1.5 **
Diazepam	6.9	2.7	3.2	2.4 *
Solvents	1.3	0.5	0.6	0.6
Cocaine	0.3	0.2	0.3	0.3
Amphetamine	1.1	0.7	0.5	0.5 **
Psilocybin	131	91	70	63
LSD	1.5	1.2	0.8	0.9
Nitrites	3.5	9.8	4.4	3.3 *
Ketamine	1.0	0.5	0.5	0.3
Ecstasy	1.4	1.2	1.0	1.3

Notes: Dose for each drug as follows: Alcohol = 1 unit / 8 gms. absolute alcohol; tobacco = 1 unit / cigarette; Cannabis = 1 unit / joint or 0.23 gms. resin; Heroin, Cocaine, Amphetamine and Ketamine = 1 unit / 1 gm; Buprenorphine, Dihydrocodeine, Temazepam, Diazepam, LSD and Ecstasy = 1 unit / tablet or capsule; Solvents = 1 unit / can or tube; Psilocybin = 1 unit / mushroom; Nitrites = 1 unit / sniff.

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$.

Gender differences

Next, drug use and gender were compared. As shown in Table 3: 4, males were more likely to have ever used six of the drug categories asked about. These were diazepam ($X^2 = 4.2, df = 1, p < 0.05$), solvents ($X^2 = 9.2, df = 1, p < 0.01$), mushrooms ($X^2 = 4.3, df = 1, p < 0.05$), nitrites ($X^2 = 10.4, df = 1, p < 0.01$), ketamine ($X^2 = 7.7, df = 1, p < 0.01$), and any other drugs ($X^2 = 4.8, df = 1, p < 0.05$). However only two drugs, cannabis ($t = 3.98, p < 0.001$) and psilocybin ($t = 2.47, p < 0.05$), varied significantly in frequency of use between male and female users. In terms of dosage males used more of all the drugs listed except temazepam. This sex difference reached statistical significance with alcohol ($t = 2.81, p < 0.01$), tobacco ($t = 2.23, p < 0.05$), cannabis ($t = 3.60, p < 0.001$), LSD ($t = 2.50, p < 0.05$) and ecstasy ($t = 2.38, p < 0.05$).

Table 3: 4, Drug Use and Gender Compared

DRUG	% EVER USED		DAYS/YEAR		LAST DOSE	
	Female	Male	Female	Male	Female	Male
Alcohol	98.0	100.0	122.5	127.6	7.1	11.2 **
Tobacco	94.1	94.0	265.0	305.3	9.6	13.0 *
Cannabis	96.1	98.8	161.9	252.7 ***	2.6	4.8 ***
Heroin	15.7	25.0	8.0	15.9	0.2	0.3
Buprenorphine	7.8	20.2	4.3	3.4	1.8	2.1
Dihydrocodeine	21.6	35.7	6.1	29.1	2.9	4.1
Temazepam	43.1	57.1	44.5	19.1	3.9	3.2
Diazepam	27.5	45.2 *	12.4	10.0	3.5	4.0
Solvents	13.7	38.1 **	1.0	3.9	0.5	0.8
Cocaine	68.6	71.4	11.0	9.5	0.3	0.3
Amphetamine	90.2	95.2	17.7	13.9	0.5	0.8
Psilocybin	72.5	86.9 *	1.9	3.2 *	86.8	89.1
LSD	86.3	95.2	12.3	19.5	0.8	1.3 *
Nitrites	72.5	92.9 **	6.8	7.3	4.7	7.5
Ketamine	3.9	21.4 *	1.0	3.9	0.5	0.5
Ecstasy	86.3	94.0	20.2	25.6	1.0	1.3 *
Others	27.5	46.4 *	3.3	6.2	-	-

Notes: Dose for each drug as follows: Alcohol = 1 unit / 8 gms. absolute alcohol; tobacco = 1 unit / cigarette; Cannabis = 1 unit / joint or 0.23 gms. resin; Heroin, Cocaine, Amphetamine and Ketamine = 1 unit / 1 gm; Buprenorphine, Dihydrocodeine, Temazepam, Diazepam, LSD and Ecstasy = 1 unit / tablet or capsule; Solvents = 1 unit / can or tube; Psilocybin = 1 unit / mushroom; Nitrites = 1 unit / sniff.

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$.

Social class differences in patterns of drug use

There were few differences in drug use between respondents from manual or non-manual social classes. There were only two differences between respondents in manual class and non-manual social class that reached statistical significance. These were that manual social class respondents had a greater lifetime experience of diazepam (50.0% versus 30.5% for non-manual respondents; $X^2 = 5.0$, $df = 1$, $p < 0.05$) and took a larger dose of cannabis on the last day they used any (dosage 4.9 versus 3.5 units; $t = 2.47$, $p < 0.05$).

From these findings it would appear that despite the varied demographics of this sample and the wide range of drugs used, drug use among the dance drug sample show a good deal of internal cohesion. That is, dance drug event attendees from different backgrounds appear to use the same sorts of drugs in a similar pattern (other than males taking larger doses). This uniformity across the sample appears to be particularly strong for drugs that are often associated with dance scene (see Chapters 1 and 5) such as ecstasy, LSD and ketamine, though younger users consumed greater doses of amphetamine. Other drugs not commonly associated with the dance drug scene, such as heroin or cannabis, had more varied levels of use across sample demographics.

Dance Drug Users and Other Drug Using Groups

Compared

Demographic comparisons with other Scottish drug research samples

As explained above, the dance scene sample shows a good deal of internal heterogeneity in terms of demographics and homogeneity in terms of drug use. The question remains as to how this group compares with groups of drug users in terms of both demographics and drug use. Table 3: 5 compares the demographics of the dance drug sample to that of seven other drug research samples undertaken in Scotland over the past decade. At first glance there are some similarities between the dance scene sample and other drug use samples. For example, the studies by Neville et al (1988), Hammersley et al (1989), Rahman et al (1989), Morrison and Plant (1990), Lavelle et al (1991), Forsyth et al (1991) and Rhodes et al (1993) were all predominantly male and had a mean age between 24 and 26 years. However, the dance scene sample had a higher proportion of females and a greater age range than these others. In other ways this sample differed greatly from these more 'traditional' drug research samples. Fewer respondents in the dance drug sample were unemployed. This was so even before considering that most of the dance scene 'unemployed' worked on the side. The dance scene sample also had the fewest respondents who had injected drugs or who had a criminal record. Only four of the dance scene sample had ever been imprisoned (only one of whom was convicted of a criminal offence). Unfortunately, the other studies did not report on levels of further education. Whether this is because there was none or because the researchers concerned chose not ask about this (assuming there would be none) is not clear. Examination of their other characteristics (e.g. custodial histories)

implies that it is unlikely that levels of tertiary education in these other samples would be higher than the eight out of ten achieved in the dance scene sample. Respondents in the other studies cited in Table 3: 5 could more typically be described as drug injectors with low levels of employment and extensive custodial histories.

Table 3: 5, Demographics of Dance Drug Users and Other Scottish Drug Research Samples Compared

STUDY (author)	AGE (years) (range)		SEX (% female)	UNEMPLOYED (% unemployed)	CRIME (% convicted)	INJECTION (% ever)
Dance Drug (n = 135)	24	14-44	38	40	28	7
Forsyth (n = 23)	24	21-30	0	100	100	91
Hammersley (n = 149)	25	-	11	-	64*1	-
Lavelle (n = 78)	24	17-31	27	90	72*2	94
Morrison (n = 115)	26	-	31	57	43	28
Neville (n = 36)	26	-	20	-	56	100
Rahman (n = 50)	24	17-35	33	86	98	100
Rhodes (n = 503)	24	16-41	30	-	-	100

Notes: *1 Currently in prison.
 *2 Criminal activity in past year.
 *3 Currently in prison.

The differences between the dance drug scene sample and these other studies may be due to either the type of drug use being investigated or because of the research methods used. Certainly, these other studies were designed to address a specific problem, such as needle sharing, criminality or imprisonment. It is therefore unsurprising that these levels of the variables should be different from that found in the dance drug sample. However, all these samples were more similar to each other than any of them are to the dance drug group. Perhaps the main reason for this is that all these samples involved drug users who were in contact with drug agencies, that is, problem drug users. The dance drug sample was obtained without the involvement of drug agencies and this may have been important in the formation of the sample's demographics. Had the other samples been obtained by a similar method to the dance scene sample, then perhaps their demographics would not have been so different. Given the lack of agencies orientated at the dance drug scene (as discussed in Chapter 1) it may be that dance drug users are also problem users.

Are dance drug users recreational or problematic drug users?

The data collected in this study was examined to find out whether the dance drug users are in fact merely a new type of problem drug users; a type who do not attend drug agencies because these have little help to offer, being orientated towards deprived, male, opiate addicts, as noted by Henderson (1992). In other words, is service provision failing to meet the needs of dance drug users? An alternative hypothesis might be that dance drug scene participants are mainly recreational drug users few of whom will ever encounter any problems requiring professional help. The lay terms 'problem drug use' and 'recreational drug use' will be used in this thesis to help estimate the potential for harm that drug use in the dance scene may entail. These

are of course somewhat subjective terms. All illicit drug use may be described as recreational and the only form of drug use that cannot cause drug problems is no use. With these caveats in mind, it can be said that the term problem drug use usually implies that the user wishes to stop, but continues use for a variety of reasons (e.g. to avoid withdrawals) in a habitual or self-medicating fashion. In contrast, recreational drug use implies occasional use at appropriate times of the user's choosing unrelated to any self-medication. In other words, problem drug use can be likened to a full-time occupation which lessens the users quality of life, whereas recreational drug use can be seen as a free-time (weekends and evenings only) activity which improves the user's quality of life. By comparing the patterns and consequences of drug use in the dance drug sample with those found in other Scottish drug samples, it is intended to measure to what extent dance drug users can be regarded as problem drug users relative to other drug-using groups.

To fit the definitions given above, the frequency of recreational drug use should be characterised as being skewed towards non-use, rather than daily use over the past year. In the case of the dance scene sample, recreational use might be limited to using less than a maximum of two days per week, the equivalent of weekend use. Potentially problematic drug use might therefore be seen as using more than twice per week, that is, at least some drug use during week days. The frequency of drug use that is most likely to be problematic is daily use. Other behaviours that can be used as indicators of problematic drug use were also measured. These were use at an early age, injection, using in large doses, spending money on drugs and having sought professional help for drug use. Table 3: 6 shows the number of respondents who used drugs daily, more than weekly, by injection, age of first use and who paid (no) money for their last drugs.

Table 3: 6, Characteristics of Drug Use in the Dance Scene

DRUG	No. USERS 365 days (%)	No. USERS >104 days (%)	No. EVER INJECTED	MEAN AGE FIRST USE	No. SCORE FREE (%)
Alcohol	2 (1.6)	70 (54.3)	0	13.9	34 (26.2)
Tobacco	60 (54.1)	94 (84.7)	0	14.1	32 (26.7)
Cannabis	25 (19.4)	93 (72.1)	0	15.8	49 (37.4)
Heroin	0	0	7 (31.8)	20.0	17 (65.4)
Buprenorph.	0	0	1 (6.3)	21.7	15 (93.8)
Dihydroco.	1 (3.8)	1 (3.8)	1 (3.3)	19.9	30 (81.1)
Temazepam	1 (1.9)	2 (3.8)	0	21.3	42 (61.8)
Diazepam	0	0	1 (2.7)	18.9	46 (92.0)
Solvents	0	0	0	15.1	16 (59.3)
Cocaine	0	1 (1.3)	5 (7.1)	20.9	66 (71.7)
Amphetamine	0	0	5 (5.4)	18.5	58 (50.0)
Psilocybin	0	0	0	18.5	101 (96.2)
LSD	0	2 (1.9)	0	18.0	55 (45.1)
Nitrites	0	0	0	18.7	91 (88.3)
Ketamine	0	0	0	24.6	4 (21.1)
Ecstasy	0	0	0	21.0	38 (31.1)
Others	1 (1.3) (Codeine)	1 (1.3) (Codeine)	4 (5.3) (Dipipanone [2]) (Methadone) (Barbiturates)	21.0	41 (54.7)

As described above, the dance drug scene group are very much poly-drug users. This does not discount the possibility that users might have at least one 'preferred drug', which is used on a near daily basis. From Table 3: 6, it can be seen that few respondents in the dance group used any drugs on a daily basis. The two exceptions to this were tobacco and cannabis. Indeed, few respondents used any drugs more than 104 days per year. This does not indicate that drug use (other than the 'ubiquitous'

alcohol, tobacco and cannabis) is certain to be greater than a weekend activity by the majority of respondents. Many drugs such as amphetamine, nitrites and ecstasy (the three 'primary dance drugs', see Chapter 5) were not used by any respondents more often than this twice per week figure. In contrast more than half the users of alcohol, tobacco and cannabis used on a more than weekend frequency (averaged over the past year). Therefore in terms of frequency, it is only these three substances which might be said to lie at the problematic use end of any recreational to problem drug use continuum among dance drug users. This is not to discount the potential for drug problems to occur after a single use. Certain methods of using drugs can be regarded as having a relatively greater potential for harm than others, even after only one use. Injection of drugs is the method of use that is often seen as being towards the problematic end of the scale. Especially following the advent of HIV, many authorities regarded injection rather than drug use per se as problem drug use (Berridge, 1992; Strang et al, 1992). From Table 3: 6, it is clear that injection of drugs was relatively uncommon in this sample. Indeed, with the exception of amphetamine, the drugs which are most often associated with the dance scene (ecstasy, LSD, ketamine, nitrites) were injected by no respondents.

Another aspect of drug use which previous research has found to be indicative of potentially problematic use is use at a young age, early teens or before (Kandel et al, 1992). This does not appear to be the norm with the dance drug group. Many respondents first used many drugs, especially drugs associated with the dance scene, at a relatively old age. Indeed, seven of the drug categories listed had a mean age of first use greater than 20 years of age. Again alcohol, tobacco, and cannabis were exceptions (with addition of the few who had used solvents), showing mean ages of first use below 16 years. How much this finding is related to the novelty of the dance scene is

unknown. It is possible that other drugs may be taken at a younger age by future generations of dance scene participants. However, research which has found high levels of alcohol, tobacco and cannabis amongst secondary school age children has to date found very low levels of drugs associated with the dance scene (Parker and Measham, 1994; Barnard et al 1996).

Finally, from Table 3: 6, ten of the 16 drugs listed were last obtained for free by half or more of the respondents in the dance scene study. If their drug use were problematic rather than recreational, then it would be expected that users were having to pay for their drugs. Yet again, alcohol, tobacco and cannabis were exceptions. This finding will be reported on in greater depth in Chapter 6.

Overall, apart from the use of the ubiquitous alcohol, tobacco and cannabis, the pattern of drug use in this dance scene sample could (at least in quantitative terms) be described as recreational. This is verified by a lack of respondents ever having been treated for drug related problems. Only one respondent was currently in receipt of any treatment for a drug problem. A further four had received some form of help in the past year. In total, only 17 (12.6%) respondents had ever had any contact with drug agencies or required help with any drug problems. The drug which the largest number of respondents had been treated for was alcohol ($n = 5$). Four of these cases were as a result of acute intoxication the other was for addiction (successfully attending Alcoholics Anonymous). The other drugs for which respondents had either sought help for or been told to seek help for were temazepam ($n = 3$), amphetamine (2), cannabis (2), ecstasy (2), heroin (2), diazepam (1), LSD (1), tobacco (1) and poly drug use (1). Only eight respondents had ever been prescribed substitute drugs. This figure includes non-repeat prescription cases, such as diazepam, being used to overcome a panic attack brought on by use of other drugs in conjunction with prolonged dancing. Other

forms of 'treatment' included: counselling (heroin), hypnotherapy (tobacco), help for psychiatric problems (amphetamine), social inquiry report attendance (cannabis) and being coerced into attending a drug agency by a parent or GP (including both ecstasy cases). From these cases, it would appear that drug problems among dance scene attendees were comparatively rare and isolated in nature. These 'problems' were less likely to be caused by 'primary dance drugs' such as ecstasy or amphetamine (see Chapter 5) than by others such as alcohol or temazepam. Moreover, in instances where dance drugs were 'to blame', it was often not the dance scene user who had defined themselves as having a problem requiring professional help. In short, the dance drug users tended to exhibit rare but acute (intoxicative or situational) difficulties rather than problems of a chronic (addictive) nature.

Drug use comparisons with two other Glasgow drug using samples

Reported drug use from respondents in the dance scene sample was compared with that obtained in two other Glasgow studies which used the same method of quantifying drug use. Studies by Hammersley et al (1990) and Lavelle et al (1991a) also measured drug use in terms of lifetime use, days use in the past year, dose on last day of use and defined current use as any use in the past 365 days. These drug use details are shown in Table 3: 7.

Table 3: 7, Drug Use by Dance Drug Users and Other Drug Users Compared

DRUG	HAMMERSLEY et al (N=210)			LAVELLE et al (N=78)			DANCE DRUG (N=135)		
	% users (current)	days /year	last dose	% users (current)	days /year	last dose	% users (current)	days /year	last dose
Alcohol	99 (96)	67.5	15.3	96 (77)	61.5	15.0	99 (96)	125.7	9.6
Tobacco	87 (82)	313.9	12.0	-	-	-	94 (86)	290.4	11.8
Cannabis	82 (81)	115.0	4.3	99 (90)	149.9	5.7	98 (96)	220.3	4.0
Heroin	13 (10)	17.9	0.2	97 (71)	93.1	0.5	22 (11)	14.3	0.3
Buprenorph.	47 (45)	63.6	2.7	94 (91)	243.0	7.4	16 (6)	3.8	2.0
Dihydroco.	31 (25)	24.5	5.7	94 (74)	71.0	14.8	30 (19)	21.2	3.8
Temazepam	72 (66)	37.0	4.4	97 (92)	160.4	11.2	52 (39)	27.8	3.4
Diazepam	31 (21)	20.8	3.4	86 (69)	84.0	13.2	39 (26)	10.7	3.8
Solvents	57 (31)	21.4	1.3	65 (1)	21.0	1.0	29 (6)	3.5	0.75
Cocaine	8 (4)	5.0	0.3	67 (22)	13.2	0.25	70 (59)	10.1	0.25
Amphet.	46 (37)	13.1	0.5	88 (31)	44.8	1.0	93 (77)	15.3	0.75
Psilocybin	65 (53)	14.0	117.9	70 (6)	9.4	172.0	82 (47)	2.9	89.5
LSD	53 (40)	11.8	1.5	87 (10)	8.0	1.0	92 (79)	16.9	1.25
Nitrites	-	-	-	-	-	-	85 (50)	7.1	6.7
Ketamine	-	-	-	-	-	-	15 (7)	3.0	0.5
Ecstasy	19 (15)	3.6	1.0	29 (29)	11.2	1.0	91 (87)	23.7	1.25

Notes: Dose for each drug as follows: Alcohol = 1 unit / 8 gms. absolute alcohol; tobacco = 1 unit / cigarette; Cannabis = 1 unit / joint or 0.23 gms. resin; Heroin, Cocaine, Amphetamine and Ketamine = 1 unit / 1 gm.; Buprenorphine, Dihydrocodeine, Temazepam, Diazepam, LSD and Ecstasy = 1 unit / tablet or capsule; Solvents = 1 unit / can or tube; Psilocybin = 1 unit / mushroom; Nitrites = 1 unit / sniff.

The Lavelle study looked at drug users attending drug treatment agencies in Glasgow. As such the Lavelle sample may be regarded as comprising (self-defined) problem drug users. The Hammersley sample is of interest because it examined a group of young Glaswegian drug users who (like the dance drug users) were not in contact with treatment agencies. Also, the Hammersley sample was recruited by a similar snowballing method to that employed in this study and was conducted in a geographical area adjacent to the West End. Hammersley's respondents exhibited a high level of delinquency and could be described as a 'street' user sample. This sample was recruited prior to the widespread advent of the rave scene. As such that sample may be regarded as comprising 'hidden' drug users of a type other than dance drug event attendees.

When comparing the dance scene sample with the users in treatment (Lavelle et al, 1991a), the overall impression is that the latter group used more drugs. This is not surprising as this group was interviewed whilst in treatment for drug problems. The drug users in treatment appear especially more likely to ever have used opiates (heroin, buprenorphine and dihydrocodeine), benzodiazapines (temazepam and diazepam) and solvents. If they were users of these drugs, they also appear more likely to have used them more frequently and in larger doses. In other words, dance drug users appear less likely to use depressant drugs. Two substances appear to differ between these two samples by being orientated in the opposite direction. These are ecstasy and LSD, which the dance drug users appear to use more of (in terms of lifetime use, frequency of use and dosage) than did the treatment sample. However, the frequencies of use of these two drugs (in mean days per year) in the dance scene group are only one third or less that of the frequencies of use of any opiates or benzodiazapines in the treatment sample. In other words, the drugs which are characteristic of the dance scene sample

are used much less often than the drugs which characterise drug use in the treatment sample.

The picture between the two samples for the remaining drugs is slightly more complicated. Although the treatment users appear less likely to have ever used psilocybin or amphetamine, if they had used, then they appear to have done so more frequently and in larger doses. In the cases of alcohol and cannabis, the dance drug sample appear to use these substances more frequently, the treatment sample in greater doses. Cocaine use did not appear to differ much between these two samples except in terms of current users. Apart from the relatively new drug ecstasy, numbers of current users of all hallucinogens and stimulants (cocaine, amphetamine, psilocybin and LSD) in the treatment group are less than half their percentages of ever having used. This would appear to indicate that these are not the preferred drugs of Glasgow problem drug users. At the time of interview depressant drugs, those substances least preferred by the dance scene sample, could be described as their preferred drug. Although these people clearly experiment with dance drugs (and doubtless many other types of drugs) it would be inaccurate to label such people dance drug users in the context of their heavier use of other substances.

When comparing the (hidden) street sample (Hammersley et al, 1990) with the dance scene sample, similar differences to those found with the treatment sample above are apparent, but mostly these were lesser in magnitude. Overall use of opiates, benzodiazapines and solvents appeared greater among the street users than in the dance scene sample, but this was much less than in the treatment sample. The street user sample was less likely to have ever used stimulants or hallucinogens (cocaine, amphetamine, psilocybin, LSD and ecstasy) than the dance scene sample. However if used some of these drugs were used in slightly greater frequencies (psilocybin) or

doses (psilocybin and LSD) by street users than the dance scene users. Again, alcohol and cannabis appear to be used by the dance scene sample more frequently but in smaller doses. Indeed, consumption of these substances appeared to be similar between the treatment and street sample.

The overall pattern of drug involvement by the dance scene sample is one of less use of (illegal) depressants than was found in the other two samples. Dance drug users appear more likely to use hallucinogens and stimulants than do respondents in the other samples. This is especially the case in terms of numbers of current users. Although the dance drug users seem to take a greater range of different substances, in general, when they use any drug, they appear to do so less often or in lesser doses than was the case elsewhere.

Drug use in the dance scene sample and in the general population compared

That the dance drug users appear different from other drug users is perhaps unsurprising. This sample was recruited in a geographical area distinct from those where much previous Scottish drug research has taken place, without the use of drug problem agencies. It may be that the dance drug users more closely resemble drug users in the general population living in areas such as the West End. If so, then such similarities might be found in general population surveys of drug use.

The only recent general population survey which has asked about drug use in Scotland is the Scottish Crime Survey (Hammersley, 1994). In that survey the highest levels of drug use were found in areas such as the West End of Glasgow. That survey used an area classification system designed by Scottish ACORN. The type of area called Group D by ACORN is described as being located in the centre of the largest towns and cities, having high levels of persons living alone, private rented flats, students and low

car ownership. In the Scottish Crime Survey, about one third of those surveyed living in such areas reported ever having used any illegal drug. The next highest levels of drug use were in ACORN Group H, the poorest council estates, in which around one quarter of those surveyed admitting to drug use. Previous (problem) drug research in Scotland has indicated that drug use is concentrated in such deprived council schemes (Haw, 1985; Haw and Liddell, 1988; Frischer, 1995). This has led to much previous drug research being conducted in or having recruited users from such areas (McKeganey and Boddy, 1988; Rahman, 1989; Taylor, 1993). This over-representation of deprived area residents in academic literature might imply an underlying assumption by researchers, among others, that drug use is concentrated in such areas. As will be explained later in Chapter 6 such an assumption would be incorrect. However, the Scottish Crime Survey did find more persons admitting to using temazepam/pills or opiates/crack (the drugs that previous drug research has focused on) in ACORN Groups H and F (less well off council estates) than elsewhere. If this is the case, then the research studies into such drug use listed above were targeting the appropriate geographical areas for their objectives. Dance drug use research in such localities would be at risk of contamination from these other types of drug user who might also use dance drugs (such as those in the samples of Hammersley et al, 1990 and Lavelle et al, 1991, detailed above). In contrast, ACORN Group D had lower reported levels of these 'problem' drugs, but had the highest levels of use of cannabis and hallucinogens/stimulants ('recreational' or dance drugs). As detailed above, the present sample was not recruited from deprived council estates but from an inner city area where private rented flats are common. The significance of this area type to patterns of drug use will be discussed in Chapter 6. The demographics of the dance scene sample fit the defining characteristics of residents living in such areas.

These respondents are also in the age group with the highest levels of drug use as identified by the Scottish Crime Survey. Nearly half the sample were aged 20 to 24, the age band that admitted to the most drug use in the Scottish Crime Survey. Given that the respondents in this thesis were recruited from the dance drug scene, are in the age group and the area type with the highest levels of drug use in Scotland, it is to be expected that drug use in this sample should be relatively common. This should be the case for all drugs, especially cannabis, hallucinogens and stimulants, but perhaps less so for temazepam, pills, opiates and crack. This was done without the need to target specific drugs during recruitment (see Chapter 2). Table 3: 7 appears to confirm that the dance scene sample resembles what might have been expected given the findings of the Scottish Crime Survey relative to drug users recruited elsewhere.

Comparisons with other dance drug using groups

The global origins of the rave scene detailed in Chapter 1 may mean that dance drug users in other parts of the world may more closely resemble this dance scene sample (in demographics and drug use) than any other groups of Scottish drug users. As outlined in Chapter 1, to date there has been little quantitative research undertaken in the dance drug scene. However it is possible to make some comparisons between this group and other dance drug groups using data from two very different sources; academic studies focusing on ecstasy (MDMA) use and surveys conducted by dance orientated magazines.

Since the advent of widespread ecstasy use, several studies have been conducted which aimed to evaluate the socio-psychiatric effects of this 'new' drug. Many of these studies recruited ecstasy users directly from the dance scene or contained respondents who may have used ecstasy in the dance environment. As detailed in Chapter 1, ecstasy

users in the USA of the 1980s were identified as being less 'deviant' (problematic) than other drug using groups, whether or not their use was associated with dancing behaviour (Newmeyer, 1986; Peroutka, 1987; Rosenbaum et al, 1989; Beck, 1990; Seymour and Smith, 1991). This would also appear to be the case with the Glaswegian dance drug-using group.

A study of recreational MDMA use in Sydney, Australia, by Solowij and Lee (1991), recruited a group of ecstasy users to distribute 100 questionnaires among their peers. These were returned anonymously by post for analysis. Those who responded were usually employed or students. The authors describe ecstasy as "primarily an inner city 'yuppie drug'". Solowij and Lee found that Australian ecstasy was most often used at dance parties, followed by private parties and in night-clubs. The acid house scene, catching on more in Australia than in the USA, was cited as one reason for this difference with American users (see Chapter 1). A typology of Australian ecstasy users was identified from this survey. These types were "dance party people and socially active types" (54% of the sample), "normal people, qualified by all types" (28%), "experimenters, sensation seekers and emotion enhancers" (26%), "recreational drug users" (16%), "yuppie scene" (14%) and "homosexual community" (11%). Again, this displays many similarities with the Glasgow dance scene group.

More detailed demographic comparisons are possible with ecstasy using groups recruited directly from the dance scene in the 1990s. Winstock (1990) examined the characteristics of ecstasy users who were contacted via DJs and record stores in London. Of 250 questionnaires sent out 89, (35.6%) were completed and returned by ecstasy users. Of these, 48 (53.9%) were found to be in the Registrar General's social classes I and II (from parental occupation), with only five (5.6%) being in classes IV

and V. This is in line with the relatively high social class of the Glaswegian dance drug users.

A study of drug agency clients and offenders by Newcombe (1991a) found two types of MDMA user. These were termed 'Group A', daily opiate injectors or cocaine users, and 'Group B', less than daily users of mainly amphetamine, LSD and ecstasy. Group B users were found to be younger and less likely to be socially deprived. The Glasgow dance drug-using sample would appear to be similar to Newcombe's Group B. It is noteworthy that increased heroin and cocaine use (more like Group A) was apparent among older respondents in the Glasgow dance scene sample (see also Chapter 5, Table 5: 5).

A dance drug sample that is particularly useful in making comparisons with this thesis is a Master of Public Health (MPH) dissertation by Gazala Akram (1997). Akram recruited a sample of 125 dance drug users in Nottingham, England during the spring of 1997. Most of these respondents ($n = 84$) were recruited in a city centre pre-club café bar, the remainder through a single key informant. Despite their different sampling strategies, the Nottingham sample and the Glasgow dance drug-using group display many demographic similarities. The Nottingham group also had a male majority (70.7% compared with 62.2% in Glasgow). The age breakdown of the Nottingham sample was: ages 15 to 20, 22.5%, ages 21 to 25, 35.1%, ages 26 to 30, 18.9%, aged 31 or over 14.4%. This is very similar to that found in this research (see Figure 3: 1). The housing tenure of both samples was also very similar, with a small majority from both Nottingham and Glasgow living in private rented accommodation (54.1% and 54.8% respectively). In both samples most respondents were single (73.2% in Nottingham and 80.7% in Glasgow) and few were married (4.0% and 3.7% respectively). There were also similar levels of education within the Nottingham and

Glasgow samples, with 22.0% of the former and 20.7% of the latter having already obtained a university degree. This is mirrored in the proportion of each who were currently students, 22.1% and 23.0% respectively. Where these two samples did differ was in levels of employment. Although Akram did not report on levels of working on the side, more than half (54.1%) of Nottingham dance drug users reported that they were in full or part-time paid employment. In contrast, even with the inclusion of students with part-time jobs, fewer than one third (31.7%) of the Glasgow sample did any (legally) paid work. In common with this research, Akram's sample were also characterised by the weekend poly-use of stimulants and hallucinogens, such as ecstasy (96.0% ever used), amphetamine (98.4%), LSD (91.2%) and cocaine (80.8%), rather than any use of opiates, such as heroin (20.0%) or methadone (4.0%).

Aside from the above difference in levels of employment, which may be explicable in terms of local job opportunities, it is remarkable how similar the demographic and drug use profiles of the Nottingham and Glasgow dance scene samples are. Despite one being conducted in the centre of an English city, the other in a distinct area of a Scottish city, each study recruited a very similar group of respondents. The Glasgow study may be said to have recruited these people in their home environment (i.e. an area with high levels of private rented housing). The Nottingham study in the environment where they go dancing (in Chapter 4 it will be shown that the Glasgow West End dance drug users also go dancing at city centre night-clubs). This implies that many of the findings of this thesis may be applicable across the UK, or at least to other large cities with West End type neighbourhoods and city centre night-clubs.

Surveys conducted by 'style magazines' in the UK also had results that showed a great deal of concordance with the Glasgow dance scene group. For example, a survey of readers drug use by *Gay Times* (1996) found that approximately half the 685 men

who responded had used each of ecstasy, amphetamine and LSD. Ecstasy was not the only drug associated with a dance environment in this sample, with 84% of amphetamine use and 92% of LSD use taking place in a night-club. Although only one respondent in the Glasgow dance drug group was a homosexual man (there were four bisexuals) the demographics of the *Gay Times* sample was very similar. Three quarters of the gay men were aged in their 20s or 30s, with half aged 23 to 32. A majority of the gay men were in professional occupational classes (including those who used dance drugs such as ecstasy). The relative popularity of drugs was also very similar between these two samples. For example, the *Gay Times* respondents were most likely to currently be using cannabis. Like the dance drug sample, the gay men reported a surprisingly high level of lifetime heroin use (one quarter of the sample). However, as with the dance drug sample this use was infrequent or users stated that they had stopped using this drug (see Table 3: 2).

Another magazine drug use survey that can be compared to the Glasgow dance scene sample is that conducted by *Mixmag*, Petridis (1996a). Although focused on ecstasy, this survey was conducted by the self-styled "World's Leading Dance Music and Club Culture Magazine". The 4003 persons who participated had a similar age range (15 to 51) as the Glasgow dance scene sample, a similar sex ratio (64.1% male) and was described as having respondents in "every conceivable occupation". The *Mixmag* sample displayed their "most positive attitude" towards cannabis and least towards heroin. Like other dance scene recruited samples the respondents in this survey appear more similar to those in the Glasgow dance scene group than was the case in any local (Scottish) non-dance scene drug use research.

The new dance drug users: A profile of West End dance drug users

The most striking feature of this sample of drug users was their variety, in terms of both their demographics and their drug use. However some characteristics of this group relative to other drug using groups were apparent.

- The respondents in this study tended not to come from socio-economically deprived backgrounds, had not experienced problems requiring help for their drug use, did not inject drugs and were not involved in acquisitive crime. As such, these drug users do not fit the drug user stereotype of young, male, unemployed, under-class, no-educated delinquent ('ned') criminal.
- Though respondents were poly-drug users, few used on a greater than weekend frequency, other than users of alcohol, tobacco and cannabis. This group was characterised by using stimulants and hallucinogens rather than opiates or benzodiazapines.
- From these data it is clear that the dance drug scene sample differs from previous drug using groups researched in Scotland. This was true for both demographics (less deprived) and drug use (less illegal depressants).
- These findings were not dissimilar to those of other dance scene or ecstasy users conducted elsewhere.

Undoubtedly these results reflect the geographical area in which this research was conducted. Such variety may not have been found had the sample been recruited in the suburbs or deprived council estates (areas in which many respondents' family homes were located). The importance of the type of area in influencing patterns of drug use amongst this group will be discussed in Chapter 6.

This group of dance scene participants, their demographics and drug use could best be described by the term "Bohemian ravers" as used by Moore (1995). In an

anthropological study of ravers in Perth, Western Australia, Moore describes these people as living “in shared houses in and around the inner city, may be studying, unemployed or working in artistic fields” (e.g. DJs). These people are members of large social networks (see Figure 2: 1), the membership of which is based on common leisure pursuits (e.g. drugs, dancing). Such groups of drug users are not limited to the international rave scene or the drug use of the 1990s. The notion of ‘West End culture’, areas in which social class mixing takes place often at legal and illegal venues, has been highlighted by commentators in a variety of dance drug scenes. Kohn (1992), in his book, *The Dope Girls*, details dance drug (cocaine) use during the early twentieth century in London’s bohemian West End. More recently, in that same location, the British acid house scene was reported to have first taken hold among the London West End bohemians of the late 1980s (Collin, 1997).

It is suspected that drug use in this scene is in part regulated (limited yet sustained) by this local culture. The other major factor in dictating drug use (which drugs and their frequency of use) is the local availability of dance events, dates and venues. The next chapter will look at the factor that might dictate and limit the use of these drugs to the weekend, that is the dance scene itself.

CHAPTER 4

JUST TWENTY THOUSAND PEOPLE STANDING IN A FIELD?:

DANCE DRUG EVENT ENVIRONMENTS AND ACTIVITIES

Introduction

In the previous chapter a sample recruited from the Glasgow dance drug scene was described. In this next section it is intended to detail the nature of these respondents' participation in this scene. From the literature reviewed in Chapter 1 it is clear that an understanding of the nature of the dance scene is essential when considering patterns of drug use in the 1990s. The advent of dance drug use (particularly ecstasy) has been linked to a change in the nature of drug use from a private sub-cultural activity to a public mainstream recreational pursuit (Newcombe, 1991a; McDermott et al, 1992c; Redhead, 1993). Rave has been cited as the cause of a widespread increase in drug taking amongst the UK population (Border and Norton, 1996). The dance event has been said to be an environment in which much drug use now takes place (Henderson, 1993c). Indeed, such drug use has been described as merely part of a night out dancing, rather than as an end in itself (*Equinox*, 1994). In common with illegal drug use, raving may be viewed by many as a deviant recreational activity.

Anecdotal reports have indicated rave events take place in a variety of settings. Like the different drugs used by ravers, each of these settings will involve different attractions, benefits and risks to the dancer (see Zingberg, 1984). In a similar way to frequency and dosage of drugs, participation in the dance scene may vary between individuals. Levels of involvement in the dance scene may vary between once only experimental attendees to habitual participants. Some persons may spend most of their

time at dance events at rest, whereas others may dance continuously without breaks. The differing dance tempos created by DJs playing a variety of rave music genres must also influence dancing behaviours.

Despite these concerns, to date there has been little empirical research into participation at these events. This means that the way in which dancing behaviour and illegal drug use are related has remained unclear. There is a need to directly target this relationship, as it is unlikely to be explored by investigations into drug use per se. Previous drug work (such as that undertaken by researchers, social services and health agencies) has been mainly concerned with the problematic activities of esoteric minority groups, rather than with more mainstream recreational activities such as ecstasy use at dance events. For example, research into drug users' sharing of injecting equipment, acquisitive crime, imprisonment, overdose and prostitution, is unlikely to produce much information about the dance scene. Conversely, the evidence presented in the last chapter indicates that these problematic activities are uncommon among dance drug event attendees.

In this chapter, the following aspects of respondents' experiences of dance drug events will be explored:

- Patterns and levels of participation in the dance drug scene.
- Types of venue, music and clientele involved in the scene.
- Motivations for participation in the scene.
- Facilities for dance drug users at venues.
- The impact of the scene on participants' lives.

These investigations are necessary because the levels of participation at dance drug events, motivations for participation in the scene and the environment of venues, are all important aspects of the scene, each of which may have implications for the riskiness

of dance drug use. As will be explained later, these risks may be greater than those presented by the drugs used in dance settings themselves.

Patterns of Attendance at Dance Drug Events

Defining dance drug events

Each respondent was asked about attendance at four types of dance events. These were night-clubs, licensed raves, illegal rave parties and private parties. Taken together these four types of dance event can be regarded as the total dance drug scene. As a check for inclusion as part of the dance drug scene, respondents were asked only to include events where the dance drug ecstasy was being used. This assumes a simultaneous onset of ecstasy use and the dance drug (rave) scene as detailed in Chapter 1. It should be noted that the term dance event was defined and applied during fieldwork prior to the Scottish Office and Scottish Drug Forum's (SDF) definition of dance events in 1995. This 'official' (SDF) definition of dance event is "an event where dance music is played continuously and mixed by DJs into an apparently seamless sequence. Events may also include personal appearances by live dance music acts. The nature and tempo, measured in beats per minute, of different kinds of dance music varies greatly" (Scottish Drugs Forum, 1995).

In this thesis night-clubs are defined as regular (perhaps weekly) dance venues, which are usually located in city centres and are subject to normal local (alcohol) licensing hours and policies. Licensed raves are defined as occasional large scale dance events, licensed as such entertainments (often alcohol free) by the appropriate local authorities. These are sometimes attended by thousands of persons rather than the hundreds found in night-clubs. Licensed raves usually take place in concert halls, community centres,

sports-arenas or in some larger night-clubs located away from city centres. Raves last longer than normal night-club licensing hours permit and many other entertainments are usually provided rather than simply a bar and a dance floor. Illegal raves (or illegal parties) are defined as being similar to the above but unlicensed. These vary greatly in size and duration and often occur in secretive venues such as fields, barns, tents, disused railway tunnels, and warehouses. All fieldwork in this thesis was conducted before the passing of the Criminal Justice Act (1995). Clause 58 of this Act defines illegal raves as gatherings with music, rather than explicitly. This refers to events which are held "on land that is at least partly open to the air", in "the presence of at least 100 people". These also involve the "likelihood of serious distress to the inhabitants of the locality", being held "during the night" and involving amplified music defined as "sounds wholly or predominantly characterised by the emission of a succession of repetitive beats". Elsewhere such events have been referred to as "site parties" (Akram, 1997). Private parties were the most difficult category of dance event to define. These are principally house parties (i.e. in somebody's home) with DJs performing. Private parties can best be described as being of a similar 'ravey' nature to the other three categories. In effect these are small private raves which could take place either in someone's house or at a small venue used for events such as birthday parties or weddings. These parties could either be dance parties or 'chill-out parties'. Chill-out parties are gatherings that generally take place in a spontaneous or impromptu fashion after night-clubs or raves have ended. At these, slower music is usually played to assist in the 'come-down' (withdrawal) from dance drugs such as ecstasy. Other 'after parties' are intended to keep the dance going beyond licensing hours.

Measuring participation at dance drug events

Respondents were asked if they had ever attended each of the events listed above. If yes, then they were asked to say how many days in the past week, month and year (365 days from the present) they had done so. This is the same method as was used to record levels of drug use detailed in Chapter 3. Thus incidence and frequency of both drugs and dancing are directly comparable in this study. Also, in a similar fashion to drug use, respondents were next asked what was their age when they first attended each category of dance event.

During interviews one further check for inclusion as a legitimate dance drug event was made with some respondents. This concerned those who stated an age when they first attended a dance drug event that would have been prior to 'acid house scene' of 1988; that is, a dance event attendance prior to the widespread use of the drug ecstasy and the new (rave) music culture. Respondents who claimed their first event was in 1987 or earlier were asked to explain why they gave this answer. In several cases this transpired to have simply been attendance at a DJ party or night-club (disco) before the advent of the rave scene. In such cases respondents were invited to give another (older) age. However, twenty responses where the respondent's age indicated pre-1988 dance drug scene activity were accepted; the earliest date of these being 1985 (two night-clubs and two parties). This includes a single instance of clubbing in the USA prior to MDMA becoming a controlled drug there.

Other questions referred to the last occasion that respondents had attended each category of dance event. These asked for the total time spent at the last event attended in each of the four categories. This was recorded in minutes, as was a measure of time spent dancing at each event. It was also asked how much if anything it cost to gain admission to each category of dance event the last time the respondent attended.

Dance events attended in the past year

As might be expected from a sample recruited from the dance drug scene, all respondents had at some time attended one of the four types of events listed above. Indeed, only five (3.7%) had just attended one type of dance event. Fifty-three (39.3%) respondents had attended all four categories of dance drug event.

All respondents had attended at least one dance event in the past year (range 1 to 204). Across all four types of event the mean number of days in the past year in which there was participation in such dancing was 44.5. In other words, respondents on average 'raved' (participated in the dance drug scene) slightly less than once per week. This figure needs a degree of caution because it is possible that some respondents may have attended more than one type of dance event in the same day (which could be regarded as over-estimating the dancing frequency figure). Alternatively, some respondents may have visited more than one dance event in the same category on the same day (which could be regarded as under-estimating this figure). For example, a respondent who attended two different night-clubs on the same evening, then went on to a private chill-out party would be coded as having attended two dance events, one night-club occasion and one private party occasion. Details of the frequency of dance event attendance can be seen in Table 4: 1.

Table 4: 1, Attendance at Dance Events

	NIGHT CLUBS	LICENSED RAVES	ILLEGAL RAVES	PRIVATE PARTIES
Ever Attended Event	99.3%	60.0%	63.7%	91.9%
Attend Event Last Year	99.3%	34.8%	51.9%	90.4%
No. Occasions Last Year	40.6	3.8	5.4	22.5
Age First Attend (years)	20.2	21.8	21.7	20.5
Free Entry to Last Event	35.8%	32.9%	52.4%	-
Cost of Last Event (if paid)	£5.57	£14.27	£3.41	-
Time at Last Event (mins.)	231.1	420.8	323.7	352.5
Time spent Dancing (mins.)	113.3	234.2	124.9	68.1
Proportion of Time Dancing	45.5%	51.8%	38.7%	21.1%

Types of event attended

As can be seen in Table 4: 1, attendance at dance events varied by the type of event. All but one respondent attended night-clubs. This one respondent wished to attend night-clubs, but at age 15 he had only been able to gain access to under 18 (licensed) raves. Almost as many respondents had attended a DJayed private party. Fewer respondents had ever attended either a licensed or an illegal rave, although a majority of respondents had done so.

The pattern of attendance in the current year was quite different. All respondents who had lifetime experience of night-clubs had attended in the past year. There was a small decrease (by only two respondents) in private party attendance between lifetime and current year. However, attendance at licensed raves had dropped by almost half. Only around one third of the sample had attended a licensed rave in the past year and only

about half had attended an illegal rave. This finding may be reflecting a widely acknowledge decline in large raves in the years prior to 1994 in favour of small night-clubs (Collin, 1997). This decline was said to have been brought about by the actions of licensing authorities and police (M8, 1996).

Frequency of dance event attendance

As can be seen from Table 4: 1, the frequency of attendance over the past year varied between types of events. The frequency of attendance by those who went to night-clubs can be described as almost weekly (approximately 41 occasions) over the past year. Private parties could be described as almost fortnightly events. Licensed and illegal raves were attended less frequently, perhaps best being described as special occasion events.

Paired *t*-tests were conducted to compare which type of events were more frequently attended between attendees of more than one type of dance event. Respondents who attended both night-clubs and licensed raves ($n = 46$; $t = 8.16$), night-clubs and illegal raves ($n = 70$; $t = 9.51$) and night-clubs and private parties ($n = 121$; $t = 6.70$) were all found to attend night-clubs significantly more often (all $p < 0.001$). Frequency of attendance was also significantly greater at private parties than licensed raves ($n = 43$; $t = 4.37$) or illegal raves ($n = 68$; $t = 5.36$) (both $p < 0.001$). Of the 46 respondents who attended both licensed and illegal raves, there was a tendency for attendance at the latter to be more frequent (3.4 versus 6.8 days in the past year, $t = 2.06$, $p = 0.05$). There were no significant differences in attendance at any of the above events between different age groups (18 or not by 1988 see previous chapter) or social class (manual or non-manual). Male respondents were more frequent attendees of illegal parties (3.7 days in the last year compared with 1.3 for females, $t = 2.83$, $p < 0.01$) only.

From these attendance figures it is clear that night-clubs constitute the most important sector of the dance drug scene in this sample. The full significance of this with regard to the relationship between night-clubs and drug use, particularly ecstasy, will be discussed in Chapter 5.

Age of dance event attendance

From Table 4: 1, the mean age of first attendance at each type of event was in the respondents' early 20s. The recent advent of the dance drug phenomena in Scotland is indicated by age of first attendance being within four years of the mean age of the sample (24.1 years of age). Taking account of respondents' current age, the mean times elapsed since first attending a night-club, a licensed rave, an illegal rave and a private party were 3.60, 3.05, 2.90 and 3.30 years respectively.

Comparing the age of first attendance between the different types of event reveals that respondents were most likely to have attended night-clubs first. From paired *t*-tests, attendees of both types of events were more likely to have attended night-clubs earlier than licensed raves ($t = 5.02, p < .001$), illegal raves ($t = 5.91, p < .001$) or private parties ($t = 5.02, p < .05$). Private party attendance pre-dated both licensed ($t = 2.88, p < .01$) and illegal raves ($t = 4.97, p < .001$). There was no significant difference between age of first attendance at a licensed rave and age of first attendance at an illegal rave.

This temporal order also implicates night-clubs as the most important sector of the dance drug scene. The importance of this with reference to initiation into different forms of drug use, especially dance drugs, will be detailed in Chapter 5.

Time spent dancing

In Table 4: 1, it can be seen that the mean length of stay at dance events varied according to the type of event. For example, respondents spent nearly twice as long at their last licensed rave as at their last night-club. This may of course be due to raves lasting longer rather than respondents wishing to spend less time at night-clubs. Time spent dancing at licensed raves was also the longest across the sample. This was even the case when measuring time dancing as a proportion of the total time spent at the event. On average over half the time spent at licensed raves was dance time; that is, over four hours activity in an eight hour session. In contrast the least amount of dance activity was at private parties, where on average less than a quarter of the time was spent dancing. Whether the relative lack of dancing activity at private parties is due to the constraints of space (one such party attended during fieldwork was too crowded to allow movement between rooms) or due to these being 'chill-out' in nature is not known.

Comparing data between those who attended more than one type of dance event confirmed this pattern. Paired *t*-tests revealed that proportionally less time was spent dancing at private parties than at each of the other three kinds of events (all $p < 0.001$). Those who attended both spent 45.9% of the time dancing at night-clubs compared with 20.8% at private parties ($t = 6.81$), 52.3% of the time at licensed raves compared with 16.7% at private parties ($t = 9.70$) and 39.6% at illegal raves compared with 18.2% at private parties ($t = 5.42$). It should also be noted that the difference in level of dance activity between private parties and other dance scene events is likely to be even greater than is indicated by this time difference. This is because post-club or post-rave chill-out parties are likely to involve slower, more 'trancey' dancing, rather than the frenetic activity of a full-blown ('hardcore' or 'gabber') rave. Perhaps for similar

reasons to the above there was also a tendency for illegal raves to involve less dance time (40.5% of the time) than licensed raves (51.5%) between the respondents who attend both ($t = 2.10, p < 0.05$).

Cost of dance event attendance

Table 4: 1 indicates that a large number of respondents last entered a dance event free of charge. This was in part due to many respondents either working in the dance scene or knowing someone who does. Their high degree of involvement in the dance scene enabled many respondents to be 'guest listed', allowing free entry to night-clubs or licensed raves. It is hardly surprising that so many of these respondents should be guest listed, given the high degree of involvement in the scene that they exhibited, either through frequency of attendance or the West End culture bohemian social network detailed in Chapter 3. It is not known whether the bulk of night-club and rave attendees fit this pattern of non-payment or if there are large numbers of occasional dance scene participants from outlying suburbs or housing schemes, with non-bohemian social networks, who always have to pay when they go dancing. (After a year of less than fortnightly attendance the author was able to become guest listed, even at expensive 'all-nighter' licensed raves).

The situation at illegal raves was slightly different. These are usually termed as 'free-parties' and in essence this is true. However, some illegal raves did take a 'gate' fee at the door. More often a bucket would be placed at the entrance to the rave or passed around in the crowd. Into this bucket money would be donated in a similar fashion to the way in which a plate is used for church collections from congregations during religious services. This money is said to go towards the costs of running the rave rather than profit for its organisers. These 'costs' might include new equipment (sound

systems, lights, records, vehicles), payment of party organisers' fines or legal fees, bribes for site owners or neighbours, and, at the time of fieldwork, funding actions opposed to the Criminal Justice Bill of 1994. It was therefore usually at the respondent's discretion whether or not to contribute to this collection and if so how much cash to donate. Some respondents stated that they incurred financial losses due to their involvement in organising the last illegal event that they had attended. Private parties are by definition free of entry charge.

It can also be seen from Table 4: 1 that, where the respondent did have to pay to enter a night-club, licensed or illegal rave, the price for each differed substantially. When the mean prices paid to enter dance events were compared by paired *t*-tests, licensed raves were found to be significantly more expensive to enter than night-clubs ($n = 36$, £15.01 versus £5.38, $t = 10.21$) and illegal raves ($n = 17$, £12.91 versus £3.70, $t = 8.73$) among those who last paid to enter each (both $p < 0.001$). Night-clubs were also found to be significantly more expensive than illegal raves ($n = 25$, £6.10 versus £3.48, $t = 2.62$, $p < 0.05$). However, as the frequency of attendance at night-clubs was much greater than for raves, it is the case that night-clubs represent an overall greater financial outlay to these respondents than all other sectors of the dance scene.

As we will see in Chapter 6, this pattern of payment for attendance at dance events is mirrored in the pattern of payment for drugs among these respondents. In both instances many people participate for free while others incurred substantial financial costs. This is at odds with the view that participation in illegal drug cultures must always involve heavy financial costs (other than the cost of the drugs themselves) with little scope for acts of generosity (Preble and Casey 1969; Agar, 1973; Nurco et al, 1988; Johnson et al, 1990).

Dance Drug Scene Venues and Music Styles

Where do drug users go dancing?

Questions were also asked which were designed to measure more qualitatively what motivated respondents to attend dance drug events. This involved a series of open-ended questions about what night-clubs they had been to in the past year and what raves, legal or otherwise. Respondents were then asked what kind of music they liked at these events and elsewhere. As a check for definitions of dance event music style, reference was made to dance scene publications such as *UK Club Guide* (Club On, 1995).

Venues of dance events attended in the past year

The names of up to ten night-clubs and five raves attended by respondents in the past year were recorded. In total 98 different night-clubs and 56 specific (licensed or illegal) raves were mentioned, that is, more than one dance venue for each respondent. A majority (56.3%) of the whole sample had been to four or more different night-clubs in the past year. As might be expected from Table 4: 1, rave attendance (both licensed and illegal) was less varied, only two respondents having attended four or more of these. The mean number of venues attended in the past year was 4.6 (3.9 night-clubs and 0.7 raves).

From this information, night-clubs or raves with ten or more attendees were coded into separate binary variables. Each of these indicated either the attendance or non-attendance at a specific venue (e.g. a night-club) by each respondent in the past year.

Night-clubs and raves with fewer than ten attendees were grouped by type of music played there. Types of music played in each was defined by their listings in the magazines *The List* (a 'what's on' in Glasgow and Edinburgh guide) and *M8* (a Scottish rave magazine), as well as *The Good Club Guide* (1995).

Night-clubs attended in the past year

Ten night-clubs were attended by ten or more respondents in the past year. From this it can be judged that the sample recruited was not skewed towards only one club's attendees or any particular clique within the local scene. Each of these night-clubs was allocated a code-name. The most popular night-club, with 60 attendees in the past year (44.4% of the sample), was code-named *Saturn*. The other nine most popular night-clubs are hereafter called *Ariel* ($n = 59$), *Pluto* (59), *Venus* (57), *Titan* (33), *Io* (23), *Rhea* (20), *Asteroids* (17), *Ganymede* (13) and *Mercury* (10). Interestingly no night-club had more than 60 attendees in the past year, though four had at least 57. As we will see in the next chapter, the above night-clubs represent the environments in which the bulk of dance drug use by this sample took place.

The riskiness of dance drugs is in part governed by the setting of use. Deaths after using dance drugs, such as ecstasy, have been blamed (at least in part) on the night-club environment (Henry, 1992; Newcombe 1994; *Glasgow Herald*, 1995a; Scottish Drugs Forum, 1995). To assist in understanding the settings of dance drug use in this sample, a brief description of each venue is given below.

Club *Saturn* is located in central Glasgow, with a capacity of around 400. Four of the other night-clubs most frequented by respondents in this sample were located nearby (all clustered in postcode area G1). These were clubs *Titan*, capacity 850, *Mercury*, capacity 650, *Ariel*, capacity 650 and club *Io* 700. There is another concentration of

night-clubs located in a different area of Glasgow city centre (clustered in postcode area G2). Here can be found clubs *Ganymede*, capacity 750 and *Rhea*, capacity 200. Nearby is club *Asteroids*, a student union with a dance-floor capacity of 700. There are several other night-clubs in this locality which were attended by fewer than ten (in several cases zero) respondents. From the attendance figures listed above, two things are apparent. Firstly, the number of respondents attending each club is not merely a function of venue capacity. The most popular club, *Saturn*, is held in one of the smallest venues. Secondly it would seem that the night-clubs in the G1 cluster are of greater significance in the Glasgow dance drug scene. This is noteworthy because these respondents, living in the city's West End, live closer to the G2 cluster of night-clubs and many would actually pass their doors when en route to the more popular venues in the G1 cluster. Such esoteric concentration of services into specific areas of a city centre is a well known geographical phenomenon called agglomeration economies (Lloyd and Dicken, 1977). It is therefore unsurprising that clubs (and their relative attractiveness to dance drug users) should cluster in this fashion. Indeed, even premises where drugs are available or used have been shown to cluster together in city centres (Jansen, 1991). Clearly there are factors that attract dance drug users to specific venues, rather than any night-club being equally desirable, decisions on which to attend being governed only by convenience.

Club *Venus*, capacity 370, was not located in the city centre, but was located locally to respondents in the West End. For some time during data collection this venue benefited from its location by avoiding a strict curfew that had been imposed on Glasgow's city centre night-life at this time. This curfew led to Glasgow being dubbed "Cinderella city" (*Evening Times*, 1993; *Daily Record*, 1993b). Night-clubs in other towns and cities were said to have benefited from this policy. One such night-club was

Pluto, capacity 500, which is located in central Edinburgh. This venue attracted many respondents by providing special coaches that departed from the West End of Glasgow. A disco night-club is also located in the West End, but only eight respondents had attended this venue in the past year.

Each of these ten specific night-clubs are associated with different types of music. Clubs *Saturn* and *Titan* play garage and house music, clubs *Io*, *Pluto* and *Ariel* play techno, clubs *Mercury* and *Rhea* are discos, clubs *Venus*, *Ganymede* and *Asteroids* varied either between floors or over time. The importance of music in this drug scene cannot be over-stated. Not only are certain types of music associated with the dance drug lifestyle but also with the use of specific drugs (see Forsyth et al, 1997). Also of importance here, in relation to venues, is the tempo of music with regard to dancing behaviour. Slower forms of music, such as 'ambient', are likely to involve less risk than the faster styles such as 'hardcore'. Dancing to faster music will involve greater exertion, especially when under the influence of drugs, some of which may have stimulant effects (see Chapter 5). Faster dancing increases the likelihood of accidents, overheating, dehydration, sweating (hence infection) strain on the heart or simple exhaustion (Cook, 1997). Back-ache was mentioned by some respondents and this was attributed to both dancing and drug use (*Sunday Mail*, 1993). Faster music also tends to have louder beats. The volume of certain styles of music played at dance drug events, such as 'industrial techno', has been linked to problems akin to industrial deafness (Russo, 1994). Again the risk of damage may be increased if the dancer is under the influence of drugs, some which may have analgesic effects.

In an article on safer dancing, *the Face* magazine detailed the increasing speed in beats per minute (bpm) of dance music since the advent of ecstasy (Smith, 1995). Dance styles that preceded the dance drug scene (such as jazz-funk at 92 to 96 bpm) were

slower, than acid house (119 to 120 bpm) or early rave anthems (124 bpm). European techno is faster (128 to 135 bpm) and hardcore (150 to 180) faster still. The fastest of all dance music styles listed is 'gabber' (180 to 200 bpm) described in *the Face* article as "big in Scotland and Holland". Gabber is a Dutch slang term for delinquent, literally "mate" (Marcus, 1997), and is comparable with the Scottish term 'ned' or English 'yob'. In Holland, 'gabberball' is a mixture of MDMA and amphetamine used by fans of this type of dance music. This style of music was simply known as hardcore among Scottish ravers at the time of fieldwork, being faster than the 'happy hardcore' more popular in England. Gabber ('up-front Euro-hardcore') was the style of music played at the Hanger 13 venue in Ayrshire which was closed following three well publicised deaths (M8, 1994; Bush, 1994).

Aside from these ten venues, other night-clubs grouped together by music produced categories for: other techno clubs (with 18 attendees in the past year), ambient clubs ($n = 16$), hardcore clubs (12), other mixed (music) clubs (18), other discos (17), rock clubs (17), non-Scots clubs (21) and other club styles (19). These figures included night-clubs in Glasgow with fewer than ten attendees and those located in other towns and cities including, Ayr, Saltcoats, Kilmarnock, Elgin, Aberdeen, Clydebank, Paisley, Coatbridge and Edinburgh (other than club *Pluto*). Night-clubs outwith Scotland were coded separately because definitions of music genres (such as techno or hardcore) differ between Scotland and other countries. Indeed the term 'tartan-techno' has been used by English commentators to encompass all Scottish dance music (Saunders, 1995a). Of the 21 respondents who had been to a night-club outside Scotland in the past year, four clubbers did so abroad, one in Northern Ireland, the remainder had only done so in England. The other club styles' category comprises nine respondents who went to gay clubs, five to world music dance clubs (e.g. Latin, Salsa and African

dance) and nine respondents who attended house music clubs (other than those specified above which had more than ten attendees).

There were few demographic differences between night-club attendees. The main difference being that all 12 hardcore club attendees were in the younger age group (under 24) ($X^2 = 11.19, p < 0.001$). Interestingly, only club *Saturn* was attended most by female respondents. Thirty-one (60.8%) females attended this night-club in the last year compared with only 29 (34.5%) of males ($X^2 = 8.86, p < 0.01$).

Rave venues attended in the past year

Only two licensed raves had more than 10 respondents attending in the past year. Rave venue *Black Hole* ($n = 23$) is located at a Glasgow concert hall, capacity around 4,000. Rave venue *Zodiac* ($n = 10$) is located in the East of Scotland in an agricultural hall and has a capacity in excess of 10,000. A variety of other licensed raves, held in venues ranging from a scout hut, through community centres, a civic centre, and an airport hanger to a national exhibition and conference centre, were attended by a total of 31 respondents.

The relatively low number of respondents who attended licensed raves may be due to a decline in their popularity at that time (Collin, 1997) or because of their geographical distance from Glasgow. Locations of these events included Ayr, Prestwick, Cumnock, Strathaven, Motherwell, Uddingston, Coatbridge, Livingston, Alness, Arbroath and Peebles. It is noteworthy that many of these rave venues were located in the same parts of Scotland where the most of night-clubs detailed above are located (e.g. Ayrshire, Lanarkshire and in the east). In these regions (and venues) hardcore was the dominant style of the music played, as opposed to the techno of Glasgow venues.

One illegal rave, code-named *Deep Space*, was attended by 11 respondents. Only seven respondents had attended any other illegal raves. These included illegal festivals and a motorway extension protest.

Types of music preferred at dance events

Respondents were also asked directly what kind of music they liked to hear at dance events. Only two respondents gave the maximum five responses that could be recorded. In total 81 different types of music were cited. The answers given to this question could be quite complicated. For example, although 38 respondents simply stated “techno”, others stated varieties of techno such as “deep techno”, “dub techno”, “acid techno”, “intelligent techno” and “hardcore techno”. Many of these types of music are fusions or hybrids rather than distinct musical genres. For example, hardcore is an acknowledged genre in its own right (Saunders, 1995a), rather than simply a variety of techno. Also the term acid was cited across several other genres (e.g. acid house or acid jazz), plus simply being described as “acid music”. These categories were collapsed, so that for example, a respondent who stated “acid techno” would be coded as a fan of both types of music, acid and techno. The most popular type of music at dance events amongst respondents was techno ($n = 54$). Other genres with ten or more citations were house music ($n = 29$), Ambient electronic music (17), hardcore (19), acid (15), trance (11). Other types of dance drug (rave music) were combined to form an ‘other’ category. This other specific dance music group ($n = 18$) included fans of garage, tribal and jungle music. The generic term “rave” was cited by only four respondents. This latter finding indicates a high level of sophistication in the dance drug scene amongst these respondents. Large-scale survey drug research with samples of Scottish schoolchildren has established a relationship between dance drug music and

drug use (Forsyth et al, 1997). However, this association has been limited to associating the generic term 'rave music' with all forms of drug use (legal and illegal), rather than the more sophisticated patterns of drug use and musical tastes of this sample.

Varieties of dance music that do not owe their existence to the rave scene were also examined. A category for 'disco' type music was created by combining fans of jazz-funk and soul music ($n = 10$). Another category for world music (music not of UK or USA origin) was made by combining fans of reggae, Latin, salsa and African dance music ($n = 10$). Twenty-seven respondents simply stated the general term 'dance music'. Whether this is music associated with the dance drug scene or simply disco music was not made clear. Varieties of music that could not be described as dance music (e.g. rock) were cited by only nine respondents. Twelve respondents said they liked all types of dance music (whether of rave origin or not) or all music. Sixteen stated what music they did not like, either all music, all dance music or a specific form of dance music (e.g. eight did not like techno). One respondent (#032) did not know what the music he liked was called.

Female respondents were more likely to say they did not like any dance drug scene music. Twelve (23.5%) females did not like the music compared with only four (4.7%) males ($X^2 = 10.70, p < 0.001$). Females who liked the music appeared to prefer house. Seventeen (33.3%) females liked house music compared with only 12 (14.3%) males ($X^2 = 6.83, p < 0.01$). This agrees with females being more likely to attend club *Saturn*, Glasgow's only regular (since 1988) house music venue. House music was also more popular with middle class respondents. Only five (10.0%) of those in the manual social classes said they liked house music compared with 24 (29.3%) of their middle class counterparts ($X^2 = 6.72, p < 0.01$). This is in line with the school survey research

of Forsyth and Barnard (1997) which indicated that house music was more popular with children attending schools in non-deprived areas. Another difference in musical taste was that younger respondents were more likely to say that they liked hardcore. Only two (3.2%) respondents in the older age category of this sample (over 23) liked hardcore compared with 17 (23.3%) of the younger group ($X^2 = 11.16, p < 0.001$). This is in agreement with the findings above concerning venues.

Types of music preferred away from dance events

To see if respondents' musical tastes differed away from the dance scene the kind of recorded music they bought was also examined. Each respondent was asked how often they bought records, tapes or compact discs on a five point scale (never, daily, most days, weekly and less often). Nobody in this sample bought music every day. Eleven (mainly DJs) bought music most days, 26 every week and 61 did so less often. The remaining 37 respondents said they never bought recorded music. They were next asked what type of music they bought last. Answers included many of the types of dance event music cited above, such as techno ($n = 9$); but also non-dance drug music genres such as punk rock, top 40 and *Motown*. These types of music were collapsed into similar categories to those detailed above played at dance events. This gave only 30 respondents who bought any form of dance drug music. Six bought a form of rock music and 17 respondents stated that they last bought more general pop music (either that currently in the charts or that which was in the charts in the 1950s to 1980s, i.e. "oldies"). Eleven respondents bought music in the jazz-funk, soul (or *Motown*), disco category. Nine respondents simply stated "dance" music. Another 11 said they liked any or all types of music. Seven only bought blank cassettes to 'pirate' other peoples' pre-recorded music.

It is noteworthy, that less than one quarter of respondents should prefer to buy any form of dance drug orientated music given the high frequency of attendance at music orientated events. From these results it is clear that this culture differs from other mainstream music cultures. The dance drug scene would appear to be more orientated towards a greater focus on 'live' events rather than pre-recorded music. This contrasts with say rock music, where fans may buy many records of a certain group or artist but seldom hear them live, should they even choose to hold a concert. This difference in music orientated culture can not be explained by expense, as the cost of CDs, records and cassettes is in the same bracket as entry to night-clubs and raves. A more likely explanation may lie in the spontaneous hedonistic nature of the dance drug culture.

Dance Drug Scene Pleasures and Perils

What do participants like and dislike about the dance drug scene?

Each respondent was asked two open-ended questions which allowed them to state what it was that they liked about the dance drug scene and what they disliked about it. It was intended that the first question would examine factors that attracted respondents to the scene, such as drugs, music or dance. It was hoped the second question would help uncover any hazards that were creating difficulties for dance drug users, such as conditions in night-clubs or drug problems. Up to five responses were recorded from each respondent. Individual responses varied from one word answers such as "music" to complicated explanations, such as how the scene had made the electronic ('progressive') music of the mid-1970s socially acceptable again. Both of these

answers were coded simply (by the verbatim word in common) as “music”, either like or dislike. These results are summarised in Table 4: 2, which gives the numbers of respondents who stated each verbatim response listed.

Table 4: 2, Respondents’ Likes and Dislikes about the Dance Scene

	LIKE	DISLIKE		LIKE	DISLIKE
Freedom	4	0	No Freedom	0	1
Safe	2	0	Not Matter How Look	3	0
Release/Relax	5	0	No Relax/No Sleep	0	2
Atmosphere	24	1	Buzz/Vibe/Feeling	9	0
Energy/Enthused/Excited	12	0	Comedown	0	1
Fun/Laugh/Enjoy	12	1	Dynamic/Varied	3	0
Aggressive Youths	0	3	(Shady) Neds	0	14
Violence	0	21	Not Violent	9	0
Gangs	0	2	Gangsters	0	2
Laws/The Curfew	0	3	Bouncers/Door Policy	0	6
Police/Drug Squad	0	2	Drug Dealers	0	1
(Place to Take) Drugs	10	3	Bad Drugs	0	6
Ecstasy	2	0	Jellyheads	0	5
Lack of Alcohol	3	1	Drunks	0	3
Youngsters	0	1	Trance	2	0
Dance	14	0	Jump About Mad With It	1	0
Night Out/Party	4	0	Everyone has Good Time	7	0
New Fashion/Trendy	1	7	Old Fashion/Not Trendy	0	1
Cliques/Rivalry	0	8	No Cliques	1	0
Sexy	2	0	No Sex/Not Pick Up	2	0

Table 4: 2, Respondents' Likes and Dislikes about the Dance Scene (continued)

	LIKE	DISLIKE		LIKE	DISLIKE
Music	36	14	Work	1	1
Financial/Cost	0	12	Cost of Drinks	0	2
Commercialism	0	9	Venues (Conditions in)	1	6
Heat/Sweat	0	7	Crowds/Crush	0	9
Culture/Scene/Lifestyle	0	2	People too into the Scene	0	4
Pretentiousness	0	9	Artificial/Mindless	0	10
People	9	2	People Drugged/Gurning	1	11
Strange/Stupid People	0	4	Social/Mingle/Meet	16	0
Friendly	17	0	Friends there	9	1
Talking/Communicate	3	0	Can't/Won't Talk	0	4
Tribal/Oneness	5	0	Impersonal	0	1
Personal Reasons	0	2	Don't Know	0	1
Everything	0	2	Nothing	6	11

Participant rated positive features of the dance drug scene

A wide range of answers was given about what respondents liked best about the dance drug scene. Perhaps, surprisingly, the most popular responses were not concerned with either drugs or dancing. Music was the most popular feature ($n = 36$). The (friendly) atmosphere and social reasons were also often cited. However, a large number of the positive features given here may in fact be related to the use of drugs such as ecstasy. These include answers relating to the "energy", "trance" or the "vibe", not drinking alcohol, and the feeling of "tribal oneness". As will be detailed in Chapter 7, these responses are almost identical to respondents' answers given later about how they felt

after taking certain brands of ecstasy. Indeed, these ecstasy users also stated that individual pills made them feel friendly or sociable as well as wanting to dance.

Participant rated negative features of the dance drug scene

The feature of the scene which was most often cited as a dislike by these respondents was violence ($n = 21$). This is surprising because of the scene's reputation for being non-violent (Newcombe, 1991b; Newcombe, 1992b; Saunders, 1995a). (The author observed only one violent incident during the fieldwork detailed in Chapter 2). Only nine respondents stated non-violence as what they liked about the scene. However, almost half ($n = 10$) of those who did not like the violence were at pains to point out that it only happened sometimes and was much less severe than elsewhere (e.g. alcohol orientated discos). For these respondents it was the fear of violence intruding into their scene, based on friendliness and peace, rather than that the scene actually was violent, that was their concern. Associated with this violence was the appearance in the scene of aggressive teenage youths (neds) who in the respondents' opinion, had taken too many drugs (usually non-dance drugs such as temazepam, see Chapter 5). A typical answer describes "jellied up neds" as something disliked in the scene. The arrival of these undesirables was in turn linked to the commercialisation that was said to have killed the friendly atmosphere of the scene (see Chapter 1). Other than the financial costs incurred by this commercialisation, there was little criticism of venues. Only six respondents disliked conditions at dance venues, including there being no seats, dirt and wet (urine soaked) floors. A further seven did not like the heat or sweating associated with scene. Only two respondents complained about the cost of drinks (e.g. water to assist in temperature regulation).

These testimonies by participants about what might attract or dissuade them from participation in the dance drug scene are not as might be expected from the popular view of raves being characterised by drugs and death (Bush, 1993). Concerns relating to people taking ill or dying was completely absent as a negative feature of dance drug events in the minds of these respondents. Doubtless this reflects the rarity of such occurrences. However, many of the negative features listed have been linked with the kinds of ill health which respondents were likely to have encountered in the dance scene. The majority of 'rave-related' ill health consists of injuries and infections caused by conditions and behaviours in venues such as overcrowding, sweating, violence and drunkenness (Cook, 1997). As will be elaborated on in Chapter 6, being able to obtain drugs at dance venues was not the main reason for attendance.

Provision and Utilisation of Facilities at Last Dance Event

Respondents' descriptions of last dance event

A separate series of questions was also asked about the last dance event, of any type, each respondent had attended. The type of event and the name of the venue of this last dance event were recorded. Respondents were then asked if the venue had a 'chill-out' or cooling off, non-dance floor section. The time spent in the chill-out was also recorded in minutes relative to the total spent at the event. Details about the availability of water and the respondents' consumption of liquids while at their last event were also recorded.

Last dance venue attended

When the name of the last event attended by respondents was examined, each was classified into one of the types detailed above. Again the centrality of night-clubs to these respondents was borne out. Of the 132 respondents who could remember the last event they had attended, 120 (90.2%) cited the name of a night-club. Nineteen respondents said their last dance event was a licensed rave, two an illegal rave and one a private party. Why the numbers of illegal raves and private parties cited here are so low is unclear. It is possible that respondents may have been disinclined to mention these simply because they do not have names. However, respondents may also have regarded chill-out or pre-club parties (private or illegal) as merely incidental to the night out. The main event of the last night out (raving) was (usually) a night-club or (less often) a licensed rave. These two types of events can be viewed as distinct, pre-planned, nights out, rather than something that happens as an after-thought. Unlike parties and illegal raves, night-clubs and licensed raves take place on a regular basis at established venues and involve pre-event publicity such as fliers and posters. These fliers and posters are often retained by dance event attendees as keepsakes and during fieldwork many of the respondents who were interviewed at home had collections of fliers on their bedroom walls, including the recruitment flier detailed in Chapter 2 (see Appendix I). Thus, many respondents would be continuously reminded of nights out at night-clubs or licensed raves. There is seldom such publicity for illegal raves or private parties. These events may be viewed only as impromptu extensions to the licensed rave or club night out. Also, as indicated above, night-clubs and licensed raves tend to involve both more expense and (proportionally) more time dancing and therefore may be more definitive as last dance event.

Chilling

The need for dance venues to provide chill-out areas has become well known in the light of several deaths at dance clubs since the late 1980s (Newcombe, 1994b; Scottish Drugs Forum, 1995). Indeed, in 1996, legislation ensuring that owners of rave venues provide such a facility was passed in the Licensing Scotland Amendment Bill (1996). When asked, 76.1% of respondents said that there was a chill-out and 23.0% said there was no place to chill-out at their last dance event. Two respondents did not know if there was such an area. Eleven (10.8%) of those who last attended an event with a chill-out area spent no time there. This figure includes one respondent (#125) who did not know if there was a chill-out area because she did not look to find it. In contrast six individuals spent their entire time at the dance event in the chill-out area. These six include one respondent (#020) who said his last 'dance' event was a Sunday 'ambient night', which operated as a chill-out club from the weekend parties.

The mean length of time spent in chill-out areas among respondents whose last dance event had such a facility was 73 minutes (range 0 to 270). The mean duration of attendance at the last dance event was 262 minutes (range 60 to 720). Thus the average length of time spent in chill-outs was 31.6% of the total time spent at the event. It is possible that some respondents danced in a chill-out area or did not dance while on a dance floor (e.g. respondent #125, mentioned above, did not dance, so perhaps she would not have needed to chill-out). However, this figure of a third of the time 'chilling' would appear to agree with the half of the time dancing at night-clubs or licensed raves detailed in Table 4: 1, allowing time left over for other activities such as obtaining drinks, using the toilets or queuing at the cloakrooms.

From this it would appear that different dancing sessions by different ravers may involve different levels of risk to the dance drug user, at least in terms of dancing

activity and in the provision of adequately sized resting areas. Of particular concern is the finding that nearly a quarter of respondents last attended a dance event with no chill-out facility.

Consumption of fluids

Another way of chilling at a hot dance event, possibly under the influence of stimulant drugs, is consumption of fluids. Following a number of heat-stroke related deaths at raves, much 'harm minimisation' drug literature has been produced giving information which encourages the consumption of fluids especially water (MTDIC, 1992, Lifeline 1992b). Since then, in the light of the death of Leah Betts in late 1995, concern has been expressed about excessive consumption of water by drug users ("Ecstasy taker killed by water", *Glasgow Herald*, 1995b; "13 pints of water nearly killed E girl", *Daily Record*, 1997). It is suspected that many ravers misinterpreted the advice to drink plenty of water, thinking that this was an antidote to ecstasy (as might also be thought with alcohol), rather than as an antidote to overheating during vigorous dancing. Drinking water faster than is regulated by instinct (thirst) is more dangerous than using MDMA and death can result from dilutional hyponatremia (Collin, 1997).

Of those who could estimate how much they drank at their last dance event, 73.1% had consumed some alcohol, 34.3% some soft drink and 60.9% some water. All respondents consumed some liquid and 7.5% of the sample consumed all three types of beverage at their last dance event. Alcohol only was consumed by 19.6% of the sample, 3.8% drank only soft drinks and 8.3% only water. With over two-thirds of respondents (68.4%) consuming more than one type of liquid, it is clear that mixing beverages is the norm at dance drug events. This in itself may be a new pattern of fluid

consumption for many individuals who may previously have only consumed alcohol on licensed premises.

Alcoholic drinks

Across the whole sample the mean number of units of alcohol consumed at last dance event was 5.0 (or 6.8 units among those who consumed any alcohol at the event).

Comparing amounts of alcohol consumed at last dance event with that consumed on the last day of alcohol use (see Chapter 3) reveals a mean difference of 2.5 units less at last event. This of course could have been on the same day. Of those who consumed any alcohol at their last dance event, 29.6% drank more than on their last drinking occasion, 56.1% drank less and 14.3% the same number of units (it is not known whether or not this was the same occasion). It is possible that some respondents' alcohol consumption at a night-club may only be a portion of a day's drinking and that a night out clubbing may actually increase alcohol consumption. On the other hand, all but one respondent was a (lifetime) alcohol drinker, so it is remarkable that more than a quarter elected not to drink any alcohol at their last dance event, given that these were almost always held in venues licensed for the sale of alcohol. Also, the last day of alcohol consumption included instances of drinking wine with a meal at home (see Chapter 5), or a quick visit to the pub during the week (perhaps to buy dance drugs, see Chapter 6) rather than constituting part of a night out at the weekend.

Of particular interest was the finding that more (86.9%) older respondents (defined as aged 18 years or above in 1988) consumed alcohol at their last dance event than younger respondents (61.6%; $X^2 = 10.8$, $df = 1$, $p < 0.001$). It is possible that this difference reflects older respondents having begun their dancing careers prior to 1988; in discos; when alcohol consumption at dance venues was the norm. It is noteworthy

that there were no significant differences between younger and older respondents in either frequency of alcohol consumption over the past year (188 and 122 days respectively) or last dose drunk (9.8 and 9.5 units).

From these findings there is no evidence to suggest that attendance at dance drug events will increase individuals' alcohol consumption. Indeed, the opposite may be true.

Non-alcoholic drinks

Of the 44 respondents who consumed any soft drinks at their last dance 59.1% consumed more than one such beverage. These drinks were unpopular because a stomach filled with carbonated water could lead to difficulties with wind if mixed with vigorous dancing.

Consumption of water was much more popular than soft drinks. Amongst the 81 water drinkers, 70.4% consumed more than one drink (i.e. usually in excess of a full bottle).

In contrast to alcohol consumption, more (72.2%) younger respondents consumed water at their last dance event than older respondents (47.5%; $X^2 = 8.4$, $df = 1$, $p < 0.01$). It is possible that this difference reflects younger respondents having begun their dancing careers after the advent of ecstasy, at which time water consumption at dance venues became the norm.

Several methods were employed by respondents in order to obtain water. Of those who consumed any water at their last dance event only 16.1% paid for all this water at the bar. Despite a legal requirement in Scotland stipulating that licensed premises must provide water free of charge if asked for by a customer, only 17.3% obtained all their water by this method. The most common method of obtaining water was from taps in the toilets. Approximately one third (32.1%) of the sample obtained all their water in

this way. This might involve drinking water directly from the taps or by filling a container, such as an empty beer glass, soft drink can or water bottle. Resealable water bottles could be carried while dancing and continuously refilled in the toilets throughout the night without the need for payment or queuing at the bar. A further 21.0% paid for one or more (bottles of) water, drank them, then filled them up again in the toilets throughout the night. Another 6.2% obtained their first water at the bar without paying, then obtained refills from the toilets. Thus, a majority of respondents (59.3%) who consumed any water at their last dance event used the toilet taps for at least part of their supply. A final 7.4% of water consumers obtained this drink elsewhere (e.g. from friends who may in turn have used the toilets).

Variance in fluid consumption may have implications for the safety of the dance drug user. On the positive side, any reduction in alcohol use must bring both short and long-term benefits to the dance drug user relative to their non-raving peers. On the negative side, restricted access to, or excessive consumption of water has been implicated in several dance drug related deaths. Differences in the provision of fluids between dance venues are a particular cause for concern that will be examined in the next section.

Differences between dance venues

Further information about individual venues could be gained from the data collected on last event attended. These findings are summarised in Table 4: 3. In this table, only venues that were cited as the last dance event attended by ten or more respondents are shown. This means the mixed music clubs' category here includes clubs *Ganymede*, *Venus* and *Asteroids* combined with other venues with less than ten attendees in the past year.

Table 4: 3, Chill-out Facilities at Dance Venues

<u>VENUE (n)</u>	<u>CHILL-OUT AREA</u>	<u>FLUID CONSUMPTION</u>	<u>WATER SOURCE</u>
Club <i>Saturn</i> (11)	yes = 2 no = 9	alcohol = 8 soft drink = 3 water = 7	at cost = 6 free bar = 3 in toilets = 4 don't know = 1
Club <i>Pluto</i> (30)	yes = 29 no = 1	alcohol = 19 soft drink = 12 water = 19	at cost = 7 free bar = 11 in toilets = 18 don't know = 1 other = 2
Club <i>Ariel</i> (21)	yes = 20 no = 1	alcohol = 19 soft drink = 5 water = 13	at cost = 6 free bar = 4 in toilets = 15 don't know = 1 other = 1
Other Dance Drug Music Clubs (19)	yes = 13 no = 6	alcohol = 13 soft drink = 7 water = 13	at cost = 11 free bar = 3 in toilets = 8
All mixed Music Clubs (18)	yes = 10 no = 7 don't know = 1	alcohol = 17 soft drink = 6 water = 6	at cost = 3 free bar = 7 in toilets = 6 don't know = 3
Non-Dance Drug Music Clubs (10)	yes = 4 no = 6	alcohol = 7 soft drink = 3 water = 7	at cost = 0 free bar = 6 in toilets = 5
Rave <i>Black Hole</i> (13)	yes = 13 no = 0	alcohol = 7 soft drink = 6 water = 9	at cost = 6 free bar = 2 in toilets = 6 other = 1
All Other Licensed Raves (6)	yes = 6 no = 0	alcohol = 2 soft drink = 3 water = 4	at cost = 2 free bar = 0 in toilets = 3 other = 1
Illegal Raves (3)	yes = 2 no = 1	alcohol = 3 soft drink = 1 water = 1	at cost = 1 free bar = 0 in toilets = 1 don't know = 1

From Table 4: 3, it is interesting to note differences in the recency of attendance at the four most popular night-clubs (i.e. those with 57 or more attendees in the past year). More than half of those who had attended *Pluto* in the past year had gone there on their last dance event occasion, as had just over one third of club *Ariel* attendees. However, the numbers attending clubs *Saturn* and *Venus* ($n = 4$) on their last occasion were small in comparison to those who had attended in the past year. Whether these differences in recency of night-club attendance are due to changes in music (DJs), the curfew or conditions within the night-clubs themselves is not known. However, when conditions between venues were compared, some clear differences in facilities that may be beneficial to dance drug users were apparent.

Variations in the provision of chill-out areas between dance venues

From Table 4: 3, there would appear to be broad agreement across respondents as to whether each venue had a chill-out area or not. With the notable exception of club *Saturn*, night-clubs playing dance drug music were likely to have such an area. There was less often chill-out provision in night-clubs which did not play dance drug music (e.g. discos, such as club *Rhea*, where no such area was observed). Perhaps the management of night-clubs which do not play dance drug music may not see chill-out provision as concerning them. However, there also appeared to be less provision of chill-out areas in night-clubs described here as mixed clubs (e.g. in club *Venus*, where 2 of 4 respondents said there was a chill-out area). These venues vary between dance drug music events and other events (e.g. discos or rock concerts) and such provision might not seem so important to their management compared with specifically dance drug music orientated night-clubs. It is also possible that such club owners might feel that providing a chill-out area would classify their venue as a rave, drawing unwanted

scrutiny from the authorities. This variance in chill-out provision may increase the riskiness of dance drug use at such 'part-time rave' venues. At the other extreme all licensed raves attendees reported that these always had a chill out area.

Table 4: 3 also details differences in fluid consumption and water availability at venues. It is clear from this that all three beverages (alcohol, soft drinks and water) are consumed at each venue type. In most cases alcohol and/or water were the most popular beverages. Though there appears to be a slight tendency for alcohol use to be more common at night-clubs and water consumption at licensed raves, on the whole these two drinks were almost equally popular everywhere. This was even the case at non-dance drug scene venues. Perhaps one clue as to why water should be consumed at these venues lies in that it was always consumed free of charge at non-dance drug music venues. Water consumption by respondents was most often free from a bar at dance venues least associated with dance drug music (including mixed clubs). At raves and dance drug orientated night-clubs (e.g. club *Saturn*) paying for water was the norm, whether or not this was then topped up the toilets.

These findings are quite alarming. Although most dance drug orientated venues have chill-out areas some still do not. This is a particular cause for concern in instances (such as club *Saturn*) where water is less likely to be obtained free of charge. During observational fieldwork, detailed in Chapter 2, water was purchased at club *Saturn* for £1.50 per small 1/3 litre bottle; this compares with £1.00 per 1/2 litre mineral water at all other events attended. That free water should be available at night-clubs where it is less likely to be needed (e.g. discos and rock clubs) begs the question of whether the operators of raves and dance drug scene orientated night-clubs are exploiting drug use on their premises. The belief that ravers will 'need' to drink water or that drug users will purchase less alcohol (while on ecstasy) may have led to a reluctance on the part

of some venues to provide free water in order to maintain or increase profit margins. Some respondents reported difficulty in obtaining tap water over the bar at some venues, notably club *Saturn*. Failure to provide (tap) water free of charge is illegal in Scotland.

Impact of the Dance Drug Scene on Respondents' Lives

The smiley faces scale

Respondents were asked to rate how participation in the dance scene had effected their lives on a seven-point scale. This involved the respondent being presented with a card that had seven 'smiley faces' on it. The happiest face being rated as 1 (☺), through 4 (☹) to the saddest face rated 7 (⊖). Smiley face scale scores between 1 and 3 can be regarded as positive, scores between 5 and 7 negative, with face 4 indicating no overall effect. This question was broken down into effects that being involved in the dance might have had on the respondents' physical health, psychological health, financial status, legal status, employment status and social life. These categories have been used in a previous Scottish drug research and life events study (O'Docherty and Davies, 1987).

With a mean smiley faces scale score of 3.51, the overall impression among respondents was that attending dance events had a positive effect on their physical health. A positive score (faces 1 to 3) was given by 35.1% of the sample, a negative score (faces 5 to 7) by 3.0%. Negative scores tended to be given due to minor ailments (e.g. respondent #023 who had back-ache through untrained professional dancing).

Positive scores were due to keeping fit by dancing (e.g. #021 stated that this was the only exercise he ever did). No respondent thought that attending dance events merited face 7 (the most unhappy face) compared with nine who scored face 1 (the happiest face) for physical health effects.

Respondents rated the effect that attending dance events had on their psychological health even more positively. The mean faces' score was 3.08, with 53.0% giving a positive face and only 4.5% a negative (all at face 5, the least unhappy of the unhappy faces). Sixteen respondents gave the effect that dance event attendance had on their psychological health as the most positive possible score (face 1).

The ratings for employment and financial status were more mixed with mean faces of scores 3.96 and 4.29 respectively. A positive rating (faces 1 to 3) was given by 15.7% of respondents for both employment and financial status effects, with another 15.7% giving a negative score for employment and 27.6% scoring negatively for financial status. This was because some respondents had obtained a job in the scene (e.g. respondent #012, an internationally respected DJ) or had made money from the scene (e.g. university student #014, who supplemented her income by making orange crush at raves). Others had spent a lot of money attending dance events or thought that the scene had adversely affected their work (e.g. respondent #019 sacked for bad time keeping, despite having ceased drug use some months earlier through fear of random urine tests by his employer).

Only eight respondents rated an effect on their legal status. Four gave a positive score (all face 3), saying attending (non-alcohol orientated) dance drug events had helped them to keep out of trouble. Four gave negative scores (including two of face 7) because of drug related legal problems.

Only one respondent (#126) gave a negative score (face 5) on how the dance scene had affected them socially. Only 19.4% respondents gave face 4 (no overall effect) to this question, the remainder rated the dance scene positively, with 23.9% of the sample scoring the happiest face. With a mean smiley faces score of 2.40, it was clear that attendance at dance events was viewed as a major positive influence on the social lives of respondents. This confirms the findings of what respondents like best about the scene detailed in Table 4: 2.

A dance beat fit for ecstasy: Dance drug event environments and activities

From the findings of this chapter, it is clear that the dance drug culture not only differs from that of other drug using populations but also from other youth subcultures. In several key ways the nature of Glasgow dance drug scene was found to be at odds with the popular stereotype of raves as often portrayed by the media.

- Raving is a weekend lifestyle feature. This is in stark contrast to behaviours which other Glasgow drug research has associated with drug use. Deviant behaviours such as theft or prostitution have been found to be carried out on a near daily basis by opiate users and drug injectors (Hammersley et al, 1989; McKeganey and Barnard, 1992; Taylor, 1993; see Chapter 3). Participation in these drug scenes clearly involve a very different set of lifestyle choices than participation in the dance drug scene. In this scene drugs are used to enhance related behaviour (dancing); in other scenes related behaviours (crime) are committed to enhance drug use.
- The Glasgow scene takes place mainly in conventional city centre night-clubs. Although not unknown in this sample, the view often presented in the media that dance drug use usually takes place at raves, with '20,000 people standing in a

field', was untrue (Q, 1989; *Equinox*, 1994). In terms of recency, frequency and lifetime attendance, night-clubs were the venues where these dance drug users chose to go dancing.

- Motivation for participation in the scene was not restricted to dancing on drugs. Music and social reasons were more often cited as what respondents liked best about the dance scene. Harmful drug use or unhealthy conditions in night-clubs were not the things which respondents usually stated that they disliked about the scene. More mundane concerns, such as aggressive behaviour (e.g. neds) and money matters (e.g. commercialism), were more likely to dissuade respondents from continuing to participate in the dance drug scene.
- Chill-out areas and free drinking water were not universally available at night-clubs. Respondents obtained water from a variety of sources. Of particular importance was water from the taps in the toilets. Water was less likely to be obtained for free at venues playing music most closely associated with dance drug use, though these were most likely to provide chill-out areas.
- On the whole, respondents felt that participation in the dance drug scene had been a positive influence, particularly on their social lives.

In this chapter a picture has been painted of the Glasgow dance drug scene as viewed by these 135 respondents. The next chapter will examine the relationship between this scene and the drug use detailed in Chapter 3.

CHAPTER 5

DISCO 2000: RELEATIONSHIPS BETWEEN DANCE EVENTS

AND DRUG USE

Introduction

Since 1988, the popular media in Scotland has been reporting an apparent rise in the use of illicit drugs at dance events (“Drugs Deals at the ‘acid’ Disco”, *Daily Record*, 1988a; “Exposed - Disco Drugs Ring!”, *Sunday Mail*, 1992). Drug researchers have identified this new pattern of drug use throughout the UK and beyond (Lyttle and Montague, 1992; McDermott et al, 1992; Henderson, 1996). Health educators in the 1990s have come to refer to certain drugs specifically as “dance drugs” (Newcombe, 1991a; Lifeline, 1992a; Gilman, 1994). To date much of the research that has provided information about drug use related to the dance scene has been anecdotal or qualitative in nature. This chapter aims to identify and quantify the use of drugs which are used as dance drugs by the 135 respondents in this study and also which drugs are not used as dance drugs. This is important because there has recently been a great deal of media coverage about deaths at dance events, which have tended to focus only on the drug ecstasy (MDMA). Headlines such as “HUNT FOR KILLER ECSTASY: Deadly rave drug claims two more victims” (*Evening Times*, 1994b) and “Ecstasy rave link fear as three die” (*Glasgow Herald*, 1997) have led to the narrow equation that dance drug use equals MDMA use. Following on from this, it is usually assumed that any drug related harm at dance events must be due to ecstasy. As detailed in the previous chapter, the setting of use is of particular significance in this drug scene.

This chapter will classify dance drugs and examine the relationship between these substances and the (rave) scene by:

- Classifying dance drugs by their setting of use.
- Comparing levels of drug use with attendance at dance events.
- Identifying the place of dance events in the development of respondents' drug using careers.

Drug Use and Dance Scene Settings

In-users and out-users

It is known that different users may use different drugs in different locations or settings (Zingberg, 1984). For example, Korf et al (1991) identified two types of ecstasy (MDMA) user according to the setting of their drug use. These were defined as "in-users" and "out-users". In-users tended to take MDMA at home, out-users at dance events. Korf stated that the in-users were not people who did not "party"; it was simply that this is not the setting in which they chose to use ecstasy. In the present study, it is not so much the differences between drug users' choice of setting that is being compared (as they are, by definition, out-users) but the differences between drugs; that is, between drugs that are used at dance events (to "party") and drugs that are used elsewhere (i.e. not to "party").

Measuring places where drugs are used

A set of questions was asked about the circumstances of last use of each of the sixteen specific categories of drugs plus 'others', detailed in Chapter 3 (see Table 3: 6), that

each respondent had ever used. These were open-ended questions, the first of which asked for the setting of last use. If this was at a dance event, the respondent was then asked for the name of that dance event. It should be noted that, in practice, drugs were often ingested shortly before entering dance events. This was done in order to time the onset of the drug's effects with successful entry to the dance event, avoiding door searches. If last use was not at a dance event, they were asked to provide the name of the geographical area they were in at the time. In a similar fashion to this, respondents were asked to say where they obtained each drug (at which dance event or in which geographical area). They were also asked to say who they had obtained each drug from and how much (if anything) they had to pay for the amount of drugs they bought. These latter questions will be examined in Chapter 6. Finally, users were asked whether they had used the archetypal dance drug, ecstasy, on the last occasion they had used each other drug (i.e. if they mixed these drugs with ecstasy).

Table 5: 1 shows the different settings in which drugs were used. Dance event settings (defined here only as night-clubs, licensed raves or illegal rave parties) can be compared here with non-dance event settings (at home, another house, outside or in a pub). House parties (that is, in someone's home) and other locations, (usually at work or other events), both of which may or may not involve dancing, tended to lie somewhere between these two extremes. It should be noted that the 'work' (included in the other locations' category) was often in a dance setting (see Chapter 3). Other events included graduations, festivals, weddings, school discos, concerts, restaurants and onboard transport that was often travelling to or from a dance scene event. It should also be noted that in this Table a house party need not always be a chill-out party, after-party or ravey party as described in Chapter 4.

Table 5: 1, Settings of Use Compared between Drugs

Percentage of users of each drug category who last used at setting below:-

DRUG (N)	night CLUB	licensed RAVE	illegal PARTY	house PARTY	at HOME	other HOUSE	OUT-SIDE	in a PUB	OTHER Setting
Alcohol (132)	17.4	0	0.7	6.1	19.7	6.8	4.6	38.6	6.2
Tobacco (116)	6.9	0	0	0.9	53.4	7.8	13.9	10.3	6.0
Cannabis (131)	0.8	0.8	0	3.8	64.9	25.2	2.3	0.8	2.3
Heroin (26)	3.8	0	0	0	23.1	65.4	3.8	0	3.8
Buprenor. (18)	5.6	0	0	11.1	33.3	22.3	11.1	0	16.7
Dihydroco. (40)	0	0	0	2.5	45.0	30.0	7.5	0	15.0
Temazepam (69)	5.8	0	0	15.9	34.8	33.3	5.8	2.9	4.3
Diazepam (51)	0	0	0	3.9	45.1	23.5	3.9	13.7	10.0
Solvents (33)	0	0	0	6.1	21.2	24.2	42.4	0	6.1
Cocaine (93)	20.4	1.1	2.2	10.8	20.4	36.7	1.1	2.2	7.7
Amphet. (119)	47.9	4.2	0	9.2	12.6	12.6	0.8	4.2	7.5
Psilocybin (107)	7.5	0.9	0.9	9.3	21.5	20.6	28.0	1.9	9.3
LSD (123)	22.0	4.1	1.6	13.8	17.9	17.1	7.3	5.7	9.8
Nitrites (107)	49.5	3.7	0	6.5	11.2	15.9	4.7	3.7	4.6
Ketamine (18)	22.2	11.1	0	0	50.0	11.1	0	0	5.6
Ecstasy (122)	59.0	3.3	1.6	15.6	9.0	5.7	2.4	0.8	2.4
Others (75)	1.3	0	0	6.7	22.1	32.0	9.3	5.3	12.0

Notes: Others are a composite figure of up to 3 other drugs listed by respondents. Numbers given in bold type above are the most popular settings for each drug category.

From Table 5: 1, four drugs (ecstasy, nitrites, amphetamine and LSD) were more often last used in a dance setting than at any other. All pharmaceutical drugs (buprenorphine, dihydrocodeine, temazepam, diazepam and ketamine) were more likely to be used in the respondents' homes than anywhere else. This was also the case for the majority of tobacco and cannabis users. Heroin and cocaine were most commonly last used at

another's house. Solvents and psilocybin were used outdoors more often than in any other setting. Finally, alcohol was more often consumed in a pub than anywhere else.

Drug use in dance event settings

Collapsing these subdivisions of setting into dance, non-dance and others, as described in Chapter 4 and above, is even more revealing. A majority of users of alcohol, tobacco, cannabis, heroin, buprenorphine, dihydrocodeine, temazepam, diazepam, solvents, cocaine, psilocybin and ketamine last did so in a non-dance setting. Most users of amphetamine, nitrites and ecstasy last did so in a dance setting. LSD use was more evenly divided, the balance being held by other occasions. Although all drugs are represented in non-dance settings, it is notable that some drugs, such as cannabis, dihydrocodeine, diazepam and solvents, were almost totally absent from dance settings. Of those drugs which were last used by a majority of users in a non-dance setting, only alcohol and cocaine had 10% or more use in the dance scene.

There are some striking similarities between Tables 5: 1 and 3: 6 (Chapter 3). From Table 3: 6, it can be seen that illegal depressant drugs (heroin, buprenorphine, dihydrocodeine, diazepam) and solvents were the drugs least often used by these 135 Glasgow dance drug scene participants. From Table 5: 1, it can be seen that these depressant drugs were all most often used last in a non-dance event setting. Conversely, of the five illegal stimulant and hallucinogenic drugs (cocaine, amphetamine, psilocybin, LSD and ecstasy), only cocaine and psilocybin were most often used last in a non-dance setting. The three drugs with the most widespread use overall (the ubiquitous alcohol, cannabis and tobacco) were also most often last used in a non-dance setting.

To test the relationships between dance settings and drug use, Wilcoxon matched-pairs signed-ranks tests were conducted. These tested whether users of any two drugs were more likely to use one drug in a dance setting. These results are summarised in Table 5: 2.

Table 5: 2, Drugs Used in a Dance Setting

DRUG	TOB.	CAN.	DIH.	TEM.	DIA.	COC.	AMP.	PSI.	LSD	NIT.	ECS.
Alcohol	-2.2*	-3.7***	-1.6	-1.4	-2.4*	0.0	-4.3***	-0.7	-1.4	-3.8***	-5.7***
Tobacco		-2.1*	-1.3	-0.4	-1.6	-2.7**	-5.4***	-0.9	-3.0**	-5.1***	-6.2***
Cannabis			-1.0	-0.7	-1.0	-3.8***	-6.5***	-2.0*	-4.7***	-6.3***	-7.4***
Dihydrocodeine				-1.3	0.0	-2.5*	-3.6***	-1.8	-3.4***	-4.2***	-4.0***
Temazepam					-1.3	-2.4*	-4.7***	-0.9	-3.1**	-4.8***	-5.5***
Diazepam						-2.5*	-3.9***	-2.2*	-3.2***	-4.5***	-4.8***
Cocaine							-3.7***	-1.8	-1.4	-3.2**	-4.3***
Amphetamine								-5.1***	-3.5***	-0.3	-1.4
Psilocybin									-2.9**	-5.2***	-5.8***
LSD										-3.2**	-4.5***
Nitrites											-1.4
Ecstasy											

Note * $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

In this table, results from drugs that had fewer than ten matchings with any other drug have been excluded. For each drug tested a dichotomous variable of last use at a dance event was created by comparing last use in the scene against use in all other settings (including house parties and work/other events). Table 5: 2 lists the Z scores for each comparison between drugs by setting of use. From Table 5: 2, it is clear that the

likelihood of having last used at a dance event differs greatly between drugs. The drug users in this sample were significantly more likely to use amphetamine, nitrites and ecstasy at a dance event than any other substances. Next in order of likelihood of use as a dance drug were LSD and cocaine. Users were more likely to use these two drugs at a dance event than any (illegal) depressants (dihydrocodeine, temazepam and diazepam), cannabis or tobacco, but not psilocybin (in the case of cocaine) or alcohol (in both instances). Psilocybin was more likely to have last been used at dance event than diazepam or cannabis. Alcohol was more likely to have been used at a dance event than diazepam, cannabis or tobacco. The remaining substances have such low prevalence of use at dance events that they can scarcely be considered as dance drugs at all (though tobacco would appear more likely to have last been used at a dance event than cannabis).

Combining dance drugs and other substances

Although many drugs were seldom last used at a dance event, the possibility remains that these may have been used before or after attending a dance event. This presents the potential for dance drugs to be used in combination with other substances. The mixing of drugs in this way is referred to here as 'co-use'. Ecstasy, the drug most often used in a dance setting, can be used here as an example to illustrate this co-use phenomenon. Table 5: 3 details patterns of co-use between ecstasy and other drugs.

Table 5: 3, Co-use of Ecstasy and Other Drugs

DRUG	NUMBER (%) OF CO-USERS USE BEFORE ECSTASY	NUMBER (%) OF CO-USERS USE SAME TIME AS ECSTASY	NUMBER (%) OF CO-USERS USE AFTER ECSTASY	NUMBER (%) WITH NO CO-USE WITH ECSTASY
Alcohol	4 (3.3)	5 (4.2)	2 (1.7)	109 (90.8)
Tobacco	0 (-)	2 (1.8)	0 (-)	108 (98.2)
Cannabis	1 (0.9)	3 (2.6)	5 (4.3)	107 (92.2)
Heroin	0 (-)	0 (-)	1 (4.0)	24 (96.0)
Buprenorphine	0 (-)	0 (-)	1 (6.3)	15 (93.8)
Dihydrocodeine*	0 (-)	0 (-)	5 (13.2)	32 (84.2)
Temazepam*	1 (1.5)	0 (-)	24 (35.8)	68 (50.4)
Diazepam*	1 (2.0)	0 (-)	10 (20.0)	37 (74.0)
Solvents	0 (-)	0 (-)	0 (-)	32 (100.0)
Cocaine*	10 (11.4)	10 (11.4)	3 (2.2)	59 (67.0)
Amphetamine*	22 (19.6)	14 (12.5)	7 (6.3)	67 (59.8)
Psilocybin*	2 (2.0)	4 (4.1)	1 (1.0)	88 (89.8)
LSD*	1 (0.9)	19 (16.2)	0 (-)	91 (77.8)
Nitrites*	1 (1.0)	39 (37.5)	2 (1.9)	58 (55.8)
Ketamine*	2 (9.5)	3 (14.3)	0 (-)	14 (66.7)
Others*	1 (1.3)	0 (-)	7 (9.1)	68 (88.3)

Notes: * Cases where respondent co-used with ecstasy but could not remember the order of use, did not state the order of use or used in more than one of the before, during and after categories are not shown. The number of cases not shown for these reasons are for dihydrocodeine 1, temazepam 5, diazepam 2, cocaine 6, amphetamine 2, psilocybin 3, LSD 6, nitrites 4, ketamine 2 and composite of all others 1.

From Table 5: 3, a by now familiar grouping of drug categories is apparent. Depressant drugs, such as opiates and benzodiazapines, were never used at the same time as ecstasy, but were sometimes used afterwards. Stimulants and hallucinogens were less often used after ecstasy, but were more likely to be used simultaneously. Hallucinogens (e.g. LSD) were rarely used before ecstasy use, but some stimulants

(e.g. amphetamine) were. The higher frequency of alcohol, tobacco and cannabis use in this sample makes it unlikely that these drugs would have last been used with ecstasy.

Defining dance drugs

From Tables 3: 6, 5: 1 and 5: 2 a clear hierarchy of dance drug use in this Glasgow sample would seem to be emerging. There are three levels to this hierarchy. The first level consists of tobacco, cannabis, opiates, benzodiazapines and solvents, which can be described as 'non-dance drugs'. Alcohol, cocaine, ketamine and hallucinogens can be described as 'secondary dance drugs' and amphetamine, nitrites and ecstasy as 'primary dance drugs'. This three level hierarchy is considered below.

Primary dance drugs

The primary dance drugs are amphetamine, nitrites and ecstasy. These three drugs were more often last used at a dance event than in all other settings combined.

Though nitrite action is that of a short-term stimulant, its high incidence of use on the dance floor may be more related to availability. Nitrites were sometimes sold in clubs (legally at the time of data collection) and bottles of 'poppers' are often passed around the crowd. As such, much nitrite use appears to be more incidental than intentional on the dance scene.

This leaves ecstasy and amphetamines as the preferred drugs of the dance scene. This is not surprising, as the stimulant effects of ecstasy or amphetamine would surely enhance or prolong the dancing experience. This confirms the findings of Henry (1992) who described ecstasy as almost exclusively a dance drug. Amphetamine use is relatively common in other Scottish drug samples (e.g. Morrison and Plant, 1990;

Hammersley et al, 1990; Lavelle et al, 1991), but not ecstasy. This seems to indicate that ecstasy use is more closely associated with the dance scene than any other drug.

From Table 5: 3, co-use of ecstasy and the other primary dance drugs reveals an interesting contrast. Thirty-nine of the 46 co-users of ecstasy and nitrites used nitrites at the same time as ecstasy, usually at a dance event (four did not state when). This is similar to the pattern of co-use between ecstasy and hallucinogens (e.g. LSD). Twenty-two of the 45 co-users of amphetamine and ecstasy used amphetamine before ecstasy, 14 at the same time and seven afterwards (two did not state when). This is similar to the pattern of co-use between ecstasy and cocaine.

Secondary dance drugs

This is a varied group of substances with little in common except that in some cases their availability might deter their use as dance drugs.

Alcohol, like tobacco and cannabis, could be described as an 'ubiquitous drug', used regularly by respondents (see Chapter 3). Unlike tobacco and cannabis, alcohol has some associations with the dance scene. Indeed, alcohol could be described as a traditional dance music drug (at discos, ceilidhs, barn or ballroom dances etc.). However, alcohol is also widely available and used in a variety of settings other than dance events.

Psilocybin is another drug that sometimes appears to be used on the dance scene. However, from Table 5: 1, its main setting of use was outdoors. This reflects the natural hallucinogen's growth in the countryside, parks and gardens around Glasgow, where respondents often both picked and used this drug. This finding was confirmed by mapping the data collected on where each drug was last used and last obtained (see Chapter 6, Figure 6:3). The other hallucinogen (LSD) commonly used by this group

has a more evenly spread setting of use. When either of these two hallucinogens were co-used with the primary dance drug ecstasy, this tended to happen simultaneously (at the dance event itself). For example, Table 5: 3 indicates that, of the 26 respondents who used LSD with ecstasy, none stated that they used LSD after ecstasy and only one before ecstasy (six did not know or state when). The remaining 19 used LSD and ecstasy at the same time (usually at a dance event). There was a similar pattern of co-use between ecstasy and the hallucinogenic anaesthetic, ketamine. None of the seven co-users of these drugs used ketamine after ecstasy.

Ketamine is a drug that only recently has begun to be illicitly used (James, 1991; Lifeline, 1992a; Jansen, 1997). This is perhaps why ketamine has the oldest age of first use in Table 3: 6. Of the 16 drug categories asked about here, ketamine is the only drug that can be said to have arrived after the advent of the dance drug scene (assuming ecstasy's arrival as simultaneous). Previous articles have linked ketamine use to the dance drug culture (James, 1991; Lifeline, 1992a; Jansen, 1993). As such, it might have been expected that ketamine use should be commonplace in this sample. However, incidence of ketamine use was relatively low. This appears to indicate that the drug has not become as prevalent on the Scottish dance scene as some press reports have indicated ("Rave scene drug a killer", *Evening Times*, 1992). The muscle relaxant effects of this drug might also be seen as deterring its use as a dance drug.

Being a stimulant with a history of use in other dance drug scenes (Kohn, 1992; James 1994; Gilman, 1994), cocaine may have been expected to have been last used more often at a dance event than was the case in this sample. From Table 5: 1, the most common place of cocaine use was in a house other than the user's home. Heroin was the only other drug most often used in this setting. This might reflect cocaine and heroin often being considered together as 'hard drugs'. Indeed, previous research has

found two types of cocaine users in Scotland, 'recreational' drug users and heroin/opiate users (Hammersley and Ditton, 1994). Interestingly co-use of cocaine with the primary dance drug, ecstasy, often took place before ecstasy use (before a dance event). From Table 5: 3, of the 29 co-users, ten took cocaine before ecstasy, ten at the same time and only three afterwards (six took continuously or did not state when). So, although fewer than one quarter of cocaine users last did so at a dance event, others may have used the drug before going there.

Non-dance drugs

From the data presented here, two types of substances cannot be described as dance drugs. The first type comprises ubiquitous drugs other than alcohol (i.e. tobacco and cannabis), the second type comprises illegal drugs with depressant effects.

Ubiquitous drugs is a term used in Chapter 3 because of these substances' widespread use in this sample and across other different drug samples (e.g. Hammersley et al, 1990; Lavelle et al, 1991). As detailed above, alcohol has some dance associations and may be described as the 'traditional dance drug' prior to the advent of ecstasy. In the dance drug group, both tobacco and cannabis had been used by almost the whole sample and for more than half the days in the past year (290 and 220 days respectively for those who had used in the last year). As such, it is unlikely that these drugs would last have been used at a dance event. That is not to say that they are never used in a dance setting, merely that most users of these drugs would appear to do so on most days, no matter where they are. That said, there did appear to be a slight tendency for tobacco to be more likely to have last been used at a dance event than cannabis. Whether this is due to some individuals using tobacco specially to enhance the

enjoyment of raving or merely a reflection of the difficulties involved in attempting to smoke cannabis in a nominally drug free environment is not known.

Illegal depressant drugs comprise opiates, such as dihydrocodeine, and benzodiazapines, such as temazepam or diazepam. Although the number of users was fewer, solvents also appear to fit into this category. These are all drugs that have been viewed as problematic drugs, rather than dance drugs (Gilman, 1991 & 1993). Also, it is perhaps unsurprising that the use of depressants should be low at dance events. The very nature of their effects would impair dancing ability. On the other hand, the legally condoned depressant drug, alcohol, is usually available at dance drug events (over the bar) and at other dances not associated with the rave scene detailed in Chapter 4.

This does not mean that these drugs are never associated with the dance drug scene, only that they are not used as an adjunct to dancing behaviour. Indeed, many users in the dance drug sample mentioned using depressants to help aid sleep after dancing while on primary dance drugs. For example, Table 5: 3 shows that 44.8% of 68 temazepam users said they last took this drug in conjunction with ecstasy. Only one user of both these drugs took temazepam before ecstasy, the remainder afterwards (five did not specify when). As ecstasy was most often used in the dance scene and temazepam rarely so, this suggests that temazepam use in this group often took place after a night out dancing. From Table 5: 1, such use would appear most likely when the user returns home, goes to another's house or a (chill-out) party.

From these data, ecstasy appears to be the drug that is most often used at dance events. This often follows the use of stimulant drugs (amphetamine and cocaine) and is often accompanied by hallucinogenic or anaesthetic related drug use at the dance event. Later, depressant drugs (such as temazepam) may also be used as a 'come down'. This indicates dance drug use is not only restricted to those drugs actually

taken at the dance event, but includes others taken before or afterwards. To this might also be added commonly used drugs such as alcohol, tobacco, and cannabis, which from their high frequency of use (see Table 3: 6) appear likely to be used by some persons before, during or after a dance event. The next section will compare patterns of use of primary, secondary and non-dance drugs to patterns of dance scene participation.

Relationships between the Dance Scene and Drug Use

Comparing dance drugs with dance events

The findings above suggest that the use of different drugs is related to attendance at dance events. To test this relationship, comparisons were made between the drug use measures detailed in Chapter 3 and the dance scene measures detailed in Chapter 4. It was expected that primary dance drugs would be most closely associated with increased involvement in the dance scene and non-dance drugs least so. In this hypothesis it was also expected that secondary dance drugs would be related to some aspects of the dance scene (e.g. types of events) but not others.

Drug use and frequency of attendance at dance events

As frequencies of drug use and dance event attendance were recorded in an identical fashion (days per year) direct comparisons could be made between these variables.

Table 5: 4 details simple correlations between the frequencies of attendance at the four

types of dance events and the frequencies of use of the seventeen categories of drugs asked about.

Table 5: 4, Simple Correlations (*r*) between Drug Use and Dancing Frequencies in Past Year

DRUG	NIGHT CLUBS	LICENSED RAVES	ILLEGAL RAVES	PRIVATE PARTIES
Alcohol	.13	.03	.13	.23 **
Tobacco	.12	.08	.10	.19 *
Cannabis	.06	-.03	.16	.21 *
Heroin	.05	.08	.19 *	-.03
Dihydrocodeine	-.03	.14	.02	-.04
Temazepam	-.07	.03	.06	-.07
Diazepam	.10	-.01	.34 ***	.02
Cocaine	.14	-.05	.21 *	.09
Amphetamine	.15	-.09	.14	.23 **
Psilocybin	.08	.00	.10	-.03
LSD	.12	.19 *	.15	.30 ***
Nitrites	.10	-.04	.25 **	.27 **
Ketamine	.00	.09	.01	.38 ***
Ecstasy	.43 ***	.17 *	.23 **	.31 ***
Others	-.02	.08	.02	.04

Notes: Drugs with less than 10 users in the past year (buprenorphine and solvents (not shown). Secondary dance drugs exclude alcohol, non-dance drugs exclude tobacco and cannabis.

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

From this Table, the use of primary dance drugs (e.g. ecstasy) was most strongly correlated with involvement in the dance scene. This was not unexpected, nor was that

non-dance drugs (e.g. dihydrocodeine) were not correlated with dance event attendance. There were also notable differences between types of events. At one extreme, licensed rave attendance was not strongly correlated ($p < 0.01$ or better) with any drug. At the other extreme were private parties, attendance at which correlated with increased frequency of the majority of drugs listed. Presumably the environment of such parties, in which less dancing takes place (see Chapter 4), increases the range of drugs that might be used there. This seems to be especially the case with secondary dance drugs (e.g. LSD). This might also be the case, though to a lesser extent, with illegal raves. Why illegal raves and diazepam should correlate so highly is not known. Interestingly, greater frequency of attendance at night-clubs was only correlated with greater frequency of use of the archetypal rave drug, ecstasy (the highest correlation in Table 5: 4, $r = .43$). It is also noteworthy that no drugs were significantly negatively correlated with any type of dance event.

To test the relationship between involvement in the dance drug scene and drug use it was necessary to conduct multi-variant analyses to control for any other factors (e.g. demographic differences) which may account for the correlations detailed above. As all respondents in this sample were both dance scene participants and drug users, it was not possible to simply compare the use of drugs with dance event attendance per se. For example, all but one respondent had attended a night-club and only six (4.4%) had refrained from using cannabis in the past year. As indicated in Chapters 3 and 4, the continuous variables measuring frequencies of both dance event attendance and drug use varied greatly over this time period.

Multiple linear regression correlation analyses (ordinary least squares) were conducted, attempting to predict drug use frequency from participation on the dance scene, controlling for demographic variations such as age, sex and social class. These

were test-wise models aimed at predicting both the total variance in frequency of use of each drug (adjusted R^2) and the unique variance accounted for by each independent (predictor) variable (R^2 change). In each regression model the response variable was the frequency of use of each of the drugs taken by respondents. Predictor variables used were the frequencies of use of each drug (other than the response variable) and the frequencies of attendance at each of the four categories of dance event (both measured in days during the past year, range 0 to 365, see Chapters 3 and 4). To these were added measures of lifetime drug experience (the total number of different drug ever taken, maximum 17) and lifetime dance scene experience (the total number of different types of dance events ever attended, maximum four). Basic demographics (age, sex, social class I to V and total financial income) were also entered (controlled for). Initial analyses revealed statistically significant multi-co-linearity (variance inflation factor, $VIF > 3$) on three variables. These were heroin, dihydrocodeine (both opiates) and the other drugs variable (which includes many opiates, see Chapter 3). The other drugs variable was excluded from further analyses. The variables for heroin and dihydrocodeine were summed to produce a single variable for opiate use for the purposes of these regression equations. The results of the thirteen such analyses undertaken are shown on Table 5: 5.

Table 5: 5, Predicting Frequency of Drug Use

DEPENDENT DRUG VARIABLE	TOTAL Adjusted R^2	INDEPENDENT/ PREDICTOR VARIABLE	R^2 CHANGE
Tobacco	9.8 *	-cocaine amphetamine	4.5 * 3.9 *
Cannabis	30.2 ***	sex (male) drug experience <i>private parties</i>	6.0 *** 5.7 ** 2.1 *
Opiates	N.S.	age	6.4 *
Temazepam	16.4 **	diazepam -age	13.6 *** 4.2 *
Diazepam	33.1 ***	temazepam <i>illegal raves</i> nitrites drug experience	10.9 *** 3.7 ** 2.4 * 3.2 *
Cocaine	29.2 ***	- <i>scene experience</i> -tobacco sex (female) drug experience total income <i>illegal raves</i>	3.7 ** 3.6 * 3.4 * 3.2 * 2.5 * 2.3 *
Amphetamine	27.0 ***	nitrites ecstasy tobacco	9.1 *** 3.6 * 3.2 *
Psilocybin	N.S.	nitrites sex (male)	7.1 ** 2.7 *
LSD	19.3 **	drug experience ketamine -age	4.2 ** 3.5 ** 3.0 *
Nitrites	31.8 ***	amphetamine psilocybin <i>private parties</i> diazepam - <i>night-clubs</i>	8.5 *** 5.3 ** 4.3 ** 2.5 * 2.3 *
Ketamine	26.4 ***	<i>private parties</i> - <i>night-clubs</i> ecstasy LSD	14.2 *** 5.5 ** 3.9 ** 3.2 *
Ecstasy	35.7 ***	<i>night-clubs</i> ketamine amphetamine -age	11.9 *** 3.4 * 3.2 * 2.4 *

Note * $p < 0.5$, ** $p < 0.01$, *** $p < 0.001$, N.S. = non significant difference.

Table 5: 5 gives both the total adjusted R^2 for each dependent variable (drug category) and that uniquely accounted for by each independent variable (predictor). These figures can be converted to percentages. For example, the total variance in frequency of ecstasy use that could be accounted for from all the independent variables in the equation taken together, including that from interactions, was 35.7%. Individual predictor variables that uniquely add significantly to this overall equation are listed in order, best predictor first. In this example, 11.9% of variance in ecstasy use frequency could be accounted for by variance in frequency of night-club attendance among respondents in this sample. A negative sign is placed before predictor variables that are inversely related to each dependent variable. In the case of ecstasy, age was negatively related to frequency of use (i.e. younger respondents used more). In Table 5: 5, it is clear that factors which predict frequencies of use vary between drugs.

Taking the three ubiquitous drugs first (alcohol, tobacco and cannabis), a significant equation could not be constructed to predict frequency of alcohol use in this sample. This was possible with tobacco, which was negatively related to cocaine use and positively with amphetamine (all stimulants). In the case of cannabis, over 30% of the total variance could be accounted for by the predictor variables. Increased cannabis use was best predicted by being male, but also by having a lifetime experience of many drugs and (to a lesser extent) an increased frequency of private party attendance.

A significant equation predicting the opiate use variable (heroin plus dihydrocodeine) could not be constructed, though frequency of use was positively related to age. The other non-dance drugs (temazepam and diazepam) were best predicted by each other. In other words, the frequency of use of non-dance drugs was best predicted by the use of other non-dance drugs. Importantly, the use of these drugs was not predicted by

attendance at dance events (other than diazepam by illegal raves, $p < 0.05$) or by the use of dance drugs (except for diazepam use being predicted by nitrites use, $p < 0.05$).

As might be expected, the patterns found with secondary dance drugs were more complicated than those for non-dance drugs. For example, cocaine was best predicted by having less lifetime dance event experience (i.e. having attended fewer types of 'rave' event), but its use was positively associated with lifetime drug experience, though the only individual drug frequency variable that predicted cocaine was using less tobacco. Being female and having a high income also predicted cocaine use. A statistically significant regression equation predicting frequency of psilocybin mushroom use could not be created, though there were relationships with nitrite use and being male. The other hallucinogenic secondary dance drug LSD was best predicted by drug experience. Frequency of LSD use was also predicted by ketamine use and by younger age. Ketamine use was best predicted by frequency of private party attendance. LSD and ecstasy also predicted frequency of ketamine as did less attendance at night-clubs.

Primary dance drugs were similar to non-dance drugs in that their use was predicted by the use of other drugs in the same category (other primary dance drugs). For example, increased frequency of nitrite use was best predicted by increased frequency of amphetamine use. Amphetamine was best predicted by nitrite use and also by increased ecstasy use. In other words, variation in the frequency of use of a primary dance drug could, at least in part, be accounted for by variance in the use of the other primary dance drugs. However, the most interesting regression equation in Table 5: 5 is that of the pre-eminent dance drug, ecstasy. Frequency of ecstasy use in the past year was best predicted by frequency of night-club attendance in the past year. No other regression equation found a positive association between drugs and clubbing. Greater use of two

drugs; amphetamine (another primary drug) and ketamine (the only drug to become widely used after the advent of ecstasy), also predicted increased ecstasy use as did younger age. Ecstasy use was better predicted than any other drug using this model (adjusted $R^2 = 35.7$) and the relationship between ecstasy night-clubs was one of the strongest found in this data (aside from that between ketamine and private parties).

These findings tend to confirm the hypothesis that primary dance drugs are related to dance events and non-dance drugs are not. Factors predicting increased use of the secondary dance drugs were, as expected, somewhere between these two extremes. Secondary dance drugs may possibly be seen as 'luxury' special occasion items rather than the staples of dance floor or (problem) drug using behaviour. It is also noteworthy that social class was not related to drug use. This runs contrary to findings from other studies of Glasgow drug users which have associated drug use and deprivation (Haw, 1985; Rahman et al, 1989; Taylor, 1993; Frischer, 1995). The finding that cocaine use was linked to high income appears to confirm what little research has been done with this drug in Glasgow (Forsyth, 1993; Hammersley and Ditton 1994). This work found that cocaine users in the city tended to have more associations with patterns of affluent consumption rather than problem drug use.

Careers in Drug Use and Dance Event Attendance

Chronological ordering of drug use and dance events

The drug use questions detailed in Chapter 3 and dance scene questions in Chapter 4 were also directly comparable in terms of age (Tables 3: 6 and 4: 1). It is possible to

construct a retrospective temporal order of first use of each drug and first attendance at each type of dance event from the first ages given by respondents. Using this data it is possible to see which drugs were first used by respondents after initiation into the dance scene and which drugs they had taken before. Initiation into drug use before any dance scene participation would seem unlikely to be attributable to the scene. This could not be said of drugs which respondents began using later than and especially at the same time as their first attendance at a dance drug event. The problem with such a chronology is the recency of the dance drug phenomenon. Older respondents are likely to have used many drugs before the advent of the dance drug scene. On the other hand, all drug use by younger respondents is almost certain to have occurred after the advent of the scene, so each of the drugs they encounter will have an increased likelihood of being first used at a later date than first attending a dance drug event. To control for this the sample was divided into the two age categories detailed in previous chapters; that is, those who were aged 18 or over in 1988 ($n = 62$) and those who were under 18 at the time when the scene began ($n = 73$). This chronology is shown in Table 5: 6.

Table 5: 6, Drugs and Dance Events Ordered by Age

	YOUNGER GROUP	OLDER GROUP	ALL RESPONDENTS
Alcohol	13.7 (-3.0)	14.2 (-9.8)	13.9 (-5.9)
Tobacco	13.9 (-2.8)	14.3 (-10.1)	14.1 (-5.8)
Cannabis	15.4 (-1.3)	16.2 (-8.0)	15.8 (-4.1)
LSD	17.0 (+0.3)	19.2 (-5.4)	18.0 (-2.1)
Psilocybin	17.4 (+0.7)	19.6 (-4.5)	18.5 (-1.7)
Amphetamine	17.4 (+0.7)	19.7 (-4.3)	18.5 (-1.5)
Nitrites	17.3 (+0.6)	20.1 (-3.6)	18.7 (-1.3)
Diazepam	18.0 (+1.3)	20.1 (-3.8)	18.9 (-0.5)
Dihydrocodeine	17.3 (+1.6)	21.6 (-4.1)	19.9 (-1.7)
Heroin	19.3 (+2.3)	20.3 (-6.4)	20.0 (-3.6)
Night-club	17.0	24.5	20.2
Private Party	17.2	24.5	20.5
Cocaine	19.0 (+2.0)	22.2 (-2.2)	20.9 (-0.3)
Ecstasy	17.9 (+1.2)	25.2 (+0.3)	21.0 (+0.8)
Temazepam	17.8 (+1.3)	25.7 (+0.9)	21.3 (+1.2)
Other	19.2 (+2.6)	24.8 (-2.8)	21.3 (-0.2)
Illegal Rave	18.1	24.8	21.7
Licensed Rave	17.6	25.2	21.8
Ketamine	19.8 (+2.2)	26.9 (+1.6)	24.6 (+1.8)
AGE NOW	20.2	28.7	24.1

Notes: Drugs with less than 10 users in the past year (buprenorphine and solvents) not shown. Figures in brackets indicate the mean number of years between first use of each drug and age of first attendance at any of the four dance events.

From Table 5: 6, a clear ordering of drugs and dance events can be seen. Overall, dance events, particularly raves, appear later in respondents' careers. Across the whole sample, only cocaine, ecstasy, temazepam, ketamine and the 'others' had mean ages of first use older than mean ages of first dance drug event attendance. This pattern is confirmed when the ages of first use of those who had ever taken each drug were compared with the age of first use attendance at any dance drug event (usually a nightclub, see Chapter 4). In Table 5: 6, the mean age difference in years between the initial use of each drug and first attending any dance drug event is indicated by a '+' or '-' sign.

As might be expected, older respondents tended to have used most drugs prior to participation in the dance scene, often by as much as a decade or more. The exceptions to this pattern were ecstasy, temazepam and ketamine. This finding concerning these three drugs corroborates the literature reviewed in Chapter 1 confirming the simultaneous advent of ecstasy and the rave scene in Glasgow, the later advent of ketamine and the intrusion of temazepam into the dance scene as a 'come down drug' (see above).

In the younger age group, the basic ordering was the same as with the older respondents, apart from the three exceptional drugs above (ecstasy, ketamine and temazepam) which were each used at a much earlier age by younger respondents. Only the three 'ubiquitous' drugs alcohol, tobacco and cannabis had minus values for the mean difference between first use and first dance scene participation.

Comparing the results for the two age groups in Table 5: 6 lends support to the view that some drugs (e.g. amphetamine) were borrowed by the rave/dance culture, while others became popular as a result of it (e.g. ecstasy). This is borne out further by Table

5: 7, which compares the number of users of each drug who used at a younger, older or same age as that when they began attending dance drug events.

Table 5: 7 is also ordered by mean age of first use (as in Table 5: 6). Again, the differences between older and younger respondents are quite apparent. Excluding the three 'ubiquitous' drugs (alcohol, tobacco and cannabis), more users of every drug in the younger age group began using after first participation in the dance scene than had done so before first dance event attendance. This was so in a majority of cases for all these drugs except LSD and psilocybin.

In contrast, older users tended to have used most drugs before first participation in the dance scene. Only cocaine, ecstasy, temazepam, ketamine and drugs in the others category were exceptions to this pattern. Temazepam and ketamine were the only drugs that a majority of older users first used after participating in the dance scene. However, the most striking finding from Table 5: 7 is that a majority (26/50) of older ecstasy users gave the same age for first use of ecstasy and first attending a dance event. No other drug, in either age group, had a majority or even the largest number of users stating first use in the same year as first dance event. All other drugs had a majority of users who first used at either an older or younger age than first dance scene participation.

Table 5: 7, Co-incident First Use of Drugs and First Attendance at Dance Drug Events

	<u>YOUNGER AGE</u>			<u>OLDER AGE</u>			<u>ALL RESPONDENTS</u>		
	Used Before	Same Age	Used After	Used Before	Same Age	Used After	Used Before	Same Age	Used After
Alcohol	61	8	2	51	1	0	112	9	2
Tobacco	54	8	7	47	1	1	101	9	8
Cannabis	42	19	10	47	1	3	89	20	13
LSD	20	19	27	36	5	8	56	24	35
Psilocybin	17	11	27	32	2	12	49	13	39
Amphetamine	13	16	35	34	4	13	47	20	48
Nitrites	14	6	32	32	7	9	46	13	41
Diazepam	3	5	19	32	6	7	35	11	2
Dihydrocodeine	2	4	10	14	1	7	16	5	1
Heroin	0	1	7	11	3	3	11	4	10
Cocaine	1	5	33	22	8	18	23	13	51
Ecstasy	1	24	40	12	26	12	13	50	52
Other	1	2	19	11	1	12	29	3	31
Temazepam	5	5	28	6	2	18	11	7	46
Ketamine	0	0	6	0	3	8	0	3	14

Notes: Drugs with less than 10 users in the past year (buprenorphine and solvents) not shown. Figures in bold are the most popular ages at which each drug was first taken in relation to first attendance at any dance drug event for each age group.

Although the data presented in Tables 5: 6 and 5: 7 are cross-sectional and retrospective, it is clear that many drug users had used (dance) drugs prior to involvement with the dance scene. The answers given by the older age group in this sample tend to confirm the order of events detailed in Chapter 1. On the other hand, younger respondents began using most drugs sometime after commencing participation in the dance scene. This does not mean that attending dance events has led these individuals to use drugs. Given that the younger age group's drug use differed little from the older's, a more likely scenario would be that dance event attendance has added to their potential repertoire of drugs, particularly ecstasy.

The floor to E: Relationships between dance events and drug use

Chapter 3 indicated that these respondents were poly-drug users. This chapter has showed that different drugs were used in different settings. Some drugs were more likely to be taken at dance events than others. Often more than one drug was used at different times throughout a night's raving. As such, dance drug users could perhaps be better described as 'poly-setting drug users'.

- Amphetamine, nitrites and especially ecstasy were the primary dance drugs. Other drugs such as LSD and cocaine were also used as dance drugs. Even drugs not used to assist dancing, such as temazepam, were used during a night's raving by many respondents.
- The frequencies of use of drugs classified as non-dance drugs were closely related to each other, but not to those classified as dance drugs. Dance drugs were also related to each other and increased use of ecstasy, the archetypal dance drug, was best predicted by increased frequency of night-club attendance (the mainstay of dance event attendance in this sample, as indicated in Chapter 4).

- Ecstasy also differed from other dance drugs in that its first use tended to occur at the same time as initiation into the dance scene for many users. Other drugs, notably temazepam, tended to be used by respondents after dance events, both in terms of first attendance and literally during a night out.

These findings imply that certain forms of drug use are related to the advent of dance drug (rave) culture. This inevitably leads to the question of; whether or not this is because of a high level of drug availability at dance events. The possibility that dance/rave events are conduits for increased drug supply will be explored in the next chapter.

CHAPTER 6

SORTED FOR E's AND WIZ: DRUG AVAILABILITY AT DANCE

EVENTS AND ELSEWHERE

Introduction

This chapter will assess the impact that the advent of the dance drug scene has had on patterns of drug availability. It was hypothesised that dance drug availability (scoring and dealing) would differ from traditional illegal drugs' markets for two reasons:

i) As detailed in the previous chapter, unlike previous patterns of drug use, dance drug use takes place in public. This conspicuous pattern of drug consumption has led to sections of the media and many local authorities coming to regard dance events as 'drug supermarkets'. In Glasgow, for example, throughout the history of the dance scene, the local media have singled out raves as places where drugs are readily available. Newspaper headlines have included "CITY DISCO LINK TO DEADLY DRUG", (*Glasgow Evening Times*, 1990); "'Party packs' put youngsters at risk on the techno-dance scene", (*the Scotsman*, 1994); and "Crooked dealers con rave kids", (*Daily Record*, 1994b). This latter article even utilised the well-worn xenophobic drug stereotype of foreigners or outsiders entrapping innocent local youths (Kohn, 1992; Melechi and Redhead, 1988; Redhead, 1991). In this instance the outsiders were dealers from England peddling fake drugs at Scottish raves.

As happened in previous media fanned 'moral panics' about the welfare of youth (Cohen, 1972), legislative reaction to these events ensued. In Glasgow, local anti-drug

campaigns targeting the dance scene have included *Drug-shield* and *Club-watch*. Undercover police have saturated local dance events and organisers have been threatened with suspension of their license should they fail to co-operate. At a national level, new legislation, known as the 'Legg Bill' after Conservative MP Barry Legg, went through parliament in 1997. This aimed to give local authorities in England and Wales powers to close dance venues where the police claimed there was a "serious problem with controlled drugs". This legislation was significant in that it shifted the burden of proof on to the accused, because venues were now to remain closed during any appeal procedure, effectively putting the promoters out of business.

As no empirical research into drug dealing at raves had been carried out in Glasgow or elsewhere, are these actions justified? The question remains whether such dance events are drug supermarkets or merely places where people are obviously under the influence of drugs? If there are many drug users at dance events then perhaps it should follow that demand for drugs would be high at these locations. Dealing at a rave might also be seen to be taking place in a relatively overt fashion when compared to more traditional 'behind closed doors' drug dealing. This might result in an increased perception of drug availability at raves, which in turn might attract other users or dealers to these events only to buy or sell drugs and not to participate in dancing. If this is the case then dance events may indeed be drug supermarkets.

The term drug supermarket has been applied elsewhere to refer to areas of a city or locale where drugs are known to be conspicuously available. In such drug supermarkets users and dealers may either take up local residence or may frequently commute there in order to sell or obtain drugs. Curtis et al (1995) details such a drug supermarket in the Bushwick area of New York, USA. In their study, the drug supermarket operated at a street level with intravenous users being the customers.

Being labelled as a drug supermarket was seen as a catalyst for neighbourhood change (decline). It is possible that in much the same way as a neighbourhood of New York might be labelled a drug supermarket so might dance venues. The labelling of dance venues as drug supermarkets by the police, politicians or the media might also result in changes in the nature of such events (decline).

Other locations have also been identified as having played a role in the spread of drug use. Johnson et al (1990) identified 'shooting galleries', social-clubs, 'base houses', 'crack houses' and 'after-hours-clubs' as being in part responsible for the American "crack explosion" during the mid-1980s. This latter example would appear to be quite analogous to (illegal) raves, after-hours-clubs being places where illicit alcohol was sold and cocaine consumed. This may also be true for dance venues and the spread of the drug ecstasy.

ii), As detailed in Chapters 3 and 5, the drugs associated with the dance scene are of synthetic origin and are manufactured illegally. Illicit production of amphetamine, LSD and ecstasy is not dependent on either exotic botanical sources (e.g. cannabis, heroin or cocaine) or on pharmaceutical leakage (e.g. buprenorphine, dihydrocodeine, temazepam or diazepam). Those involved in the manufacture of dance drugs will need a degree of chemistry expertise and are therefore less likely to fit the traditional 'drug baron' stereotype. Such persons may have limited access to traditional drug dealing networks, which may hamper sales and reduce profit margins. Problems of this nature as encountered by one ecstasy manufacturer are described by Saunders (1995a). Also, dance drug production can take place in its country of consumption. Taken together, these differences increase the likelihood that dance drug dealers could be smaller scale operators, 'independent' of organised crime. It is possible these changes in drug distribution may disrupt traditional patterns of international drug smuggling (Bayer,

1993). The recent popularity of synthetic dance drugs may even precipitate a switch from the existing global drug trafficking pattern. Currently, Third World countries are usually seen as drug producers (e.g. Morocco, Turkey or Columbia) and developed countries being drug consumers (e.g. Netherlands, Scotland or USA). Thus, the nature of drug suppliers may change from foreigner to local resident (Bovinekeurk, 1996). Research by De Loor (1991) and Kaplan et al (1989) detailed the effect of the popularisation of the dance drug ecstasy on the patterns of trafficking in The Netherlands. There, the synthetic origin of MDMA created a different shape of dealing network. This had the manufacturer at the centre, surrounded by middlemen and dealers, keeping this person apart from the consumers. This new pattern was viewed as quite distinct from traditional networks where international traffickers have 'tentacles' reaching into every city, with chains of supply leading across the globe to a 'Mr Big' at the apex of the 'pyramid'. For these reasons, dance drug availability in Scotland might seem less likely to be effected by the events abroad, customs interdiction or the controls exercised by governments and industrial corporations over pharmaceuticals, than is the case with traditional illegal drugs.

In the UK dance scene, the pattern of dealing at events is thought to have changed over time. This has happened as the dance drug scene moved from 'underground acid house parties' to 'mainstream night-clubs', where traditional drug dealers could become involved in dance drug supply (Newcombe, 1991; Newcombe, 1992c). Supply of ecstasy in the acid house scene of 1988 was not by organised crime but by independents such as "Abby the ecstasy dealer" described by Dorn et al (1991). Abby supplied drugs for ideological motives rather than profit. Such changes in the type of drug dealer associated with the dance scene might also influence the range of drugs on sale.

This chapter will ask:

- Are dance events drug supermarkets? If so, then which drugs are available at such locations and which not?
- If dance events cannot be described as drug supermarkets or if some drugs are not available at dance events, then where are these drugs are obtained?
- From who are these drugs obtained and at what cost?
- Does availability in the Glasgow dance drug scene differ from that of 'traditional' drug dealing patterns?

These latter three questions are important because of the possibility of contact being made between these 135 respondents and persons involved in other drug scenes (problem drug users and criminal dealers). This might happen if dance scene users seek out new sources of dance drugs, perhaps in response to police and local authority policy aimed at reducing drug availability at dance events.

It should be noted that hereafter in this thesis the term 'scoring' drugs will be used when referring to obtaining drugs, rather than buying, as many users in this sample last obtained drugs free of charge (see Chapter 3, Table 3: 6).

Measuring drug availability

For each of the seventeen drug categories specified (alcohol, tobacco, cannabis, heroin, buprenorphine, dihydrocodeine, temazepam, diazepam, solvents, cocaine, amphetamines, LSD, psilocybin, nitrites, ketamine, ecstasy and 'others') that respondents had ever used, they were asked whether or not they last obtained it at a dance event. If yes, they were asked to name that dance event, if no they were asked to name the geographical area in which they obtained the drug. Respondents were prompted to give as specific a geographical area as possible, without revealing

addresses, to allow this data to be allocated to postcode sectors. This is an adaptation (to account for the advent of dance drug culture) of a method previously successfully employed elsewhere to measure levels of availability and dealing patterns of different drugs (Forsyth et al, 1992).

Availability at Dance Events

Locations where drugs are scored

Locations where drugs were last obtained were subdivided into those obtained actually at a dance event and those obtained elsewhere. Table 6: 1 shows which drugs were last scored at dance events and which in a variety of geographical locations. Drugs obtained from medical sources are also shown. It can be seen that in six of the 17 drug categories (cannabis, heroin, dihydrocodeine, solvents, psilocybin mushrooms and the 'other' drugs) no respondents last obtained at a dance event (i.e. the same number of different drug categories as were last obtained by at least one respondent during trips abroad).

Table 6: 1, Location Where Drugs Last Scored

DRUG	No. (%) who last scored in each of following locations:-					
	DANCE EVENT	Postcode in GLASGOW	Elsewhere in SCOTLAND	Other UK	Locations ABROAD	MEDI- CAL
Alcohol	19 (14.7)	102 (79.1)	6 (4.7)	1 (0.8)	1 (0.8)	-
Tobacco	6 (5.1)	100 (85.5)	7 (6.0)	1 (0.9)	3 (2.6)	-
Cannabis	0 (-)	117 (90.7)	10 (7.8)	1 (0.8)	1 (0.8)	-
Heroin	0 (-)	17 (68.0)	4 (16.0)	3 (12.0)	1 (4.0)	0 (-)
Buprenorphine	1 (6.3)	7 (43.8)	2 (12.5)	0 (-)	0 (-)	6 (37.5)
Dihydrocodeine	0 (-)	21 (56.8)	6 (16.2)	0 (-)	0 (-)	10 (27.0)
Temazepam	5 (7.6)	49 (74.2)	9 (13.6)	0 (-)	0 (-)	3 (4.5)
Diazepam	1 (2.1)	29 (60.4)	8 (16.7)	2 (4.2)	2 (4.2)	6 (12.5)
Solvents	0 (-)	19 (59.4)	11 (34.4)	2 (6.3)	0 (-)	0 (-)
Cocaine	9 (10.0)	56 (62.2)	11 (12.2)	9 (10.0)	4 (4.4)	1 (1.1)
Amphetamine	25 (22.1)	73 (64.6)	9 (8.0)	4 (3.5)	2 (1.8)	0 (-)
Psilocybin	0 (-)	51 (52.0)	40 (40.8)	3 (3.1)	4 (3.0)	-
LSD	16 (13.6)	82 (69.5)	12 (10.2)	5 (4.2)	3 (2.5)	-
Nitrites	46 (47.4)	39 (40.2)	5 (5.2)	6 (6.2)	1 (1.0)	0 (-)
Ketamine	4 (23.5)	9 (52.9)	1 (5.9)	2 (11.8)	0 (-)	1 (5.9)
Ecstasy	41 (34.2)	69 (57.5)	7 (5.8)	3 (2.5)	0 (-)	-
Others	0 (-)	40 (49.4)	14 (17.3)	4 (4.9)	8 (9.9)	18 (18.5)

Notes: Dance events abroad are listed here as locations abroad, as are all duty free alcohol and tobacco.

Medical includes: legal prescription drugs, drugs obtained by fraud, drugs stolen from hospitals and drugs obtained via veterinary sources.

Comparing drug scoring and setting of use

Obviously the location where a drug is scored need not always be the setting in which it is used. Using the findings detailed in the previous chapter, it is possible to compare where these 135 respondents last scored each drug with the setting in which they actually used it. With regard to dance events, three relationships between scoring and using are possible:

A) Drugs are used at the same location as they are scored. In the case of dance events this could be regarded as 'in house' drug use.

B) Drugs may be purchased at a dance event and used elsewhere. In the dance scene this is known as getting 'take-aways'. Such scoring behaviour would fit the drug supermarket hypothesis.

C) Drugs may be obtained elsewhere in advance of attending a dance event. This practice of planned drug use scored in advance is known in the dance scene as getting 'sorted'.

A - 'In house': Scoring and using at dance events

Given the large number of respondents who used drugs in a dance setting (see Chapter 5), the most obvious location where drugs might be obtained was at a dance event. Indeed, 64.4% respondents last obtained at least one of the drugs listed at a dance event. However, none of these drugs were last obtained at a dance event by a majority of users and only nitrites were most often obtained at a dance event. There was a large degree of correspondence between those drugs used in the dance scene and drugs obtained there (see Table 5: 1). Table 6: 2 shows the numbers of respondents who both scored and used each drug in a dance event setting.

Table 6: 2, Drug Availability and Dance Events

DRUG	Number (%) of respondents who:-		
	OBTAIN DRUG ELSEWHERE USE AT EVENT (SORTED)	OBTAIN & USE DRUG AT EVENT (IN HOUSE)	OBTAIN DRUG AT EVENT & USE ELSEWHERE (TAKE-AWAYS)
Alcohol	0 (-)	19 (14.7)	0 (-)
Tobacco	2 (1.7)	5 (4.3)	1 (0.9)
Cannabis	2 (1.6)	0 (-)	0 (-)
Heroin	1 (4.0)	0 (-)	0 (-)
Buprenorphine	0 (-)	1 (6.3)	0 (-)
Dihydrocodeine	0 (-)	0 (-)	0 (-)
Temazepam	3 (4.6)	1 (1.5)	4 (6.1)
Diazepam	0 (-)	0 (-)	1 (2.1)
Solvents	0 (-)	0 (-)	0 (-)
Cocaine	8 (8.9)	8 (8.9)	0 (-)
Amphetamine	29 (25.7)	24 (21.2)	1 (0.9)
Psilocybin	9 (9.2)	0 (-)	0 (-)
LSD	18 (15.3)	16 (13.6)	0 (-)
Nitrites	3 (3.1)	45 (46.4)	1 (1.0)
Ketamine	2 (11.8)	4 (23.5)	0 (-)
Ecstasy	37 (30.8)	38 (31.7)	3 (2.5)
Others	2 (3.0)	0 (-)	0 (-)

Notes: Percentages refer to all users, not just dance event related use

B - 'Take aways': Scoring at dance events and using elsewhere

From Table 6: 2, it can be seen that this practice was relatively uncommon. This was most often the case with temazepam which was 'taken away' by four of the five respondents who last obtained it at a dance event. Though this number is small, it is suspected that obtaining this drug as a take-away might be related to its use as a 'come down drug' after dancing on stimulants (see the previous chapter). Ecstasy was taken away by three respondents and tobacco, diazepam, amphetamine and nitrites by one person each. No respondents reported alcohol, cannabis, heroin, buprenorphine, dihydrocodeine, solvents, cocaine, psilocybin, LSD, ketamine or any drugs in the other drugs category as being take-aways from a dance event when last used.

C, 'Sorted': Scoring before and using at dance events

A much more common occurrence was the practice of being 'sorted' before a dance event. This means obtaining the drugs prior to attending a night-club or rave. In such cases the drug would usually be ingested before entering the dance event to avoid detection by door staff, timing the onset of drug effects with anticipated time of arrival on the dance floor. This was noted during the participant observation phase of fieldwork, as was the belief that it was easier to gain entry to certain night-clubs, as a non-member, if you were obviously under the influence of drugs. The logic behind this being, that door staff were likely to think that someone 'on drugs' would 'fit in' at the venue and were unlikely to be a drunk, a ned, an undercover police officer, a journalist or a drug researcher.

The practice of obtaining drugs outwith the dance scene and using them at a dance event was found with 12 of the 14 drugs that were last used at a dance event (dihydrocodeine, diazepam and solvents were not last used at a dance event by any

respondents). The two exceptions to this pattern were alcohol ($n = 19$) and buprenorphine ($n = 1$) where all use at a dance event was obtained at that event (i.e. neither of these two drugs were sorted before hand nor used as take-aways). In the case of alcohol this is unsurprising given that licensed premises (clubs) sell alcohol and neither allow patrons to bring it in with them nor carry it outside.

From Table 6: 2, it can be seen that the drug that was obtained elsewhere and used at a dance event by the largest number of respondents was ecstasy. Thirty-seven of the 78 ecstasy users who last used that drug at a dance event were sorted before the event (see Chapter 5). This was also the case with each of the other illegal drugs commonly used on the dance scene. Similar proportions were found with LSD, where 18 of 34 dance event users, amphetamine, 29 of 54 dance event users and cocaine, eight of 16 dance event users last obtained the drug in a location other than a dance event. This practice was found in only three cases of nitrite use at a dance event. This presumably reflects this primary dance drug's legality during 1993 to 94 (it was sometimes sold over the bar in night-clubs) and also the way bottles of 'poppers' are passed around the dance floor. Drugs less commonly used at dance events were also on occasion obtained elsewhere before being used at a dance venue. This was the case for two respondents of the five who last smoked tobacco at a dance event, three of the four who last used temazepam at a dance event and two of the six ketamine users who last used at a dance event. Both respondents who last used cannabis at a dance event obtained it elsewhere, as did all nine who last used psilocybin in a dance setting and two instances of drug use in the other drugs category. Clearly a dance event setting is not one where a diverse range of drugs is likely to be obtained.

Are dance events drug supermarkets?

Although drugs are available at dance events, it might be misleading to label such locations as drug supermarkets. This is evidenced by the practice of getting sorted being commonplace. If drugs were readily available at dance events then one might expect there to be little need to score drugs in advance. In contrast, take-aways, or instances of scoring drugs at a dance event and using them elsewhere, were relatively uncommon. This infers that users who intend to continue drug use after a night-club or rave, at say a chill-out party, are confident of obtaining supplies elsewhere after leaving the dance event venue. Clearly dance drugs are widely available from sources other than dealers at night-clubs and raves. That said, the numbers of respondents who last used cocaine, LSD, amphetamine or ecstasy at a dance event and who also scored, in house, were similar to the numbers who were sorted for these drugs beforehand. Other (non-dance) drugs were seldom sorted before or scored at a dance event. From these data it would appear that the range of drugs available at dance events is somewhat restricted. This lends support to the rejection of the drug supermarket hypothesis. Most dance events might be described as 'specialist shops' (or 'sweet shops', see next chapter) rather than supermarkets, as only certain (mainly dance) drugs are available to only some attendees.

The next section will examine in what kind of locations dance drugs users obtain most of their drugs, that is scoring at non-dance venue locations.

Availability Outwith Dance Events

Scoring in locations other than dance events

From Table 6: 1, it is clear that a majority of all drugs were last obtained away from dance scene settings. In this Table, these other locations are broken down into those obtained somewhere in Glasgow (the GGHB area), obtained outwith Glasgow (elsewhere in Scotland, elsewhere in the UK and abroad) and those obtained either legally or otherwise from medical sources. Patterns of obtaining drugs from each of these sources will now be described.

Drugs prescribed or stolen from medical sources

This source is comparatively rare in this sample, perhaps reflecting how few respondents have ever been in drug or alcohol treatment ($n = 17$, with only eight ever having been prescribed drugs as substitution therapy, see Chapter 3). The only drugs obtained by more than 10% of their users in this sample from medical sources were buprenorphine ($n = 6$, 37.5%), dihydrocodeine ($n = 10$, 27.0%) and diazepam ($n = 6$, 12.5%). These are all pharmaceutical drugs with a relatively low incidence of use in this dance drug-using group. The remaining prescription pharmaceutical, temazepam, was obtained by only three (4.5%) of its users on prescription last time. This low number of temazepam users obtaining by prescription (for whatever reason) perhaps reflects a more established illicit market for this drug in Scotland. This is also indicated by much previous drug research in Scotland (e.g. Sakol et al, 1989; Lavelle et al, 1991; Druglink, 1992; Hammersley et al, 1992; Forsyth et al, 1993; Hammersley et al, 1995).

Only 11 respondents last obtained any drug on prescription. Other methods of obtaining medical drugs included incidences where respondents were able to steal drugs, such as cocaine or ketamine, from medical and veterinary sources. As will be shown in the following sections, perhaps because of their relative lack of popularity among dance drug users, with the exception of temazepam the patterns of scoring pharmaceutical drugs on the 'grey-market' tended to differ from that of other substances.

Scoring drugs away from Glasgow

As shown in Table 6: 1, some users last obtained drugs in each category away from the Glasgow (GGHB) area. Nineteen respondents last obtained at least one drug while abroad, and 32 did so elsewhere in the UK. All respondents last obtained at least one drug somewhere in Scotland other than in Glasgow or at a dance event. This more likely reflects respondents' propensity for travel while continuing to use drugs, rather than that they could not score locally and had to travel to do so. This is not unexpected, given the diverse geographical locations where respondents had attended dance events detailed in Chapter 4.

From Table 6: 1, it can also be seen that no single drug was last obtained by more than four respondents abroad. There were eight such instances in the other drug category. This category includes many obscure and esoteric drug incidents such as methamphetamine (ice) scored in Taiwan and 'magic apples' (datura) picked in Israel. The drugs with the greatest number of respondents last scoring abroad were cocaine and psilocybin, each with only four such incidences. It should be noted that the psilocybin mushrooms obtained abroad (such as Australian 'gold tops', *Psilocybe* or *Stropharia cubensis*) were different from those obtained in the UK ('liberty caps',

Psilocybe semilanceata). The drug most commonly obtained elsewhere in the UK was cocaine ($n = 9$, 10.0% of users). To this might be added the only instance of crack use found in this group, scored in Manchester. Of the four pharmaceutical prescription drugs - buprenorphine, dihydrocodeine, temazepam and diazepam - only the latter had any incidences of scoring outwith Scotland in this sample, including as an over-the-counter medicine in India. All non-pharmaceutical drugs were last obtained outwith Scotland by more than one individual.

All drugs were obtained by at least one respondent in Scotland but outwith Glasgow and not at a dance event. The drug with the highest level of obtaining elsewhere in Scotland was psilocybin. This reflects the greater abundance of the mushroom that contains this drug in rural areas. Indeed, as will be shown later, even those who picked this mushroom within the GGHB often travelled to fields around the edge of the city in order to guarantee adequate supplies.

In short, respondents were able to score drugs when they travelled away from Glasgow, but, as will be elaborated on in the next section, they were able to obtain all drugs in the city, apart from the exotic rarities mentioned above (e.g. ice, crack and gold tops).

Scoring drugs in Glasgow

All but one respondent last obtained at least one drug in Glasgow (the GGHB area). In 14 of the 17 drug categories, the majority of scoring took place in Glasgow and not at a dance event. The exceptions were buprenorphine, a drug undergoing a voluntary prescribing ban by Glasgow GPs (Stewart, 1991), nitrites, which are sold over the counter in Glasgow clubs and the other drugs category, which includes the exotic rarities detailed above.

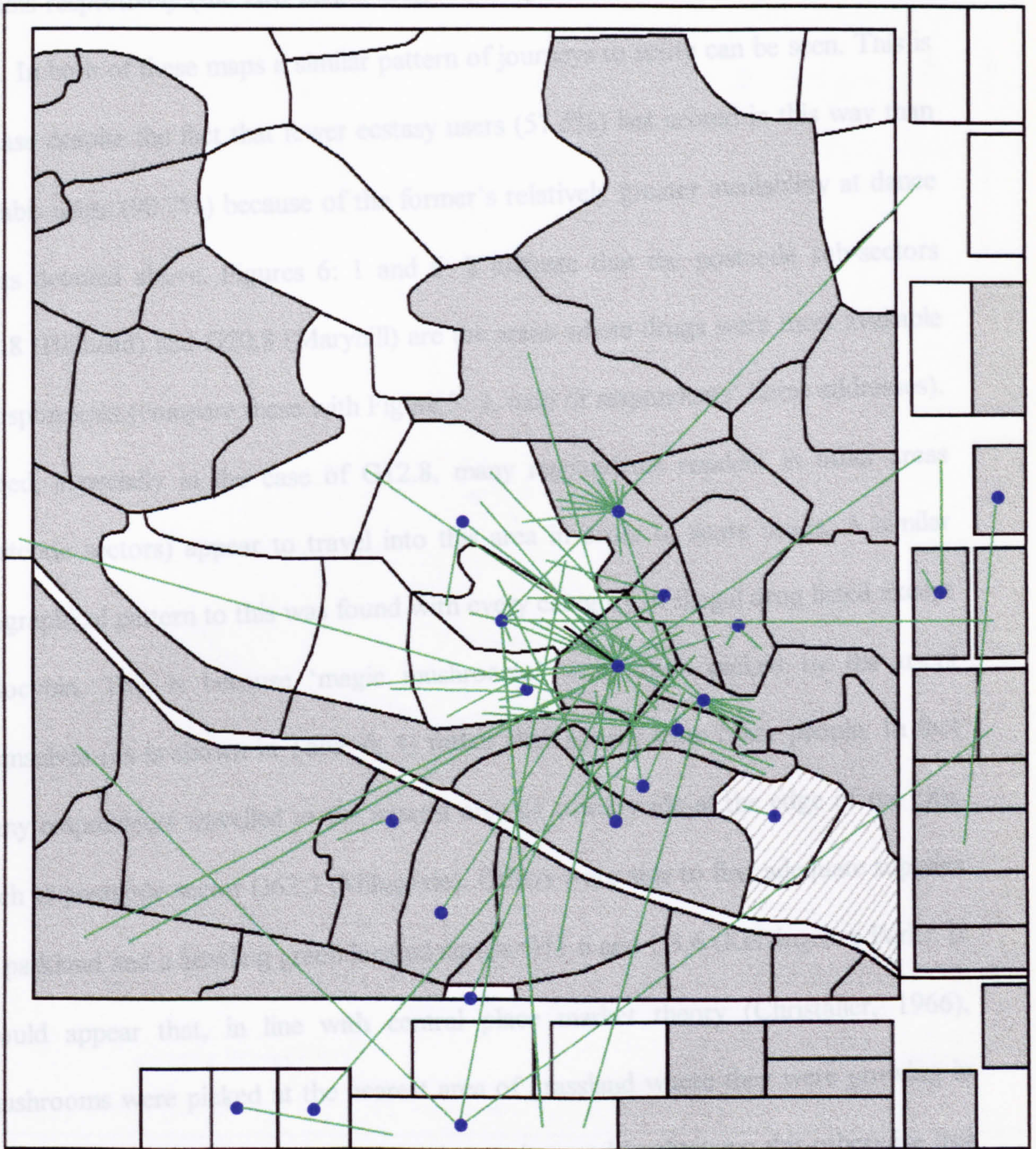
As 93.3% of respondents were also living in the Greater Glasgow (GGHB) area at the time of interview it was possible to plot journeys to score each drug made within Glasgow. By plotting the distance between respondents' home address and the area (convertible to postcode sub-sector) where they said they last scored each drug, maps of journeys to score each drug were produced. Examples of this technique are given in Figures 6: 1 and 6: 2. In these maps only journeys to score which involve crossing at least one postcode sector boundary have been mapped. Such journeys are described here as travel within Glasgow.

Figure 6.1 Map of Journeys to Score Ecstasy



- Copping area
- Journey to score
- DEPCAT 1 - 4
- DEPCAT 5 - 7

Figure 6.2 Map of Journeys to Score Cannabis

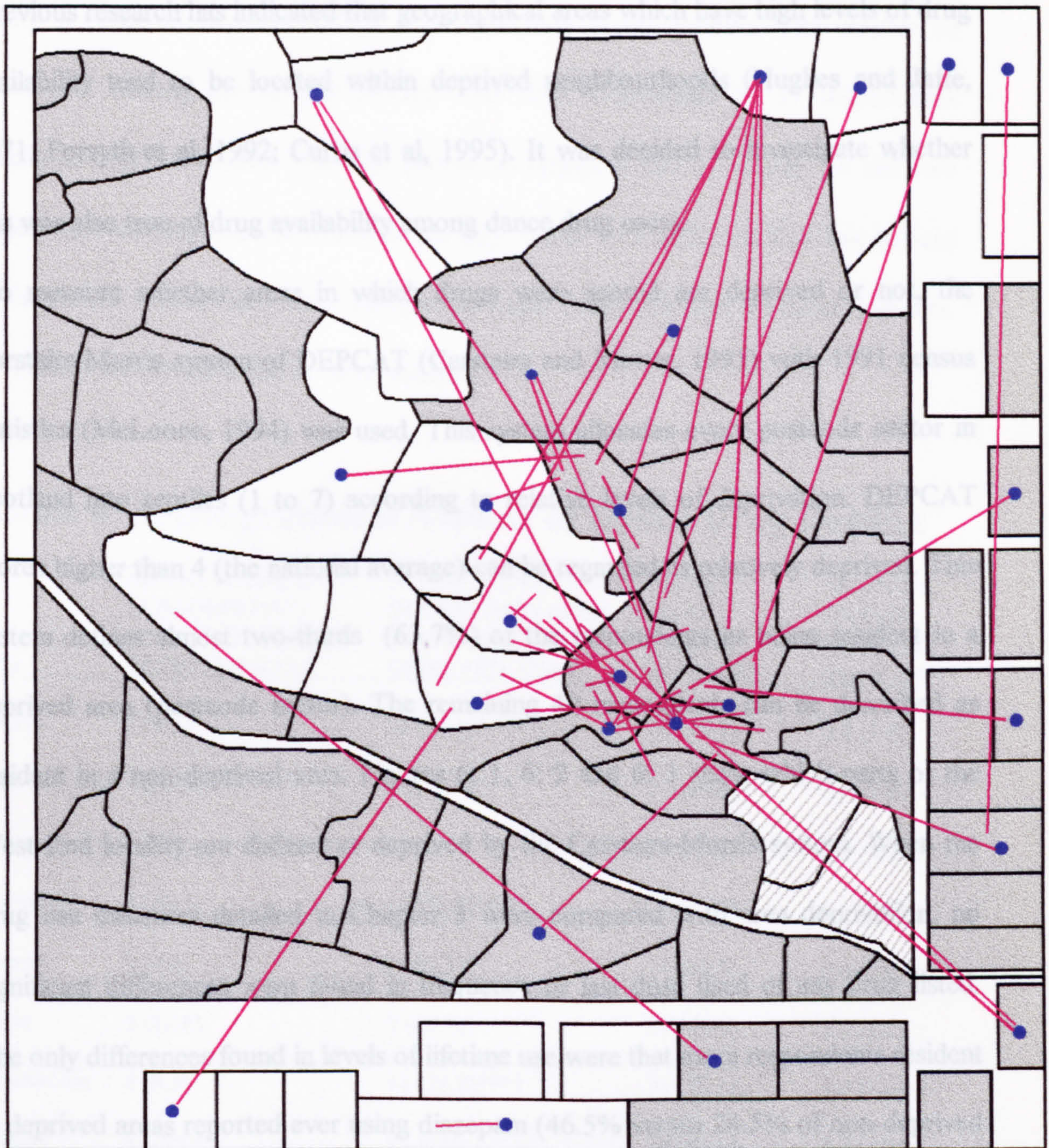


- Copping area
- Journey to score
- DEPCAT 1 - 4
- DEPCAT 5 - 7

These maps show journeys to score the dance drug ecstasy and the non-dance drug cannabis respectively (the two illegal drugs used by the most respondents in the past year). In both of these maps a similar pattern of journeys to score can be seen. This is the case despite the fact that fewer ecstasy users (57.5%) last scored in this way than cannabis users (90.7%) because of the former's relatively greater availability at dance events detailed above. Figures 6: 1 and 6: 2 indicate that the postcode sub-sectors G12.8 (Hillhead) and G20.8 (Maryhill) are the areas where drugs were most available to respondents (compare these with Figure 3: 3, map of respondents' home addresses). Indeed, especially in the case of G12.8, many respondents resident in other areas (postcode sectors) appear to travel into this area in order to score drugs. A similar geographical pattern to this was found with every category of illegal drug listed except psilocybin. This is because 'magic mushrooms' were often picked by the users themselves (as is shown in Table 6: 4) rather than scored from other people. In fact many respondents travelled to the nearest area of countryside at the edge of the city, such as postcode sector G62.7 (Milngavie). Others were able to find adequate supplies at parkland and a bowling green located across G11.6 and G3.6 (Kelvingrove Park). It would appear that, in line with central place market theory (Christaller, 1966), mushrooms were picked at the nearest area of grassland where they were growing in sufficient numbers to minimise the travel costs incurred in obtaining this otherwise free drug. This unusual geographical pattern is shown by Figure 6: 3.

Figure 6.3 Map of Journeys to Score Psilocybin

Geographical aspects of scoring dance drugs



- Copping area
- Journey to score
- DEPCAT 1 - 4
- DEPCAT 5 - 7

area residents; $\chi^2 = 6.4, df = 1, p < 0.05$) and solvents (38.4% versus 12.2%; $\chi^2 =$

10.4, $df = 1, p < 0.01$). Clearly, it was not the case that being resident in a deprived

area was associated with higher levels of drug use within this sample.

However, when drug using respondents' area of residence was compared with

location where they last scored each drug, an overall tendency for respondents who are

living in non-deprived areas to be more likely to gravitate to deprived areas to score

drugs than vice versa was apparent. For example, four respondents resident in non-

Geographical aspects of scoring dance drugs

Previous research has indicated that geographical areas which have high levels of drug availability tend to be located within deprived neighbourhoods (Hughes and Jaffe, 1971; Forsyth et al, 1992; Curtis et al, 1995). It was decided to investigate whether this was also true of drug availability among dance drug users.

To measure whether areas in which drugs were scored are deprived or not, the Carstairs-Morris system of DEPCAT (Carstairs and Morris, 1991) with 1991 census statistics (McLoone, 1994) was used. This system allocates every postcode sector in Scotland into septiles (1 to 7) according to relative levels of deprivation. DEPCAT scores higher than 4 (the national average) can be regarded as relatively deprived. This system defines almost two-thirds (63.7%) of the respondents as being resident in a deprived area (postcode sector). The remaining 49 respondents can be described as resident in a non-deprived area. Figures 6: 1, 6: 2 and 6: 3 show which parts of the West End locality are defined as deprived by the Carstairs-Morris system. When the drug use measures detailed in Chapter 3 were compared with area deprivation, no significant differences were found in frequency or last dose used of any drug listed. The only differences found in levels of lifetime use were that more respondents resident in deprived areas reported ever using diazepam (46.5% versus 24.5% of non-deprived area residents; $X^2 = 6.4$, $df = 1$, $p < 0.05$) and solvents (38.4% versus 12.2%; $X^2 = 10.4$, $df = 1$, $p < 0.01$). Clearly, it was not the case that being resident in a deprived area was associated with higher levels of drug use within this sample.

However, when drug using respondents' area of residence was compared with location where they last scored each drug, an overall tendency for respondents who are living in non-deprived areas to be more likely to gravitate to deprived areas to score drugs than vice versa was apparent. For example, four respondents resident in non-

deprived G12.9 (Hyndland and Dowanhill, see Chapter 3, Figure 3: 1) last scored ecstasy in relatively deprived G12.8 (i.e. more than scored locally). The number of respondents making the reverse journey was zero. Conversely all 17 respondents resident in deprived G20.8 who last scored in Glasgow did so locally, as did two respondents who resided elsewhere in the city. Table 6: 3 indicates that this pattern was consistent across many drug categories. Legal drugs (alcohol, tobacco, solvents, and nitrites) are not included in these analyses.

Table 6: 3, Geographical Aspects of Dance Drug Dealing

DRUG	No. (%) SCORE IN NON-DEPRIVED AREA WHO LIVE IN DEPRIVED AREA	No. (%) SCORE IN DEPRIVED AREA WHO LIVE IN NON-DEPRIVED AREA	No. (%) WHO TRAVEL TO SCORE	MEAN km. TRAVEL TO SCORE. (travel only)
Cannabis	7 (9.3)	23 (59.0)****	51 (46.8)	0.8 (1.6)
Heroin	1 (12.5)	8 (100.0)***	11 (68.8)	2.0 (2.9)
Dihydrocodeine	1 (6.7)	3 (60.0)**	10 (50.0)	1.8 (1.6)
Temazepam	5 (14.3)	11 (73.3)****	22 (51.2)	0.9 (1.7)
Diazepam	1 (4.6)	2 (33.3)*	11 (40.7)	0.6 (1.5)
Cocaine	5 (16.6)	9 (40.9)	29 (56.9)	1.2 (2.2)
Amphetamine	4 (8.5)	14 (73.7)****	34 (53.1)	1.0 (1.9)
Psilocybin	9 (29.0)	9 (45.0)	40 (81.6)	2.4 (2.9)
LSD	6 (12.5)	13 (44.8)**	38 (51.4)	0.9 (1.8)
Ecstasy	4 (10.3)	16 (61.5)****	32 (50.8)	1.2 (2.4)
Others	3 (20.0)	3 (30.0)	17 (68.0)	1.5 (2.2)

Notes: All above figures relate only to journeys to score within the Greater Glasgow (GGHB) area.

Illegal drugs with less than 10 respondents (buprenorphine and ketamine) scoring in Glasgow are not shown.

Differences between non-deprived area residents and deprived area residents scoring in an area of similar deprivation:

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$, **** $p < 0.0001$.

Area deprivation and drug scoring

In Table 6: 3, respondents who had scored each drug in Glasgow are subdivided into those resident in a deprived area and those resident in a non-deprived area. Comparisons were made between these two groups to test whether there was any statistically significant difference in the likelihood of them scoring in an area with a different deprivation category to that of their own area of residence; in other words, whether non-deprived users were more likely to travel to score in a deprived area than deprived users were to travel to score in a non-deprived area. Significant differences were found for almost all illicitly produced drugs, cannabis ($X^2 = 32.61$; $df = 1$; $p < 0.00001$), heroin ($X^2 = 12.44$; $df = 1$; $p < 0.001$), amphetamine ($X^2 = 28.98$; $df = 1$; $p < 0.00001$), LSD ($X^2 = 10.17$; $df = 1$; $p < 0.01$) and ecstasy. The sole exception to this pattern was cocaine, perhaps reflecting this drug's greater association with the affluent middle classes in Glasgow (Ditton et al, 1993). In the case of grey-market pharmaceutical drugs this pattern was less apparent. Temazepam was also much more likely to be scored in a deprived area than non-deprived area ($X^2 = 16.82$; $df = 1$; $p < 0.0001$). However, smaller differences were found between groups in the location of scoring of dihydrocodeine ($X^2 = 6.67$; $df = 1$; $p < 0.01$) and diazepam ($X^2 = 4.08$; $df = 1$; $p < 0.05$). The significance of this latter result could be rejected on the grounds that with more than 10 tests being run the difference in deprivation between locations where diazepam is scored may be due to chance alone. The differences in availability between these pharmaceuticals may indicate that temazepam is of greater importance to organised criminal dealers. Allegedly most 'grey-market' temazepam in Glasgow is supplied via corporate fraud and illegal manufacture, rather than simple 'leakage' from prescriptions, which would not be sufficient to supply the city's level of illicit consumption (*Evening Times*, 1997a). There have been many cases of these forms of

temazepam trafficking, being reported in both the local and national media (e.g. *Evening Times*, 1995b & 1996b; *Daily Record*, 1996b; *News of the World*, 1996), apparently a phenomenon peculiar to Glasgow. As indicated in Figure 6: 3, there was no relationship between area deprivation and obtaining psilocybin mushrooms.

The notion that drugs are more available in relatively deprived areas and that users from elsewhere travel to these locations to score is not new. Hughes and Jaffe (1971) describe such as copping areas in their article "The Heroin Copping Area". These authors state that their map of Chicago's copping areas "might just as readily be used to locate Chicago's most economically deprived ethnic neighbourhoods". In Glasgow, their work was verified by Forsyth et al (1992), who examined the geographical scoring pattern of 210 new 'street drug users'. As with the present sample, these street users also predominantly lived in the west of Glasgow, but were younger and more working class. The principle scoring areas for these street drug users were in G11.5 (Partick) and G14.0 (Langholm), not G12.8 or G20.8. This difference in geographical pattern must in part be due to the differing numbers of respondents resident in these postcodes, but the principle of 'least effort' (Christaller 1966), by travelling to the nearest area of availability (i.e. copping area or drug supermarket), remains the same between these unlike samples.

Drug cost and distance travelled to score drugs

Another finding of Forsyth et al (1992) was that users travelled further to purchase more expensive drugs. Again, this finding was consistent with the basic economic geography theories proposed by Christaller (1966). Christaller states that consumers will travel further to obtain more expensive goods. It was postulated that this might also be the case with this dance drug-using sample.

To confirm that this was the case, each journey made by every user, for all 11 mapped drugs, was measured in kilometres (shown in Table 6: 3). The differences between distances travelled to score between drugs were compared. Paired *t*-tests were conducted between pairs of drugs with 10 or more users of both and which have market value (not psilocybin mushrooms which are picked for free). Unlike the new street drug user sample by Forsyth et al (1992), no drug price hierarchy (in terms of standardised unit prices) was found which varied by distance travelled to score. Indeed, of all (31) comparisons run between distances travelled to score pairs of drugs, only two statistically significant differences were found. These were between cannabis (0.73 km.) and amphetamine (0.96 km.) ($t = 2.05, df = 60, p < 0.05$) and between LSD (0.77 km.) and ecstasy (1.30 km.) ($t = 2.09, df = 49, p < 0.05$). Although both these differences are in the expected direction (expensive = furthest travelled) and LSD and ecstasy could be regarded as competitor dance drugs, given the number of tests run it might be unsafe to accept these at the 0.05 significance level.

When journeys to obtain magic mushrooms were compared with the above illegal drugs, the distances involved in obtaining psilocybin were consistently greater. Mushroom users travelled further to obtain psilocybin than they did to obtain all other drugs with 10 or more dual Glasgow scorers (cannabis ($t = 4.95, df = 49, p < 0.001$), dihydrocodeine ($t = 4.22, df = 12, p < 0.001$), temazepam ($t = 3.14, df = 17, p < 0.01$), diazepam ($t = 3.97, df = 11, p < 0.01$), cocaine ($t = 2.54, df = 16, p < 0.05$), amphetamine ($t = 4.44, df = 28, p < 0.001$), LSD ($t = 3.79, df = 36, p < 0.001$) and ecstasy ($t = 3.12, df = 26, p < 0.01$)). These differences are not surprising, given the evidence of Figure 6: 3, and (although not included in this analysis) the large number of respondents who last obtained this drug outwith Glasgow (Table 6: 1). Thus the

methodology employed here appears sound and some other reason must lie behind the lack of a price hierarchy in distances travelled to score.

Are deprived neighbourhoods drug supermarkets?

From these findings it would appear that a hierarchy of dealing by area might simply not exist with this dance drug-using group. Unlike the street drug-using sample of Forsyth et al (1992), users in the dance drug scene do not have to travel into different localities in order to obtain different drugs. Comparing Figures 6: 1 and 6: 2 would appear to confirm this pattern. This may indicate that the dance drug scene of the mid-1990s involves poly-drug dealers as well as poly-drug users, or at least poly-drug copping areas (i.e. drug supermarkets). In other words, although dealing among this group is similar to other drug availability networks in that drugs are more available in less affluent areas, there is a greater range of drugs available at the nearest such area.

It is possible that this pattern of scoring has evolved because many dance drug users obtain drugs in different locations from where they intend to use them. Street drug users may be more likely to obtain and use drugs in the same location or at least on the same day as they are scored (especially near daily users or 'drug addicts'). As such they may be constantly seeking out drugs in a variety of locations, perhaps to maintain a 'habit'. From the evidence presented here, dance drug users tend to get sorted prior to attending a dance event. Such advance planning may lessen the likelihood of travelling great distances in search of drugs if they are not to be used there and then. This also invites the opportunity for advanced orders or 'shopping lists' of different drugs to be given to a dealer prior to a dance drug session (*Channel 5 Television, 1997*). It is also possible that drugs are (or have become) more readily available in the dance drug scene, making journeys to nearest source shorter. Indeed, the distances

travelled to score by these dance drug users could be described as within walking distance. The mean distance travelled to score was shorter for the dance drug group than the street drug using group for almost all the drugs recorded and measured for both. These were cannabis (0.6 km. versus 1.5), heroin (2.0 vs. 3.4), buprenorphine (0.8 vs. 2.2), temazepam (0.9 vs. 1.5), diazepam (0.6 vs. 1.1), cocaine (1.2 vs. 5.4) amphetamine (1.0 vs. 2.2), LSD (0.9 vs. 2.1) and ecstasy (1.2 vs. 2.6). Interestingly, the rank order of these drugs remains broadly similar. The only exception to this pattern was the non-dance drug dihydrocodeine (1.8 and 1.4 km) which the dance drug users had to travel further to obtain. It is also noteworthy that the street drug-using group rarely scored drugs outwith Glasgow.

The Dance Drug Economy: Scoring

Who are dance drugs are scored from?

It was felt that not having to travel far in order to sustain adequate drug supplies would also increase the likelihood that dance drug users would be scoring drugs from someone they knew (i.e. a friend rather than a strange dealer). Information provided by respondents concerning who they last scored each drug from was subdivided into drugs obtained from friends, dealers, self-obtained and other persons. The most common source of all illegal drugs (except psilocybin, which was more often self-obtained for the reasons detailed above) was the user's friends. It should be noted, however, that in this peer network recruited sample a friend was also likely to be a dealer. Such individuals were coded as friends if the respondent described their

relationship to the supplier as a friend first and a dealer second. In fact, as will be expanded upon below, most respondents (60.0%) had sold drugs themselves at some time. Table 6: 4 below details how many respondents obtained each drug from dealers, friends and other sources.

Table 6: 4, Sources of Drugs for Dance Scene Users

DRUG	<u>Number (%) of users who last scored from each of :-</u>			
	FRIEND	DEALER	SELF OBTAINED	OTHER
Alcohol	14 (10.6)	0 (-)	108 (81.8)	10 (7.5)
Tobacco	24 (20.0)	0 (-)	88 (73.3)	8 (6.6)
Cannabis	102 (77.9)	22 (16.8)	0 (-)	7 (5.3)
Heroin	19 (73.1)	4 (15.4)	1 (3.8)	2 (7.6)
Buprenorphine	9 (56.3)	0 (-)	4 (25.0)	3 (18.8)
Dihydrocodeine	26 (66.7)	2 (5.1)	7 (18.0)	4 (10.2)
Temazepam	47 (68.1)	10 (14.5)	3 (4.3)	9 (12.9)
Diazepam	35 (67.3)	2 (3.8)	11 (21.1)	4 (7.6)
Solvents	5 (15.6)	0 (-)	16 (50.0)	11 (34.4)
Cocaine	67 (72.0)	11 (11.8)	1 (1.1)	14 (15.2)
Amphetamine	88 (74.6)	21 (17.8)	1 (0.8)	8 (6.8)
Psilocybin	47 (44.8)	1 (1.0)	49 (46.8)	8 (7.7)
LSD	92 (75.4)	19 (15.6)	0 (-)	11 (9.0)
Nitrites	65 (60.2)	0 (-)	10 (9.3)	33 (30.6)
Ketamine	13 (72.2)	3 (16.7)	0 (-)	2 (11.1)
Ecstasy	95 (78.5)	17 (14.0)	0 (-)	9 (7.4)
All Others	41 (52.2)	9 (11.7)	16 (20.8)	11 (14.3)

Notes : Self obtained includes: bought from shops, bars, machines, stolen or found.
 Other includes: from parents, other family members, bosses or work-mates, flat-mates or neighbours, strangers, associates, refusals to say who it was from and legally prescribed drugs from doctors.

The cost of scoring dance drugs

One of the most striking findings of this research is the large number of respondents who last obtained drugs free of charge. This is especially interesting given that so few drugs here were stolen or obtained on prescription (see Table 6: 1). From Table 6: 5, it can be seen that most illegal drugs were last obtained for free by a majority of respondents. This was the case even with relatively expensive drugs, such as cocaine and heroin. Surprisingly some of the lowest levels of obtaining (and by default giving) drugs for free were found with the licit drugs, alcohol and tobacco. Also, it might have been expected that cannabis would have been last used for free by a relatively large number of respondents. This might occur because of the normal practice of passing 'joints' around groups of smokers. This was not usually the case with these respondents. Perhaps this reflects the very regular frequency of cannabis use amongst these respondents (see Table 3: 2). This is also inferred by the relatively high cost paid when last buying cannabis in Table 6: 5. This table shows the costs of each drug asked about, both in terms of standard unit prices and how much (if anything) each respondent who had used it last paid.

Table 6: 5, Prices Paid for Drugs by Dance Scene Users

DRUG	No. SCORED for FREE (%)	DRUG COST (in Pounds)		LOWEST COST/ STANDARD UNIT
		Mean	Mode	
Alcohol	34 (26.2)	4.06	1.60	-
Tobacco	32 (26.7)	2.37	2.50	-
Cannabis	49 (37.4)	18.37	15.00	<1.00/joint (30.00/7 gm.)
Heroin	17 (65.4)	18.33	10.00	>5.00/half bag (80.00/gm.)
Buprenorphine	15 (93.8)	1.50	1.50	-
Dihydrocodeine	30 (81.1)	1.86	1.00	1.00/pill
Temazepam	42 (61.8)	4.95	1.00	1.00/capsule
Diazepam	46 (92.0)	1.55	0.10	0.50/pill
Solvents	16 (59.3)	1.21	1.50	-
Cocaine	66 (71.7)	65.37	10.00	>5.00/sixteenth gm. (60.00/gm.)
Amphetamine	58 (50.0)	12.67	10.00	>1.25/eighth gm.
Psilocybin	101 (96.2)	3.75	2.00	-
LSD	55 (45.1)	11.23	3.00	1.50/half tab
Nitrites	91 (88.3)	4.27	5.00	-
Ketamine	4 (21.1)	14.40	15.00	7.50/eighth gm.
Ecstasy	38 (31.1)	13.09	15.00	7.50/half tab
Others	41 (54.7)	2.38	2.00	-

Comparisons between those who last used each drug for free and those who paid for it were made in a similar fashion to the comparisons above between those who scored at dance events and users who got sorted elsewhere beforehand. Again each drug was divided into two groups of users, those who paid and those who did not. Six of the drugs listed had less than 10 users in one of these two groups are therefore not included in this analysis. These drugs are, heroin, buprenorphine, dihydrocodeine,

diazepam and psilocybin mushrooms, because so few respondents last paid for them, and ketamine, because so few users obtained it free of charge the last time they scored it. Differences between the ten remaining drugs are shown in Tables 6: 6a and 6: 6b.

Table 6: 6a, Paying and Non-paying Drug Users Compared

	Number (%) for free		Number (%) for free		Number (%) for free	
	<u>FEMALE</u>	<u>MALES</u>	<u>FRIENDS</u>	<u>OTHERS</u>	<u>DEAL</u>	<u>NOT-DEAL</u>
Alcohol	22 (45.8)	12 (14.6)****	14 (100.0)	20 (17.2)****	21 (33.3)	13 (20.0)
Tobacco	16 (36.4)	16 (21.1)	23 (95.8)	8 (8.4)****	19 (32.8)	12 (20.0)
Cannabis	26 (54.2)	23 (27.7)**	41 (40.2)	8 (27.6)	32 (51.6)	17 (25.4)**
Temazepam	15 (71.4)	27 (57.4)	34 (72.3)	8 (38.1)**	16 (66.7)	26 (61.9)
Solvents	0 (-)	16 (64.0)	5 (100.0)	11 (52.4)*	2 (40.0)	13 (61.9)
Cocaine	26 (78.8)	40 (67.8)	51 (76.1)	15 (60.0)	32 (76.2)	33 (67.3)
Amphetamine	25 (61.0)	33 (44.0)	50 (58.1)	8 (26.7)**	29 (53.7)	28 (46.7)
LSD	25 (59.5)	30 (37.5)*	46 (50.5)	9 (30.0)*	23 (42.6)	31 (47.0)
Nitrites	27 (87.1)	64 (88.9)	61 (98.4)	30 (73.2)****	40 (90.9)	50 (87.7)
Ecstasy	17 (39.5)	21 (26.6)	35 (36.8)	3 (11.5)*	18 (32.1)	20 (31.3)

Note * $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$, **** $p < 0.0001$.

Table 6: 6b, Paying and Non-paying Drug Users Compared

	Mean Days Use last Year (N)		Mean Dose Used last Occasion (N)		Mean Number of convictions (N)	
	FREE	PAY	FREE	PAY	FREE	PAY
Alcohol	112.0 (34)	126.1 (96)	7.5 (34)	10.5 (96)	0.2 (34)	0.9 (95)*
Tobacco	145.8 (32)	309.1 (88)***	6.1 (31)	13.7 (88)***	0.5 (31)	0.9 (88)
Cannabis	140.5 (49)	262.0 (82)***	2.5 (49)	4.9 (82)***	0.3 (49)	1.1 (81)**
Temazepam	14.1 (42)	33.6 (26)	2.2 (41)	5.5 (26)***	1.1 (42)	1.1 (25)
Solvents	1.3 (16)	0.3 (11)	0.5 (11)	1.4 (10)	0.6 (15)	1.5 (11)
Cocaine	5.8 (66)	15.7 (26)*	0.2 (66)	0.4 (26)**	0.7 (66)	1.5 (26)*
Amphetamine	13.7 (58)	13.6 (58)	0.7 (58)	0.7 (56)	0.6 (58)	0.8 (57)
LSD	10.4 (55)	17.3 (67)	0.9 (55)	1.3 (67)	0.9 (55)	0.8 (66)
Nitrites	4.0 (91)	6.4 (12)	6.9 (83)	6.3 (11)	0.9 (91)	0.9 (11)
Ecstasy	25.1 (38)	21.6 (84)	0.9 (38)	1.3 (84)**	0.7 (38)	0.9 (83)

Notes: Dose for each drug as follows: Alcohol = 1 unit / 8 gms. absolute alcohol; tobacco = 1 unit / cigarette; Cannabis = 1 unit / joint or 0.23 gms. resin; Heroin, Cocaine, Amphetamine and Ketamine = 1 unit / 1 gm; Buprenorphine, Dihydrocodeine, Temazepam, Diazepam, LSD and Ecstasy = 1 unit / tablet or capsule; Solvents = 1 unit / can or tube; Psilocybin = 1 unit / mushroom; Nitrites = 1 unit / sniff.

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$, **** $p < 0.0001$.

From Table 6: 6a, it can be seen that there were some systematic differences between payers and non-payers. Females were significantly more likely to obtain some drugs for free. This was the case with alcohol ($X^2 = 15.26$; $df = 1$; $p < 0.0001$), cannabis ($X^2 = 9.09$; $df = 1$; $p < 0.001$) and LSD ($X^2 = 5.40$; $df = 1$; $p < 0.05$). The finding that some drugs are more likely to be obtained by females for free is not new. In traditional (non-dance scene) drug research, female drug users have been described as ‘bag followers’ (Hughes et al, 1971); that is, females ‘hang out’ with drug dealers to obtain drugs for free, the dealer gaining in social status from the presence of the female (by implication scoring drugs in exchange for sexual favours), which has led to the portrayal of female

drug users as 'victims' (Perry, 1979; Stewart, 1987). However, more recent research into female drug users has challenged this view. Female dance drug users have been identified as using independently of male influence, especially in the case of the drug ecstasy (Henderson, 1993). It has been suggested that in the dance scene females are becoming increasingly independent of men when scoring drugs (Henderson, 1993). As such women, have more experienced positive effects from drug use through involvement in the dance scene and can hardly be regarded as stereotypical victims of male 'drug pushers'. In the West End of Glasgow, Reith (1991) also found that females were more independent of male influence with (the primary dance drug) ecstasy than with other drugs. The author noted that ecstasy's price made it less likely to be given as a gift from males to females, stating "Lovers affection does not run to £20.00 per tab" (the price for a single ecstasy at that time). Other drugs, such as amphetamine, which could more easily be subdivided into smaller units, were under greater control by the male members of her peer-acquainted group of drug users. In Reith's study, the special occasion and communal nature of ecstasy use was also thought to facilitate equal involvement in use between males and females. The findings presented here appear to confirm this pattern of female drug user empowerment. Certainly there was little difference in obtaining ecstasy for free between males and females. Although large differences were found in the cases of alcohol and cannabis, there are mitigating factors involved in the supplying of each of these drugs which make it more likely that females would obtain each for free. In the case of alcohol, there is a traditional (chivalrous if not sexist) practice of men buying women a drink, which may be at work here. Also, most respondents last consumed alcohol on a licensed premises, alcohol is a legal drug and therefore largely irrelevant to patterns of illegal drug scoring. As shown in Chapter 3, cannabis is one of only two drugs which

males in this study used more frequently (the other being magic mushrooms, which are freely available to both sexes).

Less surprising was the finding, shown in Table 6: 6a, that many of the substances that were last obtained for free were more likely to have been donated by friends. Akram (1997) describes the pattern of drug scoring in the dance scene (at least initially) as one of drugs being “pulled from” friends, rather than “pushed by” dealers. Another unsurprising finding, from Table 6: 6b, was that free drugs tended to come in smaller doses than those which were paid for and that those who last used a drug for free were more likely to be infrequent users of that drug. From Table 6: 6a, it can be seen that, with the exception of cannabis, being a drug dealer was not related to free access to drugs. This was also the case with respondents who had a criminal record, see Table 6: 6b. Although 16 of those 38 respondents who had ever been convicted of any offence had been convicted of a drug offence, why this should mainly apply to cannabis is not clear.

Not shown in Table 6: 6a or 6: 6b is that frequency of attendance at dance events was not related to obtaining drugs for free. There were few differences in obtaining drugs for free between social classes or between area of residence deprivation. The exception to this was temazepam, which was more likely to be paid for by working class respondents ($X^2 = 3.91$; $df = 1$; $p < 0.05$) and by those resident in a deprived area ($X^2 = 4.01$; $df = 1$; $p < 0.05$). Temazepam was also the only drug that differed by age on this measure, younger users being more likely to pay for it last. The mean age of those who obtained temazepam for free was 25.3, while those who paid had a mean age of 21.0 ($t = 3.22$, $p < 0.01$). This confirms previous Glasgow research which has found high levels of street temazepam use among young working class users (Hammersley et al, 1990; Hammersley et al, 1992).

The Dance Drug Economy: Supplying

'Independent' and organised drug dealers

Although in some respects the dance drug scene appeared to differ from traditional dealing patterns, such as obtaining for free or female involvement, in other respects there were similarities between this and other drug scenes. Scoring drugs tended to take place in relatively deprived neighbourhoods (Hughes et al, 1971; Forsyth et al, 1992; Curtis et al, in 1995). This supports the more traditional view of drug dealers, characterised as ghetto dwellers involved with the criminal underworld, rather than those dealers identified in previous studies of ecstasy/dance drugs (Dorn et al, 1991; Rosenbaum and Dolbin, 1991). Interestingly, in this sample there was little difference between respondents who lived in a deprived area or non-deprived area being dealers of any drug in the last year (54.3 and 43.5% respectively).

A majority of respondents ($n = 80$) admitted to ever having sold drugs for profit, 68 having done so in the past year. These figures exclude two respondents, one (#042) who was worried about outstanding charges refused to say if he was currently dealing, the other was not asked any of the crime questions because of his age (14 years). It is noteworthy that of twelve crimes asked about, drug dealing, working in the sex industry, violent behaviour, accepting stolen goods, weapon carrying, shoplifting, vandalism, fraud, robbery, bicycle theft, driving without a license and fare dodging, only this latter (most minor) offence had also been committed by a majority of respondents in the past year (see Chapter 3). Though not prompted in the

questionnaire, five respondents (#008, #012, #027, #036, and #042) admitted to travelling abroad to obtain drugs directly from their producers and smuggle them back to Scotland themselves, rather than obtain their supplies through traditional drug traffickers. In four cases this was done to smuggle dance drugs for consumption in the local dance scene. Only the smuggler (#036) who did not import dance drugs had ever been caught, with cannabis oil, making him the only respondent ever to receive a custodial sentence for any reason. All but one of these individuals lived in non-deprived areas and he (#042) had only recently moved into a deprived area (from a very prestigious address) due to being busted. One of these respondents (#027) stated that people like him were not the usual type of drug supplier, claiming that “seven eighths of the ecstasy in Glasgow comes from terrorists” and that people like him (independents, similar to those described by Dorn et al, 1991 and Rosenbaum and Dolbin, 1991) were mainly to be found in the city’s West End. This observation is backed by evidence from interdiction agencies. Since 1988, the production of ecstasy (and other dance drugs) is thought to have moved off-shore to increase profits, often to Eastern Europe (*The Economist*, 1993). Such a shift to international dance drug trafficking, from local independent production, would impact on the dealing patterns in cities such as Glasgow by merging dance drug availability with that of other illegal drugs. Herein lies the potential for increased risks to the dance drug user, who may come into contact with other drug scenes, with more frequently problematic consequences, when attempting to get sorted for ecstasy or amphetamine. In this way, authoritarian reaction to drug dealing at raves may serve to create a future generation of problem drug users who might otherwise have remained insulated from problem drugs in an esoteric independent dance drug scene.

Taking care of friends: Drug availability at dance events and elsewhere

- The data presented here do not support the view held by those held by ‘anti-rave’ campaigners that “most drug dealing in Britain occurs at night-clubs” (Barry Legg, *Newsnight*, 1997).
- Apart from scoring within the dance scene, there was a great deal of geographical variation in locations where drugs were last obtained by this sample. This included (rarer) drugs being scored abroad, elsewhere in the UK or in Scotland but outwith Glasgow. When scoring drugs in Glasgow, this group of 135 users tended to gravitate into two relatively deprived geographical areas. This spatial pattern was repeated across almost all the illegal drugs they obtained in Glasgow. This was true for both dance drugs and non-dance drugs. As found in other drug research, deprived areas do resemble drug supermarkets.
- On the whole this group does not seem to fit the stereotype of drug users always having to pay increasing amounts of money for drugs. The level of obtaining drugs for free within the group seems to indicate a degree of philanthropy or at least trust, with expectations of reciprocity.
- Most respondents had sold drugs for profit and several respondents could be regarded as independent traffickers. The existence of a flow of drugs from deprived to non-deprived areas, with cash moving in the opposite direction, supports the view that organised (crime) dealers are involved in dance drug supply. Despite these findings, the dealing/scoring behaviour of this group differed from traditional patterns (including one sample obtained in the same geographical locality (Forsyth et al, 1992) in two key ways. Firstly, few users obtained drugs directly from medical sources, whether on (legitimate or fraudulent) prescription or from theft. Secondly, a greater range of drugs was available from the same locations. Such poly-drug

availability meant users had the same distance to travel to score different drugs. In this group, such journeys were invariably short, thus reducing expenditure on drugs by minimising travelling costs.

The evidence presented in this chapter indicates that ravers often obtain dance drugs 'on the street' rather than at dance events. This seems likely to increase the risk of dance drug users making contact with problem drug users and organised crime dealers. Drug agencies have for some time warned of the potential problems that may occur if these two groups of drug users could not be kept apart and dealt with separately (Lifeline, 1992a; Gilman, 1993). Should bridges form between problematic drug scenes and the dance drug scene, the former may gain new recruits, while the latter may adopt more harmful behaviours. Also, those who wish to remain solely within the dance scene may incur extra risks to their personal safety when attempting to score drugs such as ecstasy (e.g. assault or arrest).

One potential consequence of such changes in dance drug supply has been in the adulteration of dance drugs. It has been suggested that dance drugs, particularly ecstasy, have declined in quality because of the change in drug supplier outlined above from 'in house' 'independent' dealers such as Abby (Dorn et al, 1991) to traditional organised criminal dealing networks (Howes, 1990; Newcombe, 1992c; Saunders, 1995a & 1995b). Chapter 7 will focus on ecstasy, the drug which previous chapters have indicated plays a central role in the dance drug scene. It will examine whether this drug has changed, in content or quality, such that ecstasy use no longer guarantees MDMA use, and if so why this might have happened.

CHAPTER 7

MIS-SHAPES: ECSTASY TABLET DESIGN, A NEW CONCEPT IN ILLEGAL DRUG MARKETING

Introduction

In the last chapter, patterns of drug availability in the dance scene were described. This chapter will focus on the drug which previous chapters have identified as playing a central role in the scene, MDMA or ecstasy. Although there can be little doubt that increased availability of MDMA was responsible for the advent of the Glasgow dance drug scene, ever since a drug called ecstasy first appeared in the city there has been much speculation about what this substance actually is. Initial reports in the media incorrectly suggested that ecstasy was not a single chemical (MDMA), but a mixture of drugs. Ecstasy was introduced to the Scottish public by the front-page headline “COCKTAIL OF DEATH: Warning on killer drug mix” (*Evening Times*, 1987). This article claimed that “called ecstasy it is a deadly mixture of heroin, cocaine and LSD”. It was also alleged that ecstasy was being used by the city’s drug injectors in response to a police crackdown on heroin supplies. Since then, the Scottish media has alleged that several deaths have been caused either by ecstasy or fake ecstasy. Front-page headlines, such as “HUNT FOR THE KILLER ECSTASY: Deadly rave drug claims two lives” (*Evening Times*, 1994b), have now acknowledged that ecstasy is a substance more commonly used in the dance scene than by drug addicts. In common with earlier reports, the headlines of the mid-1990s failed to explain what ecstasy contains or what fake ecstasy might be. Such reports still prefer to utilise vague (and seductive) terms such as “designer drugs” or “drug cocktails”. These reports have also

stated that ecstasy is contains other drugs such as heroin (“NOW DEADLY DEALERS LACE RAVE PILLS WITH HEROIN: Dancers are warned of dangerous cocktail”, *Evening Times*, 1996c), amphetamine (“Bogus Drugs Mix to Hook Rave Kids”, *Daily Record*, 1993c), ketamine (“‘Ecstasy’ pills man is jailed: Would-be dealer had been cheated”, *Glasgow Herald*, 1996) or LSD (“Deadly Drugs Rip-off at the Disco”, *Daily Record*, 1989c). Such speculation has not been borne out by any forensic evidence currently available. Given the paucity of other sources of information about ecstasy, it seems likely that these media reports would be given more serious consideration by dance drug users than they merit. The situation is further complicated by the existence of a large number of brand names for ecstasy. These brand names are said to refer to specific varieties of ecstasy (tablets, capsules etc.). Unlike most brand names, those of illegal products are not controlled by copyright or any other consumer protection laws and so may vary geographically, temporally or demographically. To date, reports from ecstasy users about what they think the drug’s contents and effects are have only been anecdotal. This chapter will measure these beliefs by investigating:

- The great variety of forms of ecstasy (brand names) and their importance (origins) in the development of the dance scene.
- Changes in ecstasy quality over time/users’ careers.
- What drugs users think ecstasy contains.
- The differing subjective effects of ecstasy will be explored.
- Comparisons will be made between popular brands of the drug.

The value of this chapter lies in that it will report what dance drug users think ecstasy is. From these data a new trend in illegal drug use will be identified and its implications for future patterns of drug use beyond the 1990s will be discussed. Firstly, a brief history of the evolution of ecstasy from chemical substance to brand label is given.

The evolution of ecstasy and its esoteric brand names

As detailed in Chapter 1, the drug known as ecstasy first came to prominence in the USA during the early 1980s. MDMA was named ecstasy as a marketing ploy by one Los Angeles illicit producer (Eisner, 1989). Though the producer preferred the name “empathy”, as more fitting to the drug’s effects, he believed that the name ecstasy would sell better. Had the name of the drug remained MDMA or ADAM (its first nickname) it may have been many more years before the drug was made illegal in America. This was done under the DEA’s emergency scheduling powers aimed at curbing designer drugs, such as the fentanyl analogue marketed under the brand name ‘china white’. Though not a designer drug by the DEA’s own definition, the designer label stuck to ecstasy (see Chapter 1).

Since 1985, interest in ecstasy use has grown in the UK relative to the USA, though, as we will see, brand names associated with events at that time are still apparent in Glasgow a decade later. In the dance drug scene, a whole new subculture of ecstasy brand names and their alleged contents has evolved. Rather than simply being known as containing MDMA (MDEA or MDA), there has been much speculation about what these ecstasy brands contain. Such speculation has included: that some of these brands are complete ‘duds’, that dealers put other drugs in some brands to get users addicted and that some brands sold as ecstasy are really cocktails of different drugs aimed at mimicking the effects of MDMA (*Glasgow Herald*, 1992; *Scottish Women*, 1994). Such speculation among drug workers, users and the wider public was commonplace in Glasgow during fieldwork in this study. During the field observation phase of this research (see Chapter 2) it became clear that ecstasy in the Glasgow dance scene existed in a variety of forms which were being marketed differently.

Recording ecstasy design and effects

Of the 135 persons interviewed, 123 (see Chapter 3) admitted to having used ecstasy at least once. The data presented in this chapter comes from these 123 ecstasy users and 4 non-users of ecstasy who were able to describe at least one ecstasy they had encountered in the dance scene. After completing the questionnaire administered by the interviewer, each respondent was required to complete a self-complete page about any brands of ecstasy they had encountered (see Appendix II).

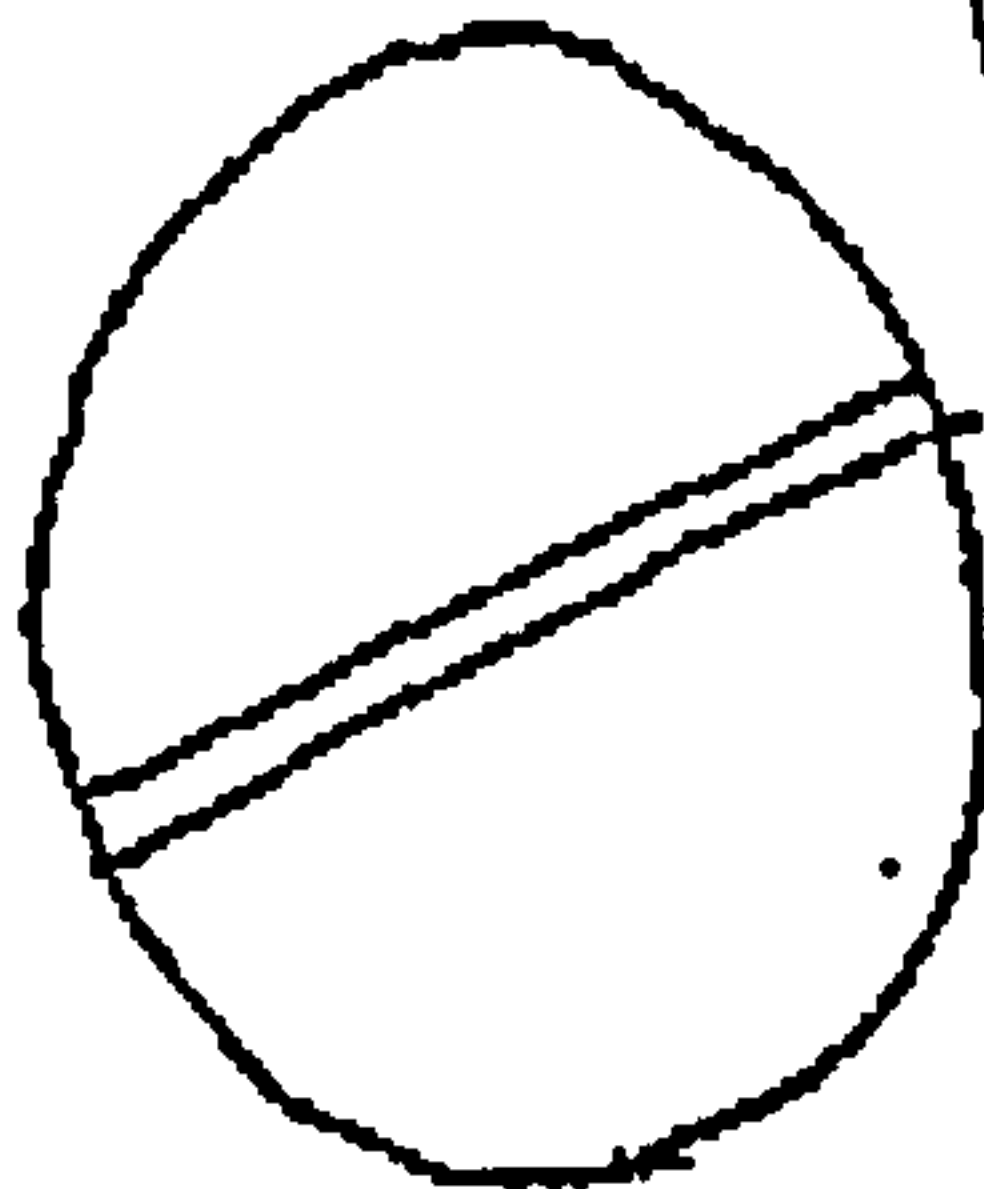
Respondents were asked to draw three types of ecstasy from a list of brands that they said they had taken. Rather than any three of these ecstasies, respondents were asked to draw the first ecstasy they had ever taken, the last ecstasy they had ever taken and the type of ecstasy they had taken most often. This ensured that a representative range of different ecstasies over the career of each user was drawn. Thus any tendency for the respondent to misrepresent by only drawing favourites or 'snidEys' (fake ecstasy) was eliminated. Respondents were further prompted to annotate each drawing by naming the brand and describing its appearance, size, colour, what effects it had on them and what drugs they thought it contained. Finally, each ecstasy was rated on a seven-point scale. This involved the respondent being presented with a card that had seven 'smiley faces' on it. The happiest face being rated as 1 (☺), through 4 (☺), to the saddest face rated 7 (☹). This is the same procedure as used to rate the effects that the dance scene had on respondents' lives (see Chapter 4). Four respondents who had not used ecstasy drew an ecstasy they had seen, but were unable to describe this further. A completed example of this instrument is given in Figure 7: 1.

Figure 7.1 Examples of Ecstasy Drawings

Brands of Ecstasy

First Ecstasy

NAME
DRAWING
DESCRIPTION
what size
what colour
EFFECTS
it had on you



WHITE DOVE,
INCREDIBLE RUSHES,
EXPANDED CONSCIOUSNESS

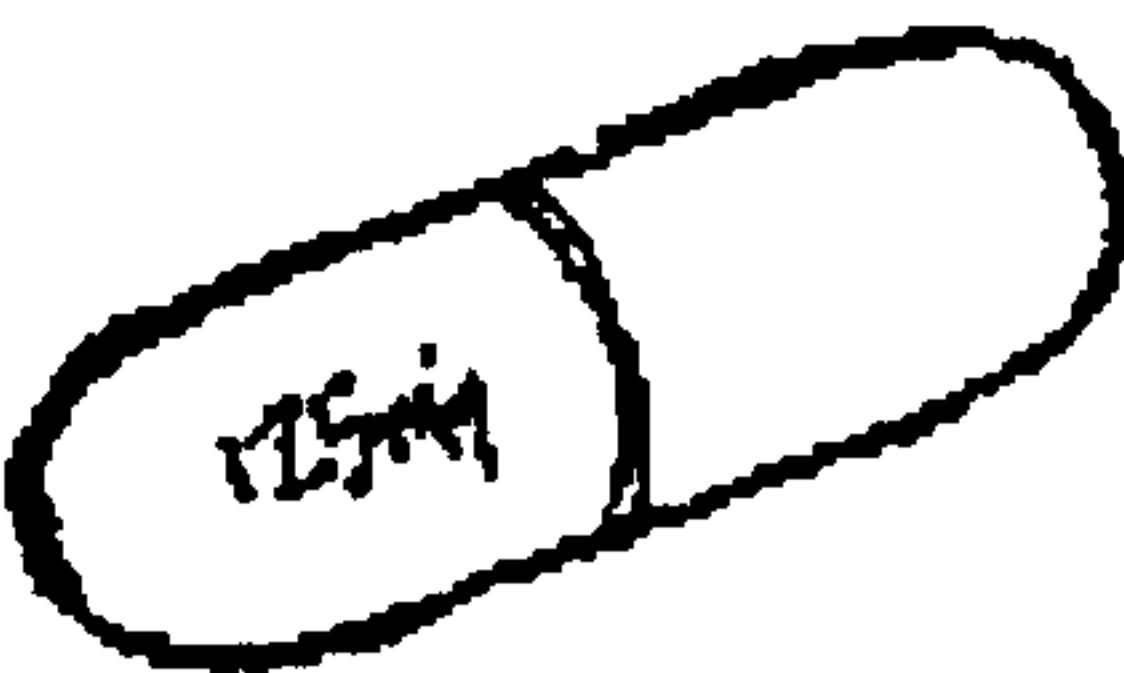
Alleged CONTENTS
COST M.D.M.A.

SOURCE
where you got it FRIEND.
when you got it AUG 91.

RANK: 1 (best) to 7 (worst) 5

NAME
DRAWING
DESCRIPTION
what size
what colour
EFFECTS
it had on you

WHITE CAPSULE
CONTAINING
PURE MDMA
(AMAZING)



WHITE CAPSULE
BEST 'E' EVER HAD
SUBTLE RUSHES,
CLEAR HEAD
NO COMEDOWN
EVEN AFTER CONSTANT
USE.

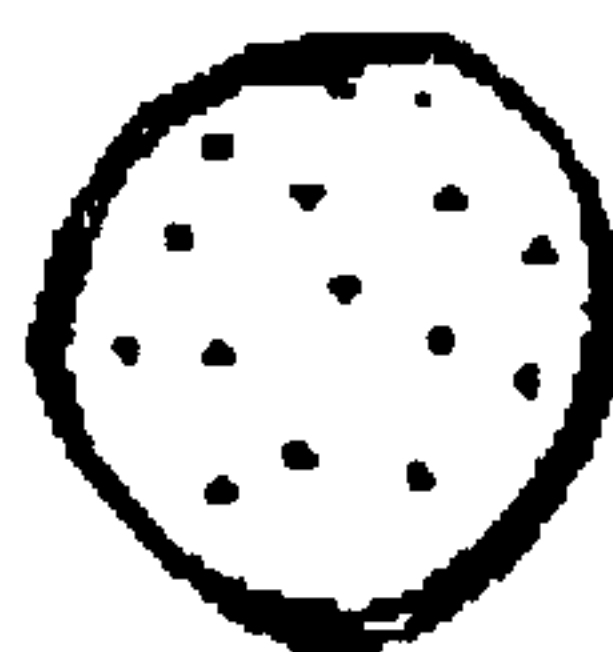
Alleged CONTENTS
COST

SOURCE
where you got it FRIEND
when you got it JAN 95

RANK: 1 (best) to 7 (worst) 2

NAME
DRAWING
DESCRIPTION
what size
what colour
EFFECTS
it had on you

MAD MEN



VERY SMALL, MAD MEN
(MDMA)
(A33R)

Alleged CONTENTS
COST M.D.M.A.

SOURCE
where you got it FRIEND.

RANK: 1 (best) to 7 (worst) 7.

HARDLY ANY
'E' EFFECT AT ALL
TOTAL NONSENSE.

This unique method of describing drugs had several advantages over simply asking respondents about the drug. These drawings provided a great deal of information about ecstasy design. This was further enhanced by annotations and the supplementary question prompts. Aspects of the drug's appearance such as shape, form, colour, size and texture were perhaps more obvious than even photographic evidence could provide. In any case, it would have been impractical to find, photograph and analyse three hundred or more drug samples.

Assimilating the data gained by this method involved several complexities. For example, some respondents had taken ecstasy on fewer than three occasions. In other cases, the same brand was applicable for more than one of the drawing categories of ecstasy (first, last and most often). In such instances, respondents were told to repeat the drawing but record any other changes, such as different effects on different occasions. Also, as these drawings were self-complete there was the possibility that the respondent may not give all the relevant information. Despite these constraints, all but one of the 123 ecstasy using respondents were able to produce at least one ecstasy drawing.

Ecstasy Shapes, Designs and Brand Names

Ecstasy tablet drawings

A total of 360 samples of ecstasy were drawn. Seven drawings were merely descriptions of tablets or capsules by non-users of ecstasy, the remainder could be analysed in detail. As indicated by Figure 7: 1, it was possible to gain a great deal of

information from these users' annotated drawings (some information has been removed from this figure for reasons of confidentiality).

Brand names

A very large number of brand names for ecstasy ($n = 106$) was known to these respondents. A full list of these brand names is given in Table 7: 1, categorised by marketing design. Numbers on this table refer to the number of drawings obtained for each ecstasy. Numbers in brackets refer to the number of respondents who reported using each ecstasy brand, but this brand was not one of their three drawing categories. Other names are those of ecstasies which were either shown to the author by respondents or mentioned in some other context during the interview (e.g. 'madwoman', 'blaster').

From Table 7: 1 it can be seen that, with over 90 users saying they had taken it, white (or love) doves was by far the most common brand of ecstasy mentioned. With almost one quarter of all drawings and one third of the most common ecstasy drawing category, doves were the most common brand of ecstasy throughout. However, a variety of "don't know" answers constituted the most common answer for drawings in the last ecstasy category (though some of these tablets may also be doves).

Table 7: 1, Ecstasy Brand Names

FORM

E capsule	5 (2)	E powder	4 (1)	liquid E	2 (1)
Bayer E	0 (1)	foam/sponge E	1 (1)	French E	0 (1)

CONTENTS

madman	11 (3)	E130	1 (3)	triple X	2 (1)
phase 4 (5,6,7,8)	1 (1)	eve	0 (1)	adam and eve	0 (1)
sadam hussain	0 (1)	pink 125	0 (1)	EVA	1 (0)
maddogs	0 (1)	E.A.	0 (1)	K capsule	-
madwoman	-				

SHAPE

snowball	46 (17)	(disco) biscuit	31 (32)	white biscuit	3 (12)
mini snowball	3 (4)	pellet	9 (0)	brown biscuit	2 (4)
(disco/ham)burger	5 (1)	grey biscuit	1 (2)	yellow burger	0 (3)
pink snowball	0 (2)	white burger	0 (2)	oval	0 (1)
rusk	0 (1)	yellow biscuit	0 (1)	pink biscuit	0 (1)
brown burger	0 (1)	star shaped	2 (0)	goof ball	-

COLOUR

dennis the menace	5 (20)	white caps(ule)	5 (12)	pink new york	4 (2)
manchester united	2 (3)	magic white	1 (2)	clear capsule	0 (3)
pink E	3 (0)	big white one	0 (1)	blue and white	0 (1)
pink and white	0 (1)	amber	0 (1)	pink panther	0 (1)
white E	1 (0)	red and yellow	1 (0)	M25	0 (1)

EMBOSSSED

(white/love) dove	86 (5)	love hearts	2 (15)	double barrel	1 (4)
(white) diamond	3 (2)	robin/superdove	3 (1)	dimple	1 (2)
(magic) square/cube	2 (1)	cartoon	2 (1)	malcolm X	1 (1)
bermuda triangle	0 (2)	shocker	1 (1)	shamrock	0 (1)
pink barrel	0 (1)	PT	3 (0)	purple heart	0 (1)
blue heart	0 (1)	(pink) passion	-	clovers	-

SWEETSHOP

rhubarb & custard	7 (30)	lemon & lime	0 (1)	salt & pepper	0 (1)
black jack	2 (0)	parma violet	1 (0)		

OTHER DRUGS

china white	12 (7)	coke burger	1 (8)	coke biscuit	1 (0)
-------------	--------	-------------	-------	--------------	-------

MISCELLANEOUS

new yorker	5 (15)	flatliner	7 (10)	greyhound	0 (7)
cali(fornian sunrise)	2 (2)	clog	1 (1)	headfucker	1 (1)
flying saucer	0 (2)	banana split	1 (1)	china split	0 (1)
underground	0 (1)	amsterdamer	0 (1)	milky way	0 (1)
little bastard	0 (1)	sledgehammer	0 (1)	smoothie	0 (1)
(wee or small) boy	0 (1)	be bop	0 (1)	fantasy	0 (1)
snowman	0 (1)	mickey mouse	0 (1)	B52	0 (1)
rocket	0 (1)	eye-opener	0 (1)	strawberry	1 (0)
huggy	1 (0)	fantasia	-	blaster	-
emerald city	-	turbo	-	"don't know"	13 (45)

Marketing techniques

From Table 7: 1, it can be seen that the nature of these brand names varies greatly. Some names are obviously referring to a drug (e.g. 'white capsule'), others contain more cryptic messages (e.g. 'triple X'). As with the original 'ecstasy' name itself, each of these brand names can be viewed as a marketing strategy. Such names may derive from the ecstasy's appearance, shape, colour, alleged contents, alleged source or alleged psychoactive effects. In Table 7: 1, brand names have been grouped according to one of eight possible naming strategies. A summary of each of these marketing strategies with possible examples of name derivation is given below.

i) *Form*

This is the simplest and most obvious way of naming ecstasy; that is whether it comes as a capsule, liquid or powder rather than the usual tablet form.

ii) *Drug contents*

The brand names in this group are those names which respondents said gave a clue to the drug's contents. For example, Figure 7: 1 shows the actual drawing in which a respondent explained how the brand name 'madman' was derived from the letters MDMA. Madman therefore is an ecstasy name that implies pure MDMA (ADAM). The brand name 'Adam and eve', on the other hand, implies MDMA and MDEA, while 'Eve' or 'madwoman', only MDEA. 'Eva' and tablets with the letter "E" embossed on one side and "A" on the other were said to contain amphetamine plus MDEA and MDMA respectively. The ecstasy called 'triple X' allegedly contained all three ecstasy type drugs, MDMA, MDEA and MDA.

Another chemistry selling point is strength rather than purity. Names such as 'E130' (written on side of capsule) and 'pink 125' (a tablet) imply strengths greater than the acknowledged standard dose of MDMA at 120 mg. It can be seen that the 'white cap' drawn in Figure 1 (most often used ecstasy) has 125 mg: on its side. The ecstasy called 'phase 4' was said to refer to the amount of amphetamine it contained being sufficient to last for 4 hours. Other phase ecstasies reputedly could last up to eight hours ('phase 8'). 'K capsule' allegedly contained MDMA plus the disassociative anaesthetic ketamine (K).

iii) *Shape*

Many ecstasies were simply named after their physical appearance. For example, 'snowballs' refer to a distinctive small rough edged almost spherical pill. 'Burgers' are shaped like a burger when viewed on their side (a shape common to many pharmaceutical products). 'Biscuits' are large flat scored pills (in this context, scored means a fracture line of weakness or thinness that bisects a tablet in order to make it easier to split into half doses). 'Biscuits' have the distinctive feature of being speckled, appearing to be made up of a conglomeration of small rough granules, like a digestive biscuit (though the surfaces of some 'biscuits' were glazed, over making them smooth). Each of these shapes existed in a variety of colours.

iv) *Colour*

The colour of ecstasy tablets was often their only form of identification. Such ecstasies were described simply either as 'pink E' or 'white E'. Other forms were more sophisticated. For example, 'M25' was a tablet either a pink tablet with a blue stripe across the middle or blue coloured tablet with a pink stripe. This ecstasy was said to

have been popular during 1989, after the passing of the Bright Bill that outlawed acid house parties (see Chapter 1). At this time, party goers drove in convoys between service stations on the M25 London orbital and other motorways in search of clandestine parties at secret locations, which were to become known in the media as “raves” (Q, 1989; Newcombe 1991; Redhead 1991; Reitveld, 1991).

The shiny colours of capsule ecstasies more readily lend themselves to names in this design group than tablets. For example, red and black capsules were known as either ‘manchester united’ or ‘dennis the menace’. The former name, one of world’s top football clubs, is said to reflect the involvement of international football casuals in the early spread of ecstasy use. Gilman (1994) details friendly encounters between supporters of rival Manchester and Yorkshire clubs at raves on the eve of matches during 1991. On the eve of the corresponding fixture during the previous season, prior to the arrival of ecstasy, such encounters would have resulted in violence. This name also acknowledges the importance of the Madchester scene in the development and diversification of the dance drug scene (see Chapter 1). The latter name refers to a macho character in the children’s comic, *The Beano*. It is possible that either of these two brand names (‘manchester united’ and ‘dennis the menace’) could be applied to the same batch of ecstasy, the name depending on who it was being marketed towards.

v) *Sweetshop*

The title of this group of ecstasy brand names is taken from the analogy, proposed Parker and Measham (1994), of young people having a “pick n’ mix” approach to drug taking. In their paper, the use of different types of drugs was likened to the consumption of different types of sweets. By extending the analogy, ecstasy could be regarded as one such sweet. Ecstasy may be seen as either a special sweet which can

come in a variety of different flavours or as a 'lucky bag drug', the contents of which remain unknown till the bag is opened (i.e. drug used). This sweetshop (dance event) analogy can be compared with that of a drug supermarket (deprived area, see Chapter 6) where both sweets and other substances are sold.

Several types of ecstasy are named after varieties of children's sweets. This is because of their resemblance to certain sweets in terms of their size, shape and colour. Such ecstasies include 'parma violet', 'lemon and lime' and 'rhubarb and custard'. "Rhubarb and custard" is a particularly interesting name. During fieldwork it was stated that the barb in rhubarb referred to the drug being 50% MDMA and 50% barbiturate. Ecstasy (MDMA) is an amphetamine-related drug. In the 1960s, amphetamines were often mixed with barbiturates both by pharmaceutical companies and illicit drug users of the 'mods and rockers era' (Cohen 1972). Such amphetamine/barbiturate (upper/downer) compounds are said to produce a "1+1=3 synergy" (Grinspoon and Hedblom, 1975). This occurs if the positive effects of each drug overcome the negative effects of the other. For example, amphetamines would remove the drowsy feeling produced by barbiturates without diminishing their pleasurable sensation. In this way the original ecstasy branded 'rhubarb and custard' was allegedly marketed. However, even if this is true, it seems unlikely that all ecstasy sold in a red and yellow capsule is a true 'rhubarb and custard' containing any barbiturate. A similar story may surround 'love heart' ecstasy (also known as 'passion'). Love hearts are another variety of children's sweet, identified by having a heart shape embossed in its centre. 'Love heart' ecstasy has been found to have contained methaqualone and MDMA (Sawyer, 1992). Methaqualone is another depressant drug commonly mixed with amphetamines in the 1960s, both illicitly and pharmaceutically (e.g. Durophet M.TM). Another compound containing amphetamine and the barbiturate, amylobarbitone, was then marketed in a

heart shaped pill (DrinamylTM) nicknamed 'purple hearts' by illicit drug users. Curiously, a type of ecstasy mentioned in this sample was called 'purple hearts'. Another was called 'goof balls', a 1960s name for barbiturates and before that heroin/stimulant cocktails.

vi) *Other drugs*

Other forms of ecstasy also imply that there are other drugs in their contents. For example, the old designer drug name 'china white' is used for a form of ecstasy. Whether this name ever implied 3 methyl-fentanyl (3-MF) was among its contents is not known. The brand names 'coke biscuit' and 'coke burger' imply that cocaine is amongst their contents. However, like the heroin in ecstasy rumours, it is doubtful whether an effective dose of cocaine could be delivered orally in an eighth of a gram tablet, alongside some MDMA, bulk products (excipients) and adulterants. However, 3-MF would certainly be active in doses less than the weight of an ecstasy tablet.

The name 'coke burger' may have another possible derivation. In fast food restaurants popular with children (e.g. Burger KingTM), CokeTM, a soft drink which used to contain cocaine, is sold as the traditional American accompaniment to hamburger. Another form of ecstasy is called 'new yorker', coincidentally also the name of a type of burger. There is even an Edinburgh dance club called *Burger Queen*, which plagiarises the Burger King logo to market itself. This fast food analogy may be viewed as yet another extension of the supermarket-sweetshop conspicuous consumerism metaphor. Indeed, Howes (1990) describes the club scene as class stratified whereby the paying customers consume 'burger' ecstasy while the VIP guests use "additive free" MDMA powder, in a comparison with health food shops.

vii) *Embossed*

If 'burgers' and 'biscuits' have a reputation for poor quality, ecstasy tablets which have shapes embossed on them enjoy better reputations in the Glasgow dance scene. Embossed designs on ecstasy are thought of as quality markers (like lions stamped on eggs). Such markings may make these pills harder to fake. Despite this, these indelibly stamped brands still manage to produce a variety of nicknames. For example, scored pills marked with the letters "P" and "T" (on the opposite side of the scoring) were called any of 'party timers', 'peeping toms', 'pete tongs' (after a DJ), or 'partick thistles' (a second rate Glasgow football club). The ecstasy called 'shamrocks' was probably the same as one known as 'clovers', though no respondent had taken this latter name. 'Squares' and 'diamonds' both first appeared in the sample at the same time during fieldwork in April 1994. Two respondents (both young, working class, males in Snowball S, see Chapter 2) cited "squares". Three respondents (more middle class attendees of Club Saturn, see Chapter 4) cited "diamonds". Looking at their drawings and rotating the page by 45° turned a 'square' into 'diamond', at least on paper. Furthermore, in this study, one respondent (#083, an ex-dealer) said that he had seen 'diamond' ecstasy, but that it was just the same as types he had sold several years before under the brand name 'flying saucers' (also known as 'compact discs' to other users).

Among all brands of ecstasy, those stamped with a dove were the most readily remembered, though some respondents chose to draw the side of the tablet that was scored (with a fracture line) rather than attempt to draw a dove shape. A variety of 'doves' were identified including 'double doves' (embossed with a bird on both sides) and 'super doves', also known as 'white robins' (which were stamped with a sitting bird resembling a robin). Even the standard 'white dove' or 'love dove' could vary,

some having “both wings up”, some “both wings down” and some “one wing up one wing down” (a variant also known as ‘turtle dove’). Soon after interviewing ceased, another variety called ‘beige dove’ appeared, though this has a poorer reputation than other dove ecstasies.

viii) *Miscellaneous*

A variety of other ecstasy brand names are more difficult to categorise. Possible themes include implied effects or place of manufacture. Names such as ‘eye-opener’ or ‘rocket’ may imply stimulant properties. ‘Fantasy’ and ‘fantasia’ may be intended to imply hallucinogenic properties. Indeed, these two brands were said to contain MDMA plus LSD and mescaline respectively. In a similar way, the prefix “disco” in front of a brand name (e.g. ‘disco burgers’ and ‘disco biscuits’) might be said to imply dancing properties, as well as identifying where these tablets are marketed. Macho names such as ‘headfucker’, ‘sledgehammer’ and ‘little bastard’ (compare with ‘dennis the menace’) may imply strength in the minds of some consumers.

Other ecstasy brands use children’s comic character names. This is a theme previously used in naming LSD varieties. LSD blotters have long been identified by having cartoon pictures printed on them, such as Super Mario, Sonic the hedgehog, Bart Simpson and Donald Duck, giving them the appearance of a child’s transfer tattoo (Sieveking, 1992). Ecstasy varieties have exploited this theme, despite being tablets or capsules rather than pictures on paper squares. These include ‘mickey mouse’, ‘cartoon’, ‘dennis the menace’ and, in common with LSD, ‘pink panther’. ‘Strawberry’ is another brand name also common to both drugs.

In mid-1995 (one year after interviewing had ceased), a type of LSD blotter with a picture of Fred Flintstone on it appeared in the Scottish dance scene. At the same time,

ecstasy tablets with pictures of Barney Rubble and Dino the dinosaur appeared. A common manufacturer or drug marketing strategy is indicated, as these LSD and ecstasy brands all depicted characters from the *Flintstones*, a children's cartoon series which had recently been made into a Hollywood movie. Other Hollywood movie logos that have appeared on LSD blotters in recent years have included 'batman', 'superman' and 'ET'. In line with recent changes in other patterns of recreation, a 'sonic the hedgehog' ecstasy appeared in 1996, joining its LSD namesake.

Names such as 'amsterdamer' and "clog" imply Dutch origin (and also ADAM or MDMA in the case of the former). Ecstasy, made in Holland, is allegedly exported to Britain (*The Economist*, 1993). Among users, Dutch ecstasy (in common with Dutch cannabis) may be thought to have a better reputation than that made locally.

Finally, some ecstasy brand names seem to provide a historical record of the development of the dance drug scene. For example, names such as 'B52' and 'sadam hussain' appear to reflect the major historical events of the early 1990s, the time when the brand name culture appears to have become the norm. 'M25' ecstasy provides a historical snapshot of the development of the dance drug scene itself, in the period following the Bright Bill.

Comparisons between different Ecstasies

Has ecstasy declined in quality with time?

To measure whether ecstasy had changed over time, each of the three categories of ecstasy (first, most often and last used) were compared. Though subject to potential

memory effect biases, by using the smiley faces rating scale it was hoped to measure changes in ecstasy quality across users' careers. With an overall mean score of 2.9, respondents consistently rated ecstasy with happy smiley faces (scores less than 4 on the smiley faces scale). The mean score for their first ecstasy used was 2.9 ($n = 117$), most often used ecstasy rated 2.6 ($n = 110$) and last ecstasy used 3.1 ($n = 110$). When paired t -tests were conducted between each category, no significant differences were found between ratings of first and most often used ecstasy or first and last used ecstasies. However, there was a significant difference in rating between most often used and last used ecstasy ($t = 2.53$; $p < 0.05$). This may indicate a belief that the quality of ecstasy has reduced over the years. Whether this decline in quality is real or simply due to tolerance or myth is unknown. Even if ecstasy has changed, it is not known whether this is qualitative, due to the changing brands of ecstasy, or quantitative, reflective of a general reduction in the strength of ecstasy.

Beliefs about ecstasy contents

The first ecstasy used was the most likely of the three categories that users thought of as pure MDMA (41.6%, compared with 33.7% and 34.3% in the most often and last used categories respectively). However, the difference in rating between most often used and last used ecstasy does not appear to be supported by beliefs about purity. Table 7: 2, shows what drugs respondents thought were in the ecstasies that they drew (this table also shows the alleged contents of the three most popular brands of the drug).

Table 7: 2, Alleged Contents of Ecstasy

CONTENTS	DOVE		BISCUIT		SNOWBALL		ALL TYPES	
	N	%	N	%	N	%	N	%
"ecstasy"	9	12.2	1	3.3	1	2.6	22	5.6
MDMA	36	48.6	10	33.3	8	21.1	117	36.7
MDA	0	-	1	3.3	1	2.6	4	1.3
MD?	1	1.3	0	-	0	-	2	0.6
MDMA+MDEA	1	1.3	0	-	0	-	2	0.6
TOTAL PHENETHYLAMINES	47	63.5	12	40.0	10	26.3	147	46.1
MDMA+MDA+opiate	1	1.3	0	-	0	-	1	0.3
MDMA+fentanyl	0	-	0	-	1	2.6	1	0.3
MDMA+'drug'+ 'poison'	0	-	0	-	1	2.6	2	0.6
MDMA+'lemsip'	0	-	0	-	0	-	1	0.3
MDMA+'downer'	1	1.3	0	-	0	-	1	0.3
MDMA+?	0	-	0	-	0	-	4	1.3
heroin+cocaine+K+MDMA+MDA	0	-	0	-	1	2.6	1	0.3
heroin+amphetamine+MDMA	1	1.3	0	-	1	2.6	7	2.2
heroin+LSD+MDMA	0	-	1	3.3	1	2.6	2	0.6
heroin+K+MDMA	0	-	0	-	1	2.6	1	0.3
heroin+MDMA	0	-	0	-	1	2.6	8	2.5
heroin+MDMA+MD?	0	-	0	-	0	-	1	0.3
cocaine+K+MDMA	0	-	0	-	0	-	1	0.3
cocaine+MDMA	1	1.3	1	3.3	0	-	4	1.3
amphetamine+LSD+MDMA	0	-	0	-	1	2.6	2	0.6
amphetamine+MDMA	1	1.3	5	16.6	3	7.9	22	6.9
LSD+MDMA	0	-	0	-	1	2.6	1	0.3
K+MDMA	0	-	0	-	3	7.9	4	1.3
TOTAL MDMA+OTHER	5	6.8	7	23.3	15	39.5	64	20.1
heroin	0	-	1	3.3	4	10.5	7	2.2
heroin+amphetamine	1	1.3	0	-	0	-	3	0.9
heroin+amphetamine+LSD	1	1.3	0	-	0	-	2	0.6
heroin+'downer'	0	-	1	3.3	1	2.6	2	0.6
cocaine+amphetamine+LSD+K	0	-	0	-	0	-	1	0.3
cocaine+amphetamine+LSD	1	1.3	0	-	2	5.3	5	1.6
cocaine+LSD+heroin	2	2.7	0	-	0	-	3	0.9
amphetamine	3	4.1	1	3.3	0	-	9	2.8
amphetamine+LSD	0	-	0	-	0	-	5	1.6
amphetamine+?	1	1.3	0	-	0	-	1	0.3
LSD	0	-	0	-	0	-	1	0.3
K	0	-	0	-	0	-	1	0.3
everything/lots mixed	0	-	0	-	1	2.6	1	0.3
not MDMA	0	-	0	-	0	-	1	0.3
TOTAL OTHER	9	12.2	3	10.0	8	21.1	42	13.2
"don't know"	13	17.6	8	26.6	5	13.2	65	20.4
TOTAL	74		30		38		319	

From Table 7: 2, it is clear that users believe in a very large number of possibilities for ecstasy contents other than pure MDMA. These included other phenethylamines drugs (alone or in combination with MDMA) and other drugs either alone or in combination with MDMA or other phenethylamines (MDA or MDEA). MDMA was identified as the sole 'ingredient' of ecstasy by 36.7% of users, the most common answer given. A total of 34 other 'recipes' for ecstasy were given, plus the responses "not MDMA", "don't know" and simply "ecstasy". These other recipes cited a wide range of other drugs including stimulants, depressants, opiates, anaesthetics and hallucinogens.

Subjective effects of ecstasy

Table 7: 3, gives the subjective effects of ecstasies, as stated by respondents when annotating their drawings. Despite the very large range of responses given here, there were no systematic differences between first, last and most often used ecstasy. The most common response for each was simply that it "makes you feel happy" (21.0%). Other common responses (over 10.0%) being "euphoria", "feeling good" and "energetic. Reports of a "rush", feelings of "empathy" and wanting to "dance" were only slightly less often cited.

Table 7: 3, Subjective Effects of Ecstasy

EFFECT	DOVE		BISCUIT		SNOWBALL		ALL TYPES	
	N	%	N	%	N	%	N	%
ecstasy	1	1.2	0	-	1	2.3	4	1.3
feel good	14	17.1	3	10.0	8	18.2	54	16.9
feel bad	3	3.7	2	6.7	0	-	9	2.8
happy/bliss	23	28.1	5	16.7	7	15.9	67	21.0
enjoy	2	2.4	0	-	1	2.3	4	1.3
euphoria	14	17.1	5	16.7	6	13.6	52	16.3
no euphoria	0	-	0	-	0	-	2	0.6
love(ing)	4	4.9	2	6.7	1	2.3	14	4.4
sexy(ual)	4	4.9	0	-	0	-	10	3.1
orgasm	0	-	0	-	0	-	1	0.3
pleasure	2	2.4	1	3.3	1	2.3	11	3.5
well being	3	3.7	0	-	0	-	6	1.9
empathy	10	12.2	3	10.0	4	9.1	28	8.8
social	4	4.9	1	3.3	3	6.8	14	4.4
talkative	3	3.7	0	-	0	-	9	2.8
disinhibited	5	6.1	1	3.3	1	2.3	13	4.1
enthusiastic	4	4.9	0	-	1	2.3	6	1.9
fun time	2	2.4	0	-	0	-	3	0.9
self esteem/ego	1	1.2	1	3.3	0	-	3	0.9
mellow	4	4.9	0	-	0	-	5	1.6
floating	0	-	1	3.3	0	-	3	0.9
bouncy	1	1.2	1	3.3	0	-	2	0.6
peaceful	0	-	0	-	0	-	1	0.3
tuned in/to vibe	0	-	2	6.7	0	-	3	0.9
musical	0	-	0	-	1	2.3	1	0.3
want to dance	12	14.6	2	6.7	2	4.6	29	9.1
tired	1	1.2	0	-	3	6.8	9	2.8
awake/alert	0	-	2	6.7	1	2.3	7	2.2
lucid	1	1.2	1	1.3	0	-	6	1.9
confused	1	1.2	2	6.7	3	6.8	12	3.8
panic	2	2.4	0	-	1	2.3	4	1.3
relaxed	2	2.4	1	3.3	1	2.3	12	3.8
paranoid	2	1.2	0	-	0	-	3	0.9
contented	2	2.4	1	3.3	2	4.6	9	2.8
excited	0	-	0	-	0	-	3	0.9
energy	13	15.9	7	23.3	4	9.1	39	12.2
rush	9	11.0	0	-	7	15.9	30	9.4
high/up	6	7.3	1	3.3	2	4.6	19	6.0
hallucinate	3	3.7	0	-	6	13.6	22	6.9
trippy	3	3.7	1	3.3	5	11.4	23	7.2
not trippy	0	-	0	-	0	-	2	0.6
speedy	4	4.9	2	6.7	2	4.6	26	8.2
not speedy	1	1.2	1	3.3	0	-	2	0.6
smacky	1	1.2	0	-	3	6.8	8	2.5
gouchy	0	-	2	6.7	3	6.8	11	3.5
like buzzing gas	0	-	0	-	0	-	1	0.3
drunk	0	-	0	-	0	-	1	0.3
alcohol effect	2	2.4	0	-	0	-	4	1.3

Table 7: 3, Subjective Effects of Ecstasy (continued)

EFFECT	DOVE		BISCUIT		SNOWBALL		ALL TYPES	
	N	%	N	%	N	%	N	%
hot	0	-	0	-	1	2.3	5	1.6
nausea	0	-	0	-	0	-	2	0.6
vomit	3	3.7	1	3.3	1	2.3	8	2.5
off balance	1	1.2	0	-	1	2.3	4	1.3
eye wiggle	1	1.2	0	-	1	2.3	7	2.2
jaw grind	1	1.2	0	-	0	-	7	2.2
numb	0	-	0	-	0	-	2	0.6
motionless	0	-	0	-	1	2.3	2	0.6
slowed down	0	-	1	3.3	3	6.8	9	2.8
shaky	0	-	0	-	0	-	1	0.3
stomach ache	0	-	0	-	0	-	1	0.3
amnesia	0	-	0	-	0	-	1	0.3
insomnia	0	-	0	-	0	-	1	0.3
tactile	2	2.4	0	-	1	2.3	3	0.9
laughter	2	2.4	0	-	0	-	4	1.3
drugged	0	-	0	-	2	4.6	1	0.3
spaced	0	-	2	6.7	2	4.6	6	1.9
wasted	2	1.2	0	-	2	4.6	5	1.6
mood enhance	0	-	0	-	1	2.3	4	1.3
mind expand	3	3.7	0	-	0	-	4	1.3
new values	2	2.4	0	-	0	-	2	0.6
short action	1	1.2	1	3.3	0	-	9	2.8
long action	0	-	0	-	3	6.8	8	2.5
clean	1	1.2	1	3.3	0	-	4	1.3
smooth	0	-	0	-	0	-	2	0.6
mild	1	1.2	0	-	0	-	10	3.1
heavy	1	1.2	0	-	1	2.3	2	0.6
mild come up	0	-	0	-	0	-	1	0.3
heavy come up	1	1.2	0	-	0	-	1	0.3
quick come up	2	2.4	0	-	0	-	2	0.6
slow come up	0	-	0	-	1	2.3	3	0.9
good come up	1	1.2	0	-	1	2.3	3	0.9
bad come up	0	-	0	-	0	-	1	0.3
slow come down	0	-	0	-	1	2.3	2	0.6
quick come down	1	1.2	0	-	0	-	1	0.3
good come down	1	1.2	0	-	0	-	6	1.9
bad come down	0	-	0	-	0	-	3	0.9
want more	2	2.4	0	-	0	-	2	0.6
spaced for days	0	-	0	-	0	-	1	0.3
good for days	0	-	0	-	0	-	2	0.6
strong E	0	-	1	3.3	2	4.6	7	2.2
weak E	2	2.4	1	3.3	0	-	6	1.9
good E	8	9.8	2	6.7	3	6.8	25	7.8
bad E	1	1.2	0	-	0	-	9	2.8
no effect	0	-	1	3.3	0	-	8	2.5
varied	2	2.4	0	-	2	4.6	4	1.3
don't know	0	-	0	-	1	2.3	4	1.3
TOTAL	82		30		44		319	

As with much of the other self-reports given here, these subjective effects need to be viewed with some caution. This is because it is not known what other drugs the respondents had consumed at the same time as each ecstasy drawn. Chapter 3 details that respondents in this thesis used a total of 67 different drugs (containing 51 discrete chemicals), many of which were used as dance drugs, often at the same time as ecstasy (see Chapter 5). Other drugs co-used with an ecstasy may act as synergists or antagonists. This may either potentate or negate the effects of an ecstasy which itself has unknown contents. Such drug interactions may (wrongly) be attributed only to the ecstasy tablet by the its user.

What is particularly striking about Table 7: 3 is the similarity of many of these verbatim recorded answers to those given in Table 4: 2, concerning what respondents liked or disliked about the dance scene (see Chapter 4). Terminology common to both tables include that concerning: relaxation, energy, enjoyment, communication, sex, heat, music, dancing, drugs, come downs, alcohol influences, social effects (e.g. empathy or friendliness), various changes in value sets (e.g. expanded consciousness or freedom) and simply “ecstasy”.

Describing the appearance of ecstasy

Ecstasies were described as “small” (31.2%) more than any other qualitative description of tablet size. Alternatively, from those who gave a quantitative estimate, the mean diameter of ecstasies drawn was only 9.2 mm. It should be noted that this figure includes all forms of the drug (capsules, pills etc.).

Most ecstasies came in pill (tablet) form. The design of these pills varied greatly. The most common drawing was that of a pill with a dove embossed on it (14.9%). This reflects the dominance of the ‘white dove’ brand (35.3% of the most often used

ecstasy category). There were only 34 (9.4%) drawings of capsules, 6 (1.7%) of powders and 2 (0.6%) of liquid ecstasy (both liquid E were in the first ecstasy category and used in the late 1980s).

White was by far the most common colour for ecstasy. Around two thirds (67.8%) of all drawings were described as white. This figure does not include a range of descriptions such as partly white (e.g. “red and white”), “off white”, “cream”, “beige” or “white speckled”.

Ecstasy brand preference

The differing appearance of ecstasies, detailed above, was the most readily used method of brand identification. Among these respondents, the three ecstasy brands known as (white or love) ‘dove’ ($n = 86$), (disco) ‘biscuit’ ($n = 31$) and ‘snowball’ ($n = 46$) were the most often drawn. All three brands were represented across all three categories of drawing (first, last and most often used ecstasy). Apart from these three brands, only ‘madman’ ecstasy had more than 10 drawings ($n = 11$), all of which were in the last ecstasy category. Also, as detailed above, these brands could be said to represent a good reputation ecstasy (‘white dove’) a poorer reputation ecstasy (‘disco biscuit’) and an ecstasy believed to be strong, but not ‘real’ (MDMA) ecstasy (‘snowball’). The numbers of these could have been increased further by the inclusion of several lesser varieties of each of these brands to the total (e.g. ‘super dove’, ‘brown biscuit’, ‘mini snowball’), but this was not done here to minimise inconsistencies within brands. Each of these three brands (including their lesser varieties) has a unique appearance, making confusion between these three types of ecstasy unlikely. For example, any coloured capsule could contain any drug compound, but tablets which have doves embossed on them, have a biscuit like construction or snowball shape are

less likely to be different. For these reasons, these three brands were selected as being most suitable for making brand comparisons.

The ease of identification and discrimination between these three brands was confirmed by respondents' descriptions of ecstasies that they had drawn to represent each variety. 'Disco biscuits' were more often described as "big" or "very big" (43.8%) relative to all other ecstasy brands. 'Biscuits' had an estimated mean diameter of 9.0 mm. The diameter of 'doves' was 7.3 mm and 'snowballs' had an estimated diameter of only 7.0 mm. 'Doves' and 'Snowballs' were both more often described as "small" relative to all other ecstasies (43.6% and 45.5% respectively) than any other qualitative description of their size.

Sixty per cent of all ecstasies called 'doves' were described as being a pill with a dove embossed on it. One third of all 'disco biscuits' were described as flat scored pills and one third of 'snowballs' as round/domed pills. These were the most common answers for describing the shape of each of these three brands. Unsurprisingly, the brands named 'white doves' and 'snowballs' were predominantly "white" (86.8% and 92.7% respectively). 'Biscuits', on the other hand, were usually described as "brown", "brown speckled" or another variety of brown in colour (63.3%).

Table 7: 2 gives the alleged contents of these three most often drawn ecstasy brands. 'Doves' were thought to be the purest in MDMA (or ecstasy), 'snowballs' the least so. From this table, the 'snowball' brand appeared to vary most in content. 'Snowballs' were most often cited as MDMA plus other drug(s). Many concoctions were given for the contents of 'snowballs', especially those containing K (ketamine) and heroin.

Table 7: 3 compares the subjective effects of users after ingesting each of these brands. 'Doves' appeared more likely to make respondents "happy", 'biscuits' more likely to make them "energetic" and 'snowball' to make them "feel good". The

'snowball' brand was most varied in its effects, especially other drug like effects. It is interesting to note that 'snowball' ecstasy was the brand most likely to produce effects similar to those produced by hallucinogenic substances, such as "trippy" or "hallucinate". This may reflect the greater variety of drug cocktails that 'snowballs' were said to be (see Table 7: 2). Alternatively this may be regarded as evidence that the 'snowballs' used by these respondents were in fact MDA (Climko et al, 1987; Lifeline 1993b; Saunders 1995a; Collin, 1997).

The initial assumption about the reputations of these three brands was confirmed from respondents' ratings of each. 'Doves' rated highest (2.4), then 'snowballs' (3.0) and lastly 'biscuits' (3.3) on the smiley-faces scale.

Baking the ecstasy cake: It's a made-up drug

From the results presented here, it is clear that ecstasy does not exist in just one recognisable form, as is the case with other drugs commonly used in Glasgow, such as amphetamine or temazepam. This makes it unclear what the drug's actual content is, though the variety of brand names may be providing users with some clues (or red herrings) about tablet contents.

It can be seen that the various brand names of ecstasy can be put into one or more of several groups. It is not known whether these brand names were coined at source or by dealers in Glasgow. The origins of names such as doves are obvious and likely to be in universal usage among ecstasy users. At the opposite extreme, anecdotally dealers in Glasgow clubs were said to be making up names for types of ecstasy 'on the spot' when asked by customers what brand of ecstasy it was they were buying. Indeed, during an interview with one of the smugglers in this study (#027), a beige coloured ecstasy was produced which the respondent had recently acquired abroad. He said this

ecstasy had no name, but that he was going to call it 'clog' because it "looked like a clog and it came from Holland".

Other brand names may have persisted after the original drug compound had changed. For example, 'rhubarb and custard' was supposed to contain phenobarbitone plus MDMA. However, any red and yellow capsule is likely to be called 'rhubarb and custard'. These are unlikely to contain any barbiturate and not even guaranteed to contain any MDMA. Indeed, nobody who drew a 'rhubarb and custard' mentioned phenobarbitone. Likewise, 'snowball' ecstasies that were in circulation after the termination of Latvian MDA production (respondent #004 gave a range of smiley faces' scores between later and earlier "versions" of 'snowballs'). Ditton (1994) tested both 'rhubarb and custard' and 'pink snowball' ecstasies in Glasgow at the time of fieldwork for this thesis. Both contained only MDMA. Some respondents even drew tablets called white doves that were neither white nor embossed with a dove. During observational fieldwork, ecstasies called 'squares' were shown to the author. These were very flat pills with no square (or diamond) embossed on them. They were being sold under the 'square' brand name, not because of their physical design, but because they had the same psychoactive effects as tablets with squares embossed on them (i.e. they allegedly contained ketamine). The basic problem here is that some ecstasies with different names may be the same while others with the same name may be different.

Brand names may also vary over time and place. This sample was all Glaswegian and the initiation of their ecstasy using careers varied from 1985 to 1993. Despite this, noting which brand of ecstasy respondents used first, most often and last revealed a large variety of brand names. Elsewhere, a variety of other brand names have been cited (Lifeline, 1993a; *Mixmag*, 1994; *Gay Times*, 1994; *Eternity*, 1995). Although not mentioned by respondents in this study, brand names such as 'orgasm', 'power packs',

'green burgers', 'red devils' (an old nick-name for Seconol™ quinalbarbitone), 'bison' and 'dolphin' (embossed) are designed with a nomenclature that would be familiar to Glaswegian ecstasy users.

Even ecstasies available at the same time in the same place may vary for many reasons. Different ecstasy producers may make ecstasy to different standards. Batches made by the same producer may differ. It is possible that different ecstasy producers may use the same pill manufacturer. This means, for example, that, just because one tablet stamped with the letters 'PT' contained 196 mg of MDEA (*Eternity*, 1995), it does not follow that the next one will. Unembossed tablets are even more likely to vary. Any tablet could in theory be sold as ecstasy. These may have included dog laxatives (*The Sun*, 1995), tropical fish deoxygenating tablets (Sawyer, 1992), anti-smoking tablets (*Daily Record*, 1993d) and even potentially lethal drugs such as paracetamol (*Eternity*, 1995). Powders, which may have been pure MDMA at source, risk adulteration in a similar fashion to traditional drugs (e.g. heroin, cocaine and amphetamine) during transfer along dealing chains. Capsules are even more at risk of adulteration than powders, because their contents can be hidden from the consumer. Given the potential for abuse, it is perhaps surprising that any real ecstasy reaches the consumer at all; even more surprising that consumers should risk buying this potentially polluted product.

That drugs free from legal controls should be 'cut' (adulterated) to increase profits by reducing purity is nothing new (Preble and Casey, 1969; King, 1996; Coomber, 1997). What is new about this drug is that users reported differences in content between ecstasies, rather than simply different strengths. Why users should think that ecstasy contains such a variety of substances is unclear. Disinformation in the media must have played a part, but such drug mythologies can also arise spontaneously. Jay Stevens'

book *Storming Heaven* (1987) details how different colours of LSD tabs were attributed different subjective drug effects by users. These American 1960s drug users were in fact consuming LSD made from the same batch that had merely been dyed different colours by its manufacturer. Something akin to this appears to be happening among 1990s ecstasy users. Descriptions such as a 'smacky E' or a 'speedy E' have been applied to brands of ecstasy, sometimes by users who have never (knowingly) taken heroin or amphetamine (*The Economist*, 1993).

The obvious way to check whether the beliefs about ecstasy's contents, reported in this chapter, are true is by forensic analysis. There are two ways in which forensic results from testing ecstasy can be used. Firstly, to assay the purity of an ecstasy sample; that is, whether it consists of a single psychoactive substance, such as MDMA, or whether it consists of a compound of different drugs. Secondly, forensic testing can give the strength of the drugs in an ecstasy sample; that is, the potency of a single dose or tablet. For example, two apparently similar tablets may contain only MDMA, but one may contain many times more MDMA than the other.

Unfortunately, few results from such testing have been published from the UK. The first such testing of samples, analysed by *Select* magazine (Sawyer, 1992), did seem to support the notion of drug cocktails and clues in their names, as detailed above for 'rhubarb and custard', 'passion' (or 'love heart') and 'fantasy' ecstasy. Although *Lifeline's* April 1993 sample shows 'triple X' as having all three types of ecstasy drug, the purity is so low as to make a single dose of this compound inactive (*Lifeline*, 1993a). Samples obtained by a Glasgow ecstasy study (January - June 1994) were striking in that they contained MDMA and little else (Ditton, 1994). The Glasgow samples also appeared to be much stronger than *Lifeline's* (up to 70% MDMA). *Eternity* (1995) magazine found a 'PT' ecstasy to be high strength MDEA. *Gay Times*

and *Mixmag* magazines also tested ecstasy samples, in September and December of 1994 respectively, but did not give tablet strength (*Gay Times*, 1994; *Mixmag*, 1994). All these ecstasy testers except for *Lifeline* and *Select* analysed 'doves' and found their only psychoactive contents to be MDMA or MDMA plus some MDEA. Tablets sold under the brand name 'biscuit' were found to be more variable in both strength and purity. *Lifeline* analysed a 'snowball' and this transpired to be strong MDA (*Lifeline*, 1993b). This brand was allegedly manufactured in ex-Soviet government laboratories in newly independent Latvia during the early 1990s (Saunders, 1995a). This may explain its differing effects from other ecstasy brands (Climko et al, 1987). Indeed, the Glasgow ecstasy study mentioned above also analysed respondents' hair for the presence or absence of MDMA, MDA, opiates, methylamphetamines and amphetamines. MDA was present in the hair of many respondents who said that they had used snowballs (Ditton, 1994). The problem with forensic testing is that no two ecstasies are ever guaranteed to be the same. This means that comparisons between forensic results and users' visual descriptions, require a degree of caution, but may be more reliable than comparing users' beliefs based on subjective effects ('street' mythology).

E is for effect: Ecstasy tablet design, a new concept in illegal drug marketing

The importance of these findings lie in their enormous variation. The pattern of ecstasy use in Glasgow appears to deviate from that of all other drugs.

- Ecstasy has a large and ever expanding number of brands.
- There was only some evidence for a reduction in ecstasy quality over time. Users felt the brand of ecstasy they had used most often was significantly better than the brand they used last (though not that which they had used first).

- Different brands were said to contain different drugs, not just MDMA of varying strength.
- Different brands were attributed different subjective effects. When using ecstasies, it was these effects that attracted the user rather than tablet contents.
- The brand known as 'white dove' was particularly popular among users, both in terms of frequency of use and subjective rating.

This subculture which has grown up around ecstasy and its brand names is not found in any other drugs. Although 'traditional' drugs such as cannabis, heroin or LSD come in many forms and occasionally have brand names, differences between these are usually quantitative. In the case of ecstasy, differences between brands are often said to be qualitative. In other words, 'skunk' is just strong herbal cannabis, 'Iranian brown' is just smokeable brown coloured heroin (base) from Iran and 'green micro-dot' simply an allegedly potent form of LSD dyed green. Though the strength of these drug forms and brands may vary, the drug which they allegedly contain and its effects do not. This is not the case with ecstasy. Users of ecstasy report different contents and effects from both the same and different brands. This is illustrated by 38 'snowball' using respondents who were able to provide alleged contents for the brand, giving 26 different recipes. It seems that respondents when buying ecstasy were buying into a concept rather than a single pharmacology. Indeed some respondents said they simply bought a substance called "ecstasy", contents "ecstasy" (i.e. that is the generic chemical name for contents of the tablet). When asked why she did not want to know what drugs were in "ecstasy" tablets, one respondent (# 125) replied that as long as it makes her feel good why care about what it contains. To such users, ecstasy was more important as part of a night out in the dance drug scene than as a drug experience for its own sake. There is an interesting parallel here between users' beliefs about the

dance drug ecstasy and the types of dance drug music listened to under the influence of the drug detailed in Chapter 4; both are mixed. Perhaps ecstasy can be seen as representative of a wider youth culture of conspicuous consumption rather than simply being another drug used by drug users. From the point of view of the user, the importance of ecstasy lies in its place as part of a wider lifestyle, not merely as a drug important only for its pharmacological effects. Whether consciously or not, when buying ecstasy in the dance scene, the user is buying a feature of a lifestyle not just a (hopefully) psychoactive substance.

Mis-shapes of things to come

It is clear from the data presented here that ecstasy consumption differs from that of other drugs. Unlike other drugs, ecstasy is seen by its users as very variable in terms of both content and effects. Ecstasy also comes in many forms, marketed under different brand names with different reputations. Ecstasy is not a designer drug in the legal sense, as in the definition by the DEA to proscribe it. This described a designer drug as one “wherein the defined psychoactive properties of a scheduled drug have been retained, but the molecular structure has been altered in order to avoid prosecution under the Controlled Substances Act” (Smith and Seymour 1985). On the other hand, ecstasy does resemble an earlier definition of a designer drug, as an “entire packaging and marketing concept”, rather than simply creative chemistry (Baum, 1985). This was what Gary L. Henderson, who coined the phrase designer drug, intended. Commenting on the fentanyl analogues, Henderson felt that a true designer drug is designed for effects, legality, undetectability, potency and appearance. Much of this is true of ecstasy in Glasgow in the 1990s. As this designer definition has become obsolete, it is felt here that the term ‘concept drug’ could be applied to ecstasy. The concept drug of

ecstasy is a product rather than single pharmacology. Ecstasy can be seen as a label rather than simply a nickname for MDMA. It is possible that such concept drugs may become the norm in future. Indeed, five respondents in this study claimed to have used a substance called 'zonks', a 'designer downer'. These 'zonks' were allegedly made in Holland by the same people who manufactured ecstasy, to be used after ecstasy use to induce sleep as a 'safer' alternative to problematic pharmaceutical hypnotics such as temazepam. Whether these tablets were illicitly manufactured or not is less important than the belief among users that they were. Zonks users' beliefs about their effects and their contents varied in much the same fashion as did their beliefs about ecstasy.

The evidence presented in this chapter indicates that dance drug users are 'buying' the drug (ecstasy) label, rather than simply pharmacology. This creates new challenges for health education and drug policies. For example, it is not possible to attribute instances of ill health or death to MDMA simply because the patient had taken ecstasy. Conversely, guidelines about the risk of MDMA use (e.g. from laboratory trials) may be inappropriate to ecstasy use in the dance scene. Health messages need to be targeted at the dance drug lifestyle rather than at the effects of a single pharmacology, as has been the case with traditional patterns of drug use. At present, the effects of ecstasy use (i.e. not merely MDMA) are as unknown to the health educator as to the drug user. Clearly the risks associated with the dance drug scene as a whole can more easily be managed than focusing on this one indeterminate substance.

CHAPTER 8

SOMETHING CHANGED: IMPLICATIONS AND CONCLUSIONS

Introduction

This final chapter will examine the implications and conclusions of this thesis. Firstly, the implications from the findings of each of the data chapters (3 to 7) will be detailed in turn. Secondly, the impact of the dance drug scene on wider society will be assessed, where possible using evidence obtained in this research (literature review, fieldwork and analysis) to support these observations. Finally, trends in drug use requiring future research are identified.

It was the main aims of this thesis to see which drugs were being used in the dance drug scene and to examine any relationships that might exist between these drugs and attendance at dance events (raves). These ends have now been achieved, using a quantitative approach, detailing the extent of drug use by dance event attendees (ravers) and measuring which drugs were directly related to participation in the dance scene. These dance drug users were found to differ from previously researched drug using groups in Glasgow, in terms of their demographics, setting of use, patterns of use, patterns of supply and reasons for use. The implications of these differences, as found in each of the data chapters of this thesis, are explored below.

The new dance drug users: Demographics and drug use

The respondents in this thesis came from a variety of backgrounds; however, few were from the deprived housing schemes that have characterised previous Glasgow drug

research. Despite using a large range of drugs, few respondents had ever experienced any drug problems. This challenges the notion that all drug use will inevitably lead to drug-related harm. This finding is particularly salient in this sample as it was the drugs which carry the most serious Home Office classification, 'Class A, Schedule 1' (Bucknell and Ghodse, 1986), such as ecstasy or LSD, that were being commonly used and which characterised this drug scene.

The Glasgow dance drug scene attendees were poly-drug users. Their use of different drugs often took place simultaneously. Mixing of drugs is of course more dangerous than using single substances (Hammersley, et al 1995). Such poly-drug mixing would seem the likely cause of dance drugs now being sold as part of a package of drugs (*the Scotsman*, 1994; *Daily Record*, 1995). Such 'party packs' might include two capsules for the price of one, comprising an ecstasy to be taken before dancing (for its stimulant effect) and a temazepam to be taken afterwards (for its depressant effect), the hypnotic action of the benzodiazapine overcoming the stimulant action of MDMA. This form of drug supply would suggest that (dance) drugs are being scored and used at specific times for specific effects rather than simply as drug use for its own sake. Further evidence for dance drug use being planned in advance was found in later chapters of thesis.

The adoption of a poly-drug mixing pattern would seem likely to increase the risks of drug-related harm to dance drug users. Health messages aimed at safer dancing would therefore be better aimed at the dangers of poly-drug use rather than just being targeted at a single substance such as ecstasy (MDMA). The dance drugs = MDMA equation, promoted by the media, is clearly inaccurate. This need for caution in the media must also apply to the reporting and interpreting of news items concerning other forms of drug use. Previously, the same Scottish media sources focused on a drug

injection = heroin use equation at a time when there was a rapid increase in deaths among Glasgow drug injectors. The media and the police attributed this to high purity heroin (e.g. “Death rate soars as heroin purity rises”, *Scottish Daily Express*, 1995). This increase in drug deaths has since been demonstrated to have been caused by poly-drug use and poly-drug mixing (Hammersley et al, 1995). Clearly there is a potential for future deaths in the dance scene to be misrepresented in the media as ‘ecstasy overdoses’.

Though these respondents used many drugs, only alcohol, tobacco and cannabis had in quantitative terms a greater than weekend frequency of use. As the night-clubs listed in Chapter 4 were only open at the weekend and most ecstasy use (and much other dance drug use) takes place in these, then a weekend only use pattern is hardly surprising. It would appear that the frequency of use of dance drugs, particularly ecstasy is limited by social factors as much as pharmacology (see Zingberg, 1984). Ecstasy may be described as a ‘something for the weekend drug’, a part of a night out, rather than a drug used anytime anywhere for its own sake.

A dance beat fit for ecstasy: Dancing and venues

Attendance at dance drug events was a recent aspect of respondents’ lives. Most had been involved in the scene for fewer than five years and had first attended a dance drug event during their late teens or early twenties. Despite an increased likelihood of having attended (licensed or illegal) raves earlier in their dance drug scene career, night-clubs were the events at which initiation into the scene was most likely to have taken place. Indeed night-clubs, rather than raves, were to prove the most important component of the dance drug scene throughout this thesis. These dance drug users attended a large variety of venues (night-clubs and others) and danced to a variety of

types of music. As such, the authorities may be wrong to single out raves as the places where dancing on drugs takes place.

Of two clusters of night-clubs in Glasgow city centre, the cluster furthest from where most respondents lived was more popular. This and other findings detailed in Chapters 4 and 5 indicated willingness among dance drug users to travel while using drugs. This travelling may be experience seeking behaviour, to attend as many different venues as possible or to seek out a particular style of music or favourite DJ. However, some journeys to dance events made by respondents in this thesis were undertaken in order to circumvent local social policy such as the curfew.

There was a tendency for hardcore (night-clubs, raves or music) to be associated with younger less affluent males. Conversely, house appeared relatively more popular with older, more affluent females. It is possible that this fastest of dance drug music styles (hardcore) and the demographics of its fans may be related to the disproportionate number of rave-related deaths that have occurred at its venues (*Glasgow Herald*, 1995a; M8, 1994; Bush, 1994). This has occurred in spite of these venues often being the best served in amenities, security and medical cover (Collin, 1997).

Despite most dance events taking place on licensed premises, exclusive consumption of alcohol was not the norm. Indeed, attendance at these events may actually represent a reduction in alcohol consumption by revellers. This was especially the case among younger ravers who grew up during a time when alcohol consumption at dance venues was not the norm. From the point of view of night-club owners, this may incur a reduction in sales of alcohol compared with what might be expected with a client group such as these respondents. Given the age gradient in alcohol consumption at dance venues found in this sample, this trend would seem likely to increase (and from

the point of view of the alcohol industry worsen) as future generations become patrons of premises licensed for the sale of alcohol.

The periodical *the Economist* (1993) estimated that the UK ecstasy market had reached equilibrium at 500,000 users by 1993, representing sales worth £700,000,000 per annum. Taken together with an estimated weekly attendance at dance events of over 1,000,000 young people, the dance drug culture can be viewed as a powerful economic force that threatens the profitability of the drinks industry. Whether this will lead to a long-term reduction in alcohol consumption, with a knock positive impact on the health of the nation, is not yet known. Any potential reduction in alcohol-related harm has to be offset against the risks of dance drug-related harm. At present, harm related to dance drug use is relatively uncommon; unfortunately this cannot be said for alcohol.

The other industry that seems certain to be economically effected by the advent of the dance drug scene is the music industry. It is indicated in this thesis that the live playing of records by DJs is more important than buying recorded music to dance drug event attendees. In terms of financial outlay and frequency, night-club attendance appears to have replaced record buying as the prime method of commercial music consumption. If these respondents are typical of the 1990s youth culture then this is likely to have major impact on the established British music business.

Evidence that the above trends may continue is to be found in research samples among school age populations. Surveys of adolescents conducted during the mid-1990s have found unprecedented levels of drug use (Measham et al, 1994; Loretto, 1995; Roberts et al, 1995; Barnard et al, 1996; Miller and Plant, 1996; Fast Forward, 1996; Balding, 1996; Forsyth et al, 1998 in press). Recent research has shown that most substance (tobacco, alcohol, cannabis and other drug) using schoolchildren state "rave" (or

another dance drug music genre) as their favourite type of music (Forsyth et al, 1997). From this it would seem likely that the substance using secondary school children of the 1990s will graduate to become the dance drug event attendees of the 21st century, with all the consequences (economic, health, social and alcohol or drug related) that such a trend would imply.

The floor to E: Drug use and dance settings

Dance drug event attendees tended to use different drugs in different settings. These settings might either increase or reduce the potential for drug-related harm (see Zingberg, 1984). For example, the primary dance drugs tended to be stimulants. The use of stimulants is known to increase body temperature. In hot night-clubs or raves the use of such drugs has been linked to several deaths due to hyperthermia related causes (Henry, 1992). The evidence found here suggests that ecstasy and amphetamine (temperature raising drugs) are those most often used in this dangerous environment. This finding has been confirmed elsewhere. In Akram's (1997) study of Nottingham dance drug users, ecstasy and amphetamine were the two principle drugs used at night-clubs, and as also found in this thesis, these two drugs were often co-used with each other or with many other substances. Such co-use in the dance event environment can also be viewed as risk increasing behaviour.

The use of depressant drugs, such as temazepam by these respondents, after a dance event might also be described as taking place in a dangerous setting. Using such drugs at home may increase the risk of fatal overdose. This could happen because using late at night (perhaps alone and in colder temperatures than during the day) decreases the chances of an overdose victim receiving medical attention in adequate time. The notion of a relationship between setting and potential for drug related harm is also applicable

to other drug using groups. For example, the secretive nature of drug injection may favour hazardous settings such as toilet cubicles or derelict buildings. Such settings may increase the risk of harm such as overdose, infection, assault or hypothermia (Klee and Morris, 1995).

The use of drugs such as temazepam in the dance scene (even if at home afterwards) may encourage the dance drug users to take these drugs in other situations. In other Scottish drug using samples, temazepam use has been associated with problem drug users (Sakol et al, 1989; Hammersley et al, 1990; Lavelle et al, 1991). Thus there is a potential for dance drug users to experience problems and appear at drug agencies through involvement with temazepam. However, despite these threats, the main risks related to dance drug use would appear to be those from acute intoxication rather than addiction.

Taking care of friends: Dance drug scoring

From this research it would appear that dance drug users have an option of either insuring drug use by getting sorted before a dance event or chancing being able to score drugs after gaining entry to a venue. Whether the decision to get sorted or wait and see is related to dance venue door policy is not known. However, the large number of users obtaining and using drugs in this way suggests that, even if it were possible to keep drugs and dealers out of dance events, it is impossible to exclude persons under the influence of drugs from dancing. The benefits of club door searches are therefore somewhat dubious. Users might put themselves at greater risk by ingesting larger doses of drugs immediately prior to entering a venue, rather than being able to judge gradual increases in dosage from conditions inside. The climate of fear created by the

possibility of undercover police being present at dance event venues may also influence choices about where to score drugs and when to ingest them.

Other less obvious dangers are likely to arise from policies that effectively encourage drug scoring in advance of attending dance events. Obtaining supplies from dealers outwith the dance scene may increase the risk of ravers coming into contact with other drug using groups with all the dangers that this might entail. In other words, fewer drugs will be obtained from dealers such as Abby (Dorn et al, 1991) and there will be increased interaction between dance drug users and the criminal underworld. For these reasons policies aimed at eliminating drug use at raves are not only likely to fail, but may even prove counterproductive in tackling the spread of problem drug use. Closure of licensed raves and night-clubs, in accordance with what was proposed in the Legg Bill, now known as the 1997 Public Entertainment's Licences (Drug Misuse) Act, would seem likely to push dance drug use further underground. The evidence presented in Chapter 5 indicates that many different drugs (not just ecstasy) were used at illegal raves and private parties more than was the case at night-clubs or licensed raves. This is what might be predicted from the findings of Johnson et al (1990), who detail the early spread of crack cocaine among patrons of underground after-hours-clubs. Akram (1997) details the rise of 'site parties' in Nottinghamshire. These events were said to be increasing in popularity among dance drug users as they were not subject to the tightening drug controls being adopted by local night-clubs in the face of the threats posed by the Legg Bill.

As most dance drug scoring takes place away from dance venues, often in advance of attendance, focusing drug enforcement at night-clubs and raves will be ineffective. Police action aimed at curbing dance drug use may be more effective if city centre pubs used as pre-club venues (the pubs where night-club fliers are circulated) were raided

rather than dance events. However, as many non-users of illegal drugs frequent such pubs, this course of action may attract less support from the non-using public.

In common with entry to dance events, many users last scored illegal drugs free of charge. This culture of generosity (perhaps with expectations of reciprocity) may be in line with the empathetic nature of ecstasy or merely with the social norms of a seemingly non-deviant, pleasurable, recreational activity, or both. The view of illegal drug users “ripping and running” (Agar, 1973; Taylor, 1993), that is stealing from each other, does not seem to apply here. Perhaps the notion of a “trading charity”, as proposed by Dorn et al (1992), would be a more apt way of describing dealing patterns in this scene. That said, it should be remembered that for many respondents spending on illegal drugs, such as cannabis or ecstasy, would represent a considerable financial outlay. Indeed, the evidence presented here indicates that large sums of money and amounts of drugs are circulating in and around the Glasgow dance scene. As with other drug scenes, this was found to represent a net movement of drugs out of and cash into the city’s deprived neighbourhoods.

E is for effect: Ecstasy design

Respondents felt that the formula ecstasy = MDMA no longer always held true. The belief that some ecstasies contain more than one (often unknown) drug is a cause for concern. Whether many ecstasies do contain a cocktail of drugs or not is perhaps less important than the fact that many users believe that they do. Two risky new trends may result from this belief. Firstly, ecstasy users may become more likely to mix drugs rather than stick to a single substance during a drug using session. If a user believes that they have taken ecstasy that is a mixture of heroin, MDMA and ketamine, then they may be more likely to use a combination of these individual substances in future.

Secondly, users may start taking other drugs that they have never (in fact) taken before if they believe they have already done so in an ecstasy tablet. Since fieldwork was conducted, some respondents are known to have started using opiates. It was stated by finder P that as they believed that there was heroin in some of the ecstasies that they had used and this had done them no harm, then they may as well just use heroin in its 'pure' form.

It is difficult to see how these potentially dangerous trends could be arrested. There is certainly a need for information to be given to dance drug users about the risks of mixing different substances. There is also a need for information to be given about what different ecstasy brands actually contain. Perhaps more importantly this would also inform users what drugs are not usually found in ecstasy tablets. Such information will require continuously up-dating to cope with the changing varieties of ecstasy. This could in part be achieved by the release of more forensic testing results from police seizures and drug research. However, even if these results show that all ecstasy is MDMA, MDEA or MDA, the next brand name to hit the dance floor will doubtless be marketed as something 'better'. Rumours of something better being held back by the producers until the current poor quality brand of ecstasy had been used up were common during field observation of this supply-led marketplace.

Another problem that may occur with the publication of test results is that these may serve to lull users into a false sense of security. Fakers may even try to emulate brands previously tested as 'good'. On site testing in clubs may be the most direct way to allay ecstasy users' doubts about the drug's contents. Such a move could however be seen as condoning drug use. Any such short-term political concerns will need to be weighed against the long-term health effects of uncontrolled dangerous drug use by a large number of young people. On site testing also has practical limitations by being able

only to identify the crude presence or absence of a narrow range of drugs such as MDMA. In the end, the only thing one can be sure of about the contents of an illegally manufactured synthetic drug is that these will vary. However, these consumers were often more concerned with appropriateness of tablet brands' effects than with their chemical contents.

Impact of the dance scene on patterns of drug use

The most obvious difference noted between drug users in the 1990s' dance scene and other drug user samples is in setting. Chapter 5 confirms what other researchers have noted, namely that ecstasy (and other dance drugs) is usually taken in public rather than in private (Newcombe, 1991a; McDermott et al, 1992a; Akram 1997). Similarly, it is detailed in Chapter 3 dance drugs are used by persons who are consumers in mainstream entertainment, rather than by persons fitting the stereotype of marginalised 'junkies' excluded from production (Henderson, 1992; McDermott et al, 1992c). The rave culture is mainstream youth culture, not a youth subculture (e.g. punks, skinheads, hippies, crusties, grungies or goths), though some persons who may have been identified with such subcultures (at least in the eyes of the author) were found in this sample (e.g. finder B's crusties). In this mainstream culture, drug use (read consumerism) is the norm and the dance scene has proven to be a major vehicle in the expansion of drug markets (Henderson, 1993c). In Chapter 6 of this thesis, drug use and drug scoring within the dance culture was found to vary little between respondents from relatively affluent and deprived areas.

A common feature between the American experience of ecstasy use and the dance drug scene in the UK is that both have challenged the notion of drug use always being an addiction. In the same way as alcohol use does not imply alcoholism, (dance) drug

use does not imply drug addiction. The new drug (opiate) users of the eighties were often stereotyped as using drugs as though it was a full-time occupation. The drugs themselves were seen as being detrimental to the lives of the user, serving only to block out the pain of everyday existence. By contrast, the new drug users of the nineties have given rise to a new stereotype, one of fun-loving hedonists, who use drugs only as an adjunct to the other pleasures of their lives (Fraser et al, 1991; Henderson, 1992). The new (dance) drug users having grown up in a time when drugs were commonplace see drug use as normal (Gilman, 1991). The pleasure resulting from using drugs is seen by these users as a natural right rather than as a deviant or rebellious activity. The new drug use, particularly that of ecstasy, is seen as one of 'something for the weekend' pleasure rather than one of daily 'taking care of daily business'.

The consumerist notion of drug use portrayed in this thesis is at odds with traditional paradigms of drug use. The medical and criminal justice explanations of drug use in the UK and USA during the 1960s to 1980s have suggested that drug use was not a matter of consumerist choice. Drug users in the past were seen as being forced into continuously using drugs to satisfy a daily habit and descending into a spiral of ill health and criminality. To be involved in drug use meant being involved in the 'street' economy and not only in the scoring of illicit drugs. Anyone who used drugs and who had not developed medical or legal problems was described as merely being in the 'pre-addictive stage'. It is debatable if the notion of pre-addictive drug use could be applied as the norm among the respondents who took part in this thesis.

Whether the above changes in patterns of drug use are as a result of pharmacology (stimulants and hallucinogens versus opiates and benzodiazapines), differences in who is using these drugs (deprived versus non-deprived), the differing research methods

employed (agency sampling versus snowballing) or merely a reflection of changing norms within society is not yet understood. For example, it is equally possible that in the early 1980s there were fun-loving, weekend, heroin users who never appeared in drug treatment samples, who consequently were never noticed by drug researchers and were not considered viable during the 'heroin screws you up' anti-drug climate of those times.

A combination of fashion, intermittent reinforcement and brand loyalty among consumers has assured these products (particularly ecstasy) a central place in the counter culture of the 1990s. Grinspoon and Hedblom (1975), in their book *The Speed Culture* about amphetamine use in the USA, refer to the concept of the Zeitgeist (spirit of the age) in drug use. The authors cite Goethe's observation that "in medicines, as in all art, literature, philosophy and science any innovative idea or theory must be compatible with the Zeitgeist". They argue that in the case of amphetamines the compatible medical Zeitgeist was in the 1920s, when many of these drugs were first synthesised. This approach can also be applied to illicit pharmacology. For example, cannabis and psychedelic drugs (LSD) can be described as being compatible with the Zeitgeist of 1960s America. More recently, Dr Timothy Leary, the proponent of LSD in 1960s America, described MDMA as America's "drug of the eighties" (seen then as a yuppie thing, see Chapter 1). In Britain, ecstasy (which may contain MDMA) and other dance drugs may be seen as being compatible with today's consumerist, leisure-oriented society. In a similar fashion, street heroin use may be seen as compatible with the spirit of the times (of mass unemployment) in the culture of the British working class during the early 1980s, "a land fit for heroin" (Dorn and South, 1987) rather than a dance beat fit for ecstasy. Dance drugs can be seen as being indicative of a new

Zeitgeist in contemporary British culture, as well as representing a change in drug use and drug issues.

There is one common feature between the dance drug scene and other British youth (or drug) sub-cultures; that is official (over) reaction. A succession of legislation, including the Bright Bill, the Criminal Justice Bill and the Legg Bill (see Chapter 1), has been devised to combat the dance scene as if it was merely another deviant sub-group, such as mods and rockers, lager louts, 'joyriders', 'new-age' travellers, 'football hooligans' or 'laser jobs': These Bills have failed to reduce the popularity of the scene and, if the demographics of this sample can be used as a yardstick, the unnecessary labelling of otherwise ordinary law-abiding young adults as deviants may prove to be counterproductive in the long term. These legislative measures go beyond mere drug control (most dance drugs were already controlled prior to the advent of scene) and have impacted on wider society in terms of freedom of association and movement, as well as other peoples 'right' to enjoy music and dancing. At first, this might seem the only obvious way in which the dance scene could have had an impact on the lives of other people who are remote from dance drug use. However, it was clear during this research that in many ways some aspects of dance drug culture were, perhaps unknowingly, being consumed by a wider audience.

Impact of the dance scene on wider society

One less tangible way of gauging the extent of dance drug culture is in looking at the commercial success of night-clubs, organised raves, dance music and dance (drug) scene publications (Newcombe 1992c; *Renegade TV*, 1997). For example, according to the Audit Bureau of Circulation, the dance scene magazine, *Mixmag* outsells the more traditional music paper, *the Melody Maker* despite being much more expensive

(*the Scotsman*, 1996). A potential reason for *Mixmag*'s popularity is indicated by its best-selling issue having a full size colour picture of a line of speed (amphetamine sulphate) on the front cover (Petridis, 1996). The chart success of recordings with overt references to dance drugs such as the No.1 hit "Ebenezer Goode" by the *Shamen* (1992) and *Pulp*'s post-rave come down "Sorted for E's and wiz" (1995) are also indicative of the normalisation of such drugs in wider (non-using) society.

These changes in music and dance culture have spilled over into other spheres of the recreation and leisure industries. The dance scene has been implicated in among other things the birth of late night (chill-out) café culture, increased usage of service stations throughout the night and increased purchases of bottled water and chewing gum (*Channel 5 Television*, 1997). Many of these changes are supported by the findings in Chapter 4 of this thesis. These include a high level of late night activity, travelling to venues far from city of residence and the purchasing of bottled water while dancing (particularly by younger respondents). In the case of chewing gum, this is commonly used to counteract the bruxism and trismus which are side effects of stimulant drug use (Peroutka, 1989), such as the primary dance drugs detailed in Chapter 5 of this thesis.

Dance drug scene imagery, slogans and even harm reduction messages have been increasingly used by advertisers to market a large range of products less obviously related to dance culture. On British terrestrial television these have included a postal service that gets you "sorted", sanitary towels where "more means less" (plagiarising MDMA use advice) and a soft drink that will help the consumer to cool down because "overheating is serious" (drawing inference from several well publicised dance scene deaths). A whole industry of fashion and design has been built up around the dance scene in which, though marketed towards a wider population, only dance drug users

will be aware of its drug-related origins (*Channel 5 Television*, 1997). This is precisely the commercialism that respondents stated they disliked about the scene in Chapter 4.

Perhaps the best example of dance drug culture being adopted by commercial interests is in the sector of British industry most negatively affected it, that is the (alcohol) licensed trade. The drinks' industry has been aware of reports, such as that of the Henley Policy Studies Institute, stating that the number of visits to pubs by 18 to 24 year olds was decreasing (*The Economist*, 1993) and that beer consumption among the under 25s was falling (*Creative Review*, 1996). These articles implicated a trend for young adults to choose dance drugs (e.g. MDMA) at raves rather than beer in pubs as the cause of this phenomenon. In response to this threat to sales, the drinks' industry has adopted the marketing techniques of its competitor. For example, one recent television commercial for *Holsten Pils* beer shows psychedelic colours moving to a rave beat (things which were attractive to dance drug event attendees, see Table 4:2). The commercial ends with the star snidely referring to the "techno-junkie" and then destroying a smiley face as he consumes his beer (*Renegade TV*, 1997). Another lager commercial, for *Grolsch*, is described as having "a thumping techno soundtrack" by one design journal (*Creative Review*, 1996). This lager campaign was said to be "attempting to redress the balance" (between alcohol and ecstasy) "by running promotions in clubs". Some new drinks have names that seem to be directly targeting club-going youngsters. A strong fruit wine called *Flavours for Ravers* even offered free entry to a night-club on purchase. An advert for *Vladivar Vodka* (by designer Mark Brown of *Negative Space*) even plagiarised the original smiley handbill of the London night-club *Shoom* on January 30th 1988 (see Chapter 1). This flier depicted cascading pill shapes, each of which was embossed with the smiley face logo (Rose 1991). From this early acid house flier, the smiley face logo was to become a coded

symbol for drug use and now apparently for vodka. An article in another design journal (*Creative Technology*, 1996) details how designers who had previously worked with techno music DJs were employed on this campaign. One designer (Anthony Burrell of *Bless the Artist*) is quoted as saying he tried to give his advert “a strange ambient club feel, a bit druggy”. The article states that *Vladivar Vodka* are targeting “happening magazines *G-Spot* and *M8*” with the message “you can have a good time sans E and *Evian* and at least Vodka’s legal”. More recently, the advent of alcopops, a form of alcohol which has been of great public health concern (Forsyth et al 1997), has been related to the drinks’ industry’s somewhat successful counter-attack on the dance drug scene (MacDonald, 1996; Collin, 1997; *Daily Mail*, 1997; *the Times*, 1997).

It could be argued that the alcohol industry’s aggressive promotional techniques are justifiable if they help to steer young people away from drugs. However, it can equally be argued that such techniques will only serve to further blur any distinction between alcohol and drugs that may still exist in the minds of young people (Ramsay, 1997). Thus, illicit drug use may seem more acceptable, being used with rather than instead of illegal drugs, and the overall use of such substances might actually increase because of these campaigns. In any event, if the most attractive marketing feature of alcohol is that “at least vodka’s legal”, then, by implication, dance drug use might be seen as more enjoyable and less harmful.

Implications for future trends in drug use

It was noteworthy that dance drugs tended to be of synthetic origin (e.g. MDMA or amphetamine) rather than organic origin (e.g. cannabis or heroin). For this reason, another impact of dance drug use may be to make the British media’s ‘crack panic’ of the late 1980s (detailed in Chapter 1) the last such ‘scare story’ of impending foreign

(drug product) invasion. Stimson (1986) noted that drugs used in the UK during the 1980s tended to be imported, commenting “This seems to reflect the general state of British industry”. The primary drugs, as classified in Chapter 5 of this thesis, were of synthetic origin and therefore their production is possible in any country (including the UK). Thus, drug importation is not a necessary part of trafficking, but should take place only when profits would be increased by off-shore production. Furthermore, if a laboratory is capable of producing dance drugs such as MDMA, it is only a short logical step to also produce the opioid designer drugs. Indeed, anecdotally such substances have already been produced and put in certain ecstasy tablets (e.g. ‘snowballs’, ‘china whites’, see Chapter 7). Such production could easily switch away from MDMA completely and target the street heroin market. In future the traditional international illegal drug supply lines from the third world to Europe and the USA as the end points could (at least in theory) be reversed. This, of course, would have legislative and political implications in the West and incur serious economic consequences for Third World producer countries.

Implications for future research

There are number of possibilities for future research directions which have arisen during the course of this thesis.

The research of this thesis has indicated that poly-drug use is the norm in the dance drug scene. This has a methodological implication in that studies targeting single substances may be of less value than those examining specific drug scenes. For example, had this thesis been focused on ecstasy (MDMA) it would have risked being compromised by the effects of all the other drugs used by respondents in both dance and other settings.

That these individuals used so many (often Class A) drugs yet experienced few problems is of interest. This is not necessarily because a group that is causing few problems requires research attention for its own sake, rather that it provides a useful comparison with other more problematic groups of drug users, such as those found in many other Glasgow studies. Such comparisons may help our understanding of why it is that these other (usually deprived criminal) drug users went on to develop drug problems, while those in the West End dance scene seem unlikely to do so.

The dance drug scene is continuously evolving and as such there is a need to monitor its development. This is particularly important because of the large number of persons involved. As these users become older the impact of their drug use on wider society seems likely to increase, especially should their shoes be filled by future generations of dance drug users. Monitoring of the scenes' development is also desirable because of the possibility that some users may cross over into more problematic drug scenes.

Instances of harm related to dance drug use have tended to be because of either drug mixing or the environmental conditions at dance venues. These respondents were certainly poly-drug mixers. As such, the effects of drug mixing need to be studied. This need is particularly great where the drug ecstasy is concerned, as many respondents' felt that the brands of this drug that they were using were ready-made drug compounds. There is clearly a need to test ecstasy tablets to ensure that users' self-reports of what they think they have been using are accurate.

Respondents also used drugs in a variety of hazardous dance environments, such as clubs with no chill out area and limited access to free water (e.g. club *Saturn*). Perhaps future dance drug scene research could be focused on riskiness associated with dance venues rather than the behaviours (drug use) of attendees. The concerns voiced by respondents in Table 4: 2, such as overcrowding, temperature, door policy or fluid

provision, would seem worthy of investigation. One recent estimate (Cook, 1997) stated that 80% of some 700 “club-related” casualties were alcohol-related (e.g. violence), only 10% were drug-related (e.g. heat illness or panic) the remainder included new dance scene specific diseases such as ‘techno toe’, ravers rash’ and ‘PVC bottom’. This article also detailed other hazards brought about by conditions in clubs such as heat, glass, floor surfaces and crowds. It is noteworthy that since the cessation of fieldwork two of the night-clubs detailed in Chapter 4, *Ganymede and Rhea*, (both in the G2 club cluster, less frequented by respondents) have lost their licenses. This occurred through both of these clubs being overcrowded, with more than double their legal capacity, rather than their licenses being revoked due to legislation targeted at dance drug use (*Evening Times*, 1997b).

Finally, the main focus of this research has been on drug use in a dance (rave) scene setting. This line of inquiry could be applied to the importance of setting of use in other drug scenes. Future research comparing places of drug use and risk might include studying the locations where drug overdoses take place, where users are more likely to be arrested, where under-aged drinking takes place and the effects of tobacco policies on setting of smoking.

Conclusions

It was the principle aim of this thesis to explore the patterns of drug use in the dance drug (rave) scene. These aims were met by recruiting and interviewing a sample of participants in this scene in Glasgow. The respondents who took part in this research appeared quite different from those other drug research samples undertaken in the city, both in terms of demographics and drug use. The overall impression provided by this research has been one of the dance drug scene being comprised largely of relatively

'normal' young adults, engaged in mainstream recreational activities, rather than one of a deviant sub-culture. These findings were not entirely unexpected. Given population estimates measuring numbers of dance drug users in millions (*Economist*, 1993), it would be surprising if this sample displayed an elevated level of deviance. For example, the relatively low level of criminal behaviour in this group is as might be expected, assuming these respondents' behaviours are typical of dance drug users elsewhere. If the elevated levels of acquisitive crime found in drug research looking at other drug using groups (e.g. 1980s opiate users, Bennett and Wright, 1986; Parker and Newcombe, 1987; Bean and Wilkinson, 1988; Neville et al, 1988; Hammersley et al, 1989) were applicable to dance drug users, then there could potentially be millions of new criminals engaged in activities such as shoplifting or burglary. The existence of such people would not have gone unnoticed throughout the course of the 1990s during which reported levels of such crimes have steadily fallen (despite a corresponding increase in drug offences, Border and Norton, 1996).

As mentioned in previous chapters, many surveys undertaken in the mid-1990s have indicated an unprecedented increase in drug use among young people. Some of these studies have even reported that lifetime prevalence of illegal drug use has reached a majority of the population by age 16 years (Barnard et al, 1996; Fast Forward, 1996). This phenomenon has been described as the normalisation of drug use among young people (Measham et al, 1994). This thesis lends weight to this argument by showing a pattern of drug use that is culturally, rather than statistically, normalised; that is, not only are these respondents likely to be representative of a very large number of persons, but also that their behaviours are for the most part non-deviant. Away from the dance drug scene most of these respondents lived unremarkable lives, typical of young adults in the 1990s. (see Sweeting and West, 1995, for Glasgow West End

general population comparison). In contrast to the view that illegal drug users must be sick, requiring medical help or health education, many of these respondents participated in healthy behaviours (other than raving). For example, respondent #073 arrived for interview on her mountain bicycle complete with fluorescent crash helmet and reflective strips on her jacket. This would seem completely at odds with the stereotype of risk-taker that is usually applied to Class A drug users. Another respondent (#045) stated his favourite sport was cross-country skiing. He claimed that his skiing friends were worried about his use of ecstasy (at the time of the Hanger 13 deaths), while his clubbing friends thought he was equally foolish to participate in his chosen sport (at a time of many deaths on the Scottish Mountains). These two cases encapsulate the pattern of these respondents' dance drug use, as just another recreational activity, one that can be viewed in tandem with cross-country cycling or in competition to cross-country skiing. Unlike opiate/benzodiazapine injecting, volatile substance inhalation or cigarette smoking this pattern of drug use did not seem to be particularly harmful or threatening to either its' participants or wider society. (It should be noted that the debate concerning MDMA and neurotoxicity continues almost unchanged since 1985, Szabo et al, 1997).

Awareness of the relative risks involved in dance drug use combined with the lack of criminal activity found in this sample leads one to the question of what role, if any, is there for drug agencies in dealing with such users? Few of these respondents had ever sought help for drug-related problems and even among those who had this usually involved non-dance drugs (e.g. alcohol or heroin), usually some years in the past. However, given the large estimates for the number of users, at least in a statistical sense, some dance drug users are certain to encounter difficulties. At present, these difficulties would seem likely to be of a more similar prevalence and order of

magnitude to those experienced in the general population from social drinking than those experienced with opiate and benzodiazapine addiction.

Summary

From the findings of this thesis, five concluding statements can be made.

- Many different types of people were found to be attending dance drug events and using dance drugs. This is at odds with the view, often portrayed in the media when referring to the rave scene (and in common with previous music scenes), that dance drug events are predominantly attended by disaffected 'teenagers'.
- Night-clubs, rather than raves, were found to be the most important component of this scene. This was true both in relation to patterns of attendance (e.g. initiation, dancing and finance) and drug use, particularly ecstasy.
- These respondents were poly-drug users and it would be wrong to use terms such as raver and ecstasy user as though they were interchangeable. That said, ecstasy was by far the most important drug in relation to their dancing behaviours, particularly in relation to night-club attendance.
- Although night-clubs were the principle setting of dance drug use and are often the source of such drugs, it is clear that simply closing down such venues would fail to prevent this behaviour. The existence of other night-clubs (many of which may be currently drug free), respondents' willingness to travel (while continuing to use), other drug sources (where non-dance drugs are also available) and alternative venues such as illegal raves and private parties (where more drugs are used) indicate that such actions may prove counterproductive.

- Respondents used brands of ecstasy that many believed were not just MDMA. The alleged contents of these tablets mirrored the patterns of dance drug use of these respondents, from MDMA only to complicated mixes of drugs. This in turn reflects their overall pattern of drug use, one of different drugs used for different effects in different settings.

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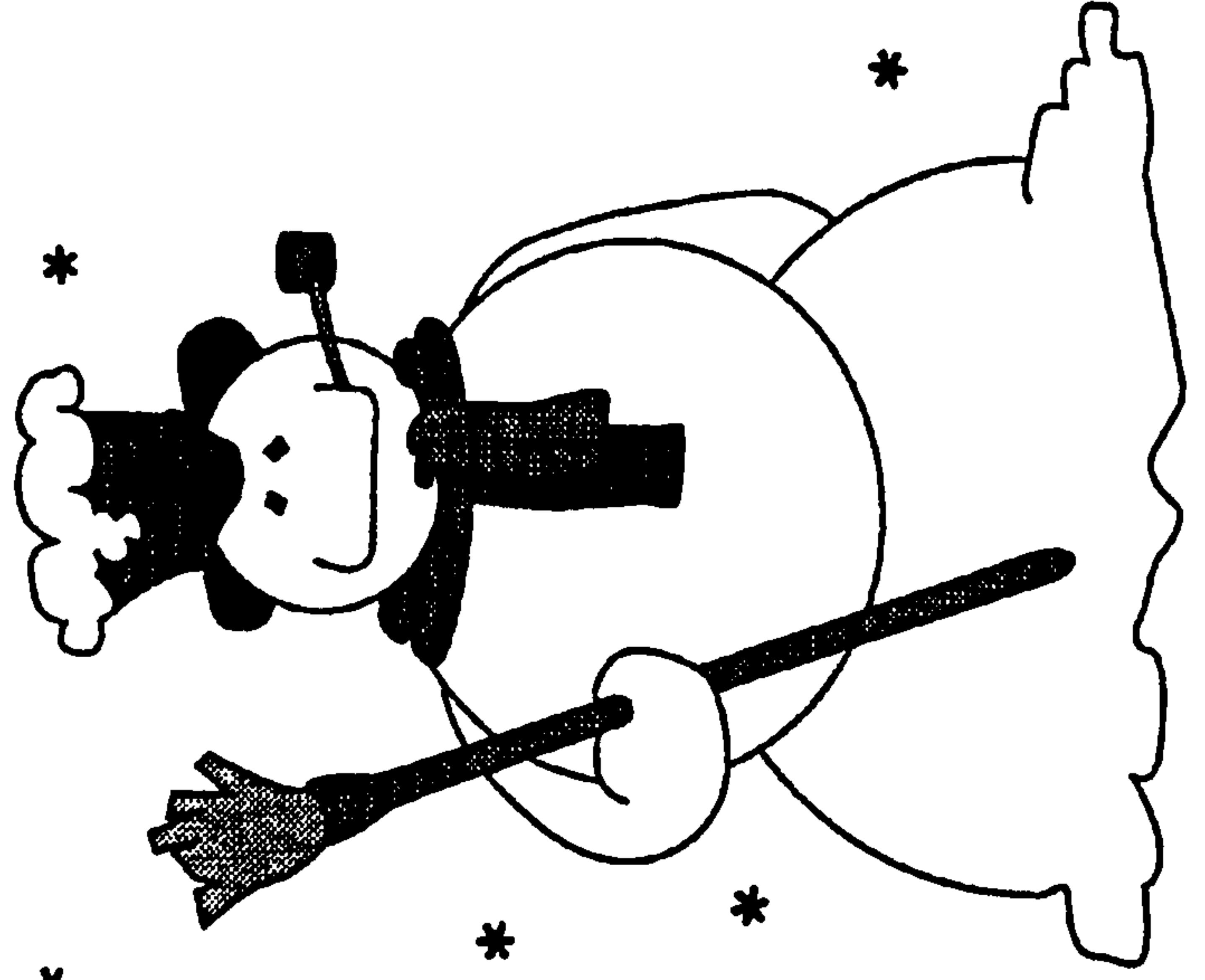
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APPENDIX I: THESIS RECRUITMENT FLIER

The Research Project

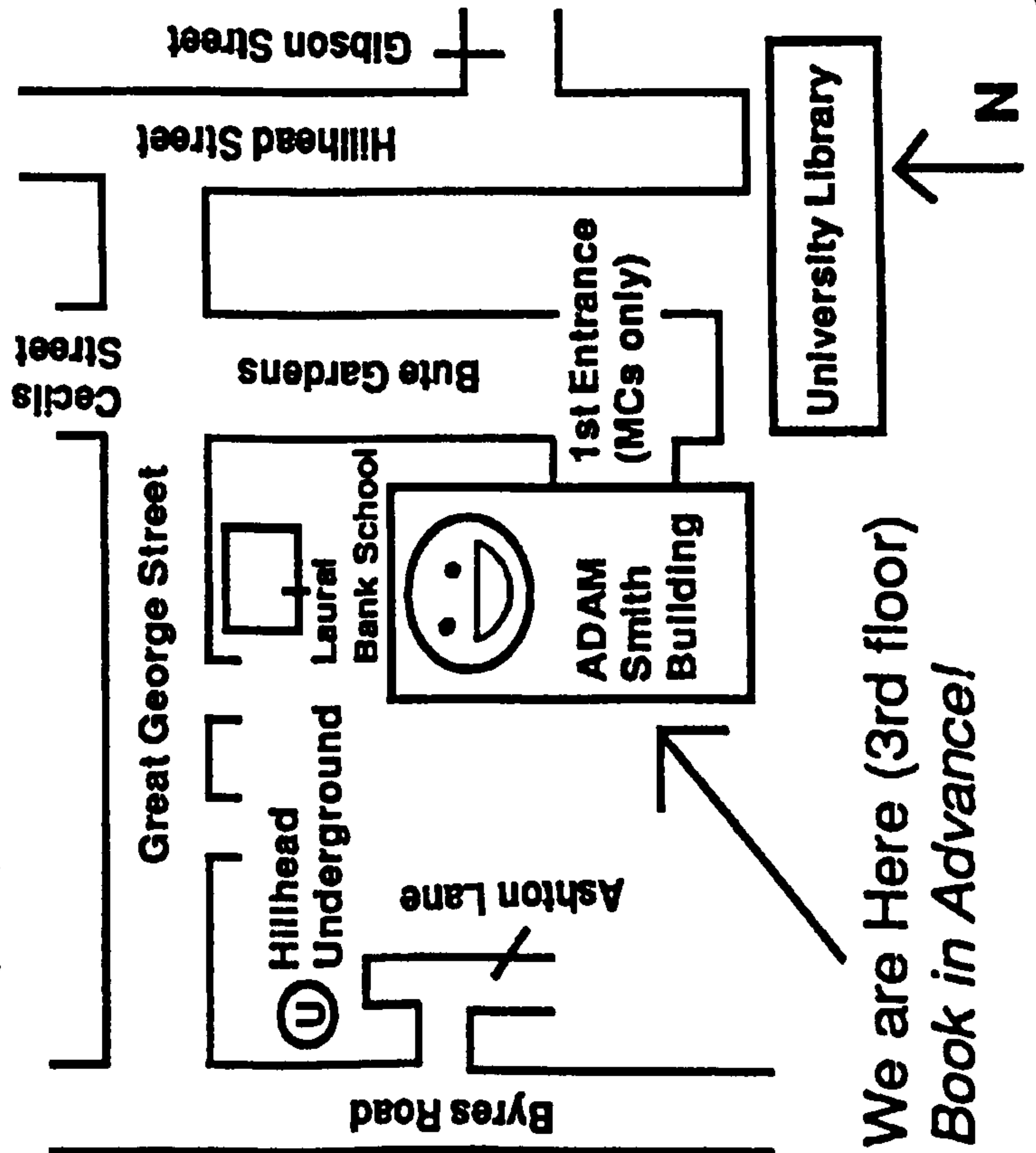


The Research Project



University of Glasgow
Rooms S305/S306
Adam Smith Building
Bute Gardens
Glasgow

Tel: (041) 339 8855 Ext. 4978



We are Here (3rd floor)
Book in Advance!

APPENDIX II: PHD QUESTIONNAIRE

QUESTIONNAIRE

INTERVIEW DATA

Date of Interview

____ Day ____ Mth ____ Yr

Interviewer Name (initial)

Location where contacted (name)

Interview location

Street 1
Pub/club..... 2
Interview unit..... 3
Home..... 4
Other..... 5

Specify _____

Interview start time (24 hr clock)

____ Hrs ____ Mins

Interview finish time (24 hr clock)

____ Hrs ____ Mins

Number of people (excluding interviewer)
able to overhear interview.

DEMOGRAPHICS

First some questions about you.

Sex
 Male..... 1
 Female..... 0

AGE

How would you describe your ETHNICITY ?

White Scottish 1
 Other white 2
 Indian..... 3
 Pakistani 4
 Bangaladeshi 5
 Other Asian 6
 Other 7
 Specify

How would you describe your MARITAL STATUS?

Single 1
 Cohabiting 2
 Married 3
 Separated 4
 Divorced 5

How many CHILDREN do you have?

What area do you live in? (Area name)

How long have you lived in this AREA?

What is your HOUSING tenure (circle)?

Private 1
 Council 2
 Housing Association 3
 Private landlord 4
 Other 5
 Specify

Who's HOME to you live in (circle)?

Own place 1
 Parents 2
 Partners 3
 Friends 4
 Other 5
 Specify

WHO ELSE lives with you?
(If any, how many of each)

- 1. Partner
- 2. Children
- 3. Parent(s)
- 4. Other family
- 5. Friends
- 6. Other

Specify _____

What area did you LIVE in most up to the age of 16 years?

At what age did you leave SCHOOL?

How many 'O'/STANDARD GRADES did you get?

How many HIGHER GRADES or A levels did you get?

Have you been in FURTHER EDUCATION?

- Yes, currently 1
- Yes, in the past 2
- No..... 0

What QUALIFICATIONS have you obtained/ are studied for?
(which of each?)

		Studied	Obtained
1.	ONC	<input type="checkbox"/>	<input type="checkbox"/>
2.	HND	<input type="checkbox"/>	<input type="checkbox"/>
3.	Degree	<input type="checkbox"/>	<input type="checkbox"/>
4.	Post-grad.	<input type="checkbox"/>	<input type="checkbox"/>
5.	PhD	<input type="checkbox"/>	<input type="checkbox"/>
6.	Professional	<input type="checkbox"/>	<input type="checkbox"/>
7.	Other	<input type="checkbox"/>	<input type="checkbox"/>

specify _____

What's your employment status?

- Employed 1
- Unemployed 2
- Long-term sick/disability 3
- House person..... 4
- Student 5
- Other 6

Specify _____

What is your current occupation?

What was your previous occupation?

What area do you work/study in ?

How long have you been unemployed for?

Do you know what your FATHERS
USUAL JOB is? (was?)

Do you Know what your MOTHERS
USUAL JOB is? (was?)

How much money do you make last week
from?

£
Full-time work _____
Part-time work _____
Work on side _____
Grants/Loans _____
Benefits _____
Crime _____
Other _____
Specify _____

Do you own a car/motorbike?

Yes 1
No..... 0

How much do you SPEND per week on the following?

£

Mortgage/rent/heating & lighting

Basic food

Eating out/take-aways

Travel (including car etc.)

Alcohol

Tobacco

Ecstasy

Other Drugs

Clothes

Luxuries

Payment of fines

Other

LIFE STYLE

The next questions are about your life style. First of all we want to know if you have ever attended dance events such as raves or house parties either at clubs or elsewhere, where you believe the drug ecstasy has been used.

	-1-	-2-	-3-	-4-	-5-	-6-	-7-	-8-
NIGHT CLUBS	_____	_____	_____	_____	_____	_____	_____	_____
LISCENSED RAVES	_____	_____	_____	_____	_____	_____	_____	_____
ILLEGAL PARTIES	_____	_____	_____	_____	_____	_____	_____	_____
PRIVATE PARTIES	_____	_____	_____	_____	_____	_____	_____	_____

1. Have you EVER attended this kind of dance event (1 = yes, 0 = no)?
2. How many days have been to any such events in the last WEEK ?
3. How many days in last MONTH, i.e. 4 weeks from now?
4. How many days in last YEAR, i.e. since one year ago?
5. How much did it COST to get into the last one in £s?
6. What AGE were you when you first attended such an event?
7. How many HOURS were you there for last time?
8. How long did you spend dancing last time?
9. What clubs have you gone to in the last year? _____

10. What raves have you been to in the last year?
(Promotion Co, Rave, Location) _____

11. What kind of music do you like at these? _____
12. Which DJs would you pay to see? _____
13. What do you like best about the dance scene? _____
14. What don't you like about it? _____

Do you exercise or play any SPORTS? Yes..... 1
 No 0

What sports have you played in the last year? (e.g. swimming, step classes, football) _____

And how often? (1=daily, 2=most days, 3=once week, 4=less often)

Have you ever used anabolic STEROIDS? Yes..... 1
 No 0

How many times have you used them in the last year? _____

What methods have you used to take them? _____

Which of the following ACTIVITIES have you done in the last year? _____

And how often? (0=never, 1=daily, 2=most days, 3=once week, 4=less often)

Attended sports matches? _____ which _____
 Watched video at home? _____ which _____
 Visited friends/had friends round _____ which _____
 Done hobbies/artistic activities _____ which _____
 Gone to pub/wine bar _____ which _____
 Eaten out in restaurant _____ which _____
 Computer/Video games _____ which _____
 Cinema/theatre/concerts _____ which _____

Which of the following ITEMS have you bought in the last year? _____

And how often? (0=never, 1=daily, 2=most days, 3=once week, 4=less often)

CDs/cassettes/records? _____ which _____
 Magazines? _____ which _____
 Tabloid newspaper? _____ which _____
 Broadsheet newspaper? _____ which _____
 Sweets/sweetened drinks (e.g. Irn Bru) _____ which _____
 Take-away meals _____ which _____
 Software discs _____ which _____

How would you describe you sexual Orientation? Heterosexual 1
 Homosexual 2
 Bisexual 3
 Other 4

DRUG USE

Now some questions about your use of drugs over the last year.

	-1-	-2-	-3-	-4-	-5-	-6-	-7-
ALCOHOL	_____	_____	_____	_____	_____	_____	_____
TOBACCO	_____	_____	_____	_____	_____	_____	_____
CANNABIS	_____	_____	_____	_____	_____	_____	_____
HEROIN	_____	_____	_____	_____	_____	_____	_____
TEMGESIC	_____	_____	_____	_____	_____	_____	_____
DF118	_____	_____	_____	_____	_____	_____	_____
TEMAZEPAM	_____	_____	_____	_____	_____	_____	_____
VALIUM	_____	_____	_____	_____	_____	_____	_____
SOLVENTS (e.g. aerosols)	_____	_____	_____	_____	_____	_____	_____
COCAINE	_____	_____	_____	_____	_____	_____	_____
AMPHETAMINE	_____	_____	_____	_____	_____	_____	_____
MUSHROOMS	_____	_____	_____	_____	_____	_____	_____
LSD	_____	_____	_____	_____	_____	_____	_____
POPPERS	_____	_____	_____	_____	_____	_____	_____
KETAMINE	_____	_____	_____	_____	_____	_____	_____
ECSTASY	_____	_____	_____	_____	_____	_____	_____
OTHER (eg Methadone)	_____	_____	_____	_____	_____	_____	_____
OTHER	_____	_____	_____	_____	_____	_____	_____
OTHERs	_____	_____	_____	_____	_____	_____	_____

1. Have you **EVER** used this drug in your life? (0 = no, 1 = yes)
2. How many days in the last **WEEK** have you taken it (0 to 7)?
3. How many days in the last **MONTH**, i.e. 4 weeks back from today (0 to 28)?
4. How many day in the last **YEAR**, i.e. since this time last year (0 to 365)?
5. What **AMOUNT** did you use last time?
6. What **AGE** were you when you first took it?
7. Have you ever **INJECTED** any drug? (0 = no, 1 = yes)

The next questions about the circumstances of your drug use

	-1-	-2-	-3-	-4-	-5-	-6-
ALCOHOL	_____	_____	_____	_____	_____	_____
TOBACCO	_____	_____	_____	_____	_____	_____
CANNABIS	_____	_____	_____	_____	_____	_____
HEROIN	_____	_____	_____	_____	_____	_____
TEMGESIC	_____	_____	_____	_____	_____	_____
DF118	_____	_____	_____	_____	_____	_____
TEMAZEPAM	_____	_____	_____	_____	_____	_____
VALIUM	_____	_____	_____	_____	_____	_____
SOLVENTS (e.g. aerosols)	_____	_____	_____	_____	_____	_____
COCAINE	_____	_____	_____	_____	_____	_____
AMPHETAMINE	_____	_____	_____	_____	_____	_____
MUSHROOMS	_____	_____	_____	_____	_____	_____
LSD	_____	_____	_____	_____	_____	_____
POPPERS	_____	_____	_____	_____	_____	_____
KETAMINE	_____	_____	_____	_____	_____	_____
ECSTASY	_____	_____	_____	_____	_____	_____
OTHER (eg Methadone)	_____	_____	_____	_____	_____	_____
OTHER	_____	_____	_____	_____	_____	_____
OTHERs	_____	_____	_____	_____	_____	_____

1. WHERE were you when you were last on this drug (e.g. club, at home, party)?
 2. What AREA was this in (e.g. Glasgow city centre, Hillhead)?
 3. Did you BUY/TAKE it there or somewhere else (specify AREA)?
 4. WHO did you get it from (e.g. stranger, friend, family member)?
 5. How much did this amount COST in £s for each one of each drug?
 6. Did you use it to at the same TIME as ecstasy?
- (0 = no, 1 = yes before , 2 = yes same time, 3 = yes after 4 = other _____)

CRIME

	Done since aged 15	Done in last 12 months
Travelled on a bus, tube or train without a ticket or having paid to low a fare.	_____	_____
Driven a car on a public road without a licence	_____	_____
Taken a bicycle with no intention of putting it back	_____	_____
Taken money or something else from someone outside the family by using force or threats	_____	_____
Fiddled an insurance claim	_____	_____
Deliberately damaged property such as a phone box, a car a window or a street light (but without stealing anything)	_____	_____
Taken things from shops or stores without paying	_____	_____
Carried a weapon for self-protection or in case it was needed in a fight	_____	_____
Bought or accepted things thought to be stolen	_____	_____
Been involved in a physical fight with someone outside the family	_____	_____
Been involved in the sex industry	_____	_____
Sold drugs (other than ecstasy)	_____	_____

How many times have you been.....

ARRESTED _____

CONVICTED _____

FINED _____

IMPRISONED _____

How much time have you spent.....

in PRISON? _____ (inc. remand)

In LIST D SCHOOL _____

In CARE? _____ (any reason)

How many CHARGES do you have against you NOW?

What for? _____

BRANDS OF ECSTASY

FIRST ECSTASY

NAME
DRAWING
DESCRIPTION
what size
what colour
EFFECTS
it had on you

Alleged CONTENTS
COST

SOURCE
where you got it
when you got it

RANK: 1 (best) to 7 (worst)

ECSTASY USED MOST OF

NAME
DRAWING
DESCRIPTION
what size
what colour
EFFECTS
it had on you

Alleged CONTENTS
COST

SOURCE
where you got it
when you got it

RANK: 1 (best) to 7 (worst)

LAST ECSTASY

NAME
DRAWING
DESCRIPTION
what size
what colour
EFFECTS
it had on you

Alleged CONTENTS
COST

SOURCE
where you got it
when you got it

RANK: 1 (best) to 7 (worst)

