

**The intentionally unseen: exploring the illicit drug use of non-treatment  
seeking drug users in Scotland.**

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## Declaration

No portion of the work referred to in this thesis has been submitted in support of an application for another degree or qualification of this or any other university or institution of learning. Some of the results of this thesis have been presented at:

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## **Abstract**

*There is a perception that drug use is a serious and growing problem to be solved by medicine, social work and drug enforcement agencies. This thesis takes a critical standpoint against such populist views and interprets drug use as one of any number of normal activities that people engage. This qualitative research utilising a bricoleur ethnographic methodology focuses on the drug taking of non-treatment seeking illegal drug users. The data reveals that they manage several social identities and the potential stigma of being discovered as an illicit user of illegal drugs utilising several strategies to remain intentionally unseen. The thesis explores how and in what way socially competent drug users differ from visible treatment seeking drug users. In order to develop this understanding, several gatekeepers were identified and within their social networks the participants were recruited into this research. The participants (n=24) were recruited from a wide range of age groups (21-52) and geographical locations within Scotland. One to one interviews, a focus group, and several pair bonded partners were interviewed together providing rich sources of data. Interviews were transcribed and analysed thematically from a social constructionist perspective. The findings illuminate the ways in which the intentionally unseen identify and manage risks from drugs, drugs policy and the potential shame and stigma were their hidden social worlds revealed. The practical implications of the results of this thesis are explored and recommendations for future research are discussed.*

## Table of Contents

Abstract.....	4
Chapter one: Introduction .....	8
Defining problem drug use .....	9
The challenge of measuring deviant activity .....	10
The approach adopted in this research .....	12
The outline of the thesis .....	16
Chapter two: the review of the literature .....	18
Introduction .....	21
Defining drug taking in UK drugs policy .....	28
Temperance ideology .....	30
Estimating drug use in the UK.....	36
Estimating the use of illegal drugs in Scotland .....	40
The Scottish drug policy context.....	42
Controlled use of illegal drugs .....	44
Defining drug use: concepts and theories .....	49
Deviance and Stigma.....	52
Social Control theory.....	54
Social Learning theory.....	56
Conflict theory and drug taking .....	59
Labeling theory .....	61
Cultural identity theory.....	67
The drug normalisation thesis .....	75
Defining drug talk.....	82
Discussion.....	87
Rationale for research.....	89
Chapter three: the research methods .....	92
The epistemology.....	94
The theoretical perspective .....	96
The methodology .....	98
The sampling strategy .....	99
Participant Recruitment.....	99
Semi structured interviews .....	102
Focus groups .....	104

Non participant observation .....	105
Ethical Considerations.....	109
Researcher’s Role.....	112
Limitations .....	114
Analysis .....	114
Reflections on the use of field notes .....	119
Reflections of the coding of data .....	121
Results.....	124
Discussion.....	132
Chapter four: bonding and identification .....	135
Identity rejections .....	137
Explaining problem use as biological in origin .....	139
Explaining the drug as causal.....	140
Social structures as causal factors .....	143
Identity exchanges .....	147
Identity concealment .....	149
Drug users with children .....	152
Drug use and employment.....	155
Drug use and health.....	161
Discussion.....	162
Chapter five: managing use .....	172
Drugs of choice as risk factors .....	174
Stimulants .....	175
MDMA.....	175
Cocaine.....	178
Depressant drugs .....	179
Alcohol .....	180
Gamma-Hydroxybutyric acid (GHB).....	181
Ketamine .....	182
Hallucinogenic drugs.....	185
Cannabis.....	186
Rule boundary recognition .....	188
Drug risk factors .....	190
Overdose .....	191

Craving .....	194
Tolerance .....	197
Intoxication .....	200
Withdrawal.....	201
Rule boundary creation .....	204
Managing drug risks: long term abstinence.....	206
Rule boundary maintenance.....	207
Discussion.....	211
Chapter six: sourcing drugs.....	215
Defining the market for illicit drugs .....	217
Sourcing drugs – open and closed markets .....	218
Sourcing drugs: the users view .....	220
Sourcing drugs: The dealers view .....	224
Partners as dealers.....	227
Sourcing drugs from open markets.....	231
Sourcing drugs: Bulk buying.....	236
Alternative sources of drugs .....	239
Exchanging and bartering drugs .....	243
Discussion.....	244
Chapter seven: drug policy .....	248
Defining prohibition .....	248
The activities of drug enforcement agencies and the police.....	256
Alternatives to prohibition.....	259
Discussion.....	262
Chapter eight: discussion and conclusions .....	267
Conclusion.....	275
References .....	279

## Chapter one: Introduction

Drugs that have an influence on perception and mood are categorised as psychoactive<sup>1</sup>. Humans have ingested psychoactive substances as long as history has been documented (Inglis, 1975). Some scholars believe that humans and some animals have brains which have adapted to the use of psychoactive substances, and from which pleasure is derived (Weil, 1972; Inglis, 1975; Erickson, 1996). There are numerous substances which can be categorised as drugs that are not psychoactive, that is they do not influence how the brain, or more exactly how the mind processes information. The difficulty in defining a drug is made increasingly complex by the amounts of substances that can be used both recreationally and as medicines. There are many substances that are medicinal but are not psychoactive: antibiotics, antacids, and aspirin are examples of such 'licit' substances. Thus by addressing medical motives one can explain the use of some drugs. Other drugs which are not used as medicines or considered to have therapeutic value require other explanations for their use. Psychoactive drugs which influence cognitive processes and emotion have been used as medicines, but they can also be used recreationally, and to aid social functioning. Alcohol can be considered to be a medicine, is used recreationally for its psychoactive properties, and is often considered a social lubricant, enhancing social intercourse. Caffeine based drinks such as tea and coffee are psychoactive drugs, and are used functionally as stimulants, but are not considered medicines. Hence, the pleasure and sensation seeking as well as the functionality of drugs that keep us awake, help us relax or sleep explain such use. Drugs derived from natural plants such as psilocybin mushrooms, cannabis, cocaine and opium are illegal, meaning that their possession and sale have become controlled by law, and they may also be used secretly or illicitly. Hence, their legal status is implicated in why some people choose not to try them, or associate with people

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<sup>1</sup> This term describes any drug which has an effect on the brain, or more specifically the mind. Drugs which are categorised as 'narcotics', define those drugs which have been made illegal to possess. This term once referred to drugs which promoted sleep, but has more recently been used to label all drugs which are regarded as illicit if used without a valid medical reason, or without medical supervision.



who do. The licit and illegal categories overlap, as do the psychoactive and medicinal categories: MDMA or ecstasy is both psychoactive and a substance controlled by law, and opiate drugs are used as medicines, and are psychoactive as well as being illegal to use or possess for non-medical or recreational purposes, hence its category as 'illicit', as well as medicinal.

## **Defining problem drug use**

Categories of drug users can be defined by distinguishing between various drugs or combinations of drugs, age groups, treatment modalities, and behavioural characteristics like whether they inject drugs, or engage in crime linked to their habitual drug use. Most popular definitions of drug taking rely on a medical epistemology, and stress the importance of treating the symptoms arising from the use of drugs, or in promoting the health benefits of abstinence. The terms drug use, drug misuse and drug abuse can be used interchangeably. In this thesis, drug use will refer to all drugs, and the pejorative terms abuse and misuse will not be used unless forming part of a quote, or to highlight the moral underpinning of the use of such terms.

It is important to recognise the difference between drug use, drug dependence and drug abuse. Dependence, also termed addiction, has most commonly been defined by a *loss of control* over consumption and an apparent inability to modify patterns of use or habits despite adverse consequences. The term *misuse* implies an element of choice; such a definition may refer to illegal, or unsafe use, or the use of certain substances at inappropriate times or places, which may be harmful to self or others (Erickson, 1996). Addiction (dependence) is identified or 'diagnosed' by harmful patterns of compulsive, chronic drug-seeking behaviour. The primary hallmark or symptom is a loss of control over decision-making concerning the use of drugs (Rinaldi *et al.*, 1988; Morse & Flavin, 1992).

Goode (2006) helpfully outlines several categories of researchers and various professions who may be interested in the study of the use of drugs; criminologists may be interested in how drugs are linked to offending, therapists may be interested in their use as aids in therapy or helping others work through emotional issues. Some economists may consider drugs as a commodity of exchange that follows the same patterns of supply and demand as any other commodity. It is clear that anthropologists have gathered evidence of the types and uses, and even the meanings of drugs among sub populations of people, and in such examples cultural factors in use predominate. Such approaches often criticise pharmacological and biological based explanations for use (see MacAndrew and Edgerton, 1969; Heath, 1995). Political scientists and policy experts examine the consequences intended and unintended of implementing drug policies. Pharmacologists may be interested in effects of substances; psychologists and neurologists direct their studies to the interactions between the brain and pharmacology. In all of this activity, a range of opinions and theories are generated on what drugs are, who uses them, why they use them, and why they continue or stop using them. This thesis will focus on the drugs that cut across all such definitions and concentrate on drugs that are psychoactive, and focus on those people who use them illicitly. Drugs that strongly influence how the brain processes information and thus the mind most often become heavily regulated. Drugs that have the capacity to alter mood and perception, as well as result in pleasure when consumed, are most commonly prohibited to manufacture, sell or distribute, and their possession is a crime. The effects of criminalising drugs and the harms that this may cause are rarely studied.

## **The challenge of measuring deviant activity**

In Scotland, the possession of drugs that have been defined as illegal breaks the law within the confines of the Misuse of Drugs Act 1971. Illicit drug use refers to drug use that breaches certain ethical or moral standards and can refer to drugs that are illegal to possess. While

these terms can be used synonymously, the terms illicit in this thesis mean those drugs which are used secretly, which have become condemned by certain groups or professions and which may or may not be illegal to possess. It is only in the past one hundred years that drug use has been linked to deviance, crime, addiction, and disease, (Goode, 2006). Emphasising the moral underpinnings of risks posed by illegal drug taking is difficult without an historical perspective. Jock Young (2004) has argued that the study of deviance disregards three major problems in its measurement. These are the problems of representativeness (whether the sample surveyed is representative of the target population), of truth (whether the methods produce socially and culturally influenced narratives or a 'truth') and of the plurality of definition (phenomena are difficult to measure without precise categorical definitions). All three problems apply to the definition, measurement, and the origins of drug use defined as problematic. Some theories explain drug use using cognitive behavioural models such as sensation seeking, and how drugs act on certain areas of the brain, the 'pleasure reward pathways' for example (Erickson, 1996). Differences in how and in what way pleasure is defined among societies, social categories, and individuals in the population, as well as among drug types, are not explained or accounted. The predisposition to experiment with drugs because they are part of a culture is a necessary but not sufficient explanation of their use (Goode, 2006). A recent online survey compiled the drug taking habits of 15,500 'hidden users', and found that illegal drug use was reported most often without the difficulties experienced by highly visible problem drug users, and that the most common patterns were sensible and controlled<sup>2</sup>. However finding a *consensus* on how to measure drug taking and the problems associated with it is fraught with difficulty. Goode (2006) has stated that it is the task of social scientists to establish:

*"...a distinctive voice in the din of competing perspectives and disciplines investigating drug use. Their focus is on what makes drug use a specifically social activity, how socialization, culture, social interaction, social inequality, deviance, and*

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<sup>2</sup> [www.globaldrugsurvey.com](http://www.globaldrugsurvey.com)

*group membership play a central role in the use of psychoactive substances; what people do under the influence; and what societies do about the control of—or why they tolerate or accept—drug use and distribution”, (Goode, 2006: 415-6).*

The drug-using population is known to be heterogeneous and research is directed increasingly towards specific groups, often recruited in or around treatment agencies such as problem users. One group that is less well studied is the ‘sensible’ and ‘controlled’ or socially competent illegal drugs user who is not recruited from an environment where drug taking can be common, such as clubs and pubs. The ‘normalisation thesis’ (Parker et al., 1998) states that drug use is normal in the sense that it is not unusual, rare, or restricted to deviant subcultures. In this sense it represents a major challenge to drug research. However despite some drugs becoming accommodated or normalised among some people, groups and geographical areas in the UK, we still understand little about how and why people choose to use or develop patterns of habitual use which eventually excludes other activities. This thesis explores the relationship between drug use and social distinctiveness, suggesting that keeping drug use hidden is an important aspect of the identity of some users. If keeping one’s drug use hidden is important in preserving a ‘clean’ identity, then we must understand why. This thesis proposes that the UK drug policy of prohibition constructs competing and adversarial accounts of drug use at three levels, the individual, the group, and society.

## **The approach adopted in this research**

This research explores the social worlds of drug users who are not in contact with treatment services. Drug users are often recruited from health care or criminal justice settings, or access drugs users in a setting where they may be over represented, for example clubs and pubs. Drug users seeking treatment are the easiest to reach and tend to be over used in

drug research. A great deal is known about the 'typical' problem drug user in contact with services. As there is a lack of empirical data that has been conducted with non-treatment seeking drug users their opinions are largely absent from discourse. As a result the consequences of prohibition and the consequences of drug use are often combined in drug discourse. In this thesis, the focus of the study is to identify and document the illicit drug use of a hidden population of drugs takers not formally identified as problem drug users, who have never sought treatment, nor been in prison due to their use of illegal drugs. Accessing a hidden population of this type was necessary since there are crucial differences in the drug use of people that define themselves or are labelled as problem users, and those users for whom the greatest problem is the illegality of the commodities they choose to use.

This thesis explores the central research question:

- How and in what way does prohibition impact on the social worlds of non-treatment seeking illicit drug users?

The central objectives explored in this thesis are:

- To identify a hidden group of non-treatment seeking illegal drugs users,
- Assess the extent to which drug use influences their shared identity and those with whom they identify,
- Explore how they manage the risks from drugs and drug prevention policy.

This thesis will approach the first objective by describing how and why the research participants were recruited. The second and third objectives are addressed in the analysis of coding structures that emerged from the data, and form the basis of four analysis and discussion chapters exploring identity, coping with the risk posed by illicit drug taking, accessing illegal drugs, and how the risk from a climate or moral and legal censure which underpins a drug policy of prohibition were understood and managed.

The methods that were employed, while recognising the limitations of research in the ethnographic tradition, have been designed to provide what is described in anthropology as an 'emic' and an etic combined perspective, (Pike, 1954, cited in Headland et al., 1990). This is an account that is articulated within the frames of reference of an insider, as opposed to a purely 'etic' framework of understanding that is explained from the perspective of the 'objective' outsider. Interviews and informal discussions with over 30 drug users at varying stages of their 'drug careers' were held. Transcripts and summaries of 24 of these have been produced that document their views and insights. Two sets of couples were interviewed and one focus group of three participants was conducted. Extracts from all 24 participants, as well as field notes recorded at two social events where drug taking took place have been used liberally in this thesis to provide a rich source of data that relate to the key issues under investigation. According to May and Foxcroft (1995) using focus groups in addition to one to one interviews allows the researcher to have distance and perspective from the respondent and to introduce a 'reality check' on the respondent's account. Traditionally, focus groups are considered valuable in highlighting the processes through which a consensus is constructed and on the various elements that come together for this to occur (Morgan, 1988; Kitzinger, 1994).

In presenting these multiple perspectives I have also been guided by discussions and social interactions with several drug users who remain hidden in plain sight in contemporary society. There will be an expected impasse between the accounts in this research and conventional views of drugs and drugs users. This thesis will explore drug myths, effectively challenging commonplace misconceptions. In this thesis I have, on the basis of the available evidence, attempted to identify the specific changes that occur from initiation into regular and intermittent sensible controlled use, challenging the accepted wisdom that drug users 'mature out' from 'deviant careers' (Winnick, 1962). I attempted this from a detached 'outsider's perspective, but one that has been very much guided by my understanding of the views from within, so as to provide a conclusion to the task with which I addressed this

research. My views have changed as a researcher, and I now understand that the 'truth' is very much driven by several competing perspectives. I have attempted to understand the biases I bring to the research, while rigorously adopting the training I received at the hands of my more experienced colleagues and supervisors.

The issue of identification is a vital and often missing component in understanding the aetiology of problem drug use. The competing discourses have constructed 'polarised collective identities' which accentuate perceived (cultural) differences between illegal drug users and non-illegal drug users and thus play an integral role in shaping how we identify and respond to the 'drug risk'. Furthermore, the construction and maintenance of 'typical' problem user identities not only has a tendency to homogenise populations, but also creates antagonistic and divisive stereotypes. This thesis explores the significance of identification and negotiation as it pertains to various competing representations of drug use. Particularly, this thesis examines the ways in which adversarial identities are socially constructed according to notions of difference which simultaneously encourages a comparison to, and rejection of certain stigmatised identities, in particular problem users of drugs, identified as 'junkies', and especially those who attend drug services for treatment (Radcliffe and Stevens, 2008). Drawing upon the notion of the 'outsider' (Becker, 1963), this study examines some of the ways in which identity is constructed through a variety of social and historical processes, and articulated within a range of discourses evoking different and often mutually exclusive combinations of sameness and difference. Using a social constructionist lens, it will be argued that representations of drug use are constructed from within specific discourses which accentuate similarity to a construction of drug use linked to addiction, crime and immorality. This analysis therefore explores how drug users identify with certain drug user stereotypes and reject others. The thesis will also borrow on occasions from a Foucauldian perspective, and how discursive representation, ways of knowing, power and language intertwine.

## **The outline of the thesis**

This research employs a qualitative research design to produce a rich set of data. In depth semi-structured interviews with 24 participants help develop an understanding of the characteristics that this population share, which allows them to use illegal drugs and yet remain 'intentionally hidden' from view. Analysis was undertaken borrowing from a social constructionist paradigm focussing on 'deviance'. There is an 'impasse' between the lived experiences of the people who can or have used drugs with few problems and the dominant paradigm which explains drug problems, and specifically drug addiction as primarily 'drug induced' (Davies, 1992; Alexander 2001).

Chapter two is a review of the literature on drug use historically, how illegal drug use is commonly researched, and the main theories that seek to explain it, and a brief tour of the development of British drugs policy. In addition, two key theoretical perspectives are explored: the normalisation thesis, and subcultural theory. A focus on the sociology of deviance, in particular labelling theory, is then followed by an overview of how cultural identity theory explains the development of drug problems, before addressing what will be thereafter referred to as 'drug talk', and the power that is exercised through it.

Chapter three addresses the issues from the literature of researching deviant groups such as drug users, and the methods most often utilised to access them. It will then explain how the participants were accessed before exploring who took part, explaining why they took part, and how they differ from 'typical' problem drug users, who are commonly the target group of the majority of research into drug use.

Chapter four introduces the first of four themes which emerges from the analysis of the data: the issue of identity and identification, how the participants engaged with their community as 'intentionally unseen' users of illegal drugs.



Chapter five explores techniques the participants utilise to reduce risk and harms arising from the use of illicit drugs and the rules and sanctions that separate controlled use from problem use.

Chapter six addresses how the participants access illicit drugs in a climate of prohibition, in particular how they define sellers of drugs, and the practices they use to source drugs while minimising risks to themselves and others.

Chapter seven explores the participant's view of drug prohibition, how this impacts on their identity, their use of drugs, the perceived and actual availability of illicit drugs, and how they understand the efforts of law enforcement to prevent the supply and demand for drugs.

Chapter eight is a discussion of the key themes that emerge in the literature and in the analysis, and will describe the policy recommendations based on the research findings.

## Chapter two: the review of the literature

This research study emerged from a review of the available literature using search terms such as 'drug use, drug problems, illegal drug use, hidden drug use, hidden populations, controlled drugs use, drug prohibition, qualitative research, symbolic interactionism and illegal drug use. Attention was paid to the UK and Scottish context and on non-treatment seeking drug users' experiences, in particular the controlled or 'sensible' use of illegal drugs, and in particular the use of heroin and cocaine.

Qualitative research that has recruited controlled users are sparse and are largely concerned with how certain groups of 'addicts' for example work through their drug problems to achieve normality, constructed most often as being abstinent, drug free or in 'recovery'.

Two competing and co existing discourses are to be found in the available policy and treatment literature relating to the drug problem, that drug use is a moral issue, that addicts are criminals and should be punished or have their criminal behaviour 'corrected' or disciplined. The other discourse constructs drugs use as a health problem to be solved by medicine. In this view addicts are ill, and require treatment. Both discourses are supported by the addiction concept that posits that drug exposure leads to inevitable craving, withdrawal, and a loss of control underpinning criminal behaviour, in particular acquisitive crime to fund a 'drug lifestyle'. Challenging this medico-determinism and simple stimulus response behaviourist models that underpin much criminological research is the view that drug taking and related consequences are not determined by simple drug exposure, that is the drugs the (mind) set, and the cultural environment (setting) all act to mediate consequences (Zinberg, 1984).

Symbolic Interactionism explores the level at which institutional or structural power can be revealed in micro interactions between social actors. The themes in the literature stemming from this perspective are:

- How does inequality manifest itself in the minutiae of daily life?
- How do users of illegal drugs experience inequality and power being exercised on them and those whom they identify or reject.
- The strategies illicit users of illegal drugs use to manage social affronts and stigma.

The first theme is explored initially by exploring how problem use is constructed and estimated in the review of the literature on problem users that attend services. The second theme is addressed utilising labelling theory stemming from the work of Becker (1963). The third theme driven by the work of Erving Goffman (1990) emphasises the ability of social actors, particularly those whose activities are labelled as unhealthy, strange and risky to successfully accomplish and manage social encounters and thereby salvage a positive sense of self.

The main challenge to medico determinism of drug use leading inevitably to drug problems requires an eclectic approach to its understanding and critique. This eclectic or bricoleur approach refers to the deliberate mixing of qualitative methods and ways of thinking in order to address the research aims. The bricoleur approach allows an understanding of the inter-related connections between theory, research practice and the lived experiences of stigmatised illegal drug users. Denzin and Lincoln (1994) make researcher as *bricoleur* their leitmotif. They make use of Claude Levi-Strauss's concept of *bricoleur* described in his work 'the Savage Mind' (1966) to explain what can be understood from data. This is a multifaceted approach to the research process. Jacques Derrida extends this notion to any discourse and suggested that every discourse is *bricoleur*, (Derrida, 1970). A 'bricoleur' literally translates from French as a jack-of-all-trades, and 'bricolage' as a method of inquiry has been used within academic qualitative research to describe a pragmatic and eclectic approach to qualitative research. This translation does not however mean that there is a lack of expertise, but that purism in a research method or design is replaced by pragmatism and eclecticism.

The review of the literature begins to outline a perspective that links current beliefs about the power of drugs, and the determinism of biology to theorise that addiction discourse or 'drugs talk' stem from temperance ideology where intoxication at the emergence of capitalism is viewed as wrong, undermining God given freedom, and the ability to take part in civil society.

This chapter begins with a review of the literature on how illegal drug use is defined and commonly researched, and the main theories that seek to explain it, and gives a brief tour of the historical development of British drugs policy. Also examined are two key theoretical perspectives that seek to explain drug taking: the normalisation thesis, and subcultural theory. The chapter then has as its focus the sociology of deviance, in particular labelling theory, followed by an overview of how cultural identity theory explains the development of drug problems, before addressing what will be referred to as 'drug talk', that underpin addictions discourses and the power that is exercised through them.

Social control theory explores how bonds of conformity create a stake in society. In short it examines how those with little or no stake in society may become deviant. Social learning theory is then explored, in particular how such a perspective adds complexity to the simple stimulus - response model of behaviour which underpins constructivist theories of problem drugs use and related interventions aiming to 'correct' such deviance. In particular the processes that might lead to a social actor to interpret withdrawal, tolerance and the intoxicated experience are illuminated by the work of Norman Zinberg's (1984), 'Drug, Set and Setting' which suggests that people interpret affective states, which mediates related decision making and behaviour.

Social conflict theory explores group conflict and inequality in how drug use becomes defined by certain groups and individuals in a society, and how such deviance is interpreted as a problem. Labelling theory stemming from the work of Howard Becker outlined in his work 'Outsiders' (1963) suggest that everyone is a deviant. Describing the labelling process explains how the most powerful in society can label others, often in an attempt to impose

order and rationality in social relations. This leads to the genesis of this research building a thesis that drug problems are in part culturally produced and influenced, that medico determinist theories of drug problems that rest on biology, pharmacology, or psychology are superficial, neglect an historical perspective, and both individual agency and the influences of social structures. Finally the review will explain the term 'drug talk' and introduce the rationale for the research that informs the thesis. The glaring gap in the literature is the paucity of evidence exploring the non-visible non treatment seeking drug users' point of view.

## **Introduction**

Most people have never used illegal drugs habitually. The vast majority of the population in Scotland are presented with accounts of problem drug use from a viewpoint of the addict, or the recovering addict, or from popular fiction in television shows dealing with criminality, or the accounts of drug related crime that form the mainstay of populist newspapers, written from a law and order perspective. Few of these consumers of such news have any reason to doubt the veracity of these accounts and often lurid depictions of drug taking. Yet among drug experts, there is a great controversy as to why people use drugs, and even about how many addicts there are at any given time, and even in what *addiction* actually means. Some researchers challenge research methods which view the individual as defective, or link drug use with *offending*. Young (2003) has suggested that an explanation of criminal action needs to answer two pertinent questions: why do individuals wish to commit the crime; and why is the offending behaviour in question considered criminal or deviant in the first place? Young asserts that positivism has mystified both answers: the first by taking from the offender any sense of human purpose, the second by ignoring or downplaying the issue of social reaction (ibid). Labelling behaviour as deviant and criminal imagines a consensus of rational citizens agreeing on what deviance is, and how society should reasonably respond

to it. Young (2003) argues that society does not consist of a monolithic consensus, but rather of a pluralistic array of values. In such a highly charged and emotive landscape, maintaining an objective stance in the field of drug research is demanding. In any drug debate one can usually be placed into one of two camps, either pro drug and 'for' legalisation or anti-drug and 'for' prohibition. Norman Zinberg helpfully outlines this situation:

*"On every panel, radio show, and TV show, and even at professional meetings, where one would expect objectivity, the program must be 'balanced'. A speaker who is seen as pro-drug is 'balanced' by someone who is considered anti-drug. Since the 'anti's' take the position that prohibition and abstinence is essential, any opposing view is perceived as pro-drug", (Zinberg, 1984, preface to 'Drug, Set, and Setting').*

Zinberg demonstrates the simplicity with which complexity can be reduced. Drug users can be categorised into two populations: one group, drawn almost exclusively from the unemployed working class, are seen as social deviants involved heavily in drugs and crime and causing disorder in their communities. The second group are viewed as 'respectable' youth who are at 'risk' of being 'contaminated' by drug addiction (Buchanan and Young 2000). As a result of such polarised views the language expressed in drug discourses play an integral role in defining the parameters of thought, talk and action. Discourse according to Hall (1997), can be summarised as being able to:

*"...define and produce the objects of our knowledge. It governs the way a topic can be meaningfully talked about and reasoned about. It also influences how ideas are put into practice and used to regulate the conduct of others. Just as a discourse 'rules in' certain ways of talking about a topic, defining an acceptable and intelligible way to talk, write, or conduct oneself, so also, by definition, it 'rules out', limits and restricts other ways of talking, of conducting ourselves in relation to the topic or constructing knowledge about it." (Hall, 1997: 44)*

For Hall (1997) discourse, which includes institutional and social practices, offers up (and closes down) particular *subject positions*, that is, possible social locations which afford or delimit the particular experiences or 'ways of being'. Sutherland (1992) has written that omissions, distortions and confusing associations with causality are standard in human reasoning. Certain myths are repeated as they serve a useful purpose in regulating behaviour deemed inappropriate, unhealthy or dangerous. A form of typical addiction discourse would be for example taking drugs for fun becomes an addiction which forces the addict to sell sex or steal to purchase drugs and reduce craving and withdrawal distress. While some drug users describe these scenarios, they are by no means typical. Several researchers have argued that such life histories are socially constructed for personal and socially functional reasons, to explain and rationalise conduct that has become stigmatised (McAdams, 1993; Davies, 1997; Weinberg 2002; Reinerman, 2005).

Concepts such as 'addiction', 'drug abuse', 'drug abuser' and 'drug dealer' are, in a very important sense, specific social productions historically and socially. This occurs via communicative networks in which they are implicated to shape conduct and subjectivity in particular ways. Drug discourse is a means by which certain privileged 'truths' about drug use act as a technology through which concepts are brought into existence and ordered as a domain to be governed. Drugs discourse routinely describes drugs as 'addictive', which stems from the belief that exposure to certain dangerous drugs *inevitably* cause people to 'lose control'. Bruce Alexander has argued that this evidence has been embellished to the point where the belief in drug-induced addiction has acquired the status of an obvious truth that requires no further testing (Alexander, 2008). Perhaps widespread acceptance of this belief is a better demonstration of the power of repetition than of the influence of empirical research, because the great bulk of empirical research runs against it.

Jacques Derrida (1993:2) challenges the scientific logic within drug discourse stating that beliefs about drugs are instituted on the basis of moral and political evaluation and not on the accumulation of scientific evidence. Derrida explains that this is achieved through obscuring the true history of drugs as rather benign albeit potentially dangerous commodities by labelling drugs and users as immoral, unhealthy and criminal. From this perspective, power is not imposed directly by the state but 'at a distance' through the diverse operations of a constellation of more or less independent institutions, agencies and experts granted authority to define and direct human conduct. Foucault, (1982) theorized that institutions control people with discipline exercised through discourse. For example, the modern prison (more specifically the panopticon) controls by the ideal use of the disciplinary and regulatory power of surveillance. In *Discipline and Punish* (1991) his genealogical study charts the historical development of the 'gentler' modern way of imprisoning criminals rather than torturing or killing them. While recognising the element of genuinely enlightened reform, Foucault particularly emphasises how such reform also becomes a vehicle of more effective control, he states that it is the function of the contemporary state: "to punish less, perhaps; but certainly to punish better", (Foucault, 1977: 81-82).

At the core of Foucault's picture of modern 'disciplinary' society are three primary techniques of control: hierarchical observation, normalising judgement, and the examination. For Foucault, power can be achieved merely by surveillance. So, for example, the use of closed circuit television systems (CCTV) allows security cameras to scan the landscape for law breaking and disorder. A perfect system of observation allows one 'guard' to see everything (a situation approximated in Jeremy Bentham's Panopticon). A distinctive feature of modern power (disciplinary control) is its concern with what people could potentially be observed doing, the constant threat that one could be under surveillance. This illustrates the primary function of modern disciplinary systems: to correct deviant behaviour and to achieve certain standards of behaviour and this includes the use of illegal drugs, or legal drugs illicitly for non-medical purposes. The goal is not necessarily revenge (as in the case of the tortures of



pre-modern punishment) but reform, where, of course, reform means coming to accept standards or norms in society. The imposition of precise norms through the use of discipline is quite different from an historical system of judicial punishment, which merely judges each action as allowed by the law or not allowed by the law. This concept of normalisation is pervasive in society: a continual centralisation, and normalisation of products, policy, of thought, and of speech.

The assessment (for example drug users in treatment) combines hierarchical observation with normalising judgment. It is a prime example of what Foucault calls power/knowledge, since it combines into a unified whole what Foucault defines as the deployment of force and the 'establishment of truth' (Foucault 1975:184). It both elicits the truth about those who undergo the assessment (tells what is known about the state of health) and controls behaviour utilising several agencies of social control, such as health care and criminal justice systems. For Foucault the term 'knowledge is power' means that knowledge is an instrument of power, although the two exist quite independently. Foucault's point is that the goals of power and the goals of knowledge cannot be separated: in knowing we control and in controlling we know (Hoy, 1986). Discourse theory arising from Foucault's insights do not rest on a grand theory of power in the conventional sense; it does not view power as centralised, possessed by an individual or groups hierarchically operating on the powerless. Instead, it sees modern power as everywhere and as productive (Foucault 1991). In modern societies, Foucault argues we have metaphorically cut off the head of the King. Relating this to addiction, addiction is not something we are trying to discover, but it is a category of behaviours and identity that has been constructed. Discourse in this sense is a form of social control and a way of understanding how we govern ourselves, regulate and discipline our own bodies. The production of knowledge by the state plays an integral role in the process of regulating behaviour. For Foucault the exercise of power and the production of knowledge are inseparable. Clearly, for any domain to be governed there must first be 'a way of rendering it into thought, so that it can be analysed, evaluated, its ills diagnosed and

remedies prescribed' (Foucault 1982). Knowledge presupposes power in the sense that it is produced and legitimated within a complex of power relations. Thus power and knowledge directly involve one another; in this sense Foucault indicates that:

*'There is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time power relations' (Foucault, 1991: 27).*

Foucault's earlier works focus on the systematic (structure like) nature of how madness and attempts to contain it are understood. Later he becomes pre-occupied by discourse, and in particular discursive formations or epistemes. Epistemes are conceptual frameworks which define their own truth criterion, according to which particular knowledge problems are to be resolved, and which are embedded in and imply particular institutions.

In *Discipline and Punish and the Birth of the Clinic* (1975; 1991) Foucault demonstrates that madness is distinct from mental illness. Madness is a social construct. He looks to the past for evidence. In his work he describes the exclusion of certain stigmatised groups, and in particular lepers. He also describes the exclusion of the 'strange' cast out in his description of the 'ship of fools'. In *the Birth of the Prison* (1991) Foucault explains that brutal demonstrations of state power, for example public executions are examples of 'monarchical punishment' and demonstrates how this has become 'disciplinary punishment', and has largely become the domain where the professional pronounces 'judgement' on the population. Such discipline leads to self-policing by the population. Foucault explains that a carceral continuum runs through contemporary society, through the discipline of norms. Rorty (1983) has criticised Foucault for merely representing history, and for suggesting to his readers that they should not look to history to aid rationality and progress. He is also criticised for being strongly influenced by Nietzsche, leading to pessimism of the ability to have a humanistic social science.

Foucault argues modern power can be described by the term 'bio-power'. Bio-power does not operate in relation to a series of acts but rather in relation to the lives of individuals. Bio-power has two poles; discipline and governmentality. Discipline operates on particular individuals in a particular space. Such processes legitimise the increase of information about an individual and acts according to that information. Governmentality operates on particular groups of individuals. It receives information through statistical analyses, financial reports and population registers. Its techniques of power are directed to making adjustments in the population and their economic condition. Legislation is one technique which is used to make these adjustments.

Drug discourse or 'drug talk' allows the justification of political choices based on privileged ethical preferences of abstinence from illicit drugs. Such discourse acts to suppress evidence of conflict between those preferences and an underlying reality. Several authors have suggested that the disease concept of addiction is an example of a modern myth (Szasz 1974; Peele 1985; Finagarette, 1988; Davies, 1992, Hammersley, 2002; Shewen and Dalgarno 2005). All have more or less described the difficulties inherent in loosely linking social discourse, moral dilemmas, psychology, pharmacology and biology together, proposing that the drug problem is less well defined than acknowledged in the scientific literature. Several have argued powerfully that the concept should undergo major revision (Akers, 1991), or be replaced altogether (Heather and Robertson, 1985). The contemporary belief that addiction is driven by 'abnormal' craving, tolerance and withdrawal leading to a 'loss of control' is underpinned by fears of contagion and of losing control (Werner & Riviere, 2007). Drug discourse serves the function of signifying which behaviour is deemed acceptable, and which is not. This is evidenced in how the concept of addiction is flexible enough to include behaviours such as compulsive relationships, overwork, overeating, gambling and other problems deemed to require a medical or legal intervention (Szasz 1974; Peele 2010). Richard Hammersley summarises six beliefs associated with the use of illegal drugs that continue to be accepted as truths in addiction discourse (1) exposure to drugs

leads quickly and easily to addiction, without requiring long prolonged heavy misuse, (2) addiction drives otherwise law-abiding citizens to commit crimes, (3) Drugs diminish or eliminate rational, moral, and legal responsibilities, (4) death and serious health damage are inevitable after drug exposure, (5) drugs are supplied by ruthless criminals, (6) addiction is an all or nothing concept. One is either an addict or a recovering addict. (Hammersley 2002:9).

## **Defining drug taking in UK drugs policy**

In 2008, the Scottish Government published 'The Road to Recovery' (2008) in which the SNP minority government identified three broad categories of people that were not 'drug free'. These groups are described as 'Experimenters', 'Regular users' and 'Problem Drug Users' (The Road to Recovery 2008:12). Drug taking in the first two categories of user are potentially benign. In this policy document there is a conjecture that experimentation leads inevitably to problematic use. The Scottish Government Minister for Community Safety Fergus Ewing suggests that:

*"Although Government policies can do much to address the factors associated with drug use, it is inevitable that people – across all societies – will always consider the use of drugs. However, it is our view that no-one in Scotland today should take drugs in ignorance of the consequences. It is essential that there is a range of credible and accurate factual information available to allow people to make informed decisions", (ibid).*

On discussing the normative range of behaviours which define a productive citizen, Norman Zinberg suggests that:

*“Many policymakers have assumed that behaviour can be shaped by providing individuals with “information” on the consequences of behavioural decisions. The emphasis, however, has always been placed on the prevention or avoidance of behaviours presumed to have a negative impact on the individual or society. Such information has frequently been laden with ethical and moral judgments so that the “proper” decision for the individual has been preordained”, (Zinberg, 1980).*

The drug policy stance contained in the ‘Road to Recovery’ (2008) categorises all drugs as dangerous and all users as equally at risk of addiction by stating that:

*“People who use drugs undermine their potential to lead rich and fulfilling lives. They put at risk their relationships; their chances of employment and their health...in short drugs ruin lives” (ibid 2008:13).*

The proposition presupposes a distinction on health and welfare rather than legal grounds between licit and illegal drugs. In using language that describes drugs as ‘dangerous’, prohibition is presented as the antidote to the corrupting influence of drugs on the body. Foucault’s idea that the “body becomes a useful force only if it is both a productive body and a subjected body” becomes pertinent (1975: 25). The government legitimates its power to subject the body to its rules and regulations concerning drugs with the argument that a body subjected to drug use cannot be economically productive.

Since the early 1980s, examining and establishing the link between drugs and crime is considered to be a defining feature of the drug problem in Britain (Parker and Newcombe 1987; Dorn *et al.*, 1994; Bennett 1998; 2000; Seddon 2005; Holloway *et al.*, 2004). In policy circles, it is believed that individuals heavily involved in using heroin and crack-cocaine are likely to be profoundly involved in acquisitive crime or drug dealing. This notion of ‘drug-related’ or ‘drug-driven’ crime has been the central element of recent drugs policy (Stimson,

2000). During the same period, the connection between drugs and deprivation emerged as a central aspect of the drug problem in the UK (Pearson 1987; 1989; 2001; Parker *et al.*, 1988; ACMD<sup>3</sup> 1998). Less well researched however are the processes that might link together the three issues of drugs, crime and disadvantage. Toby Seddon (2005) asks why the associated problems of drugs, alcohol and crime tend to blight the poorest communities within the UK and suggests that 'drug-related crime' cannot be adequately understood without examining the underpinning issues of poverty and exclusion (Buchanan 2004). The research literature has not successfully demonstrated definitive links between drugs and crime (Bennet & Holloway, 2005:94). Therefore, in part, the links between drugs and crime may be an artifact of the drug laws themselves, by stating that the most common drug crime is possession of illegal drugs; indeed some researchers are outright skeptical of the links between offending and problem drug use (Chaiken & Chaiken 1990: 212). One must look to history to discover why this situation has arisen.

## **Temperance ideology**

Temperance discourse was created in a period of great political, social and religious upheaval from within a newly formed America, and in Great Britain. The emergence of Temperance discourse was first developed through their formations of quasi-religious and quasi-secular groups as a response to the separation of the state from the church in the late eighteenth century (Room, 1991). The United States has exported several cultural innovations to the rest of the world (Alexander, 2008). However its approach to those drugs it has helped make illegal is moralistic, illogical and fundamentally violent and vengeful (Alexander, 1990; Boaz, 1990; Peele, 1989; Trebach, 1987). Among the manifestations of an American style of dealing with drugs is a literature which ranges from anti-drug propaganda to a collection of academic writing that appears in medical, psychological, and

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<sup>3</sup> Advisory Committee on the Misuse of Drugs.

social science journals. The themes in mainstream academic writing and the moral tone of much of it and popular drug discourse can be traced historically to the early 'ascientific' temperance literature that began appearing in the United States at the beginning of the 19th century (see Benjamin Rush, 1790.1805/1947, 1819; Kobler, 1973; cited in Alexander, 2008).

The publication of William Hogarth's engravings 'Gin Lane' in the mid-18<sup>th</sup> century highlighted ideas which would later be more fully expressed in 19<sup>th</sup> century temperance ideology that alcohol use could lead to a type of social malaise or illness defined as inebriety, categorised as similar to other medical ailments (Alexander, 2008). In the twentieth century this would be renamed an 'addiction', (Peele, 1985), and later 'dependence', (Peele, 1989). The ideology underpinning the temperance movement gave birth to ideas that would ultimately lead to the contemporary conception of the addict, as out of control, and the architect of their misfortune, because of an indulgence in dangerous drugs. The early temperance movement advocated the use of alcohol in moderation, whereas the more radical movement that emerged later as a reaction to the failure to promote abstinence through persuasion favoured 'total' abstention from alcohol. The temperance movement was led by middle-class social reformers and philanthropists who sought to achieve their goals of social reform by influencing the conduct of the working classes (Berridge, 1999). These social reformers tried to convince working men to spend their wages on clothes and food rather than on beer or spirits. The implication was clear, poverty was not exacerbated by low wages, poor housing, lack of education and opportunity and lack of steady employment, poverty was caused by alcohol. Temperance rhetoric and narratives argued that spending money on alcohol would inevitably lead to a drunkard's grave, and destitution for the family. Opium use, which at this time was not demonised, partly due to Thomas Dequincy's *Confessions of An English Opium-Eater* (1821), allowing its use to be construed as an eccentric pastime of a few middle- and upper-class dilettantes

(Yates, 2000), whereas the drinking of the working and lower classes was perceived to be an urgent public health problem (Edwards, 1996; Berridge 1999).

The class dimension of intoxication produced a fundamental distinction between public and private spaces (Heather and Robertson, 1985). Being intoxicated in public was not a crime *per se*, but public drunkenness could become a petty crime or nuisance when supplemented by bad behaviour. Working people and the poor were often jailed for "drunkenness and disorderliness" or "drunkenness and riotousness." As the middle class had an overriding tendency to drink alcohol and use drugs privately, an attitude developed that drunkenness visible in social celebration, was unpleasant. Hence the underprivileged were condemned for appearing to be having more fun than their 'betters'. The temperance campaigns against drunkenness were an indication of larger middle class ideals, such as distaste for mobs and their entertainments, the partaking of recreation out with one's family, a non-participation in religion, and a belief that frugality with its stress on individual self-respect, personal moral and physical effort, and prudence were being rejected by the working classes (Zieger, 2002).

The fundamental temperance premises eventually became simple and coherent: (a) alcohol use and alcohol addiction were primary causes of society's problems; (b) universal abstinence would solve or at least ameliorate health, social and legal problems. The temperance claims regarding the use of alcohol were stated in language that was moral and accusatory. The Temperance Movement began to develop an ideology that was constructed on moral, religious and medical beliefs that many of society's problems such as poverty, criminality and immorality were caused by alcohol. In the 19th century, temperance movements occurred in a number of countries. Their campaigns highlighted the social and moral evils of alcohol and generally promoted abstinence as the solution. As the century wore on, the movement became split between the moral suasionists, who saw individual voluntary abstinence as the solution, and prohibitionists, who believed that societal action in the form of legislative intervention was the only means to produce a sober, moral nation (Yeomans 2011). In some countries, notably the USA, prohibition was successful to the



extent that the production of alcohol was (temporarily) outlawed. Despite the prohibitionists coming to dominate the British temperance movement in the 1860s and 1870s, such legislation was never enacted and by 1900 British temperance societies were disintegrating (Shiman, 1988). The message of the early temperance movements began with blaming strong distilled alcohol as the cause of many highly visible societal problems. The early messages underpinning temperance thinking backed away from the more extravagant claims and more violent forms of repression, which came to define the war on distilled alcohol, but nonetheless adhered to essential temperance premises underpinning organised campaigns to prevent the use of alcohol (Yeomans, 2001). The simpler highly politicised message of abstinence was adopted as the key temperance message, which found its greatest success in alcohol prohibition in the USA from 1920 until 1933. Temperance ideas have been extended, almost unchanged, to other drugs. Current beliefs about heroin, cannabis, cocaine, methamphetamine and the former legally available drug mephedrone are virtually identical to temperance ideas regularly circulated about alcohol.

Although most medieval superstitions are dismissed by modern audiences the myth of demon possession revitalised in the 19<sup>th</sup> century had become repackaged in a new, pharmacological guise (ibid). As that century progressed, more and more people came to believe the temperance narrative that anyone who voluntarily ingested alcohol, in particular gin permanently fell under its control, and became a helpless slave to drink, possessed by “demon drink”. Unless these ‘inebriates’ were saved by Christian conversion, or signed ‘the pledge’ to abstain, they remained under the control of their craving for alcohol forever after, until the story ended with their ghastly deaths, (Alexander, 2008).

Judeo Christian ethics are supported by tension between the belief of individual free will and a world where laws are determined by divine fiat. This has created a cultural acceptance that free will could be suppressed or bypassed altogether by external forces, for example demonic possession. The assumption that people are essentially good but could be corrupted by external influences has become culturally acceptable (Blum, 1970). Many

intelligent individuals trained in science who scoff at the suggestion that demons exist may be only too willing to suspend their rational critical faculties in the conviction that drugs have equally odd and powerful properties (Inglis, 1975; Weil, 1972).

Temperance discourses formed important contexts for the development of the disease model of alcoholism. The idea of personal responsibility and agency still resides in the notion that although ill, addicts can cure themselves through the reassertion of self-discipline. Aspects of temperance ideology like contemporary twelve step beliefs, promote this emphasis on personal choice supported by a community of like-minded companions, on ritual pledging, and submission of personal culpability and responsibility to a higher power. The proliferation of public confessions is fundamental to the construction of the addict as 'other', a tainted identity to be left behind after becoming 'clean' (Weinberg, 2002). Therefore the major innovation of temperance was the mass politicisation of personal habits, (Zieger, 2002).

The birth of the disease model of alcoholism may have originated separately yet almost contemporaneously with two physicians on different sides of the Atlantic: Benjamin Rush of Philadelphia (c. 1785) and Thomas Trotter of Edinburgh, (1804) although the basis of such a view may have existed a significant time before this. The increasing *moral* priorities surrounding the topic brought the public discussion of illicit substances to relative fever pitch; wildly exaggerated stereotypes regarding drug use and misuse were either originated or perpetuated in the late nineteenth century (succeeded in the 20<sup>th</sup> Century by new classifications such as 'junkie', 'addict' and so on), such as the idea that those with a supposedly inherent lack of wilful resistance would have no defence against the corrupting spectre of moral deviance. This was followed by the acceptance of the medical establishment, who saw self-administered drug use and subsequent addiction as an almost purely clinical problem to be 'solved' under their supervision (Bailey, 2005). The belief that alcoholism was a disease gathered support, and moved on slightly from a moral viewpoint to a view that the alcoholic was ill (Levine, 1984). Shifting the identity of the addict from weak

willed to a victim of their inherited or acquired vulnerability to deviance fundamentally changed how addicts were treated. It allowed medicine to treat and care for such victims; however and more importantly it also reinforced the belief that deviance was a personal deviance, outside the influence of structural factors. An important view as the blame for deviance lay not in structural inequality, but in defective individuals, unable to compete, and contribute to an ordered society (Zieger, 2002). Whether the susceptibility lay in the soul, the mind, or the body was not as important as the view that the individual was at fault, due to personal deficit. As both popular and to an extent scientific discourse shifted the aetiology towards mind and body, a diagnostic category was required to locate the knowledge and power to utilise these labels to regulate the addict / alcoholic, the mental defective. This dominated both objective and subjective definitions and evaluation of drinking and drug taking (ibid).

The ascendance of a medical theory of addiction gave rise to an interesting paradoxical effect: drinkers and drug takers could cling to a notion of being weak willed, and driven by an obsessive compulsion to seek out their drug, which allowed a rationale for continuing with their deviant behaviour. This also allowed problem drinkers to identify with a group of abstinent or controlled drinkers, and create a new non-stigmatised identity (Bateson, 1971; Denzin, 1987; Neale, Nettleton and Pickering 2011). Thus everyone labelled as a problem user would have to confront such a choice, to use or to stop. This choice can have devastating consequences on personal, social and relational identities. From an extreme perspective, the choice is stop using or die (AA for example), or minimise the consequences of such a label and become part of a hidden population at risk of further stigma if discovered. The choices open to illegal drug users alternate between those that connect them to a visible straight world, characterised by abstinence as a definition of normality, and a hidden world at risk of disgrace if discovered by those who label the use of drugs as unsafe (Radcliffe and Stevens, 2008).

The belief that one could be possessed by a 'demon' drug has been applied essentially unchanged to many drugs, (Alexander, 2008). The temperance movements began viewing alcohol as the source of problems, and later extended this to opiates. Contemporary versions of the demon possession narrative have been utilised to demonise cannabis users as the 'mentally ill in waiting', methamphetamine users as chaotic criminals, and mephedrone users as gambling with their sanity and their lives.

## **Estimating drug use in the UK**

Surveys remain a mainstay of drugs research. They vary from well-designed albeit costly national surveys such as the GHS<sup>4</sup>, conducted by Leitner, Shapland and Wales (1993), to other national surveys that ask about drugs amongst many other issues BCS<sup>5</sup> and the SCVS<sup>6</sup>, and to opportunistic samples of clients attending treatment services (SDMD<sup>7</sup>). Other common types are those which access school aged children (salsus<sup>8</sup>, 2010), offenders (Doris<sup>9</sup>) and people that are socially excluded or marginalised (Goulden and Sonhi, 2001). There appears to be little targeted research that accesses drug users out with pubs and clubs who are in stable employment or education, who do not live in areas of deprivation and who are not caught within the criminal justice system. One exception may be Pearson's study of middle class drug takers (Pearson 2001), whose use of cocaine caused some concern at its apparent 'normalisation'. Drug users can remain hidden because they are affluent (an early example of hidden users was Dequincy's 'Confessions of an English opium eater'), and because their deviance has not come to the attention of any agency of social control. Much of the drug taking that occurs among the affluent is less likely to come to the attention of state surveillance mechanisms (Lea and Young 1984). There is a paucity

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<sup>4</sup> General Household Survey

<sup>5</sup> British Crime Survey

<sup>6</sup> Scottish Crime and Victimisation survey

<sup>7</sup> Scottish Drugs Misuse Database

<sup>8</sup> Scottish adolescent lifestyle and substance use survey, 2011.

<sup>9</sup> Drug Outcome research in Scotland, 2008.

of research into drug use in older people. In any event, the representativeness of any research is problematic. Methods of representing the population (household samples, school surveys and crime and victimisation samples) tend to underrepresent drug users and may unintentionally lead to the assumption that drug taking is not widespread. Sampling special groups, such as club goers or treatment populations, may lead to an overestimation of the incidence of drug taking in a population. People who do not take part for whatever reasons in any survey mean that estimating prevalence of drug taking is problematic.

The earliest research into the use of drugs was driven by a fear of a drug epidemic being caused by exposure to a drug (Courtwright 1982). The imagery and fears surrounding an epidemic of drug addiction, loss of control and social chaos remains powerful. Research in the epidemiological tradition focuses on the use of substances, the risks of addiction, and other pathologies deemed to result from identified patterns and prevalence. Drug use is described in this model as spreading like a contagion across sex, gender, and ethnic boundaries. This fear of addiction and other related pathologies fuel and inflame drug war rhetoric, and divert money from public health to criminal justice research and policy and treatment responses. For Ball and Chambers (1970:2) the language used in such research is on 'aetiology, incidence and prevalence of addiction'. Such research 'uses the methods of biomedical science – qualification and correlation informed by clinical observation' Glassner and Loughlin, (1987) suggest that:

*"The central element of the epidemiological perspective has been the attempt to define drug use as a progressive and predictive pattern and to identify the sequence of drug initiation, and its link to other pathologies' (ibid: 4).*

Within this research paradigm, there is the *a priori* assumption that a causal relationship may exist between drug use and various deviant behaviours. If a person is identified as a drug user certain judgements are made about them. From this perspective, drug users are thought to be rebellious, at risk of homelessness, mentally ill, suffer from abuse, at risk of

prostitution, or a life of crime. The emphasis on large scale surveys directed at young people is due partly to their perceived risk of addiction and crime, and partly because they are an easily accessible research population. A cursory glance at such surveys and the trends they reveal from longitudinal designs indicates that little is known about whether there is a 'natural progression' or a 'career' from casual experimentation to drug addiction. A review of the literature proves a wide and largely unfocused array of lexicons to describe drug takers, addiction, and recovery from problems (Yates 2011). Research tends to concentrate on clinical groups usually in a medical setting (Ying-Ing et al., 2007; Van der Geest et al., 2009). It often describes career trajectories and problems associated with regular excessive consumption of illegal drugs. This type of research is most often quantitative. Another type of research focuses on non-treatment populations often denominated recreational drug takers (Malbon 1999, Measham et al., 2001, Sanders 2006, Jarvinen and Ravn 2011). This type of research is most often qualitative, and tends to be dominated by youth or cultural studies (Blackman 2004). There is a dearth of comparable data to establish trends in drug use: official surveys have not, until recently, included routine questions about illicit drug use. The most useful drug-related data in the UK, which do allow some comparisons over time, are probably the drug misuse data; however the data for England and Wales and Scotland are collected separately, making comparisons difficult<sup>10</sup>. The British Crime Surveys of the 1990s represent the first surveys which allow a comparison of continuity and change in drug use amongst a representative sample of the general population. This makes the data from the BCS and from the Scottish Crime Survey the best available when taking into account the inevitable constraints on such self-report data.

Some longitudinal studies take a great deal of time and effort and there are probably less than 50 such studies worldwide that have examined substance use in useful detail (Hammersley, 2004). Some key studies include Jessor & Jessor (1977), Taylor et al.,

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<sup>10</sup> It is recognised that treatment and criminal justice data are largely unrepresentative of the population of people who are drug users. Data from a representative sample of the population are the British Crime surveys and the Scottish Crime and victimisation survey collected on an annual basis.

(1986); Elliot, Huizinga & Ageton, (1986); Werner and Smith, (1982); Vaillant (1995); Tobutt Oppenheimer and Laranjeira (1996); Aldridge, Parker and Measham (1999). These find that drug and alcohol related problems can be found in users who have poor or disrupted family backgrounds, do not fare well in education, have poor social skills, are caught within the criminal justice system, may have suffered childhood trauma, such as abuse, and have related psychological or mood disorders. Longitudinal studies tend to find that drug use and related problems tend to increase into the early twenties, but only a minority of users increase use rapidly. Research consistently shows that most users stop or cut down problematic use, and that these patterns continue well into adulthood. As with other problems, other competing factors such as employment, significant relationships and children tend to ensure that problems cease or diminish into adulthood. Several studies, including Glassner and Loughlin (1987) have found that problematic drug taking is not associated with such 'risk' factors, and that risk factors do not necessarily result in problems.

Several authors have pronounced drug use as normal, controlled, uneventful, without the hyperbole used in government policy documents, (see Zinberg, 1984; Shewan et al., 1998; Gossop, 2000; Orford 2000; Shewan & Dalgarno 2005; Warburton et al, 2005). However despite research which has concluded that drugs may not be as dangerous or as addictive as some people believe, several dogmas about the power of drugs remain. While controlled drinking of alcohol is now widely accepted as a truth (Heather and Robertson, 1985) the controlled use of drugs can be dismissed as a fantasy. Research has consistently indicated that the controlled use of opiates is possible and a common pattern of use (Robins et al, 1977, 1979; Zinberg & Harding, 1982; Blackwell, 1983; Zinberg 1984; Shewan et al, 1998, Shewan & Dalgarno, 2005; Warburton et al., 2005). The research of Cohen and Sas, 1993, 1995; Ditton & Hammersley, 1994; Decorte, 2000, indicate that long term controlled use of cocaine is possible. Despite a growing body of evidence that challenges drug talk and the ideological stance taken by drug talkers, the belief that drugs remove the ability for rational thought persists.

## Estimating the use of illegal drugs in Scotland

In Scotland, 'problem' drug users are in the main described as habitual users of opiates, benzodiazepines and crack cocaine and are most often likely to be seeking treatment as 'service users' (Casey et al.,2009, SDMD<sup>11</sup> 2011). However some people caught within this definition of 'problem' drug use may have used drugs such as heroin or cocaine on occasions in a non-problematic pattern. This of course is not accepted in government policy document definitions. In Table 1, there is no acknowledgement that heroin, methadone and crack can be used recreationally without problems. It is worth pointing out that in Table 1, for every drug there are more recreational users than problem users.

**Table 1 estimated numbers of problem drug users in Scotland 2009**

Drug	Problem	Recreational	Total
Heroin	50,077	-	50,077
Methadone (illicit)	18,019	-	18,019
Crack	15,697	-	15,697
Cocaine	14,813	100,111	115,541
amphetamines	6,135	63,791	70,182
MDMA	12,049	89,867	102,418
Cannabis	40,294	321,352	363,323
benzodiazepines	42,892	49,113	93,790

(Source: Casey et al, 2009).

Table 1 allows a visual comparison between the estimated numbers of users within the two categories of 'problem drug users' (service users) and 'recreational' (non-service users) in Scotland. It also highlights another very important point in policy, how can such precise figures be estimated?

In addition to estimating the patterns and prevalence of drug use in the UK, there is a growing tendency to describe drug use in terms of what it 'costs' society. The preferred

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<sup>11</sup> Scottish Drugs misuse Database



calculations used to estimate costs to society from drugs are arrived at by estimating the numbers of recent crimes reported by drug users entering treatment in the National Treatment Outcome Research Study (NTORS; Gossop et al., 1998), and then multiplying them by the estimated number of problem drug users. The problem with this, as was shown in the earliest US treatment outcome studies (Anglin and McGlothlin, 1984), and was reconfirmed with the National Treatment Outcome Research Study (NTORS) data (Gossop et al., 2006), is that the offending of a small but persistent number of drug users tends to peak in the months preceding their entry to treatment. So extrapolating from the relatively small numbers who entered NTORS (which recruited 1,075 people at entry to treatment) to the much wider population of problem drug users (which the UK government estimates to be around 280,000) is likely to substantially overestimate the amount of crime that can be attributed to drug users. This is rarely if ever commented on by government or broken down by reporters when they cite such statistics.

The findings from a Home Office study on social and economic costs of drug misuse (Gordon et al., 2006) applying Scottish problem drug use prevalence figures from 2003, Audit Scotland estimated the economic and social costs of drug misuse in Scotland to be £2.6bn in 2003/04 (Audit Scotland 2009). In a report commissioned by the Scottish Government, published in 2009 by Casey et al., (2009) it was estimated that the social and economic cost of illicit drug use was £3.5bn in 2006. It was estimated that half of these costs were made up of wider costs to society as a result of premature deaths and victim or other consequence of crime costs. An estimated 96% of the social and economic costs relate to problem drug use with the remainder relating to recreational drug use. Challenging this assertion, Transform, a charity established to promote the regulation of illicit drugs<sup>12</sup>, published a cost benefit analysis comparing legal, regulated drug markets against the current prohibition framework. It indicated that if use doubled (which it claims is highly unlikely) if drugs were decriminalised, overall costs of drug use would reduce by £4.6bn (Transform, 2009).

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<sup>12</sup> Regulation can mean anything on a drug policy continuum from decriminalisation to legalisation

Transform point out that calculating the cost of drug use takes little or no account of the costs of making drugs illegal to possess, or the costs of creating and running massive government bureaucracies of medical and law enforcement agencies (Cohen, 1985).

**Table 2        estimating the costs of drug related deaths in Scotland**

Type of user	Number of deaths	Costs
Recreational	22	£19,324
problem	399	£350,464
total	421	£369,788

(Source Casey et al, 2009).

The number of drug related deaths and estimated costs per user are summarised by Casey et al., (2009) in table 2.

**Table 3        estimating the costs to the economy from drug use in Scotland**

Total cost to the economy by type of drug user	
Recreational	£23,545,729
Problem	£795,376,802
Total	£818,922,530

(Source Casey et al, 2009).

The estimated costs to the economy per drug user type are summarised in table 3. It costs the economy in Scotland twenty three and a half million pounds for all recreational users, and just less than eight hundred million pounds for all problem users. From such figures it would seem appropriate to eradicate problem use. However as has been discussed, defining the line that demarcates problem use from recreational use is not defined scientifically, and is therefore arbitrary and depends on a moral viewpoint. The evidence of what drugs ‘cost’ Scotland influences policy direction, but it does not underpin it.

## **The Scottish drug policy context**

A historical examination of the United Kingdom's strategy to limit the harms resulting from drug use, misuse and abuse are beyond the scope of this proposal<sup>13</sup>.

The Misuse of Drugs Act (1971) is the United Kingdom's primary legislation for controlling drugs. This Act sets out the basis of drug enforcement policy in England and Wales, Northern Ireland and Scotland. The first policy document to emerge from a devolved Scottish Government was titled '*Tackling Drugs in Scotland: Action in partnership*' (1999). The Scottish Executive, a coalition of Labour and the Liberal Democrats, continued their support for prohibition. *Tackling Drugs in Scotland* (1999) was a loosely disguised version of *Tackling Drugs Together* (1998) repeating the four pillars approach of the UK document.

In 2001, just two years after devolution, Scotland created a USA style Drug Enforcement Administration (DEA) and called it the Scottish Drug Enforcement Agency (SDEA), later renamed the Scottish Crime and Drugs Enforcement Agency (SCDEA). The SCDEA works alongside other Scottish police forces and is answerable to Scottish Ministers through the Scottish Police Services Authority. The Director of the Agency is responsible to Scottish Ministers and the Scottish Parliament for financial and administrative matters. The SCDEA shares some functions with the UK National Serious Organised Crime Agency (SOCA). The aim of SCDEA is to address problems associated with drugs. The Scottish Police Services Authority (SPSA), a Non-Departmental Public Body (NDPB), maintains the SCDEA and is accountable to Scottish Parliament. SCDEA are able to operate with a degree of autonomy using the following performance indicators: (1) numbers of successful prosecutions, (2) ability to act as a deterrent, and (3) annual quantities of drugs seized.

The release of the 10 year drug strategy by the UK government 'The Protection of Families and Communities 2008-18' and the publication of 'The Road to Recovery: A New Approach to tackling Scotland's drugs problem' by the Scottish Government have set policy from now until 2018. Extensively focussing on a strict prohibitionist model and enforcement practices,

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<sup>13</sup> See Blackman S., (2004) and Yates, R. (2002) for a superb historical overview

a devolved Scotland with limited powers adopted American style policies in their approach to resolving the issue of drug misuse. In England and Wales, there are guidelines stipulated in parliamentary acts which give the police a degree of discretion in dealing with citizens found with controlled drugs on their person, similar to that of Sweden. The SNP Government focus on a strict interpretation of drug policy deviated from that of Westminster and from other countries in the European Union. Scotland chose to utilise strong enforcement practices and focus treatment and anti-drug education on a desire for abstinence. The use of measures which clearly mimic those from America may be due to several important factors. Firstly, Scotland's policy on tackling drug misuse had since 1971 closely followed that of Westminster. After the election of New Labour in 1997, Scotland under the control of a Labour and Liberal Democrat coalition government adhered to the National Labour government's criminal justice-focused drug policy constructed in Westminster. Secondly, the criminal justice target-driven drug policies had minimal effects in reducing the number of people taking drugs, and more importantly in achieving 'recovery' from a dependence on them. Whether this can be attributed solely to the adoption of a drug policy more structured to be effective to the needs of England and Wales, or because policy emerging from Holyrood in the early stages of devolution was hurried, is unclear. The Scottish Government undertook several key policy directions after devolution, and in particular after the SNP victory, one of which was that on the issue of focusing on 'recovery', a loosely based concept underpinned by a desire to be 'drug free', a term which has not become clearer with its over use.

## **Controlled use of illegal drugs**

Norman Zinberg (1984) studied both addicted and non-addicted or controlled users of heroin. The non-addicted users were not 'overwhelmingly involved' with their drug. It did not

consume their lives, they did not commit crimes to obtain them, and they were not criminalised as such. The non-addicted users described by Zinberg were no more likely to escalate to addictive use than to reduce their use or become abstinent. Zinberg followed up a group of non-addicted users of opioids 12-24 months after an initial interview. He was able to re-interview 60% of the original group. Of these, 49% were using drugs in the same way as at the first interview, 27% “had reduced use to levels below those required for them to be considered controlled users”, and 13% were using more opioids than at the time of the first interview, (Zinberg 1984:71).

In a recent study in Scotland by Shewan and Dalgarno (2005) they located 126 people in Glasgow, who had used heroin and other opiate type drugs for an average of 6.8 years and who had neither been in prison or in treatment for drug misuse. Of the original 126 users, 85 were located again for the second interview, with an average of 15 months between the two interviews. The purpose of the study was to document problems that arose within this group before the first interview and between the first and the second. The subjects were unexceptional in employment, occupational status, housing status, and living arrangements compared to UK and Scottish norms. For example, at the first interview, 74% had jobs at all levels of occupational status except the very lowest, 11% were occupied as full-time students, and 15% were unemployed. At the first interview, 64% had some higher education; 89% were settled in their own living accommodations, which they either rented or owned; 11% lived with family or friends; 57% were “in a relationship”; and 33% had children. This picture was essentially the same at the second interview, except that average incomes and occupational status had risen somewhat. There was a very wide range of heroin consumption ranging from a light consumption group of 35 people who had consumed heroin an average of 13 days in the past 2 years to a heavy consumption group of 29 people who had consumed heroin an average of 536 days in the past 2 years. In addition to heroin, the subjects in this study also used a great variety of other opioid drugs, generally in lesser quantities. Also, virtually all the subjects had used cannabis, ecstasy, amphetamine, LSD,

and cocaine either in the form of powder or “crack”. In response to a ‘Severity of Dependence<sup>14</sup>’ Scale administered at the first interview, the subjects reported a mean self-rating of dependence on heroin of 4.7 (out of a possible 15). They gave higher mean self-ratings of dependence to tobacco (8.3), cannabis (5.6), and alcohol (5.6). The normal cut-off for recognising a person as dependent is 5.0. Between the two interviews, six subjects had entered treatment because of increasing heroin use and deteriorating of health. All of these had become daily or nearly daily injectors of heroin at the time they entered treatment. Of the six subjects who had entered treatment, five were receiving methadone. None of the remaining 79 follow-up subjects perceived a need for treatment. Most of the subjects maintained a similar level of heroin consumption in between the two interviews. There was no statistically significant increase in the frequency or amount of heroin use from the first to the second interview. Six were regular injectors at the first interview and four were at the follow-up (not counting those who had presented themselves for treatment and had switched to methadone). Of the 85 follow-up subjects, 17 did not use heroin at all between the two interviews although only two said they would definitely not use it again in the future. These results show that it is possible for many people to use heroin regularly, including daily injection, without needing treatment for addiction and without experiencing serious health problems. No doubt many other people in Glasgow experienced heroin use problems during this same period, but this study shows that exposure to heroin alone is not a sufficient cause of ‘addiction’.

Similar results were found in an UK study by Warburton Turnbull and Hough (2005) who recruited volunteers who had used heroin at least once in the previous six months but were experiencing no legal or medical problems connected with their drug use. The volunteers in their online subsample of 123 people responded to a questionnaire on the Internet. The

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<sup>14</sup> Gossop M, Darke S, Griffiths P, Hando J., Powis B., Hall W, Strang J (1995). The Severity of Dependence Scale (SDS): psychometric properties of the SDS in English and Australian samples of heroin, cocaine and amphetamine users. *Addiction*, 90(5):607-14.

volunteers in the interview subsample of 51 people, all from the UK, were interviewed face-to-face. The Internet sample provided primarily demographic data and the interview sample provided more detailed accounts of people's changing patterns of heroin use over the years. The great majority of people in both samples were employed or students. Most owned or rented their own home, although 20% still lived with their parents. Most purchased heroin with money that they had earned themselves. They generally used a great variety of other illicit drugs and drank alcohol. Three patterns of heroin use were identified among these subjects. The first, "occasional non-dependent use", entailed using heroin at least once every six months but not as often as once a month. Of the 54 online volunteers who fit this pattern, seven had been doing so for more than 10 years without any episodes of dependence or other drug problems. The second pattern, "frequent non-dependent heroin use", entailed using heroin somewhere between a few times a month and a few times a week. Of 56 online subjects who fit this pattern, six had been doing so for more than 10 years, without problems or dependence. The third pattern, "controlled dependent heroin use", usually entailed daily use and withdrawal symptoms when use stopped. However, there were no significant problems attributable to heroin use other than withdrawal symptoms. Of 13 online subjects who fit this pattern, five had done so for more than 10 years. Although some of the volunteers appeared permanently settled into one of the three patterns, many subjects changed from one pattern to another, changes that the authors of the study called their "heroin careers", a term first coined by Becker (1968). A majority of the volunteers had been uncontrolled dependent users or addicted earlier in their heroin careers. However, they had decreased their use when they became aware of the growth of their dependence or addiction and the likelihood that it would harm other important aspects of their life. They had then become either occasional non-dependent users, frequent non-dependent users, or controlled dependent users. Most users of all three types smoked or snorted their heroin, but a few in each category injected it. Contrary to the demon drug myth, there was no inevitable movement to addiction, even among people who had been injecting daily. In fact, the most frequent career move in these heroin careers was to move from

emergent addiction towards non-dependent use. Of course, there are also heroin users who move from emergent addiction to regular excessive use or addiction and such users are the usual subjects of clinical research. The authors did not deny the dangers of heroin addiction, but they did reject the myth that all regular users of heroin become out-of-control junkies. The percentage of heroin users, who remained occasional users or controlled dependent users, rather than addicts, may be unknowable, since people's use of heroin is normally shrouded with secrecy. However, these authors point out, that studies indicate that "... non-dependent or controlled users outnumber those whose use is uncontrolled and problematic", (Warburton Turnbull and Hough, 2005:4).

That users of drugs often adopt controlled patterns of use than uncontrolled is well documented (Hammersley, 2008; Davies, 1992). So why do certain people demonstrate control and others do not? Alexander (2008) has suggested that for some people, the addict identity is a well-recognised form of symbolic protest, or a recognised identity that one is not willing or able to play by the normal rules of their community. Using drugs becomes an end in itself. An identity that is meaningful, although highly stigmatised. Having such a strong albeit negative identity is preferable to, as Erikson (1970) stated that of being a contradictory bundle of identity fragments, or an identity in crisis. The psychosocial benefits of being a junkie, including a compelling sense of purpose, a well-recognised identity, relief of boredom, and the ability to shock and horrify 'straight' people have been extensively documented by social scientists and by authors who have documented drug taking (Hammersley, 2008; Alexander, 2008). Being an addict is painful, and may be eventually fatal, but it provides a substitute for psychosocial integration for people who find they have no sense of purpose in their community. It remains conceivable that there are two kinds of addicts: those who believe they are possessed by a demon drug and those who use their addiction as a form of adaptation.



## **Defining drug use: concepts and theories**

The field of social sciences has devised an array of theories to explain or account for drug use. Few of these theories are sufficient to fully account the regular use of drugs; instead, each argues that certain factors and conditions could make drug use more likely than would be the case without these conditions and factors. Current theories depict illicit drug use as a subtype of deviant, non-normative, and criminal behaviour. Therefore contemporary theories explain drug use account for the consumption of drugs with the same concepts used to explain the violation of society's laws and norms. Gottfredson and Hirschi (1990) have argued that most theories of crime and deviance are theories of motivation. However motivation and measures of tendencies to behave a certain way is not a complete explanation (Goode, 2006). As a result, one must be careful to remain critical of models of drug use which Hammersley (2002) had caution us on, of reductionism, grand theory and empiricism. Such medico-determinism, even within social theory should not be accepted uncritically.

The first systematic drug use research was conducted in the 1920s by early 'Chicago School' sociologists such as Bingham Dai, (1937) who situated the cause of deviant behaviour in the social disorganisation of areas of large cities, characterised by deprivation and social conditions that produced moral cynicism in residents. This explained increased opportunities for crime, deviance, and diminished social control as cultural, rather than solely related to individual pathology (Goode, 2006). The study conducted in the 1930s by Bingham Dai (1937) utilised a 'Chicago School' style of research, which suggested that crime and deviance were at least in part, socially influenced. Dai recruited 2,500 addicts from a psychiatric hospital during the period from 1928 to 1934, and included 300 non-addict drug dealers and 118 female addicts. Dai produced several case studies from his interviews indicating that the lives of Dias participants were marked by unemployment, poverty, weak or non-existent family ties, and high rates of acquisitive crime which were attributed to their

drug addiction. Dai (1937) stated that his sample shared low levels of community spirit. Many of the males were unmarried, who had sparse employment recorded who moved constantly in search of work. Many of the addicts gave accounts of family disorganisation, criminality and mental health problems, including suicides (Dai, 1937:189). He concluded that deprivation encouraged deviance and drug addiction. Dai (1937) concluded that some opiate addicts were psychologically normal and had not committed crime prior to their addiction. His subjects tended to commit property crimes rather than crimes of violence and, most important, Dai indicated that opiates were not necessarily harmful to the human organism (Dai, 1937: 72). Dai's social disorganization thesis emphasised that addiction was not necessarily the result of biology meeting pharmacology, however that many of his participants were recruited from a mental institution; it is unsurprising that many of the accounts of their addiction experiences were defined from a medical ecology.

Alfred Lindesmith helped Dai conduct his research also studied drug addiction, but made very little use of the focus on communities typical of the Chicago School whose research focused on certain specific geographical locations to document social changes. Lindesmith devised a perspective that tested a micro-interactionist theory of opiate addiction. In *Opiate Addiction*, Lindesmith (1947, 1968) argued that in the initial stage of opiate use, pleasure is the primary reinforcer. Lindesmith suggested that volitional opiate addiction occurred as dose increased to accommodate tolerance, and to stave the craving and withdrawal that was associated with long term use. He thus postulated that opiates administered in a hospital for example are less likely to result in addiction, as pain and suffering are attributed to the medical condition, and not necessarily the reduction of the dose. In contrast when the 'street' addict uses drugs and recognises that it reduces the discomfort of withdrawal, results in an association of use alleviating the craving associated with withdrawal discomfort. Hence, the addict does not become addicted voluntarily but is trapped by the cycle of use or habit of using drugs to alleviate discomfort. In this manner, Lindesmith had described demonised drug users as essentially normal people ensnared in a compulsive habit over

which they had lost control over decision making. Therefore criminality was entirely dependent on securing drugs, caused by their addiction to powerful opiates. Moreover, he argued, addicts had begun to state that for them, drug use was no longer pleasurable. Interestingly, the research by Lindesmith begs the question of what it was that led the addict to experiment with drugs in the first place. Lindesmith also never explored the reasons addicts accounts of drug taking reject the notion of pleasure which would have stigmatised them as wilful hedonists, engaging in a vicious indulgence of their own volition. Lindesmith, while sympathetic to his research subjects, accepted their accounts of drug taking as non-pleasurable uncritically. Despite this the conclusions Lindesmith reached were profound ideologically. If addiction is a consequence of the addict coming to associate craving and withdrawal reduction by the repeat administering of drugs, then by implication they are not fully responsible by their own volition for their condition, and therefore it was an issue in the domain of medicine and health care. Dai had concluded that addicts had begun to become dependent on drugs because they were living in areas characterised by high levels of community disruption, the addicts described by Lindesmith were innocent victims of their altered biological and cognitive processes. Addiction therefore was a medical not a criminal problem. Lindesmith thereafter became a critic of American drugs policy which criminalised users.

Howard S. Becker experiences in college allowed him to interact with musicians who used drugs recreationally. Lindesmith had explored how someone becomes an opiate addict; the research of Becker explored how one becomes a cannabis user. The connection of the physiology of effects from cannabis and three social/cognitive processes (1) learning how to use it, (2) learning to perceive its effects, and (3) learning to enjoy its effects. All three provide the mechanism that account for the cannabis use. However once the cannabis user had learned to interpret the effects, why they continued to use in a climate of moral censure had to be explained. Becker suggested that once one learns to interpret and learns to enjoy the effects of cannabis, to continue using it, one must engage in processes that begin to

counter the forces of social control that conventional society exercises to prohibit this behaviour. In effect, the regular user has to consider how to maintain a supply of the drug, learn how to maintain the illicit behaviour, and restructure a sense of morality that accommodates the illicit behaviour as a norm for the deviant, but which is disapproved by others. The addicts that Bingham Dai described were a product of community disruption. Lindesmith formulated addiction as a medical illness that required treatment, not punishment and stigmatisation. Becker's descriptions of cannabis smokers had challenged the drug users as a defective psychopath which compelled them to use drugs. Becker did not begin or end his thesis with the premise that effects of cannabis are harmful. Challenging the accepted wisdom of the time, Becker asked not how one ends the career by striving for abstinence or recovery, but it is precisely the reverse. Becker had explained how and in what way cannabis, a demonised drug had become a common part of a person's life.

## **Deviance and Stigma**

In the theory of social stigma by Erving Goffman's (1963), a stigma is an attribute, behaviour, or reputation which is socially discrediting in a particular way: it causes an individual to be mentally classified by others in an undesirable, rejected stereotype rather than in an accepted, normal one. Goffman defined stigma as a special kind of gap between *virtual social identity* and *actual social identity*:

*"Society establishes the means of categorizing persons and the complement of attributes felt to be ordinary and natural for members of each of these categories. ... When a stranger comes into our presence, then, first appearances are likely to enable us to anticipate his category and attributes, his "social identity" ... We lean on these anticipations that we have, transforming them into normative expectations, into righteously presented demands. ... It is [when an active question arises as to whether*

*these demands will be filled] that we are likely to realize that all along we had been making certain assumptions as to what the individual before us ought to be. [These assumed demands and the character we impute to the individual will be called] virtual social identity. The category and attributes he could in fact be proved to possess will be called his actual social identity”, (Goffman, 1963:2).*

Goffman (1963) suggests that the disparity between the virtual and the real constitutes a special incongruity between virtual and actual social identity. Despite such concerns between the real and the virtual, Bruce Link and Jo Phelan (2001), apply a sociological perspective to Goffman's definition of stigma and propose that stigma exists when four specific components converge: (1) individuals give labels to differences and variances, (2) cultural beliefs link the labels with negative attributes, (3) labelled individuals are placed in groups that mystify and create outsiders (4) the outsiders experience 'status loss and discrimination' leading to unequal conditions. In the model proposed by Link and Phelan (2001), stigmatisation is contingent on access to social, economic, and political power that allows the identification of differences, the construction of stereotypes, the separation of labelled persons into distinct groups, and the full execution of disapproval, rejection, exclusion, and discrimination. The term stigma is applied when labelling, stereotyping, disconnection, status loss, and discrimination all exist within a power situation that facilitates stigma to occur. Identifying which human differences are salient, and therefore worthy of labelling, is a social process. There are two primary factors to examine when considering the extent to which this process is a social one, and is therefore at least in part a social construction. The first is the fact that significant oversimplification is needed to create groups of outsiders. Those who have ever tried drugs and those who have not are examples of this process. Secondly, the differences that are socially judged to be relevant differ vastly according to time and place. For instance drug taking has been viewed as a part of human culture, and has also at various times, and in various places, been defined as criminal and as an illness. In examining stigma, Fine and Asch (1988) state that disability is highly

stigmatising, and becomes a major part of the disabled person's identity. Applying their model to addiction, one can suggest that there are four assumptions to lead to the label becoming the identity<sup>15</sup>, that addiction is located solely in an individual: (1) problems are due principally to the taking of drugs (2) the addict is a victim of craving and loss of control, (3) drug taking is central to the addicts identity and reference groups, (4) the addict identity is synonymous with requiring help and social support. Thus these stigmas or marks of difference become in essence the defining characteristic of problem users.

## **Social Control theory**

Rooted at the micro level but looking less at the specific dynamic of interaction and more at the relationship between individuals and society is Travis Hirschi's "Control Theory of Delinquency," first written about in 1967. Labelling theory assumed that people readily engage in acts of deviance and focused on explanations of the process of identity change that occurs when individuals are caught and labelled, control theory finds such internal process unnecessary. One of Hirschi's most radical arguments indicated that delinquent peers had little direct effect on delinquency when social bonds inhibiting delinquency were taken onto account. He argued that similarly unattached youth *drifted* together into delinquent groups. Like Dai had discovered in the 1930's among his opium addicts, weak social bonds resulted in both delinquency and identification with delinquents. Hirschi argued that there were four 'social bonds' that could constitute significant barriers to becoming involved in delinquency. He listed these as: attachment, commitment, involvement and belief. Attachment encompassed the emotional bonds of youth to other people and attachments to parents and teachers were viewed as particularly crucial. Commitment was measured in terms of the aspirations and goals of youth, encompassing rational as well as emotional investments. Involvement referred to behavioural investments in conventional

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<sup>15</sup> adapted from Fine and Asch's (1988) work on stigma and disability:

lines of action that could preclude involvement in delinquent behaviour. Belief referred to the personal embracement of moral or normative conceptions that inhibit delinquent choices. Hirschi (1969) theorised that social control lies in the extent to which people develop a stake in conformity, a bond to society. People who have a greater investment in society will be less likely to risk losing this through deviance or criminal acts and follow the rules more willingly. Such people are bonded by their job, relationships to friends and family, or their reputation in the community. Their stake may be fostered by any of the four components discussed in this selection: attachment to conventional others, commitment to conventional institutions, involvement in conventional activities, and deep beliefs in conventional norms. The extent to which society is able to foster inclusion, will affect the constraint or spread of its deviance. It is these ties that influence individuals in their choice between deviant or non-deviant pathways. To social control theorists, it is the attachment of people to the 'straight' world that explains being drug naive; conversely it is the absence or weakness of such attachments that explains drug use, as Dai had postulated in the 1930's. In examining social control theory, it is clear that crime, illicit drug use included, varies enormously independent of any underlying traits. For instance all other factors being held constant, people are less likely to engage in criminal acts when they are in a long term stable relationship, with commitments that occupy their time, and from which they have an investment, as such they have much to lose by being a regular deviant. In the research conducted by Glassner and Loughlin (1987) young people who regularly engaged in deviant activities had much less involvement with and identification with conventionality, labelled 'burnouts', and non-users were 'straight's' (Glassner and Loughlin, 1987). Although these overarching perspectives and the theories nested within them differ in the level at which they place their explanations, they all locate them squarely in the social domain. In this they renounce the prevailing tendency toward grand theory explanation that roots causation in pathology or maladjustment, explanations whose over simplicity and inadequacy in our contemporary world cannot be overstated.

## **Social Learning theory**

Social learning theory poses a challenge to social control theory, suggesting that people have to specifically learn the positive value of behaviours which deviate from the norm. The theory of differential association (Sutherland 1939, cited in Goode, 2006) suggests that young people associate differentially with certain groups that provide social environments for exposure to definitions of correct or incorrect behaviour, models of behaviour to imitate, and opportunities to engage in certain kinds of behaviour. Such social environments may support or discourage drug use. Family definitions and opportunity are important in defining drug use as a positive aspect of lifestyle, or indeed most commonly as a negative potentially stigmatising aspect of one's life choices. Primary agents of socialisation include family members, neighbours, religious figures, teachers, and the mass media, each of whom has varying degrees of effect on decisions to use, to continue to use and whether one stops or becomes abstinent. Typically, however, those with whom one identifies are most influential; the family is a distant second, and other socialising agents trail far behind (Akers 1998:171–72). Learning theory suggests that drug taking is more likely if the following three conditions are satisfied:(a) repeated exposure to people who use rather than abstain from drugs; (b) one hears definitions favourable rather than unfavourable to use; and (c) associates use with pleasurable consequences that are also positive. In addition, use escalates to the extent that a person associates with dependent regular users and with parties who define regular use in positive terms and who develop a pattern of heavy use that is reinforcing or pleasurable (Akers 1998:175–76). Psychologist John Davies and others have shown that the attribution of irresistible addictive power to drugs by addicts can be best explained by a set of psychological principles known as “attribution theory” (Davies, 1992). Most people, consciously or unconsciously, attribute qualities to people and things more to maximise their personal gains than to objectively describe reality. Thus, what addicts say about their identities, and even what they experience about their identity, could serve more to excuse their deviant behaviour than to actually describe the reason for their addiction. To claim that



one has been transformed into an addict by a drug has all the advantages of pleading guilty to a lesser offence. Rather than accepting responsibility for actions that offend their society, addicts need only admit to the ill-judged experimentation that led to their addiction, after which the responsibility is no longer theirs, but must be attributed to the demon drug. Davies' own research demonstrated that addicts more often describe themselves as being under the control of the drug when they are being interviewed by an authority figure than when they are speaking to another drug user. Here they describe their use more in terms of hedonism and pleasure, as they perceive the user to be less judgmental than the 'official' researcher, who they perceive to represent the moral majority who condemn drug taking.

John Booth Davies (1992) has suggested that few people who transgress boundaries of normality into deviance or crime regard themselves as wicked people, and the myth of addiction provides rationales and justifications for their behaviour. No one likes to admit to being bad or stupid and drugs provide an explanation for actions which one can avoid responsibility (Davies 1992). Ex addicts and people in 'recovery' are often vehement in their support of the myths of addiction especially those schooled in 12 step beliefs (Reinarman, 2005). The main reason for this is that their new identity allows their rebirth, and to ascribe their negative behaviours to the 'old' addict self (Reinarman, 2005). Habits that were useful in accessing a steady supply of drugs are replaced by habits which defend a new belief system. Therefore ex addicts accept their status, as being in recovery to maintain abstinence, as to reject this belief would result in their death. Independent researchers have viewed this as cult like<sup>16</sup> (Bateson, 1971; Keene and Raynor, 1993; Bufe 1998). However, some non addicts have had to for various reasons endorse some of the myths to ensure their fiscal and status security, for example the celebrity model Kate Moss - who was publicly shamed in tabloid newspapers for using drugs may only have been an irregular user of drugs, who has had to go through a treatment programme to satisfy a public, a fan base, or a product sponsor.

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<sup>16</sup> A religious belief in predestination, where the chosen cannot alter their fate is also cult like.

John Davies (1992, 1997) suggests that the addiction paradigm is a technology that substitutes 'illness' for 'badness'. Davies continues along this line, saying that:

*"One crucial facet of 'addiction' which influences treatment offered, outcome success, and all aspects of the substance-abuse system, as well as the nature of the individual cognitions of sufferers, is that it involves behaviour which in terms of conventional societal values needs to be explained as malfunction. It would therefore involve the notion of guilt, for which punishment rather than treatment is generally felt to be appropriate; or worse imply that using drugs was a reasonable adaptation to the world in which we live, should an explanation be offered in terms of personal responsibility or voluntary action."*

Given the prevailing moral condemnation of drug use, Davies (1997) argues it is functional for addicts to disseminate a viewpoint of having lost control, being powerless to do anything other than be an addict, rather than offer an alternative which lays them vulnerable to moral condemnation. Davies is pointing out that, statements given by 'addicts' are functional, and can change depending on context, users are not necessarily being deceitful, but that to give any other narrative is dangerous to their sense of self, and their esteem. However it is extremely difficult to operationalize these constructs and measure them, although this is certainly an area that requires further research.

Jarvinen and Ravn (2011) explore the transition from recreational to problem use of illegal drugs among young people in Denmark. Both Lindesmith and Becker argue that rule breakers are not in any way different from other people who do not break rules or commit crimes. Jarvinen and Ravn, suggest that drugs become a way of life which develops after regular users become labelled as deviant by themselves or others. They recruited 53 young clubbers from five different night clubs, and used focus groups, double interviews and individual interviews. The median age was 21 years, and there were no significant

differences between these groups than other groups who did not have drug problems; however they speculated that having an unfulfilling job such as bar work, or not being in college could have contributed to their temporary excessive drug taking. They describe the process of moving from recreational to regular use of illicit drugs dependent on a model consisting of six career contingencies relevant to describe the process. They were: closing of social networks, changes in the form of parties, intoxication as a goal in itself, easier access to drugs, learning to recognise alternative effects of drugs, and experiences of loss of control. They found that users who had closed networks of users rather than open networks (both users and non-users) delineated a boundary in which regular use was all but guaranteed, and where 'normal', or ordinary users were excluded. They indicate that the problems users developed a social grouping of regular party going drug takers from which the normal or intermittent users were excluded. This happened because the problem group felt they could no longer connect with non-users when they were under the influence of ecstasy, amphetamine, cocaine and so on. These were drugs that in other settings are defined as 'social facilitators' (Jarvinen & Ravn 2011:6). What is most interesting is that in utilising a research tradition that is critical of the monolithic properties of a disease model of drug addiction, they utilise its core component, i.e. 'a loss of control', to describe one of the six career contingencies, when in fact there was no loss of control insofar as their definition of losing control could only be defined post hoc by their participants, and that their participants had largely moved on from problematic patterns of use to controlled use again.

## **Conflict theory and drug taking**

Conflict theory suggests that group conflict and inequality are root causes of problem drug use, and in particular those drugs such crack cocaine and heroin. The problematic use of such drugs, proponents of this theory argue, is strongly related to social class, geographical location, gender and ethnicity. A significantly higher proportion of people who reside in areas marked by multiple deprivations tend to choose to use, and develop a habitual use of drugs

such as heroin, crack cocaine, and the benzodiazepine Temazepam (ACMD, 1998). This occurs suggests conflict theory because of the impact of a number of key structural conditions that have their origin in economics and politics (Hamid 1990; Levine 1991; Bourgeois 1995). Conflict theory conjectures that drug dealing is more likely to occur in communities that are characterised by inequality and poverty than in more affluent organised communities. In poor neighbourhoods residents cannot organise and attract the social and political power necessary to act against the activities of drug users, drugs dealers and other crimes which may be likely to occur. In such economically deprived areas anomie is likely to take hold, making the development of habitual regular excessive drug use appealing and attractive. Pearson (2001) helpfully outlines such an argument:

*“Where drugs such as heroin and crack-cocaine are concerned, the most serious concentrations of human difficulty are invariably found huddled together with unemployment, poverty, housing decay and other social disadvantages”, (Pearson, 2001: 53).*

Most of the people who live in areas of deprivation resist identification with the regular drug misuse that characterises the ‘junkie’ lifestyle. But sufficient numbers adopt such a lifestyle to make the lives of the majority insecure, unpredictable and often dangerous. A drug subculture flourishes in response to what some residents have come to see as the hopelessness and despair of the reality of their everyday lives. And it is poverty that generates these feelings. In the words of Harry Levine (1991), “The three most important things to understand about the sources of long-term crack and heroin abuse are: poverty, poverty, poverty” (Levine (1991: 3).

A crucial assumption of the conflict approach in explaining problem drug use is that there are two overlapping but conceptually distinct forms or varieties of drug use: intermittent recreational use, and regular and habitual problematic use. Such users rarely become a problem for society except they may be regarded as a problem by others. From such a

perspective, it is precisely social class that acts as a protection for the middle classes against such types of drugs taking, and that may affect the working classes more acutely (Levine, 1991:4).

## **Labeling theory**

In essence this approach suggests that one should try to understand the world as understood by social actors, and to try to see how they make sense of their world and cope with hostile groups and agencies such as the police, politicians, newspapers, and therefore one should try to achieve sensitive empathy and participant observation. Very often the concept of 'career' accounts for the way a new social identity (as drug taker) is negotiated and understood. This involves learning appropriate behaviour, applying initiative, and even resisting unwelcome labels imposed by others, or maintaining boundaries (Cohen, 1985). Simply taking a drug may not change a person; however once discovered within the gaze of the medical or legal institutions in society, a social identity is imposed. This labeling and its consequences may lead to a change in the perception, interaction and identity of the social actor, and thus a deviant career may be started. Generally such methods imply a sympathy or empathy for the underdog, the powerless, and the deviant (Becker 1968). While the researcher may identify with their research participants, it is not a precondition. Some users of drugs resist being pressured by powerful institutions, while actively maintaining a sense of dignity and rationality in the face of such processes. However despite the plausibility of trying to account for the experiences of drug takers, certain problems do remain. The first and most obvious are that social structures could be neglected. Social institutions are acknowledged as a backdrop to interaction but social systems and their related structures of economic and political power cannot in any real sense be analysed, and only their influence can be 'measured' by asking the correct questions. The claim that social life consists solely of actors definitions is not a coherent claim. The consequences of class relations are very real, and the consequence of actions in complex social structure is often outside the control

or indeed knowledge of social actors. In order to understand and attempt to document the influence of these structures on individual agency, one must account for these structures. These criticisms aside, the symbolic interactionism stance is not the only 'action' theory which may be criticised for minimising or failing to account for external influences, but concentrating largely on the degree of conscious monitoring of action and manipulation of social situations. The symbolic interactionism perspective is in this instance a preferred alternative to holistic theories.

Although structural and cultural theories give insight into some explanations for deviance, there are interactional forces that inevitably intervene between the larger causes they propose and the way deviant behaviour takes shape. Many people are exposed to the same structural conditions and cultural conflicts and pressures that could account for deviance but still resist engaging in deviant activities. Interactionist theories explain this by looking more closely at what prevents deviance rather than suggesting that individuals and groups in society are passive citizens.

Deviance exists at the macro societal level of social norms and definitions through the collective attitudes we assign to certain acts and conditions. But it also emerges at the micro everyday life level when the deviant label is applied to someone. The thrust of labelling theory is twofold, focusing on diverse levels and forces. Labelling theory suggests that many people dabble to greater or lesser degrees in various forms of deviance. Becker (1963) identifies four types of citizens in his seminal work 'The Outsiders'. The 'conforming citizens', who mostly abide by the rules of society and conform to social norms in the main, and another category he labels 'the falsely accused', who may be labelled as deviants or criminals without necessarily have broken any rules or norms (Becker 1963). Those citizens that do break rules and norms and are labelled deviant he labels 'pure deviants', while those that break rules yet avoid being labelled are termed 'secret deviants' (Becker 1963). Becker (1963) suggested that everyone breaks the rules, conducting acts of norm violation without ever seriously encountering the deviant label. He noted that:

*“The deviant is one to whom that label has successfully been applied; deviant behaviour is behaviour that people so label.” (Becker, 1963: 9)*

Becker highlights that deviance lies in those who have the power to label it as such, and to exert power and influence over particular institutions, access to education for example. In so doing, he integrates some of the arguments of conflict theory with the interactionist everyday-life perspective by starting with the power struggle between dominant and subordinate groups and following through with the interactional consequences. There is nothing inherently deviant in any particular act, he claims, until some powerful group defines the act as deviant. Taking the onus off of the individual, Becker underlines the importance of looking at the process by which people are labelled deviant and of understanding that deviance is a consequence of the reactions by those with not only the power to label, but to deny access to certain institutions, for example housing or education, or treatment. This approach forces us to examine why some acts are labelled and others ignored, and the circumstances that surround the commission of the act. Thus, deviance only exists when it is created by society. The key emphasis of the labelling theory approach to deviance lies in the importance it places on group interaction in understanding the root cause of human behaviour.

Becker describes rules as the reflection of certain social norms held by the majority of a society, whether formal or informal. Becker's approach concentrated on 'enforced rules' that are applied differentially and often facilitate certain favourable consequences for those who apply the label. As a result of such differentials members of society who can and do make rules may label rule breaking behaviour deviant (Becker 1963). The application of deviant labels is not merely a punitive response or an expression of mistrust or disapproval, but also an attempt by social groups to produce a sense of order in social relations. This process affects how the labelled perceive themselves, and the subsequent patterns of behaviour and interactions critical process is the public exposure and dissemination of such activity as

deviant, between them and others. Such a label can serve to 'spoil' an identity. The critical point in such a process is how such activity is disseminated to the public. Becker observes:

*'one of the most crucial steps in the process of building a stable pattern of deviant behaviour is likely to be the experience of being caught and publicly labelled as a deviant...Being caught and branded as a deviant has important consequences for one's further social participation and self-image' (Becker, 1963:31-2).*

The process of being stigmatised leads to a re-evaluation of a deviant identity by others. One is then viewed and interacted with on the basis of what this label means to the individual being labelled, and the person interpreting the identity via the label. A new status is thus accorded the deviant, and the possibility of being perceived as normal and untainted, non-stigmatised, and being seen as clean' again is difficult, if not impossible. This master status takes over any other conception and interpretation that the person labelled may wish to project. Certain behaviours, labels, and conviction of certain crimes are more stigmatising than others. Therefore what deviants do, or have done, is transformed into who they are, what they are, and determine how they will be included, excluded, punished or forgiven.

The term 'outsider', refers to deviant or rule breaker that accepts the label conferred upon them. Deviants may consider themselves more 'outside' of a society than others similarly labelled. However this process works both ways, those who are engaged in secondary deviance view those outside their subgroups as outsiders as well as themselves being viewed and perceiving themselves as 'outsiders'. Becker (1963) explains the process of how deviant outsiders can become involved in 'secondary deviance'. Primary deviance is the first part of the process, and this primary act may be either intentional or unintentional (Becker 1963). Becker believes that most people think of committing deviance or criminal acts, and the study of why certain people conform while others give in to deviant impulses is crucial. The process of being caught and labelled deviant by a person in position of authority is the most crucial step on the road to secondary deviance.



The part of the process leading to secondary deviance (Lemert, 1957) is acceptance of the deviant label which leads to a 'career' in deviance. When rule-breakers accept the label of "deviant", this becomes their 'master status'. This deviants' personal identity is linked strongly to this master status (Becker 1963). When the deviant rule breaker accepts the label as their master status, they then become an outsider and are thereafter denied access to civil society. Becker stresses that not every rule breaker progresses in such a manner and certain people have alternative 'careers'. An outsider denied access to normal society may turn to crime to survive. The final step in the creation of a deviant career involves a progression into a deviant subculture. The specific cultural group of outsiders provides the labelled deviant who accepts their label with moral support and a self-justifying rationale (Becker 1963).

Becker (1963) focuses on those in positions of power and authority that make and enforce the rules that determine morality. Rules suggests Becker are created by moral entrepreneurs, and describes people who wish to change society or alter it 'for the better' in some fashion. The moral entrepreneur's motive may be to elevate the social status of the disadvantaged, or indeed to reinforce the power that the moral entrepreneur enjoys. Becker states that the realisation of every moral crusade brings with it a new group of outsiders with new responsibilities given to an agency of control, such as the police or social work, or healthcare. According to Becker, enforcing the rules of society is an 'enterprising act'. The enforcement of a rule occurs when those that desire certain rules be enforced, usually to some sort of gain to their personal interests, bring the rule violation to the attention of the public. Modern examples of rule enforcers in Scotland include the SCDEA discussed earlier.

The prototype of the rule creator is the crusading reformer. The prohibitionist serves as an excellent example, as does the person who wants to suppress gambling, pornography or the selling of sex for commercial gain. The crusader is not merely interested in imposing a world vision on others to justify their understanding of the world. It could be driven by a strong conviction that if they do what is right it will be good for all of society. Prohibitionists did not

believe that they were simply forcing their morals on others, but were attempting to create a better way of life. Social reform was an end in itself. The fact that moral crusades were typically dominated by those in the upper levels of the social structure means that they add to the power they derive from the legitimacy of their moral position, and their superior position in society. Naturally, many moral crusades draw support from people whose motives are less pure than those of the crusader. It has been argued that some industrialists supported alcohol prohibition in the USA because they thought it would provide them with a more manageable labour force (Zeiger, 2002).

With the establishment of organisations of rule enforcers, the crusade becomes institutionalised. The final outcome of the moral crusade is a police force. To understand, therefore, how the rules creating a new class of outsiders are applied to particular people we must understand the motives and interests of police, the rule enforcers. Although some policemen undoubtedly have a kind of crusading interest in stamping out evil, it is probably much more typical for the police to have a certain detached and objective view of their role in policing drug laws. Prohibition provides justification for their actions (Goode, 1972).

Enforcers of rules may have little interest in the content of rules, and as a result may develop their own private evaluation of the importance of various kinds of rules and their infraction. This set of priorities may differ markedly from how they are understood by the public. For instance, drug users could believe that police do not consider the use of cannabis to be as important a problem or as dangerous a practice as the use of opiate drugs such as heroin. This conclusion is based on the belief that opiate users commit other crimes (such as theft or prostitution) in order to get drugs, while cannabis users do not. Enforcers, then, responding to the pressures of their own work situation, enforce rules and create outsiders in a selective way. Thus opiate users and dealers are subject to more police attention than cannabis users for example. It is an interesting observation that a great deal of scientific research on deviance focuses on the people who break rules rather than with those who make and enforce them (Bilton, et al, 1991). To achieve a full understanding of deviant

behaviour, we must see deviance, and the outsiders who personify the abstract conception, as a consequence of a process of interaction between individuals and groups. Although these overarching perspectives and the theories nested within them differ in the level at which they place their explanations, they are all located squarely in the social domain. In this they renounce the prevailing tendency toward grand theory explanation that roots causation in pathology or maladjustment, explanations whose over simplicity and inadequacy in our contemporary world cannot be overstated.

## **Cultural identity theory**

The term 'identity' has its origins in Latin *identitas*, meaning 'same', or sameness. In the social science literature this term usually refers to "people's concepts of who they are, of what sort of people they are, and how they relate to others" (Hogg and Abrams, 1988: 2). Even though human beings continually change and adjust to their circumstances, their personal identity imposes some stability and continuity on their thoughts and behavioural choices over time (Baumeister, 1991: 94).

Identity is a complex process that involves cognitive, behavioural and affective components. The processes of identity assimilation and accommodation are well articulated in the literature (Breakwell, 1986). Theories of identity can be contrasted between identity as a personal phenomenon and identity as an interpersonal phenomenon (Young 2010:2). A wide range of identity theories fall between these dichotomies; however for brevity they can be categorised into three distinct approaches: personal identity, social identity and relational identity.

Personal identity is underpinned by the theoretical frameworks of Freud (1927) and Erikson (1963) and later theorists who expanded their concepts to incorporate personal beliefs, motives and drives in categorising, measuring and determining behaviour. These theories dominate popular discourses in advanced western cultures underpinned by individualism

(Morling and Lamoreaux, 2008) and self-determination (Chirkov, Kim, Ryan and Kaplan, 2003; Ryan and Deci, 2000). Many are medico deterministic theories and stem from the beliefs that addiction can only be arrested and an unshakeable faith that abstinence is equated with 'normality'. However challenges arise from cognitive behavioural frameworks which suggest that identities can be manipulated by altering cognitions, attitudes and behaviours of individuals (Miller and Rollnick 1991), and directly challenge the addiction as disease paradigm.

Social identity is underpinned by theories of the self within a culture. Theories within this category of social identity are less rigid than those located in personal identity theories, insofar as social identity is perceived as fluid and can change over the lifespan of the individual (Jenkins, 1996). Such theories rest on the beliefs that what society knows about drugs is transmitted through culture so that drug users become the living confirmations of powerful beliefs, for example that drinking alcohol inevitably leads to a loss of control (Room, 1991; Heather and Robertson, 1985; Heath, 2000).

Relational identity has been articulated by Mead (1982) and Bakhtin (1981), who emphasise that the meaning ascribed to any phenomenon of identity emerges in human interaction with others. People understand who they are only when they understand how they differ from other people and jointly ascribe significance to these perceived differences. Language is used to distinguish fine degrees of difference and commonality. Language is fluid and reflexive, and therefore from this perspective identity is too. This is in contrast to the fixed beliefs that underpin personal identity theories which are conceptualised as fixed, immutable and determined by biology or brain chemistry. In this theoretical framework, meanings about roles and groups are negotiated interpersonally; however this view negates or ignores the structural factors which influence behaviour.

The boundaries between these three theoretical frameworks of personal, social and relational identity are somewhat arbitrary; however they serve to illustrate the differences

and significance of each of the salient points within them. One significant difference is the role of individual agency. Personal identity holds that an individual is born with certain traits, but has a great deal of control of their expression. Social identity likewise ascribes agency to the individual, but social and environmental contexts limit and channel the exercise of that agency (Stryker 1980). Relational identity sharply curtails individual agency, insofar as theoretical constructs might allow control of behaviour and expression of agency, but such theories view structural factors, and certain environmental to be beyond the control of the individual.

The cultural identity theory outlined by Anderson (1998) proposes several processes that determine a drug related identity. Anderson theorises that problem drug use can be defined using the following four criteria: (1) a pattern of regular and heavy use over a significant period of time; (2) a set of drug related problems, (3) previous and failed attempts to stop using drugs; and finally (4) self-identification, the describing of one's self as a problem user, addict or alcoholic. The theory posits that the greater the identification with each of these four criteria, the greater the risk problem drug use. Anderson (1991, 1994) previously had added a power dimension to her thesis by describing two types of marginalisation: personal marginalisation and social marginalisation. Marginalisation has several levels that are comprised of knowledge, affective and behavioural components. The concept describes the social status of certain experiences or traits that may have been identified by the individual or others during the socialisation process (Anderson, 1998:243). These labels act to place the social actor outside the boundaries of what may be considered acceptable or even lawful in a given social context. Goffman termed these 'blemishes of character' (Goffman 1963) and Erikson called them 'violations of the boundaries of normal behaviour' (Erikson, cited in Coles, 1970). Most people will have experienced these processes at some point in their lives. It is the defining of such acts of deviance as stigmatising that result in negative outcomes for certain individuals. Cultural identity theory posits that the greater the number of such marginalisation experiences, traits, or statuses one has, the greater the likelihood

that one is or will be categorised as a problem user. Saliency is also a factor. It is clear that these vary between age groups, gender, and social class, as well as geographically.

Personal marginalisation refers to a micro level concept that leads to drug experimentation and the identity changes that take place afterwards. This theory posits that children have no knowledge or awareness of social structures or of relationships until they become conscious of variations in social linkages between themselves and others (Couch, 1989); certain key events are believed to be risk factors (such as childhood trauma) change ones social status from being acceptable to a stigmatised identity (Glaser and Strauss 1971, Glassner and Loughlin 1986).

Although the term 'identity' has taken on different connotations depending upon the context within which it is deployed, one thing appears clear: identity only becomes an issue when it is in crisis, when something assumed to be fixed, coherent and stable is displaced by the experience of 'doubt and uncertainty' (Mercer, 1991:43). Indeed the user of drugs has such an identity crisis; such a crisis is the search for the key to abstinence or recovery from the use of addictive drugs, as is the loss of status and standing if one is branded a drug addict, or identified as a drug user. Research indicates that the addict as a form of identity is a contingent identity, it can be altered, and is dependent on being compared to that which it is not i.e. a controlled user. This view is driven by the belief that once the body is regularly exposed to drugs, particularly drugs defined as addictive, the addict identity becomes fixed and immutable; one is either a user or an ex user. Laclau (1990:45) suggests an identity is dependent on the differences it constitutes to other identities, and is therefore contingent on how power is exercised. Laclau explains this process in two ways. First, he suggests that, if a contingent identity is a threatened identity, it can only establish itself through repressing the identity which antagonises it. Thus, to study the conditions of existence of any established identity is to delineate the power mechanisms making a clear definition possible. Secondly, he argues that, because an established identity is not a homogenous point but an articulated set of elements, there can be no identity without the exercise of power. As this

articulation is not a necessary articulation, its characteristic structure; its 'essence' depends entirely on that which it denies (Laclau, 1990:32). Laclau suggests that an identity can only be revealed once the conditions of its existence are challenged and in conflict.

In her work 'Identity transformation in drugs using and recovery careers', Anderson (1993) argues that interactionist theorists have suggested that a deviant career is contingent on transformations, which are either sudden and dramatic, or gradual and occur to alter or change identity, for example from being a drug injector to being in 'recovery'. Deviant career structures or contingencies are models of the processes believed to occur in deviant careers. Certain socially defined deviant careers have been well documented with drug users, particularly problem users (Ray, 1968; Biernacki, 1986; Becker, 1963; Pearson, 1987, Shewen and Dalgarno, 2005). The careers of alcoholics have been documented (Denzin, 1987; Brown, 1991). The career paths or contingencies of deviants have also been studied and made significant contributions to the literature and understanding of deviant careers (Goffman, 1961).

Early work by Goffman (1961, 1963; Glaser and Strauss, 1971) viewed identity transformation as an outcome of career movement and or status passages. This work began the literature on career contingencies or the processes leading to identity change. Theorists in the interactionism tradition agree that identity change follows career shifts or status passages. Career shifts are believed to feature moving from one 'normal' social context to a 'deviant' social context (Travisano, 1970; Lofland and Stark, 1965). Other researchers document the identity transformations that occur when careers change from one to another be they non deviant or deviant, (Becker, 1963; Pearson, 1987; Waldorf et al., 1991; Anderson 1993), however it is also possible that identity shifts occur without career shifts (Anderson, 1993). Travisano (1970) documented identity and identification shifts without dramatic shifts in deviant careers. Anderson's (1993) study of 30 addicts in recovery utilised a semi structured interview schedule which explored identity process before use, during use, and during recovery. There were 15 males and 15 females, aged between 21

and over 50, who had been sober from a range of one to more than five years, and recruited a representative racial mix. The qualitative analysis uncovered two types of identity transformations that occurred during respondents' drug using careers, temporary conversions and alterations, that appeared to occur when the participants underwent an identity conversion that occurs within groups such as AA and NA, (see Reinerman, 2002; Weinberg, 2005, Greil and Rudy, 1984). She distinguished between temporary identity transformations that occurred when the participant documented their use, from euphoria to the dysphoria (the come down), and the less temporary conversion that occurred after exposure to 12 step groups when in recovery, (Anderson, 1993). Earlier Becker (1963) had documented that drug euphoria's and drug lifestyles were necessary contingencies that accompanied the movement into a deviant career, from recreational to problem patterns of use, and then a career shift to 'recovery'. Anderson (1993) recognised that a deviant can within a 'using career', be located in a non-deviant social context that has one identity script (as evidenced by its universe of discourse, set of members and expectations for the behaviour) and later be resituated in a different social context that requires a different social identity, (Anderson, 1993, 134). For example hiding one's deviance while at work, or taking to neighbours or some friends who do not know of your drug taking, and another identity and set of scripts for that social context. These social contexts can of course overlap, getting high while at work for example. Anderson speculates that identity transformations are common without career shifts, (Anderson, 1993:135). Travisano attempted to add a boundary between slight and massive transformations that occur without career shifts, by suggesting that 'alternations' were slight shifts in identification, and conversions described more dramatic identity shifts which may or may not occur with a shift in the career of the deviant (Travisano, 1971). Travisano's work was explored by Glanz and Harrison (1978) and Bankston et al., (1981) who added some complexity to the definitions of conversion and alternations. It is without doubt that problem drug use is a radical shift in identity, which is highly stigmatised (Radcliffe and Stevens, 2008). Therefore 'recovery' or abstaining after prolonged misuse of drugs requires a shift in identity. Some organisations require abstaining



from drugs as a requirement for continued membership. The AA and other 12 step self-help groups qualify as (ITO's) or identity transformation organisations as they promote identity through the radical conversion and reconstruction of personal biographies, and require a specific discourse of dysfunction and illness requiring abstinence to maintain a 'clean' identity, (See Reinerman 2005, and Weinberg, 2002).

Biernacki's (1986) work with heroin addicts investigated the 'spontaneous' remission, i.e. deviant career change without medical treatment of heroin addicts, which challenged the accepted wisdom that considerable expertise was required to exit from the disease of 'addiction'. Biernacki considered that addicts displayed three types of identity change to occur that led from drug use, to abstinence and 'recovery', without the aid of medical treatment. These were: *emergence* (creating a new identity); *reverting*, (reassuming an unspoiled identity), and *revising*, (augmenting a spoiled identity). It should be noted that such studies document career shifts and identity change from one to another, and do not document identity transformation within a career. The research by Biernacki with former heroin addicts, highlighted that even heavy drugs users could stop using an 'addictive drugs' such as heroin without medical help. Such a view challenged the accepted wisdom that drugs were a medical problem to be solved under medical supervision. When people stopped using heroin, they face a variety of problems that went beyond the cravings for the drug. These additional problems related specifically to attempts to fashion new identities and social involvements in worlds not associated with their former identity as a stigmatised user of heroin. Biernacki pointed out, that if addicts had strongly identified with a world of addiction, and the identity required to fit with that world was related to it, by that he meant that they screened out all straight people and had only friends who supported their habit, and had thus alienated others or damaged straight relationships with non-users, led to a sternly spoiled identity. This he postulated was also related to the degree of distress in withdrawal. This means that the less one identifies with the life of the addict, and has kept up some relationships with others outside of the social world of addicts, the less salient were

the pains of withdrawal, and the more likely that behaviour change were to occur and be maintained.

Former users of heroin may be reluctant to engage with ordinary people because they feel socially incompetent and stigmatised, and they may feel shame and guilt for past actions. As already discussed, the influence of temperance thinking has fostered a low opinion of drug addicts, which creates a formidable barrier for those wishing to move on from drug addiction.

For his participants the transformation from being a problem drug user to being a non-user can appear to some to happen abruptly and simply, however the process can be prolonged and complex. Biernacki described three major forms of identity transformation. Some participants *reverted* to a former untainted identity that had not been damaged by problematic heroin use. His participants after making a resolution to stop using heroin attempts were made to re-establish an old relationship and revert to the identity rooted in it. Other participants *extended* an identity that was present during heroin use but had somehow remained undamaged. This course of transformation was typically taken by someone who managed to maintain other identities during their addiction – examples given were jazz musician and poet – that were not spoiled as knowledge of their addiction became widespread. A third course of recovery described the construction of an *emergent* identity that was not present during or before the period of problematic heroin use.

Biernacki pointed out that identity materials with which the non-addict identity can be constructed were fundamental to leaving the addict identity behind. These identity materials describe aspects of social settings and relationships (e.g. social roles, vocabularies) that can facilitate the construction of a non-addict identity and a positive sense of self. He emphasised that the availability of these materials is in part related to the stigma associated with the addiction. Biernacki stated that addicts wishing to change their identities may first have to overcome the fear and suspicions of non-addicts before they will be accepted and responded to in ways that will confirm their new status which is often a long and arduous

process. Eventually, acceptance may be gained by the ex-addicts behaving in conventionally expected ways. Following “normal” pursuits, remaining gainfully employed, meeting social obligations, and possessing some material things will often enable non-addicts to trust the abstainer and, over time, to accept and respond in “ordinary” ways. At the same time, the addict’s feelings of uncertainty and doubt will lessen as he comes more fully to accept the new, non-addict life. Over time therefore cravings for drugs become diminished. At this point, the addict can be said to have recovered. A successful transformation from an identity focused primarily on the use of drugs requires the availability of identity materials from which a new untainted identity can be created. Identity materials describe those aspects of social settings and relationships (social roles, vocabularies) that construct a non-addict identity and a positive sense of self. In part, the availability of such materials is related to the stigma associated with addiction. However it must be noted that social class, geographical location is also part of such identity materials, and as such cannot be understated.

## **The drug normalisation thesis**

Normalisation means that drug use is normal in the sense that it is not unusual, rare, or restricted to deviant subcultures. In this sense it represents a major challenge to temperance thinking. Normalisation has made the boundaries between different subcultures permeable and demonstrated that research which focuses on a minority is essentially prejudice (Hammersley & Reid, 2002). Normalisation means that even if many young people do not use drugs, they have seen them used, or know of their use, or have information regarding how to use them. It is argued that cannabis use and to a degree ecstasy use is fairly routine and not viewed as abnormal (Parker et al., 2008). Heroin and crack cocaine use, and especially injecting are still viewed as deviant, although smoking heroin and crack may be normalised in certain areas of the UK. Normalisation involves use that is integrated into users’ lives, and to some extent, accommodated, tolerated or even ignored by society (ibid),

including in the sense that drug taking is normal, acceptable, or even unavoidable in some people's lives (partners of users for example). Finally it is normalised insofar as patterns of use can be explained without necessarily defining it as pathology. Drug taking can be explained as normal, without it necessarily being the defining part of a user's life or identity. Users can be well dressed, polite, and even respectable, only their purchasing and possession of drugs puts them at risk of criminality. In such a way drugs can be said to be normalised if it is accepted that some drug use is not necessarily defined as self-medication, deviance, illness or immorality. Why it continues to be labelled as such will be discussed later. Why some drug taking can be dismissed (the use of cocaine by Kate Moss for example, or politicians from all parties) as part of an earlier youthful experimentation, and other drug use is not can only be explained by how power is exercised through language, institutions and disseminated through a mass media (Brown, 2007). However normalisation is a site of conflict, and certain discursive gaps rather than closing are merely widening. As Shiner and Newburn (1997) point out, echoing Michael Gossop, (2000) we often forget that for some people in some places, not using drugs could be considered deviant. Thinking of normalisation as a process rather than state helps resolve these issues. As drugs normalise, everyone becomes tolerant or at least less judgemental of them, but it does not necessarily mean that they become accepted. Drugs can be normalised without being approved of. There are many types of deviance or crimes that are normalised without being approved of, examples include speeding, non-payment of tickets for the use of public transport, driving while over the legal limit for alcohol in the blood, and the use of 'junk' food for example.

Norms are notoriously difficult to establish and measure for activities that are illegal. The prevailing consensus is that abstinence from drugs is a norm, and non-drug taking is viewed as virtuous (Alexander, 2008). The term 'problem drug use' has become associated with danger, addiction, health and social problems; however the legal risk by far outweigh any other risk associated with their use. Terms which underpin addiction discourse reveal the

power exercised through them. The term recreational, which refers to the use of illicit drugs for pleasure, can be traced to the late 1970's, and the work of addiction theorists such as Norman Zinberg (1984) and Stanton Peele (1985). In the UK, a monograph by Rowdy Yates (1979) entitled 'Recreation or Desperation' discussed the possibility that any drug might be 'normalised' (that is acquire a normal use-profile giving an even distribution of experimenters and social users with a smaller, atypical group of dependents) given wide enough availability, long before the term was popularised by Parker et al.,(1998). In a community where there is little or no access to alcohol, those who drink are less likely to have normal drinking patterns or normal personality profiles. Where alcohol is readily available, the typical characteristics of the drinking population are likely to be more normal (Heath, 2000). Yates, (1999) argued that the same must apply for illicitly obtained substances. Most users of drugs are social users with a smaller, atypical group of problem drug users (Yates, 1999). This population of typical problem users tend to be over represented in treatment and prison populations as 'service users'. As a result they are often perceived to be representative.

The current drug normalisation debate is shaped by two competing ideologies of cultural separation or cultural integration (Blackman, 2004). Supporters of drug prohibition see the concept of normalisation as a threat to the notion of 'zero tolerance' to drugs use (ibid). This discourse rests on the premise that drug use is situated outside of society and conceptualise normalisation as a threat to normal law-abiding citizens. Mass media has played a role by simultaneously constructing drug users as both criminals and chaotic addicts, which supports prohibition. The utility of the normalisation thesis is useful insofar as the drug user is not conceptualised as suffering from pathology per se. It is however an untidy concept in that it over generalises and lacks the ability to distinguish between soft and hard drugs and between different types of drug users. Thus its utility is limited in allowing a full understanding of drug use; it does however represent a small step in breaking free from the dominant ideology that constructs drug users as both immoral individuals requiring punishment and or pathological sufferers requiring treatment.

Normalisation in the context of recreational drug use cannot be reduced to the intuitive phrase 'it's normal for young people to take drugs'; that is both to oversimplify and overstate the case. Parker defined recreational drug use as drug use which is sensible and occasional, as opposed to regular and excessive. A great deal of research has been carried out in this tradition which rarely makes it into the mainstream; it concentrates on strategies for managing risk (Decorte 2001; Maycock 2002) and demonstrates that drug taking does not inevitably lead to regular excessive use of drugs, but can be controlled (MacKenzie et al., 2001, Hammersley and Ditton 1994, Hunt et al., 2007, Zinberg 1984). Although tobacco use is clearly normalised and most young people have tried a cigarette only a minority are regular smokers and even then their behaviour is only acceptable to their peers in certain settings. So normalisation is suggesting that while drugs are normalised, it is recognised that it is still a stigmatised activity.

Drug normalisation thus consists of six elements: high availability of drugs; increased drug-trying rates; regular use of illicit drugs; high levels of drug knowledge; future intentions to use drugs; and the cultural accommodation of 'sensible' drugs use, even among abstainers (Parker et al., 2005). They found that that one or two in ten young people, by the age of 18, had ever tried a drug. Prevalence has climbed with each adolescent cohort so that from five to six in ten young Britons are now disclosing drug-trying by this age. The trend has been quite clear. The normative nature of drug-trying has been further demonstrated by the closure of gender and social class differences. With regards to drug use, they demonstrated that young people make recognisable cost-benefit assessments and the fact that so many broadly settle primarily for cannabis rather than poly-drug use is a clear illustration of this. However Parker et al., (1998) did not realise that it was the cultural acceptance of rave culture, the relative safety of ecstasy use, which could have accounted for drug taking in the 1990's. They suggested that 'being drug-wise' was becoming more prevalent because abstainers demonstrated their considerable knowledge of the recreational drugs scene simply because they could not escape encounters with drugs and drug users. However it is

also possible that users become drug wise through popular culture anyway, such as music, film, television aimed at adults. They speculated that since young people indicated that they had potential future intentions to try drugs, that drug use had become accommodated culturally. This open-mindedness about future drug use by young adults, adds a further dimension to the normalisation thesis.

Within sociology and much criminology the theory most commonly associated with explanations of drug use is subcultural theory. However because drug use has moved from being a small minority to majority activity, subcultural theory struggles to account for such a shift. Indeed normalisation, because it is about the accommodations of previously 'deviant' activities into mainstream cultural arrangements, sits uncomfortably with subcultural explorations (Hammersley, 2004).

The drug use Parker et al., (1998) encountered among their sample was largely recreational and centred on drugs not considered physically addictive such as ecstasy and powdered cocaine. Parker et al., insist that drugs have become normalised or accommodated because most adolescents and young adult users fit their leisure into busy lives and then in turn fit their drug use into their leisure and 'time out' to compete alongside sport, holidays, romance, shopping, nights out, drinking and, most important of all, having a laugh with friends. Moreover such use now belongs as much with females as males and to young and indeed older people from all social backgrounds. While drug taking is not without risks, as much from being discovered as from the substances themselves, it is clear that Parker et al., demonstrate that drug takers make rational decisions about consumption which lie at the heart of the normalisation thesis as they do with the McDonaldisation of modern societies (Ritzer, 2011). Drug users are essentially extending the same decision-making processes to illicit drugs as others do in respect of smoking cigarette or drinking alcohol or indeed any other risk taking activity. After their thesis received some criticisms, Parker et al., added a further component in 2005 concerning the perceived increased recognition in drugs policy of

the possibility of non-problematic drug use, although this is hotly debated given the increased politicisation and criminalisation of UK drugs policy (Seddon, Ralphs and Williams (2008:818). Some have been supportive of the thesis (Taylor, 2000) which argued that the symbolic allure of drugs was being commodified to sell rebellion and risk to consumers using the power of drug knowledge, and its effects, which could not have happened without some understanding and acceptance of them. Others have argued that while drug use may be 'normalised' this is only true for certain types of drug consumer and not users of 'hard' drugs such as heroin (Pearson, 2001). Some researchers (Shiner and Newburn, 1997) have indicated that only 'party drugs' like MDMA have truly been normalised, and that 'hard' drugs have not. Shiner and Newburn (1997) claim that the Parker et al., (1998) normalisation thesis lacks understanding of the normative context in which drug taking occurs. Knowledge and even trying of drugs may have increased; it remains a small minority of the public who engage in such activity. Therefore while drugs may be normalised, they are very much still stigmatised. Shiner and Newburn go on to suggest that drug takers employ techniques based on Sykes and Matza (1957) theory to neutralise feeling of guilt they may have about engaging in activities that are demonised by the general public. People who do not use illegal drugs in particular associate drug taking with crime, in the same way that drug policy is also built on such a premise. Shildrick et al., (2007) has argued that drug policy and the processes revealed through labelling theory stigmatises some form of youthful experimentation and proposed the term 'differentiated normalisation' (ibid). Gourley (2004) argued that subcultural explanations reveal the interplay between groups in society, insofar as they underline how important such sub cultures are in initiating, maintaining and regulating the risk associated with criminal and deviant activity. Pennay and Moore (2010) have argued that there exist two broad narratives which they argue act to regulate use among their sample of recreational drug users in Australia. These are micro political factors, pleasure and self-control. Blackman (2004) has argued that drug use has essentially been 'normalised' in previous historical and cultural epochs, in Victorians times, the 'beats of the 1960's, the 'punks' of the 1970's and the ravers on the 1980's and 1990's. He also sees



'normalisation as an untidy concept insofar as it cannot account for differences between drugs, and users, or between soft drugs and hard drugs, (Blackman 2004:147).

The main alternative to the normalisation thesis, deviant subculture theory, proposes that forms of drug taking occur within specific subcultures where they are accepted and perceived as normal, but are not necessarily happening outside these groups. Non users are largely excluded from being defined part of such groups (Oetting & Donnermeyer, 1998; Pierce, 2005); therefore a pertinent question becomes can these separate viewpoints be combined to create a cohesive perspective? The issue is in defining what a subculture actually might be. Most drug scenes or environments and groups have a number of dedicated career user experts who identify very strongly with that user culture, a larger number of less dedicated users will also form part of that group, with a smaller number who drift in and out can be referred to as '*tourists*'. Such intermittent users on the fringes of a scene are only there for the weekend, the evening, or even just to source drugs (Pierce 2005). People can and do move from group to group depending on various factors that compete with their time and resources, parenting for example or employment. A deviant sub group which has strong boundary lines can only really occur when they have been marginalised and ghettoised; several parts of cities in the USA fit such criterion (ACMD 1998; Golub and Johnson, 1999; Schensul et al., 2005). Some of the most deprived areas in Scotland may also fit this criterion (Taylor 1994; McKeganey and Barnard, 1992; Neale 2000). However these areas are not where most drug taking occurs and neither is it where most problematic use occurs; it is just more concentrated. There are boundaries of deviance which can be accessed by non-deviants, for example to purchase drugs (Pierce, 2005, Shewen and Dalgarno, 2005; Warburton et al., 2005). In the UK and to an extent the USA, the dance scene with its recreational use of dance drugs such as MDMA, cocaine and other drugs, for example ketamine, involves a very diverse mix of the population, who would not view themselves as part of a potentially stigmatising social group, or identify with other

stigmatised drug users, such as heroin injectors. There is a need to understand how various scenes interact and even avoid interacting and to discover if it is a matter of real boundaries, such as geography and location, or whether it is culturally determined such as drug of choice, social class, age, education and employment. The UK Drug Policy Commission (Lloyd, 2010) identified that the stigmatisation of people who use illicit drugs has a negative impact on all users, but particularly those who have developed problems. Drug users can feel overwhelming shame and a sense of worthlessness, which may exacerbate drug problems and thus any recovery from them. People who use illegal drugs fear discrimination in treatment, employment, and education. The stigma of a drug problem is often as great as or greater than the stigma associated with mental health problems. The language used by newspapers and other media reinforces creates negative perceptions of drug users. The power of stigma acts as a significant barrier to challenge such stereotypes.

## **Defining drug talk**

Addiction discourse is engaged in by those who will from hereon be termed 'drug talkers'. Anyone can engage in 'drug talk', indeed drug talkers need never have tried a drug, met a drug user, or even understand drug policy. All a drug talker requires is a belief that they understand drug use, and drug addiction as one and the same thing, to be solved by medicine, law enforcement and universal abstinence. Drug talk can include 'recovery talk', which in itself can range from a belief and acceptance of harm reduction talk to an absolute belief that abstinence saves lives, and any use after addiction is diagnosed will result in death. Drug talk links drug use to drug addiction, links drug users to organised crime, and views drug dealers as highly organised and in a pyramid like structure with a head of a gang at the top, and several categories of organised criminals underneath. This discourse will be explored. In order to prevent excessive repetition, whenever the term 'drug talk' is used, it

refers to a belief in drugs as the cause of loss of control, criminality, which ignores or denigrates any suggestion that structural factors may also contribute to drug problems.

Simon Hallsworth has discussed 'gang talk' as a series of legends designed to create a mythical world of criminality which serves to legitimise the accusatory language of politicians, and the activity of the police (Hallsworth & Young, 2008). Drug talk is similar to gang talk insofar as it is a distinctly self-referential discourse; it is embedded within a narrative of war metaphors and creates anxiety in both 'drug users' and 'drug talkers'. Drug talk and the language drug talkers use to represent drug use require a technology or methodology to deconstruct and interpret them. Drug talkers use symbolic terms to create mythical drug users, who are on predetermined self-destructive paths to hell or enlightenment, therefore the distinctions between anti-drug talk and pro-drug talk must be made. The representation of drug users, drug markets and the criminal gangs believed to distribute drugs require deconstruction and criticism. Derrida (1995) has explained that drug talk anchors itself to a past where drugs are airbrushed out of history altogether. Drug talk refers to a utopian future that can only be tackled or reached by drug prohibition (Levine, 2001). Drug talk is a collective discourse engaged in by drug talkers. Anyone can engage in drug talk, they need never have spoken to or worked with a drug user. Such is the power of the mythology that everyone can proclaim knowledge of drug users, drug use, and the negative consequences perceived to be associated with drugs, such as addiction, criminality and death. Drug talk is a simulacrum (Baudrillard, 1988) and is very powerful because drug talk statements cannot be falsified (Popper, 1963). If data or evidence challenges a working 'drug talk' hypothesis, then rescue hypotheses are created. Drug talk is seductive and powerful. Drug talk taps into our deepest fears and constructs several archetypes, the addict, the drug injector, the pusher who does not use drugs, the free samples given out to tempt the unwary, and so on. Drug talk is a technology of power, and it lends itself to repression of certain 'othered' groups, who are stigmatised and made scapegoats. The model developed by Fine and Asch (2001) to discuss stigma associated with being disabled was easily adapted to apply to drug users.

This indicates that the four assumptions based on the stigma of disability can easily be applied to drug users who are similarly marked and stigmatised for their assumed differences.

The concept of control as it relates to drug use requires some examination. Addiction is about a loss of control, and it has been derived from a moral position, condemnation about supposed excess of illicitly derived pleasure that has not been legitimised, primarily by medicine. It rests on a mind body dualism and is conceptualised as a failure of the self to govern control over bodily desires and functions, and yet consumption as Young (2003) has argued is used as a source of identity. This is a threat to the autonomous self-governing individual, at risk of not being able to produce or consume, and therefore is an identity in crisis. Addicts and non addicts, drug users and non-drug users must define themselves in opposition to a state defined as pathological (Bailey, 2005:539).

The addiction concept is used to identify various forms of normality as deviance and illness, addiction is both normal and pathological. Popular discourses on addiction rest on widening the label, by suggesting that poor relationships, being dependent on credit to consume goods and services, and staying too late at work are also addictions (Peele, 1998). Critics of the drug talk which underpins addiction discourse point out that these popular discourses view the addiction inherent in the person. As an example, if one shops or works excessively, then the issue is not in the credit card or the work per se. So these problem users are shopaholics, and workaholics (Bailey 2005:540).

Helen Keane's work 'what's wrong with addiction' (2002) asks challenging questions regarding why addiction has become demonised by modern society. In addressing these questions Keane analyses the way both mainstream and specialist discourses have located addiction. Keane identifies a range of addiction narratives, and in so doing reveals that addiction is in part socially constructed. By examining smoking, as Prochaska and Di Clemente (1983) did to create their heuristic 'stage of change model', Keane examines

smoking using different texts. The use of nicotine is good insofar as it is a drug that has been used by many people, and more importantly has been stopped, cut down, started and restarted many times. Keane (2002) notes that much of the 'how to give up' information is located firmly within the domain of medicine and pharmacology. This is of course in contrast to how a 12 step programme would tackle the issue of giving up. The same ideas were used by Heather and Robertson when they examined that nature of addiction by introducing Mary, someone who was addicted, in their book 'Problem Drinking', first published in 1985. All of the terms in the text describe Mary as a problem drinker; using language that is firmly within a disease view of addiction, describing how Mary's problems such as constant craving, loss of control, relapse etc., are tied to her problem consumption. However it is revealed that Mary actually has a problem with chocolate! The language of addiction can be used to describe any problem. Therein lays the issue revealed by Heather and Robertson. Addiction is a problem if it is perceived as such. The text emphasises future risk, what will happen if relapse occurs, leading to a *loss of control*, and a progression of the 'illness'. Heather and Robertson reveal that the language of addiction may be used to label any problem behaviour, but that does not make that unwanted or condemned behaviour a disease. Keane (2002) also attempts to identify common threads through multiple discourses in particular the discipline and regulation of the body through ideas of legitimate and illegitimate pleasure and risk, with consequent implications for the identity of the user. She clearly illustrates that, in talking about other deviances, in particular sex, there are ways of understanding addiction that lie outside dominant discourses, arguing that these discourses exhibit gaps and tensions suggestive of alternative understanding, multiple perspectives, and dominant 'readings' and meanings of what terms mean. Keane's work is largely critical of current discourses, and further research is required to build on her insights (Bailey, 2005:542).

These examples suggest that power is revealed in how knowledge and disciplinary practices from various institutions dependent on both government for funding and the public for

support, the drug enforcement agencies for example, hospitals, asylums and other institutions that form part of a carceral continuum that Foucault has described (Foucault, 1977, 1990), seek to define and 'own' the discourse, and the power that is wielded through them. Foucault studied sexuality, the prison and the asylum to reveal how power is exercised through knowledge. However other institutions reveal certain discursive practices that discipline and govern the populace, in particular the 'child protection' agenda that punishes deviations from approved parental practices. Alcohol is can be used by some parents and is not claimed to unduly affect the ability of the parent to look after children, however certain illegal drugs are not approved, and their use is condemned by linking their use to child neglect, criminality and ill health.

Brass (2000:307) has suggested that knowledge and power are intimately connected in modern societies, principally to regulate norms of behaviour. In short to determine control and regulate normality and pathology. Certain behaviour thoughts and conduct are constructed as the 'norm', abstinence from illegal drugs or the public condemnation of their use for example, while the use of illegal drugs are described in medical discourse as a risk for ill health, and in criminal justice discourse as a risk for criminality. The work of Becker (1963) demonstrated the process whereby the law is used to regulate and discipline infringements of conduct. Techniques of power described by Foucault discipline conduct, both internally by individuals and collectively in societies (Brass: 200:307). In many ways our lives is increasingly organised, structured and disciplined by drug talk. An historical analysis reveals the development of such practices. Foucault argued that in the sixteenth century a process began which has continued into the current century, a process of 'governmentalisation' that is the extension into society of new techniques and technologies of governance of individuals in society. Along with this process is an ever increasing search and acceptance of what is normal, and discovering and legitimising new ways of governing such 'normality'. In this process insists Foucault is laid both the legitimacy of governance, and ways in which it may be criticised and resisted. However Foucault was profoundly

distrustful of humanism within social sciences for example that might lead to a dispersal of power, and considered such criticisms could become themselves part of the technology of governance, and power. Harm reduction is an example of such resistance, which has as its goal the reduction of drug related harm without necessarily demanding abstinence, or equating this with normality, (Heather and Robertson, 1985). One can see how the concept of harm reduction can be criticised because it does not lead to one being 'drug free', the description of normality used by the Scottish government in the policy document 'The Road to recovery', published in 2008. As a result, demands for normality, equated with being drug free, labelled 'recovery' can be seen in how drug talk acts to maintain support for the policy status quo, prohibition. Drug talk also underpins anti-drugs education, based on the belief that saying 'no' to drugs is equated with decency, and therefore such discourse acts to link drug use to pathology. These are examples of how drug talk governs, regulates and disciplines conduct to maintain approved 'norms'. In many ways Foucault makes us aware that when it comes to certain drugs, all modern states have become police states.

## **Discussion**

Norman Zinberg's 'drug set and setting' (1984) suggests that the (mind) set and setting (the environment) mediate the experiences of drug intoxication and the drug experience. His model challenges simplistic stimulus response models that explain drug use as a simple process of reaction to brain chemicals, biology or pharmacology. The review of the literature from sociology has revealed research that while little known to the public, has consistently challenged such determinism. Drug talk is supported by other simplistic notions, and can be seen in how 'drug careers' are conceptualised as beginning with drug use, and leading to addiction or problem use, before ending with either a lifetime of ill health, criminality or that such a decline is halted or arrested by long term abstinence, prevalently defined as 'recovery', and end state increasingly linked to 'normality'. Norman Zinberg (1984)

interviewed non addicted opiate users, up to 18 months after the initial interview he discovered that some had stopped using opiates, some had remained at patterns of use similar to the first baseline interview, and some had used more drugs; he described no typical career trajectory. He described no typical 'addict' use pattern.

The research conducted by David Shewen and Phil Dalgarno (2005) accessed 126 hidden users of opiates in Scotland. Their participants were asked to rate the drug they considered to be most addictive. They report that the majority of their sample rated alcohol and tobacco more addictive and difficult to stop than heroin. Their research findings also challenged the view that drug use follows a predictable pattern of use from experimentation, misuse and finally abstinence. Likewise the research conducted by Warburton, Turnbull and Hough (2005) interviewed 51 subjects face to face, accessed 123 users of opiates online, and they found no typical drug career or typical use pattern associated with 'addiction' or loss of control. They stated that the most common patterns of use were sensible and controlled, even among daily users of opiates.

The work of Tammy Anderson (1998) on drug use and identity suggests that problem use is more likely to occur if the drug taker identifies strongly with all four of the following elements: regular use over time, negative consequences, previous failed attempts to stop using drugs and identifying with the 'typical' addict lifestyle and identity. Anderson suggests that some problem users experience two types of marginalisation, personal and social, and that a deviant career is contingent on transformations. Like Becker she marries conflict theory with symbolic interactionism; however her work assumes the typical career trajectory of problem use beginning with non-problematic use, leading to problem use and then a need for abstinence.

Becker's labelling process outlined in 'Outsiders' (1963) emphasises group interaction in understanding behaviour. He describes how the labelled perceive themselves and how others perceive them. As a result what deviants do, or have done, becomes who they are,



and determines inclusion or exclusion, forgiveness or punishment. This would strongly suggest that deviance is not behaviour per se but how we respond to behaviour. He asserts that certain privileged social groups the 'moral entrepreneurs' create deviance by making rules, and who for various reasons and motivations work to have their ideas about deviance enshrined in law. The literature on patterns and prevalence of use in Scotland demonstrated that there are more problem users from deprived areas caught within the agencies of social control and thus one may conclude that that the law is differentially enforced. However the threat of a life ruined by a criminal record remains for all who use illegal drugs. The stigma associated with being labelled a drug offender is applied via degradation ceremonies (e.g. court processes), and often results in exclusion and reduced opportunity for those who accept the addict identity as their master status. The review of the literature on social identity stemming from the work of Tammy Anderson (1993, 1998) suggests that the addict identity can become the basis of personal identity. The work by Becker (1963) on the labelling process highlights that everybody does deviant things from time to time, however only a few are caught. Those not caught go on to adopt conventional lifestyles. Lemert's (1957) use of the term 'Secondary deviance' indicates that the subsequent behaviour of those who are caught can become a permanent feature of one's personal identity. This involves only a small number of people, and that the labelling process and subsequent societal reaction converts primary deviance into secondary deviance. However it is clear that labelling theory is extremely useful in identifying the role of agencies of social control. The theoretical perspective focuses on social interactions and reactions, not just individual pathology, and allows one to distinguish between deviant acts and deviant careers.

## **Rationale for research**

Users of illegal drugs not in contact with any agency of social control such as medicine or law enforcement are a hidden population, they are also hidden from research, and as a

result from drug policy creation and implementation. Drug researchers invariably recruit participants from two locations, treatment agencies and clubs where drug taking is common. This type of drug user is easy to access, but may not be representative of all types of drug users. This highlights the need for research which accesses another type of drug taker, hidden from view who is neither seeking treatment nor attends nightclubs where drug taking is commonplace, who do not view themselves as requiring a biomedical, social or psychological intervention to 'cure' them of their illness, syndrome or condition.

This review ends on a cautionary note. Everything we know about the way social control ideologies originate from and function should caution us about the delusion of ever expecting a synchronisation of words and deeds. As Stanley Cohen (1985) helpfully points out in his book 'Visions of Social Control':

*"If progressives are like children who believe that fairy stories are actually true and that those who tell them always good, then radical demystifiers are like adults who laboriously try to prove that fairy stories are not really true, that those who tell them are always bad", Cohen (1985:155).*

This then is the review of a radical where I have attempted to point out that drug use has historically been viewed as normal, rather benign, and not at all as harmful as contemporary anti-drug rhetoric would have one believe. Drugs are substances that are ingested into the body, resulting in biological and psychological changes, often constructed as permanent and life changing. Certain agencies of social control, in particular medicine, have become accepted as the authority in which to document 'addiction'. Drug use has also in more recent times in Scotland, become the domain of law enforcement. The belief that taking drugs is wrong in a moral sense has resulted in an entire social control apparatus attempting to enforce rules created by certain privileged moral entrepreneurs. The proposed research explores the views of drugs takers who are not normally included in drugs research, and will

investigate the social worlds of an intentionally unseen group of non-treatment seeking drugs users in Scotland.

## Chapter three: the research methods

The focus of the study is to identify and document the illicit drug use of a hidden population of illegal drugs users not formally identified as problem drug users, who have never sought treatment, nor been in prison due to their use of illegal drugs. This thesis explores the central research question:

- How and in what way does prohibition impact on the social world of non-treatment seeking illicit drug users?

The central objectives explored in this thesis are:

- To identify a hidden group of non-treatment seeking drugs users,
- Assess the extent, to which drug use influences their shared identity and those with whom they identify,
- Explore how they manage the risks posed by drugs and drug policy.

This thesis will approach the first objective by describing how and why the research participants were recruited. The second and third objectives are addressed in the analysis of coding structures that emerged from the data, and form the basis of four analysis and discussion chapters exploring identity. These themes addressed in the four chapters that form the basis of this thesis are:

- How does inequality manifest itself in the minutiae of daily life?
- How and in what way do users of illegal drugs experience inequality and power being exercised on them and how this affects whom they identify and bond
- The strategies illicit users of illegal drugs use to manage social affronts and stigma.

The methods were qualitative stemming from a constructionist epistemology, with an ethnographic research design consisting of semi structured interviews, focus groups and field notes taken from two instances of non-participant observation at two social events where drug users were together. The bricoleur theoretical perspective borrowed from symbolic interactionism, and in particular Howard Becker's (1963) theories on the labelling process, the work on stigma by Ervine Goffman (1963), and Tammy Andersons (1998) work on Identity.

Increasingly research into the use of illegal drugs has focused on quantitative evaluations of how drug use is correlated with various pathologies and criminality, accessing easy to reach samples often recruited via treatment or criminal justice agencies. This qualitative research study interviewed 24 people reflecting on their experiences as intentionally unseen illicit users of illegal drugs exploring how and in what way they managed the drug risk and the risk from drug policy.

The sample were accessed via chain referred purposive sampling using strict inclusion criterion of never having accessed treatment or been caught in the gaze of criminal justice agencies. Semi structured in depth interviews one to one, in pair bonded partnerships, in a focus group and using field notes from non-participant observation explored four themes, identity, and managing risk, accessing illegal drugs, and managing the risks arising from drug policy. These themes were analysed using adaptive coding through the lens of symbolic interactionism. The thesis is a liberating interpretation that attempts through the understandings of the research participants to describe and theorise how and in what way they challenge their experiences as oppressed beings in their social world. In particular what it is like to experience stigma and inequality produced by structures and reproduced in discourse.

Chain referred purposive sampling was considered appropriate for this research project as it allowed the researcher to form a sample which included various types of drug takers

including male and female ex users, current daily users, current intermittent users, opiate experienced users, and opiate inexperienced users, from a variety of age groups from early twenties to early fifties (Nachmias, and Nachmias, 1996) and compare this to what is known about the 'typical' drug taker, in particular the assumptions made in epidemiological research, which links a priori incidences in a population with pathology (Glassner and Loughin 1987). This sampling strategy is appropriate when the researcher is exploring a particular issue within a particular population who have key experiences and knowledge that is pertinent to the research project (Mays and Pope, 1995). It was important to garner as wide a range of perspectives and views of drug taking as possible from the research participants and the five categories identified (see table 7) were considered to cover as many sub identities within this population as possible.

## **The epistemology**

This research stems from a social constructionist epistemology. Michael Crotty (2009) has stated that stemming from the work of Immanuel Kant in the eighteenth century there has been the view that there is no direct connection between an independent, objective world ('noumena') and our experience ('phenomena'). Therefore what science has had is a set of interpretations of our perceptions and experiences that lead us to believe that a world exists 'out there', (Hanna, 2009). If that connection is always hypothetical, research then must be concerned with what guarantees a 'truth', or in constructionist language, the 'authority of knowledge'. Social constructionism, suggests then that the authority of knowledge ultimately derives from a 'knowledge community' of people who agree about the truth (Warmoth, 2000:01). As Thomas Kuhn stated, in *The Structure of Scientific Revolutions*,

*"Knowledge is intrinsically the common property of a group or else nothing at all"*  
(1970, p. 210).

The key to understanding the difference between the constructionist view and more traditional views of knowledge or truth is that for constructionists, knowledge is not what individuals believe, but rather what social groups, or knowledge communities, believe. Quantitative research methods still take precedence as more scientific than qualitative methods, however neither one can claim that they result in research that is a truth more credible than the other, (Crotty, 2009). Both are fallible, have inherent biases, methodological flaws, and philosophical weaknesses. Science is a fallible human and social activity, and as such can be politically and ideologically driven. Hammersley (2008) has argued that science can be presented as a form of accurate truth; it is important to be wary of explaining drug use and problems using single grand theories, such as reductionism, and empiricism. Single grand theory or mono-causal models explain problem drug use as an acquired or inherited 'disease'. Several writers in the field suggest that we must be cautious that any substance has inevitable effects of human behaviour (Davies, 1992; Shewen and Dalgarno 2003), or that any one factor is in essence the cause of another (Armstrong, 2004). Reductionist theories stemming from neuroscience (Leshner, 2000)<sup>17</sup> often fail to consider the meaning and setting of the activity under investigation. Substance use is a social activity as well as a pharmacological / chemical one and occurs purely for social reasons, without sufficient consumption of the active substance for the pharmacology to be relevant, Hammersley (2008). Examples include placebo effects of drugs, where effects are demonstrated from expectancies or beliefs about behaviour (Johnson et al 1985; Stewart, Williams and Podd, 2004).

Those engaged in research using utilising quantitative data assume that with sufficient methodological sophistication, data can be gathered accurately, without bias, including the conceptual bias inherent in the ways that problems are relabelled. The collection of data on

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<sup>17</sup> That certain brain chemicals cause craving and explain drug addiction.

drug use, and related problems use self-reported data<sup>18</sup>, are often prone to sampling and measurement biases. Therefore the triple inaccuracies of grand theory, reductionism, and empiricism are common in drugs research.

From a positivist view, addiction is a theoretical construct, but it has to be given some means of being measured empirically. Addiction is conceptualised as a general syndrome of different objective and subjective feeling states which emerge from certain relationships between drug users, their drug and their environment. Addiction is said to exist when drug users are unable to control their subjective feeling states and biological processes (craving or withdrawal) and are sufficient to explain motivation to consume. From this stand point addiction is the degree to which measures of craving or withdrawal can be causally related to another variable such as acquisitive crime. It has been well documented that craving is notoriously difficult to measure<sup>19</sup>. Confirming the disease concept of addiction involves the collection of empirical measures of subjective states, and relating them to a loss of control. An example is using questionnaires to collect data on craving, withdrawal, and signs of biological and psychological deterioration and attributing these to uncontrolled drug use. Health effects such as abscesses are attributed to drugs rather than the prolonged injection of dirty drugs. Long term psychological distress, involving anxiety, depression are also attributed to drugs.

## **The theoretical perspective**

Symbolic Interactionism allows the researcher to explore the level at which institutional or structural power can be revealed in micro interactions between social actors (Berger and

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<sup>18</sup> In particular, McKeganey et al (2006) *Abstinence and drug abuse treatment: results from the DORIS study* *Drugs: education, prevention and policy* Vol.13(6) 537-550

<sup>19</sup> While craving for certain drugs can cause anxiety and distress, this is by no means a universal symptom (see Light, A. B. & Torraine E. G., (1929). *Opiate addiction. VI: The effects of abrupt withdrawal followed by re administration of morphine in human addicts with special reference to the composition of the blood, the circulation and the metabolism.* *Arch. Intern. Med*; 44: 1-16).



Luckman, 1966). In contrast to a constructivist approach, primarily but not exclusively based on the individual perspective of one social actor at a time, the principle ontological claim of a symbolic interactionism perspective is that reality is not immutable or fixed but is constantly under revision through the meaningful interaction of social actors. Social actors are continuously engaged in constructing and negotiating the meaning of reality with one another. This social constructionist perspective infers that social identity is fluid, and is in a constant state of being built up, broken down and reinterpreted as a result of interaction; the analogy of career is invoked to illustrate these processes. Ervine Goffman utilises the concept of career to explore the role of the individual labelled as 'ill' requiring treatment in 'Asylums' (1968) and earlier dramaturgy (Goffman, 1959), to explain social identity as a process of identification, interpretation, and acting out and reacting to the 'lines', roles, and motivations of other actors. However in doing this, this micro interactionist stance can be limited in accounting for structural factors. Epistemologically, social reality can only be known through understanding the point of view of social actors, their meanings, definitions of their situations, and the logic of positivism is rejected. The constructions of a hypothesis based on a priori assumptions are not followed. Documenting the incidences or measurement of socially determined categories such as craving, withdrawal, etc. are replaced by open ended questions such as exploring subjective experiences at the micro level, and getting a naturalistic account of drug use and what it means through the understanding of the social actor. By asking the correct questions, one can also ascertain how structures impact on the minutiae of daily life of the hidden drug user.

The logic formulating this approach, is that understanding and meaning can only be discovered or emerge through the continual interplay of theory and method in the field. Investigation is concerned with the discovery of challenging views, disconfirming cases, in order than assumptions can be continuously refined. From this perspective, addiction is at least in part, a social construct. Social actors are not merely driven by unconscious processes, and biology, but by what things mean to them and how they interpret sensation

and affective states. Through conscious reflexive thought communication and meanings are symbolic. From a social constructionist perspective, culture largely directs our meaningful behaviour, what G. H. Mead (1964) termed 'significant symbols'. However such symbols are fluid and reflexive and an historical sensitivity reveals that social reality is a function of shared meanings. Anthony Giddens (1976) has suggested that in natural science research there is a single layer or level of language and meaning and therefore meaning can be documented, typologies produced, and laws theorised and determined. Social scientific research has two interpretative levels, a double hermeneutics, a language of social science, and the language of everyday ordinary usage. From a constructionist epistemology, the key ontological claim infers that humans are not simply driven by innate programming or learned behaviour patterns, instead they monitor their behaviour consciously in relation to how they understand their social world, groups they identify with, and the roles they assume within such groups.

## **The methodology**

The primary data for this research were collected from a hidden group of illegal drugs users, who were socially competent insofar as they had not been identified as problem users, had never sought treatment for their use of drugs, and they had never been caught in the gaze of healthcare or criminal justice agencies and labelled as problem users, or addicts. One to one interviews, focus groups and non-participant observation were all used to provide a rich source of data. Hughes et al (1993) suggest that using ethnographic methods in research is a rejection of variable analytic quantitative social investigation methods, mainly survey and experimental research. Such methods, it is argued, by the structured character of their data collection processes, impose the researcher's assumptions on the data. Such contemporary positivism may act to reify social phenomena by treating them as more defined and distinct than they really are, and assumes that those phenomena enter into law-like regularities of

association. Further, in making claims about what happens in natural settings on the basis of data produced in artificial situations, or by using pre structured questionnaires, they engage in a highly questionable generalisation procedure (Hammersley 1990). The research design utilised three primary methods of data gathering, semi structured face to face interviews, a focus group with three participants, and field notes gathered from two social events where the use of illegal drugs were evident.

### **The sampling strategy**

'Hidden populations' is a euphemistic phrase often applied to marginalised and excluded groups such as the homeless, criminal and deviant populations, sex workers and heavy-end drug users. However, hard to reach, 'invisible' non treatment seeking drug users who may have little in common with other 'hidden populations', are also a type of population that are hidden. The specific empirical objectives of this project were to explore the participants' subjective experience of being a hidden drug taker and how this interacts with their status as otherwise 'normal' and productive law abiding citizens and in particular how they manage the dual careers of drug user and 'normal' productive member of their communities. A particular emphasis rested on the role that drug use plays in the social identity of this hidden population.

### **Participant Recruitment**

Initially four 'gatekeeper' contacts were asked to provide the researcher with an introduction to drug users who fitted the inclusion criterion. They had to have been current or former users of illegal drugs (controlled within the confines of the Misuse of Drugs Act 1971) and not have had any contact with a treatment agency as a service user, or have been in prison.

After initial contact had been made with people who met the inclusion criterion, the aims and purpose of the project were explained to participants and they were provided with an information sheet to read. Some participants were able to take part upon meeting the researcher for the first time and where possible the interview was carried out at the participant's convenience. Other participants requested some time to think about their involvement and then contacted the researcher later to confirm their desire to take part. Interviews took place usually within the homes of the research participants, at the office of the researcher, or in a public place, for example a coffee shop.

The principle gatekeeper contacts were two males and two females, two of them worked in the field; one was a recreational user who had been a participant in previous research and one was an active illicit drug taker who was under 30 and regularly was in the company of other non-treatment seeking illicit drugs users. Gaining access to other users allowed me to secure access to their friends, some of whom agreed to take part when contacted via telephone.

Potential participants were excluded on the basis of having had experience of formal treatment or the criminal justice system, for example a criminal conviction related to offending, including possession of illegal drugs, and offence within the confines of the Misuse of Drugs Act 1971. Potential participants were also excluded on an impromptu basis. I asked other 'gatekeepers' who had contact with the types of drugs user I was interested in interviewing were asked to give me names and telephone numbers of potential research participants. Several colleagues and ex-students working in the addiction treatment or law enforcement field all put forward potential participants and on speaking to these contacts, most were rejected as they did not fulfil the inclusion criterion. Only one participant was recruited in this manner, a former user of cocaine and MDMA and no longer used these drugs with the exception of cannabis intermittently.

The researcher has been working with drug users for 23 years. In these years of working with drug users face to face, in therapeutic agencies, and in research, the researcher was comfortable talking to drug users. That said, risks are understood, and appropriate safeguards were taken to ensure the safety of both the researcher and any participant interviewed.

As safety of the researcher was of importance in this case risks were reduced by a 'safe home call' whereby the partner of the lead researcher was called before the interview to alert them to location and approximate time that the interview occurred. A mobile phone was on at all times, and the number of the partner on speed dial.

Some potential participants did however decline to take part believing that anonymity could not be guaranteed, or that they feared the risk of discovery. Several stopped taking my calls or answering texts, and therefore self-excluded for reasons best known to themselves. Sampling problems also occurred in the context of the purposive recruitment strategy. While it was easy to control the inclusion criterion, treatment seeking and a criminal record excluded, the participants were not asked for demographic information prior to interview as gathering this information required consent and so controlling for diversity in ethnicity, socio economic status and educational levels was not possible.

After the primary gatekeepers had exhausted their social networks of potential participants who fitted the inclusion criterion the author reverted to a wider chain referral network to recruit further participants. This method of selection via the first social gathering to recruit participants yielded several suitable participants. This method of selection involved mentioning exactly what type of user the researcher was interested in, for example an equal number of male and female users<sup>20</sup> and a large enough sample of opiate experienced users, although only recruiting two in this manner. The other four opiate experienced users were

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<sup>20</sup> However examining gender differences in detail was not an objective of this study.

revealed during interview and did not know that the researcher was interested in this drug, or their views having experience this drug.

### **Semi structured interviews**

In-depth semi structured interviews allow the researcher to ascertain how participants think and feel, exploring experiences, opinions and concerns (Nachmias, and Nachmias, 1996). Semi structured interviews allow the researcher and participant the opportunity to enter into a free and deliberate discourse. In depth interviews are appropriate when investigating complex behaviour and motivations for actions, and are particularly suited to research that aims to elicit data about a range of experiences (Kvale and Brinkman, 2009). Semi structured interviews are also especially suited towards accessing the rich texture of normative influences on attitudes and behaviours, which makes their use ideally suitable for achieving the aims of this project (Corbetta, 2003).

The researcher spent time discussing the purpose of the research with participants prior to the interview commencing, and to put them at ease. During this initial conversation it was made clear that the researcher held no bias or preconceived notions about the research and that the purpose of the interview was to give the participant an opportunity to discuss the issues that were important to them and not for them to say what they may have thought the interviewer wanted to hear. The participants were made aware that they were being consulted as practised drug takers, able to remain hidden in a culture that would condemn that part of their identity they have concealed.

This research used an interview schedule which included a significant element of oral history interviewing. Participants were asked questions about their initiation into drugs and their relationship with others who had not experienced illicit drugs in a society that condemns their

behavioural choices as deviant. Significant problems can arise with this sort of interview such as the participant having a view of the past based upon their status and powers of recall (Shopes, 2002).

This research endeavoured to explore meanings, concepts, reasons and motivations, and required an interview schedule that was structured enough to maintain a focus on the objectives under investigation. It had to be flexible enough to allow the data to be participant led and to encourage participants to disclose usually private or hitherto thoughts and feelings, therefore in-depth semi structured qualitative interviews were deemed appropriate (Hakim, 2000).

One pilot interview was conducted early in May 2009; the remaining interviews took place between June 2009 and April 2010. Based upon the data collected in the pilot interview the interview schedule was decided to be a little restrictive and did not allow for a free flowing conversation between the researcher and participant. The schedule (see appendix a) was revised and the same participant who took part in the pilot interview was re-interviewed. The subsequent interview yielded richer data and the revised schedule was used for the remaining interviews. The revised schedule however was not static. As new themes emerged they were incorporated into the interview schedule and proposed to future participants. One participant was interviewed on two separate occasions (one year apart) and was asked the exact same questions, on the exact same location by the same interviewer. The answers were of a similar quality and therefore veracity, validity and reliability of responses were able to be checked at two separate time points.

Interviews took place most commonly in the homes of the participants, or at a quiet place in the university and on two occasions in public places. The first issue that arose after interviewing in public places was participants feeling uncomfortable about discussing the highly subjective and often emotive topics relating to drug taking in a public place. The second relates to the recording quality. Realising that this was essential to be able to

transcribe recordings faithfully, I decided that either the participants wore a clip on microphone, or that a quiet location be chosen in future.

Interviews were recorded onto a high quality Sony Walkman MP3 player/recorder. The Walkman was chosen for its recording performance and discreet design. The interview process began by asking the participant background information regarding their past and current drug use, level of involvement in obtaining and distributing illegal drugs, residency and their personal circumstances regarding employment and financial income. This allowed the rest of the interview to be tailored to the participants' specific circumstances. For example, if the participant was a current opiate user then the interview would be focussed towards how they navigate this career as a user of this with other identities such as parent, or worker. Alternatively if the participant was abstinent the interview would focus more on the details of the reasons for stopping, and the risk involved when they did use.

The disadvantages of semi structured interviews include the possibility of the participant focussing on one topic or some aspect of the interview schedule that is specifically important to them. However it is the responsibility of the researcher to guide the discussion back to the topics included in the interview schedule without making the participant feel as though they are being pressurised or unduly influenced (Arksey and Knight, 1999).

### **Focus groups**

Two couples were interviewed together, and a group of three friends were interviewed as a group. This was the only way of securing access to them. It could be argued that this in some way changed how they answered the questions put to them by the researcher; however it could be argued that as they took drugs together regularly, and were very comfortable with each other's use of drugs, this helped reveal truthful responses to questions. According to May and Foxcroft (1995) using focus groups in addition to one to



one interviews allows the researcher to have distance and perspective from the respondent and to introduce a 'reality check' on the respondent's account. Traditionally, focus groups are considered valuable in highlighting the processes through which a consensus is constructed and on the various elements that come together for this to occur (Morgan, 1988; Kitzinger, 1994). In the focus group, all participants were asked the questions separately, this made the interview process longer, but it yielded richer data, and ensured that no single participants' voice was heard more than any other.

### **Non participant observation**

The researcher attended two social events in order to recruit participants into the research initially and later to observe how they behaved and interacted with others. The role adopted was of a non-participant observer; whenever offered drugs, a polite refusal usually sufficed, aware that the author had a role there as a researcher, and was required to either access potential research participants, or document what was observed. As in most social situations one must give thought to impression management, those things that might inhibit access must be minimised, while those that might facilitate acceptance were to be encouraged, but only within the limits set by ethical considerations (Hammersley & Atkinson, 1995). Often after refusing to take drugs, the author was asked questions which were designed to leave them in no doubt that they were a *tourist* in the social setting where drug use was taking place, implying that the 'intentionally unseen' were most definitely *native*.

At the first social event, the researcher was introduced by one of the gatekeeper contacts as someone who was interested in their views on drugs, and that anonymity was guaranteed<sup>21</sup>. These social gatherings proved to be an excellent opportunity to meet potential participants. The second social event attended just under 12 months later, also proved to be useful to observe how and in what way drug users managed drug use, risks, and also allowed an

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<sup>21</sup> Within the limits set out in the ethical approval process at Stirling University.

insight into how they had constructed their identity in a culture where what they were doing was illegal, potentially dangerous, and put them at great risk should their identity as a drug user be discovered.

By definition participant observation is observation carried out when the researcher is playing an established participant role in the scene studied with non-participant observation being the opposite. However, Atkinson and Hammersley (1998) contend that this dichotomy of roles is not helpful since it suggests that the non-participant observer plays no recognised role when in fact it is difficult to study the social world without being part of it. Instead of this confusing dichotomy, Atkinson and Hammersley (1998) point to the widely used fourfold typology developed by Gold (1958), of (1) complete observer, (2) observer as participant, (3) participant as observer, and (4) complete participant. Taylor (1993) suggests that the role of the researcher in this instance more closely resembles participant as observer where the researcher (observer) wished to be accepted as an acquaintance, if not a friend rather than a direct participant.

The nature of ethnographic research suggests that it should be considered an art as opposed to a science. Research methodology stemming from an ethnographic perspective allows one to interrogate data, be informed by the themes in the literature, index and categorise data, and finally code it into meaningful sections. It allows one to look for messages. The *bricoleur* is an artist, but not a fantasist; Adorno (1977) suggests that one looks for the 'exact fantasy' in research stemming from constructionist ontology, (Adorno 1977, cited in Crotty, 2009). Crotty (2009) helpfully summarises this position by stating that:

*"Constructionism is not simply subjectivism. It is curiosity, not conceit" (Crotty, 2009:52).*

This philosophical debate focuses on the understanding of scientific principles within social science research. For research to be scientifically valid, many social scientists suggest that quantitative measurements must form the basis of the data used in testing hypotheses

(Atkinson and Hammersley 1994). Central to this positivist view of social research is that since data requires rigorous testing to confirm its validity, there requires a degree of control over the variables either physically such as in the establishment of control groups or control with statistics such as survey design (Hammersley and Atkinson 2007). It therefore argued that as there is no control over variables in ethnographic forms of research findings are merely speculative.

### **The emic and etic perspectives**

Borrowing from phenomenology to interrogate the literature, and the participants' social worlds, this thesis is the search for a meaningful reality that the research participants share. However the researcher must be aware that subjectivism is a potential outcome of any data interrogation. In acknowledging one's biases, one can attempt to control for them and demonstrate an objective perspective, from the 'outside'. Phenomenology is for Sadler (1969:377) 'a fresh perception of existence unprejudiced by acculturation'.

Such sensitivity demands a change in attitude and perception, allowing the bricoleur researcher to be dispassionate, critical and even radical in interpreting data. It is acknowledged that culture can be liberating and equals freedom, it can also be limiting in setting boundaries. Boundaries (discourses) are our ways of knowing and determine acceptable and unacceptable conduct. As Heidegger (1962) suggests, 'cultural understandings are masks, screens and blindfolds, and that the discourses which dominate are merely 'seductive dictatorships', (Heidegger 1962:164, cited in Crotty, 2009)

The terms 'emic' denoting an insider status and 'etic', an objective scientific or outsider perspective, were derived from an analogy with the words 'phonemic' and 'phonetic' coined by the linguistic anthropologist Kenneth Pike (1954). Pike considers there to be two perspectives that can be employed in the study of a society's cultural system. As a result it

is possible to take the point of view of either the insider or the outsider. The emic perspective focuses on the intrinsic cultural distinctions that are meaningful to the members of a given society. For Pike (1954) the arbiters of the validity of an emic description are the natives themselves. The etic perspective relies upon the extrinsic concepts and categories that have meaning for scientific observers (e.g., per capita alcohol consumption). As a result, scientists are the main arbiters of the validity of an etic account.

Besides Pike, the scholar most closely associated with the concepts of 'emics' and 'etics' is the cultural anthropologist Marvin Harris (1976), who made the distinction between the emic and etic perspectives an integral part of his paradigm of cultural materialism. According to Headland et al., (1990), Pike and Harris continue to disagree about the precise definition and application of emics and etics (Headland et al., 1990). This disagreement concerns the goal of the etic approach. For Pike, etics are a way of accessing emics; for Harris, etics are an end in themselves. From Pike's point of view, the etic approach is useful for penetrating, discovering, and elucidating emic systems, but etic claims to knowledge have no necessary priority over competing emic claims. From the perspective Harris takes, the etic approach is useful in making objective determinations of fact, and therefore etic claims to knowledge are superior to competing emic claims to truth. For Pike, objective knowledge is an illusion, and all claims to knowledge are ultimately subjective; Harris believes that objective knowledge is at least potentially obtainable, and that the pursuit of such knowledge is essential for a discipline that aspires to be a science.

A methodological pluralism by the bricoleur researcher allows one to draw upon a variety of methods to access a variety of voices from a culture. Hammersley & Atkinson (1995) note that observational notes capture certain 'distanced' and 'researcher-led' formulations of a given element of a culture (Vidich and Lyman, 2001), while narratives of group members reveal meanings that may remain hidden. In this sense, ethnography opens up a dialogue between different voices and meanings. What the researcher does with these meanings illustrates analytical dilemmas. With this in mind it is worth stating that Paechter, 1996) has

identified that self-evaluative [reflexive] accounts seem in the main to be written by (and expected of) three main groups: established researchers looking back on mistakes they are assumed to have learned from, PhD candidates writing methodological appendices, and action researchers, who are often teachers. The latter two groups are made up of some of the least powerful individuals in the research community, and it is pertinent to ask who their accounts are for, and how they affect the power-knowledge relations within that community (Paechter 1996, p92).

## **Ethical Considerations**

Written consent was obtained prior to any recorded interview taking place, to demonstrate that the participant understood the nature and purpose of the study; that they had an opportunity to ask questions; and that they agreed to participate on a voluntary basis. All participants had the right to see any written transcript or listen to any recording made by the researcher in accordance with the Data Protection Act 1984. The researcher abided by the spirit and the letter of this Act. Information was considered confidential unless in exceptional circumstances the researcher is in future instructed by courts or officers of the courts to reveal such information. Within this Act, there is a legal duty to disclose information related to drug trafficking, terrorism and child abuse, and the research complied with section 38 in the British Sociological Association which states that 'Research data given in confidence do not enjoy legal privilege, that is they may be liable to subpoena by a court and research participants should be informed of this'. The participants (the person(s) interviewed) were informed that transcripts (written notes of the recorded interview) would contain as little information as possible capable of identifying the participant; directly or indirectly. Information used by the researcher is presented as statistics or as quotations and false names replace the participants' actual name.

This research adhered to the guidelines outlined in the British Sociological Association <http://www.britisoc.co.uk/students/PGStudy.htm>, and the Caldicott<sup>22</sup> Principles which refer to six overarching conditions required for study with vulnerable groups, and principally within caring and helping environments.

The competence of the participant to take part was established by ensuring that they understood the purpose of the study and that they were included as participants of their own free will and accord (Nachmias & Nachmias 1996:83) that they read and understood the information sheet (appendix a ), and signed the consent form (appendix b).

Psychological and emotional risk may occur with service users who have a long drug using career traumatised by both their drug use, societal responses to their inability to stop or cut down without help. If participants interviewed by the researcher had appeared to be in distress, the interview would have been stopped, allowing them time to regain composure. The information sheet left with each participant offered free confidential advice from the National Drugs Helpline, a 24 hour 7 day per week service (see appendix b). As the participants were consulted as experts, they were validated in recalling their experiences to the researcher. They actively chose to take part, and no incentive was offered. Participation was entirely voluntary. An incentive for taking part may be that this research is attempting to challenge stereotypes that underpin 'drug talk', and therefore policy implications arise which challenge current beliefs about what must be done about the drug problem.

The interview often did stray into sensitive topics, and explored how and in what way participants have engaged in buying, and selling of drugs to and from others. Exploratory, non-sensitive questions were exploring non-threatening areas of interest, before asking

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1. Justify the purpose of using confidential information
  2. Do not use participant identifiable information unless it is absolutely necessary
  3. Use the minimum necessary participant information that is required
  4. Access to participant identifiable information should be on a strict need to know basis
  5. Everyone with access to participant identifiable information should be aware of their responsibilities
  6. Understand and comply with the law

about more sensitive areas. However there was at all times, a stress that interviews while being recorded to aid recollection and understanding, that no question need be answered if it made the participant in any way uncomfortable.

With regards to the non-participant observation that gathered data on the interactions and practices of a group of drugs users, Avril Taylor's (1993) study of women drug users in Glasgow raises issues regarding the role of observer as participant which is central to the nature of this bricoleur research in the ethnographic tradition. Whilst Taylor (1993) does not directly refer to the issues of ethics it is currently a key consideration which requires consideration and addressing. O'Reilly (2005) notes that ethnographic research may be considered inherently unethical since it involves moving into people's lives, watching them, questioning them, analysing them and potentially being critical of what they say and do. One may argue that to fully engage with and understand the group being observed, the research should in fact be conducted covertly i.e. without the group's knowledge or consent but the International Sociological Association's (ISA) codes of ethics ([http://www.isa-sociology.org/about/isa\\_code\\_of\\_ethics.htm](http://www.isa-sociology.org/about/isa_code_of_ethics.htm)) refutes this by stating that covert research should be avoided in principle.

There is no suggestion that this thesis is constructed around the data gathered via covert observation but the debate around how much the researcher informs the subjects' remains contentious. O'Reilly (2005) suggests that being completely open with subjects about why you are there, what you are doing, how you think and what will happen to the collected material may cause difficulties so, it appears that whilst ethical considerations require the ethnographic researcher to obtain informed consent before embarking on the study, balance is required on how overt the researcher is with the research participants without being covert.

## Researcher's Role

My interest in illegal drugs began with some minor exposure to them in my late teens, and working in the music industry, and with some part time work in a helping agency in the late 1980's. I found the motivation to enrol on an undergraduate social sciences programme, studying psychology and sociology, financed by working in a homeless unit in Glasgow. During this time the misuse of alcohol, benzodiazepines (mainly Temazepam) and heroin was becoming largely associated with disaffected dislocated people from areas of economic and social deprivation in Scotland. These groups were not only without a proper home, they were presenting to homeless agencies with other problems. I successfully completed an honours degree, and continued to work with problem drug users. Now in my early 30's as a graduate working in the homeless sector and the addiction field, I had an understanding of how treatment agencies functioned. My exposure to the victims of an uneven distribution of wealth, resources and opportunity resulted in meeting problem drugs users who had a strong desire to be free from drug problems. Many of them seemed to come from the same postcode areas from all major towns and cities in the UK. Realising I had no idea how or why this was happening, I embarked on a postgraduate study programme at the Centre of Alcohol and Drugs Studies, based in the Paisley Campus of the University of the West of Scotland<sup>23</sup>. On completing this study, now firmly employed in the addiction field, still working part time in a homeless unit, engaging in voluntary work with a recovery group in Glasgow, as well as working in a rehabilitation agency with drug users of various types and learning the intricacies of one to one and group working with problematic drug users led me to another epiphany. Some users were able to tolerate using drugs for long periods and not identify as an 'addict', and others did not. I was then employed as Project Leader of National Drugs Helpline. A year and a half later, I was employed as an Addictions Officer employed by Paisley area Social Work Department. During which time I was delivering drugs education to teachers, and to young people, an experience that was frustrating as I could

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<sup>23</sup> Formerly University of Paisley.



only disseminate one simple message 'just say no to drugs'. I was also picking up part time teaching slots at the University of Paisley's Centre for Alcohol and Drugs Studies on their undergraduate BSc. Health Studies programme. In January 2000, I was employed as a lecturer at the University of Paisley, teaching full time on the postgraduate programme in alcohol and drugs studies. As my research and experience in the field expanded, I was asked to become an expert witness in drug cases, and access information written by STOP units, a group of police officers who write reports for the Procurator Fiscal and attend court as expert witnesses. This experience led me to another epiphany: how the Police viewed addiction, crime, and drugs was based on simplistic notions of how drugs worked, and how people 'behaved' when they used them. The police perspective on drug dealing and drugs markets, I now understood, was based on only one perspective. Drugs caused problems due to addiction. My own experience, having access to much specialist literature, and working directly with problems drugs users and accessing non-problem users in research, was different.

Having had 23 years in the addictions field, the first nine working face to face with addicts, and the latter 14 engaged in teaching and academic research, it should be clear that interviewing someone for an hour or more provided an opportunity to form judgements about honesty and consistency. There is awareness that people construct narratives in a way that helps them to make sense of their history, and that at times this may mean participants – often unintentionally – present self-serving or self-deluding accounts of their illicit drug use. Researcher effects are a common concern in qualitative data collection techniques, and the possibility exists that the researcher may influence the participants' responses at some point during the interview (Silverman, 2005:48-49). The participants were fully aware that they could stop the interview at any time without prejudice, if asked a question that they did not fully understand.

## **Limitations**

Due to the small sample size (n=24) employed for this project the possibility that findings can be generalised is rendered difficult. However generalisation was never an objective of the research; the experiences of this hidden population are deeply subjective and generalising findings and applying them to other populations would be an unproductive endeavour. While the research attempted to recruit an equal number of males and females to this research, gendered analysis was not a primary objective of this research. Indeed the review of the literature revealed that much of the gendered research that recruited female participants concluded that women were often less powerful than males. While this is almost certainly the case in populations recruited from treatment and criminal justice agencies, the females in this research did not identify, or present themselves as less powerful than males. However it is acknowledged that future research would greatly benefit from such a gendered focus.

Whilst it can be contended that the debate around ethnographic research's rejection of positivism is a significant critique, critics also point to the issue of representativeness (Bell 2010). Often in ethnographic observations the group may be small in number (even one person). Is this small group representative of others in similar cultures? Is Taylor's (1993) study of female drug users in Glasgow representative of other female drug users who do not inject drugs? The secret would appear to be to ensure that if the study is well designed, well-structured and makes no claims which cannot be justified.

## **Analysis**

All of the recordings were transcribed into word documents. Every participant, whether part of a focus group, or one to one interview was assigned a pseudonym, and their individual voice was identified easily. In the focus group, all participants were asked the questions

individually, this made the interview process longer, but it yielded richer data, and ensured that no single participants' voice was heard more than any other.

In one interview two males were interviewed together. One of the participants in their twenties found it easier than the other to construct statements regarding their experience of drug taking, and the skill of the researcher, experienced in motivational interviewing techniques, and having had several years' experience in assessing drug users in various treatment and therapeutic settings, allowed the researcher to ask the same question in several ways to elicit coherent responses. Because of this the statements often required exploration to reveal reasoning (Scully, Banks and Shakespeare, 2006). The need to explore and interpret reflexively was realised during the first few interviews. While most of the research participants were extremely articulate, this one participant did not articulate their experiences well and this was controlled for by probing reasons and justifications for explained behaviours further as the interview progressed. Occasionally, during the course of an interview, participants would make normative assumptions in which it was taken for granted that the researcher would know what they mean, indeed one would say the words 'know what I mean'? The main aim of the interview being semi structured was to draw out these assumptions and make them explicit thereby constructing a chain of reasoning that constituted a coherent explanation of the participants experiences within the transcript.

The first stage of validation in any research project is to ensure that the purpose of the research is understood and explained to the participant (Cho and Trent, 2006). In attempting to achieve this, the researcher consistently explained the aims and objectives to the participant prior to requesting consent for interview. Cho and Trent argue that for an empirical project to be valid the research aims and objectives must be made clear to participants and that the method of analysis must be tailored in order to achieve those aims (ibid). In order to increase validity transcriptions of interviews were checked against the audio recordings for accuracy.

The analytical approach was a type of adaptive coding (Layder, 1998; Radcliffe & Stevens 2008). A random selection of interview transcripts was used to identify broad themes in the data. Second, a further 10 interview transcripts were randomly selected and used to check whether or not any other broad themes could be added to divide the existing broad themes into sub-themes. Once the themes and sub-themes had been identified, they were used as a set of master codes for each interview transcript. Siedel (1998) simplifies the qualitative research process as a process of noticing, collecting and thinking about the data. Therefore the process of analysing the qualitative data was not linear, and had the following 3 characteristics.

1. Iterative and progressive: the cycle repeats continuously. For example while one is thinking, one can also notice and also collect, and notice, and so the process is an infinite spiral.
2. Recursive: it is recursive because one part can direct you to a previous part.
3. Holographic: each step in the process contains the entire process. For example when noticing things, you are already mentally collecting and thinking about those things.

There are 2 levels of noticing, (1) making observations and writing field notes and (2) recording interviews. Gathering and reading documents also inform the coding process. Once records were produced a process of naming themes began, beginning with parent codes, then child codes and so on. Coding the data was a simple process with two types of coding available for use, codes as heuristic tools and codes as objective transparent representations of facts (Kelle & Siedel, 1995). Once codes were recorded, they were collected and sorted in a continuous process, in effect this was driven by the questions which were asked using the semi structured questionnaire, and by instances noticed in each of the transcripts as a whole and as parts of the entire document. As a result data were broken down into manageable pieces. As Jorgensen suggests:

*“The researcher sorts and sifts them, searching for types, classes, sequences, processes, patterns or wholes. The aim of this process is to assemble or reconstruct the data in a meaningful or comprehensible fashion”, (Jorgenson, 1998:107, cited in Siedel 1998:4).*

At first this process can be confusing, however by constant study, reading, rereading and further coding, not forgetting to read the transcripts in their entirety for clarity, a semblance of order took shape, similar to the ‘grounded theory’ tradition. However while this process was systematic, it is not the only way in which data was coded, sorted, and sifted.

The goals of the analytic process were to make sense of collection of the data (after coding), to look for and establish patterns in this data, including relationships within each individual transcript and across each transcript, and to make discoveries in the data that can only be revealed using this type of systematic analysis. This is a time consuming process but it did reveal typologies (in terms of strategies used to recognise and limit risk) and also gaps in the transcripts where a lack of information become glaringly apparent, in particular not asking systematically about amounts of drugs used, typical or preferred routes of administration, and amounts typically purchased for consumption.

Using this process there were potential problems in data analysis. For example Wiseman (1979) suggests that the simple act of breaking down the data into manageable chunks can distort interpretation and mislead the researcher.

*“...a serious problem is sometimes created by the very fact of organising the material through coding or breaking it up into segments in that this destroys the totality of philosophy as expressed by the interviewee – which I closely related to the major goal of the study” (Wiseman, 1979: 278).*

It was essential that each transcript was read in its entirety so that the meaning and context was not lost. However, sorting the data, finding themes and sub themes can mean that in finding the codes you risk losing the phenomena (Siedel 1998:7).

Initially, a primary coding was conducted through a pen and paper analysis. Themes were attached to segments of data and occasionally several codes were attached to specific segments. Certain segments of data were both descriptively and inferentially meaningful; data that falls into this category was generally rich in both categories of meaning and in this context multiple coding is acceptable (Miles and Huberman, 1994). The first stage of a primary coding was necessarily selective in nature and focussed on the meaning of the data rather the words used by the participant (Ibid). In this context, coding itself became an interpretive process in which meaning was understood through the significance of the context within which the words used to describe the situation were uttered. Coding was undertaken in two main methods. The first was a primary coding in which the data from each interview was taken as a single occurrence and codes were generated without reference to previous interviews. This method was unstructured and focussed only on the interview under consideration at the time. The codes generated were solely in reference to that interview although many themes did crossover into other interviews. The second level of coding was conducted and focussed on standardising the initial codes in order to compare interviews using the same conceptual framework. During the second stage of coding themes that could be replicated or had similar meanings were identified and removed or replaced. This made the entire coding exercise quite laborious and time consuming however, it was necessary in order to elicit the best analysis of the data.

This two tier level of analysis also helped to reduce the possibility of researcher bias and helped to maintain a level of objectivity during the coding stages. Using a standardised coding framework from the outset could have resulted in data segments being placed into categories that they did not quite fit into; creating new categories did increase the time it took for analysis but it also created a much more balanced analysis. By coding in this manner,

new themes were created whenever necessary. This presented the researcher with the opportunity to discard or maintain the themes created in the second stage of coding. Multiple themes or very closely related themes were standardised during the second stage of coding. Occasionally during the second stage certain themes were decided to be unnecessary; when this happened the segment was recoded if the researcher felt the data still held value that was attributable to a new or other existing code.

It is also worth noting, whilst discussing analysis, what this research was not attempting to do. There are various possible analyses that could have been conducted on these data and therefore there are aspects of the data that have not been analysed that may otherwise have been insightful. It would have been interesting to discover and map every drug they had ever tried however this was not the primary focus of the research, and their preferences were being sought, not everything they had experienced throughout their drug career. A comparison of several groups of preferred drug using type would have been an interesting and valuable exercise. However, as the focus of the research was to establish the experience of drug use among non-treatment seeking hidden users of illegal drugs it is first and foremost important to establish this circumstance before breaking the data down into groups that can be compared. But for the purpose of achieving the aims of this project, analysis of the data focussed on assessing the participants views to access representative examples of the experience of drug taking from the perspective of the non-service user, whether they are current drugs purchasers, user, injectors, or opiate users or not.

## **Reflections on the use of field notes**

The use of field notes in addiction research often takes central place in observational studies in general and ethnographies in particular (Mullhall, 2002). A number of authors have discussed the use of field notes, their form, meaning, use and construction (Van Maanen 1988, Sanjek 1990, Emerson et al. 1995). However it is pertinent to consider what is meant

by the 'field'. How researchers conceptualise the field may influence assumptions and practices within it. Realist researchers consider that the field represents a natural entity, out there, which requires to be objectively described by an observer, who acts as an impersonal channel through which information is conveyed to the reader. In contrast, many researchers utilising an ethnographic methodology consider that the field is 'something we construct both through the practical transactions and activities of data collection and through the literary activities of writing field notes, analytic memoranda and the like' (Atkinson 1992, p. 5). This viewpoint indicates that the practices of researchers in the field the ways in which they present to others (impressions management) can be shaped both by their disciplinary interests and by themselves as people. Within the type of non-participant observation utilised in this research, specific detailed accounts of events were not required, and capturing broad patterns could be achieved at a distance from an 'etic' perspective. Spradley (1980) has suggested that observations that are merely descriptive are both time-consuming and ineffective. Thus it can be argued that field notes are a representation or a construction of events by the author from an insider perspective that can be analysed objectively from an 'etic' perspective. Recognising that researchers can be guilty of focusing on certain activities, key events, and their reactions to them, an emic and an etic perspective was adopted. As has been discussed impression management and the ethics of collecting data are difficult; however these issues were recognised at the outset, and have been discussed previously. The methods of collecting data utilised not only a triangulation of observation, group interviews and face to face interviews, but also a *bricoleur* approach to data analysis.

An 'insider' working and teaching in the field of addiction undertaking observation of users of illegal drugs is at an advantage 'in the field'. One can intuitively recognise situations that are sensitive, embarrassing, or generally 'off limits' and best avoided, creating a level of trust that would be impossible by any 'outsider'.

Van Maanen (1988) describes three classic genres of ethnographies. (1) Realist fieldwork represents the ethnographer utilizing an etic approach, allows the researcher to adopt the



role of objective social scientist, (2) confessional tales often include the researcher's personal experiences and methodological confessions alongside, but separate from, the descriptive fieldwork account, that seeks to maintain the ethnographer's authority as interpreter, and (3) *impressionist* tales is an attempt by the researcher to provide accounts that create a sense of being inside interpreting the events as they unfold. Although field notes are not as polished or structured as final ethnographies, they may encompass one or more of the above approaches. Concerning the focus of field notes, Emerson et al. (1995) distinguish between descriptive texts documenting the physical environment, people, actions and smells which make up a setting, and dialogue (or transcriptions) which is the written representation of something that was said. Focusing on both actions and dialogue in a social situation is practically quite difficult, but may often enrich the ensuing account. In the real world, researcher can and do combine a variety of these strategies. Although the matters of recall and focus present practical problems, they also underpin the *bricoleur* stance of the research. The data gathered in social situations as a non-participant observer was to observe the actions of the drugs users in a social setting and discover whether what was observed challenged or supported the data gathered in the face to face and focus group interviews. It should be noted that several of the observations regarding drug mentors, discussed in chapter five supported the interview data from the focus group, pair bonded partner interviews, and the single participant interviews.

## **Reflections of the coding of data**

When embarking on the coding of the themes that began to be identified in the first of the interview transcripts, some themes were driven by the design of the questionnaire, itself informed by the review of the literature, and other themes were revealed on repeated reading, coding and comparing participant transcripts. There were several layers of themes waiting to be discovered. The validity of interpretation is based on the level of triangulation

of data through coding and the reflexivity of the thematic analysis. The level of reflexivity was determined by the time spent in analysis of the data, individually, by theme, and in reading the transcripts in their entirety.

The data was analysed from the emic perspective of an experienced participant with insider knowledge of such social situations, but also from the detached viewpoint that can be used to give an etic perspective.

The researcher as bricoleur learned a great deal about how important it was not to rely on any one perspective, and that both competed on occasions, requiring further reflection before returning to the data. Richardson (2000) disputes the utility of triangulation, asserting that the central heuristic for qualitative enquiry should be the crystal not the triangle. Mixed genre texts suggest Denzin & Lincoln (2003) have more than three sides in a post experimental period that qualitative research is now associated. Thus the critical politically aware *bricoleur* must understand the complexity of interpretation, and the bias that are inherent in multiple perspectives and interpretations.

Becker (1958) describes the process of analysis as a 'sequential' one in which much of the data collection phase and its analysis is carried out while the fieldwork is in progress and, as such, forms an integral part of that phase of the research. That is, it uses sociological interpretations, albeit provisional ones, to inform the direction of subsequent fieldwork. Language discourse represents and articulates our concepts of reality, which in turn reproduce or reflect reality, or the way things are. This Interpretivism allows one to relate the part to the whole and vice versa. Interpretivism can reveal privileged meanings, which can serve hegemonic interests, and such awareness allowed a critical reading of government policy documents, which informed the research design, and indeed the analysis of the research participants' data. The conclusion reached from the research methods utilised in this research is that knowledge is not what individuals believe, but rather what social groups, or knowledge communities, believe. As such there is an impasse between drug policy

representations, public perceptions and the perceptions of the research participants. This forms the basis of the thesis.

## Results

Demographic details were taken from all participants at the onset of the semi structured interview. Information regarding the participants age, the area they live in, age at first drug use, age they first injected drugs, their current status as drug users, and in particular whether they had ever used heroin, a drug particularly feared and demonised.

Race was not considered to be an important factor in the demographic profile and most of the participants were white Scottish. While several of the participants were from working class backgrounds the majority of the sample (n=24) were, due to their occupations, or home ownership status, could be considered middle class. Two participants were at the time of the interview unemployed; one recently diagnosed with a degenerative medical condition, and the other was a part time student and single mother of two children at the time of interview. This renders the possibility of analysing differences in socio economic status amongst the sample possible, although this was never an objective of the project. Although this aspect of the sample does appear homogenous, marked differences in their status as drug users resulted in a degree of diversity in the sample. All of the participants who decided to take part stated that they did so because they were motivated by the research which sought their views which they believed challenged certain 'consensual' beliefs about drug use, and their identity.

One female participant was interviewed twice a year apart to discover if the initial statements had any veracity. All of the same questions were asked, and the answers were remarkably similar, indicating that the interview process was eliciting responses that were a 'truth' for that participant. This encouraged me to continue with the remaining interviews. Each participant was offered a copy of their interview transcript, and only one wished to see it. There were no requests to change or alter any of her statements, and this could have meant two things, either she had a great memory, or that there were sufficient consistencies in her

answers to guarantee recall and her version of events recalled had a truth and a consistency.

The research participants were unremarkable in terms of the Scottish average for employment, education, home ownership, and the types of drugs used compared to data gleaned from other research discussed in the review of the literature. However future research would benefit from accessing a proportionate number of drugs users from other ethnic backgrounds. There was no attempt to recruit a representative sample, and the participants may not be representative of a typical functioning drug user. There was an equal sex mix, and perhaps this may not accurately reflect the numbers of drugs users 'out there'. Among service users seeking treatment the ratio is three males to one female, (SDMD, 2001). Two of the primary gatekeepers were female and easily gave me access to several friends and acquaintances, and this may account for the equal number of males to females. A profile of the sample recruitment areas can be seen in table 4 below.

**Table 4            The research participants**

		number
sex	Male	12
	female	12
age	20+	06
	30+	07
	40+	08
	50+	03
Drug use pattern	abstinent	02
	Intermittent users	17
	Daily users	05

Source: the intentionally unseen research participant interviews.

**Table 5 The research participants**

pseudonym	age	sex	area	employment	have children	Accomm	qualification	Drug 1	Drug 2	Used heroin
Ms I	35+	F	E	Self employed	yes	owned	HNC	cocaine	GHB	No
Ms S	40+	F	E	Self employed	yes	rented	Degree	MDMA	Alcohol	No
Ron	35+	M	E	Self employed	no	rented	C & Guilds	cannabis	GHB	No
Abby	35+	F	E	student	no	rented	Dip.	MDMA	GHB	No
KT	52	M	I	Self employed	no	owned	Dip.	cocaine	MDMA	No
Kay	34	F	E	catering	no	rented	HND	cannabis	MDMA	No
Rob	45	M	E	catering	yes	rented	HND	cannabis	MDMA	Yes
Mr G	26	M	G	engineering	no	rented	MSc	cocaine	MDMA	No
JJ	45+	M	G	Self employed	yes	owned	Degree	cocaine	Mephedrone	No
Don	50+	M	I	Emergency services	yes	owned	Degree	cannabis	MDMA	No
Jamie	25	M	G	Builder	no	owned	C & Guilds	MDMA	cocaine	No
Chris	26	M	G	Insurance	no	rented	Higher	cocaine	MDMA	No
Mr R	52	M	I	Risk management	yes	owned	Prof. Qual	MDMA	cannabis	yes
Ms C	25	F	G	Office	no	rented	Degree	cocaine	Ketamine	No
Ms J	24	F	G	Office	no	rented	A level	MDMA	cocaine	No
Mr B	26	M	G	Landscaping	no	rented	GCSE's	alcohol	cocaine	No
Renee	32	F	E	unemployed	no	rented	Dip.	Mephedrone	Ketamine	yes
Ms M	41	F	B	Self employed	no	owned	none	MDMA	cannabis	yes
Mr K	42	M	B	Caring profession	no	owned	Degree	cocaine	cannabis	yes
Millie	49	F	G	media	yes	owned	MSc.	cannabis	MDMA	No
Mr HM	40	M	G	Caring profession	yes	owned	SVQ3	cannabis	MDMA	No
Ms H	35	F	E	Student support services	yes	owned	HND	cannabis	MDMA	No
Kath	35	F	E	catering	no	rented	HND	cannabis	MDMA	No
Ms Y	29	F	B	unemployed	yes	rented	none	cocaine	MDMA	Yes

Source: the intentionally unseen research participant interviews

**Table 6 drug use status of the intentionally unseen research participants**

	Ex users (abstinent)	Current daily users	Current intermittent users	Opiate experienced users
N=24	2	5	10	6

Source: the intentionally unseen research participant interviews

There is some crossover in drug use status within table six. Several of the current intermittent users had been daily users, experienced abstinence, and could be included in the opiate naive and experienced categories. The drug ‘careers’ of the participants were considerably fluid, with periods of abstinence occurring frequently for several reasons, not all of which were related to the classic problems of ‘addiction’.

**Table 7 Preferred drugs of choice of problem users and research participants**

problem drug users <sup>24</sup>	Research participants <sup>25</sup>
95% used heroin	25% (6) used heroin
30% used cannabis	38% (9) used cannabis (21% (5) used daily)
01% used MDMA	25% (6) used MDMA as first drug of choice
09% used cocaine	33% (8) used cocaine

It is worth mentioning that 95% of service users reported heroin as their main drug of choice, none of the research participants had heroin as their first or second drug of choice, although six of the 24 (25%) participants had used heroin in the past, with 1 describing himself as an intermittent user. 11 of the research participants listed MDMA as 2<sup>nd</sup> drug of choice, 3 of the research participants listed GHB as 2<sup>nd</sup> drug of choice, 3 of the research participants listed

<sup>24</sup> Source: Scottish Drugs Misuse database, 2011.

<sup>25</sup> Source: the intentionally unseen research participant interviews

cannabis as 2<sup>nd</sup> drug of choice, and two 2 of the research participants listed ketamine as 2<sup>nd</sup> drug of choice

**Table 8 Relationship to drugs: the intentionally unseen**

Ex users	The inclusion of ex users of certain drugs provides a rich source of data on the topic of what it means to be abstinent. Both ex users (one male and one female) continued to use alcohol, and one used tobacco daily and cannabis intermittently.
Current daily users	The inclusion of this population allowed an exploration of 'addiction' and how this impacts on identity, relative to the treatment seeking problem user.
Current intermittent users	The inclusion of this population reflect the views and experiences of recreational controlled users, and explore the concept of 'normalisation', management of risk, and how this impacts on identity.
Opiate experienced users	This population was included in the sample to ascertain their experience of using a drug considered by society to be so powerful that exposure to it results in addiction.
Opiate naive users	The inclusion of this group adds a further dimension to the sample of both current intermittent users and daily drug users.

Source: the intentionally unseen research participant interviews

Categorising participants into the groups discussed in table 8 above occurred after the first stage of the interview process. Participants were asked background questions pertaining to their involvement with drugs and their drugs of choice, and their preferred patterns of use. Some participants could be categorised in more than one group. For example one opiate experienced female user was at the time of interview unemployed, and abstinent.



**Table 9 Demographic data of problem and recreational drugs users in Scotland 2011**

<b>Problem drug users<sup>26</sup></b>	<b>Research participants<sup>27</sup></b>
Male: female ratio was 3:1.	Male female ratio of 1:1
Median age of clients was 31.	Median age 41
73% were unemployed, although this increases to 86% if one includes those in colleges or on short term work experience. (13% of the total)	8% sample were unemployed
80% lived in owned or rented accommodation, and 2% reported that they lived in supported accommodation.	46% were home owners
No distinction was made in this data category	54% lived in rented accommodation
20% had previously been in prison, 16% reported that they were homeless	None were homeless or in prison
42% had dependent children under 16.	42% (10) were parents; 21% (5) had children under the age of 16

It is worth pointing out that the research participants described in table 9 are unremarkable in terms of Scottish norms for employment, home ownership, and parental status.

**Table 10 Research participants' use of opiates, stimulants and alcohol by age**

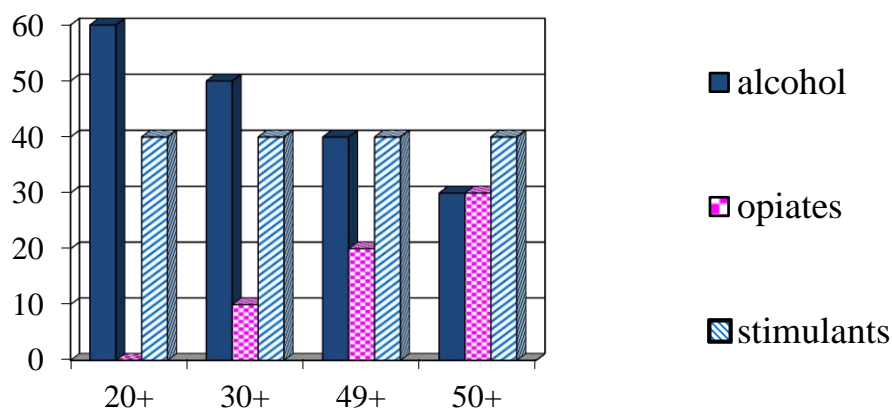


Table 10 highlights several points for discussion<sup>28</sup>. The use of stimulants was stable across all ages; the use of alcohol appeared to decrease with age, although this could be due to sex and regional differences. The older participants were more likely to have used heroin. This may be due to several factors: (a) opiates are becoming socially unacceptable by young

<sup>26</sup> Source: Scottish Drugs Misuse database, 2011.

<sup>27</sup> Source: the intentionally unseen research participant interviews

<sup>28</sup> the intentionally unseen research participant interviews

people, (b) government anti-drug messages stigmatising its use have succeeded in preventing its widespread use, (c) availability and demand for this drug is in decline. However problem users who attend treatment indicate consistently that heroin is the drug of choice of service users, most of whom are young unemployed males residing in areas of deprivation. What could be happening is that a less deprived lifestyle and identification with other more fulfilling identities may be acting as protective factors allowing older heroin users to remain intentionally unseen. As will be discussed later, the younger users of illegal drugs who had never used heroin and other opiates tended to demonise this drug and its stereotypical user, in much the same manner that several of the participants demonised the typical alcohol user as aggressive and anti-social. It could be inferred that it is daily use of heroin that causes most problems. That argument may be sound, however evidence would indicate that daily prolonged use of such a drug does not inevitably result in problems (Shewen and Dalgarno 2005; Warburton Hough et al 2010).

The research participants were on average older and more stable than the average treatment seeking drug user (Casey et al, 2009) insofar as the majority were in employment, were home owners, and were in stable relationships. In contrast the typical problems user of treatment services is unemployed, living in unsecure accommodation, with little or no employment history, and few qualifications. Just over 40% of service users were parents, and just over 20% of the research samples were parents.

As can be seen in table 11, there are several demographic differences between the crude use categories described by Casey et al 2009. There is an even sex split in the recreational use category, and the ratio in problem users is 3:1. There have been several reasons given for such differences which are summarised in the literature review. Suffice to say that as alcohol use patterns between sexes are converging, it may be possible to tentatively conclude that drug use patterns may also be converging. However the small size of the sample means that this can only be a speculation.

**Table 11 use of drugs by research participants**

Type of drug	Not reported	Used in past only	Used in previous month
Alcohol	-	02	22
Cannabis	00	19	05
Tobacco	10	09	05
Opiates	18	05	01
Ketamine	09	05	10
GHB	07	08	09
Mephedrone (4mmc)	07	07	08
Cocaine	-	12	12
Benzodiazepines	10	10	04
MDMA (ecstasy)	-	13	11

Source: the intentionally unseen research participant interviews

Some of the participants in this research used drugs occasionally, some daily, one had recently given up smoking, and all but two were intermittent users of alcohol, one was a daily user. Two considered themselves abstinent from drugs (Mr HM and Ms Y), although one (Mr HM) smoked tobacco daily, and cannabis rarely, and both used alcohol intermittently. Twenty one of the twenty four participants drank alcohol regularly<sup>29</sup>, three were abstinent from alcohol, and did not identify with typical users of this drug. Seven of the twenty four participants smoked tobacco, and one had recently stopped (Millie). All of the research participants had used alcohol, cannabis, cocaine and MDMA.

Six of the participants had experience of using opiates on more than one occasion, and one was a regular user, and was not dependent on it. Of the six who had experience of opiates, one had recently stopped using tobacco, but did continue to use cannabis daily after work. As eighteen of the twenty four participants had never tried opiates; their views on the power of this drug to create addicts contrasted sharply with the opiate experienced participants'

<sup>29</sup> Defined as a minimum of one occasion per month where alcohol was consumed. None were daily users of this drug.

views of its power. The opiate experienced viewed it as unremarkable, and not in the least as pleasurable as the myths implied.

## **Discussion**

In drug policy documents, drug users are described as 'at risk' of various pathologies, and are portrayed as non-productive citizens, putting strain on our economy. Abstinence or being drug free or in 'recovery' is depicted as normal and as a result there is tension in how non treatment seeking drugs users are represented. There exists the belief that drugs problems are caused solely by drugs, and that problems can be solved by abstinence. However themes explored in later chapters critique such views that drugs and biology are of themselves causal in drug problems. This requires an analysis of how and in what way hidden drugs users actively avoid the lifestyle of the 'typical' treatment seeking 'addicted' drug user. Derrida (1981) deconstructs such binary oppositions revealing that they are rarely neutral and that one is often perceived to be more dominant, exposing power relations. Examples include White / Black, and Male / Female. Regarding the binary opposition at the heart of this production, the non-user is from a privileged perspective at least, the dominant pole and is constructed as 'the norm'. By drawing attention to the existence of binary oppositions underlying belief systems, Derrida challenges the essentialism inherent in such dualism.

The intentionally unseen research participants were unlike the typical problem user seeking treatment insofar as their drugs of choice were largely stimulants, and the hallucinogenic, mild depressant drug cannabis. The participants taking part in this research were remarkably 'normal' in how they compared to Scottish norms in terms of employment and education. Drug taking was often subordinated to other activities and were not as important

a factor in their personal and group identity as the 'typical' problem user, who may accept or had conferred upon them the label of 'addict', 'offender', or 'problem' user.

The primary data for this research were collected from a hidden group of illegal drugs users, who were socially competent. The participants provided multiple perspectives of their experiences and those who fitted the inclusion criterion were enthusiastic in their telling of their narratives. Accessing a hidden group of illegal drugs users is difficult, time consuming, frustrating, and often disappointing if they pull out or fail to keep a pre-arranged appointment; however despite these concerns those who eventually took part provided a rich source of data, and a multitude of perspectives. Complete anonymity was guaranteed within the confines of the ethics procedures that had to be followed. Not one of the participants was asked their full name, and a pseudonym was used at the outset. Only their age ranges were asked for, and all were happy to provide this. Most participants were interviewed on a one to one basis, however one focus group was interviewed consisting of three participants, and three couples were interviewed together. A group with three or more participants could be defined as a focus group (Stewart and Shamdasani 1990) while focus groups of two participants are outside such definition. The pair bonded partnerships provided a rich source of data on the experiences they shared being drug users, accessing drugs, learning to use drugs, and the processes they utilised to maintain an identity of sensible controlled use, and negotiated loss of control through intoxicating experiences. A loss of control is theorised as a defining characteristic, the '*sine qua non*' of the addiction concept and is linked theoretically and conceptually to the drug problem.

The next four results and data analysis chapters explore who these participants are, how they situate themselves in their community as hidden users of drugs in a climate of moral and legal censure. The research will then explore how they manage the risk associated with drug use, how they source drugs for themselves and others, and how this impacts on their sense of identity, and finally how they situate themselves as normal in a community where

the influence of drugs prohibition would stigmatise them should their hidden and illicit social worlds be revealed.

## Chapter four: bonding and identification

Ervine Goffman (1959, 1971) has argued that the ability to present oneself as a moral actor is crucial in enabling one to participate in and maintain membership of a moral community. He used the notion of 'career' to apply to any practice that implies the career path of an identity. Goffman's concept of a career (1961:119) refers to 'any social strand of a person's course through life'. He is in essence arguing that progression through life as a social actor was a career of sorts. This thesis contends that the personal identity discourse of each participant is an attempt to align themselves to a normalised sensible controlled user identity in order to prevent or minimise potential for stigma, by presenting themselves as part of a moral social group which they wish to remain part of, but by certain behaviours they choose to engage they do not agree with. It explores language as a social action as well as the content of what is described. The author cannot pass judgement on whether the accounts are truthful or not, merely that some arguments are better presented than others. The social experiences that the participants describe and live as they progress through their careers as drugs takers in a moral universe from which they could be excluded from if their 'true' identity were to be revealed to someone who was not an 'outsider' (Becker 1963) are explored.

In a survey of 3000 people, Singleton, (2011) revealed a contrasting picture of fear and confusion about drug takers in the UK. At the heart of the report almost 60% consider drug dependence as an illness like any other long-term chronic health problem; almost 60% agreed that one of the main causes of drug dependence is lack of self-discipline or will power; just less than 50% would not want to live next to someone who had been dependent on drugs, and finally 34% of respondents felt a person would be foolish to enter into a serious relationship with an addict who has suffered from drug problems, even if they seemed fully 'recovered'. Many of the findings discussed by Singleton (2011) challenge public attitudes towards people with mental health problems, a group acknowledged as being stigmatised. While drug taking may have been normalised (Parker et al, 1998, 2005) it is also like mental illness, still decidedly stigmatised. The belief that drug taking is an illness

which inevitably leads to acquisitive driven by cravings for drugs, and that drug users are different from people who are drug naive is clearly widespread. Therefore concealing what is potentially stigmatising is understandable, if not essential in such a stigmatising environment. However research which challenges the inevitability of drug exposure leading to addiction requiring treatment was conducted by Biernacki (1986). His research describes problem users as displaying three types of identity change that led from drug use, to abstinence and 'recovery', without the aid of medical treatment. These were: *emergence* (creating a new identity); *reverting*, (reassuming an unspoiled identity), *revising*, (augmenting a spoiled identity). It should be noted that such studies document career shifts and identity change from one to another, and do not document identity transformation within a career. Therefore what is proposed in the research presented here is that identity formations occur within the deviant careers of the participants, as they have not essentially changed their identity<sup>30</sup>, it remains hidden from view. This chapter will focus on three themes of identification within the 'career' of the socially competent drug user; these are (1) identity rejections (2) identity exchanges (3) and identity concealments.

Taking drugs in a society that has labelled such behaviour risky for health has created legal penalties for possessing certain substances constructs boundaries of identities from which individuals can choose to identify with. Some of course have little choice but to comply with certain labels that have been given to them and others come to accept certain labels, even if these labels are stigmatising, because there are some gains to be had. For example being a problem user of drugs has the advantage of giving an otherwise meaningless life a *raison d'être*. Hustling for drugs becomes an end in itself (Preble and Casey, 1969). However, otherwise law abiding citizens who are found with illegal drugs in their possession, or people who might be found out after taking a blood or urine test, for example for work, face

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<sup>30</sup> It should be noted that the two participants who had not used their drugs of choice for a period of time, cocaine and MDMA, they still used cannabis intermittently.



condemnation as irresponsible risk takers. The athlete who takes a substance for a cold or flu might find themselves labelled a cheat, after having used 'performance enhancing drugs'. Transgressing the boundaries of ethical behaviour is much studied in social sciences; from Durkheim who believed that crime was necessary in order to make society function, to those criticisms of agencies of social control that see such structures as an abuse of state power (Foucault 1976; Cohen, 1998). Two groups of drug users consistently condemned are drug injectors who use heroin, or users of crack cocaine. And yet there is evidence that use of these drugs can be sensible and controlled, and even normalised. In this study, two drugs create clear boundaries of risk that most users did not wish to breach, heroin and cocaine. The participants who had experienced opiates had very different views of this drug compared to opiate naive participants. Also there were several explanations for what constituted problem use, and the aetiology of problem use. These explanations were categorised into three themes representing (a) biological explanations, (b) psychological explanations and (c) structural or cultural explanations. The participants were also keen to distance themselves from categories of risk by rejecting, exchanging, or concealing identities that served to protect them from potential stigma. By only speaking about their lifestyle with other 'outsiders', and making sure that their potential sources of shame and stigma were concealed could they operate these contingent identities that allowed them to pass as rational 'normal' law abiding citizens. However hiding potential sources of shame resulted in certain participants keen to pass themselves off as responsible risk assessors by describing other types of drug user (heroin users for example) as 'waster's' and as a drain on society.

## **Identity rejections**

Mr G, an intermittent user of MDMA, cocaine and ketamine gives a clear definition of what he considers the typical problem user to be like, an identity he clearly rejects. He states that users of heroin are in general:

*'The lowest of the low, people who would rob you, they don't work, they get by in life on drugs and that's completely wrong I think', (Mr G, 20's)*

The participants were asked what they considered to be the signs of having a drug problem. Abby states that it's when users are:

*'...completely out of control, promiscuous, not thinking about their values any more, losing control in that way. It just changes the way they view things to the point that the social network just starts to disappear', (Abby, 30's).*

The statement from Abby is interesting insofar as she uses the words 'out of control' and 'promiscuous' to describe problem drug use. She describes the typical career trajectory defined in the literature about recreational users being at risk of problem use given sufficient exposure to drugs. This type of statement was given by all of the opiate naive participants. The opiate experienced and former heavy cocaine users had different views. Mr K, a user of opiates on occasions, rejects the widespread view that drugs are causal in addiction and suggests that problem users of heroin are largely the poor and that regular dependent cocaine users are in general the more affluent. His opinion appears more balanced insofar as he does not consider drugs to be the main factor in causing problem use. He states that:

*'If you've got a coke addiction then you've got to be a high-flyer, you've got to be pulling in the money. I don't see those types of people in a sort of greasy-haired spotty way as I would imagine heroin users, junkie types. The occasional unsavoury types I would see up my end are not pleasant people at all to be around', (Mr K, 40's).*

It is interesting that Mr K makes his comparisons of problem users based on economic status. He is not inferring that the use of drugs caused problem use per se; he is inferring that a user's economic situation could be an important factor in drugs of choice, and whether

they developed a problem. His statement also reveals his view that some heroin users are unpleasant to be around, and that problematic cocaine users are different. He is not inferring that they are any more pleasant to be around at all, merely that he thinks that cocaine is used by the affluent, in general, and that heroin is used problematically by the deprived; a simplistic view that was challenged by several of the participants. Zinberg (1984: 153) notes that '[o]ne way in which controlled users can assert their normalcy is to spurn and condemn junkies'. In the Rhodes et al., study of public injectors in South Wales, the disadvantaged injecting drug users interviewed reported that the 'shunning, dissing and cussing' of junkies come from other drug users (Rhodes et al., 2007: 581). In these interviews, drug users often repeated and endorsed the prevailing view that heroin users are not to be trusted, and different from *their* sensible controlled use (Parker et al, 1998).

### **Explaining problem use as biological in origin**

The participants expressed the commonly held view that addicts are biologically different from other people. One participant suggests that one might be 'born an addict', and in so doing holds the view that users are biologically different from normal individuals. However she makes reference to 'a heroin baby'. This refers to the commonly held view that if addicts can suffer withdrawal and craving, the 'sine qua non' of addiction, then that also must occur in babies. The literature on neonatal abstinence syndrome or NAS refers to a constellation of symptoms thought to be drug related. There is a great deal of debate in the literature about whether these symptoms might be drug related, or are merely symptoms of stress, poverty and other factors. The existence of 'crack babies' has largely been discredited as the fantasies of North American 'drug warriors' keen to further stigmatise African American drug using mothers. However the myth of 'heroin babies' survives and is repeated by Ms J who states that:

*'Some might have been born an addict, a heroin baby and they've got it in their blood', (Ms J, 20's).*

The view that drug users with problems may suffer from an acquired or inherited psychological condition, resulting in drug seeking behaviour or addiction, was a commonly held view among some participants. Ms I expresses the view that addiction is almost certainly inherited by stating that in her view addicts have:

*'...a tendency to be schizophrenic, so they've got that imbalance in their head anyway. I don't think these drugs will necessarily make you a schizophrenic or give you psychological problems but if you have that gene within you anyway then that might be the thing that sways it', (Ms I, 30's).*

The hijacked brain theory (Leshner 2000) stemming from research into brain chemistry views addiction as biological in origin. Several research papers support this view and several have discredited the research as merely building on existing prejudices about behaviours deemed unhealthy and immoral (Reinarman, 2005).

## **Explaining the drug as causal**

Many participants described the connection between addictive drugs such as heroin and cocaine as the root cause of addiction. The demon drug hypothesis which underpins temperance thinking and much of treatment and drug policy was expressed by Abby, who states that:

*'For heroin, the information I have on it is that it is very easy to become addicted to it', (Ms Abby, 30's).*

The 'never try it even once or you'll become addicted' view was expressed by several of the participants. This view that drugs are the cause of addiction expressed as a complete loss of control is a view consistent with the world view of Bob who states that:

*'...drug abusers ...they are just waiting for their next dole cheque or their next wage to get more drugs. That is somebody who lets the drug use them rather than them using the drug', (Bob, 40's).*

As a former user of heroin, his view of others as being out of control and having no will power is a view commonly held by opiate naïve users. However, two opiate naïve participants had known of heroin users who did not fit the stereotype. They state that:

*'...I think society generally think if you use the words drug addict, thinks it's like some sort of skanky bum who would rob an old granny without really thinking that every single smoker among us is actually a drug addict because obviously it's a hugely addictive drug. ... I suppose it depends on who you are talking to', (Ms H, 30's).*

Many of the participants considered the power of drugs to be the primary causal factor in defining addiction from controlled use. It was in the creation of these boundaries, which acted as boundary through which they could safely proclaim their difference from 'addicts'. While there were competing explanations for what caused problem drugs use (biological, psychological and social explanations) in the literature, and from the participants descriptions of what caused drug addiction, a great many of them linked users of heroin with the addict stereotype. Ron sums up how he views heroin users:

*'When it comes to scag<sup>31</sup>, most people who end up becoming scagheads all tend to turn out the same I think, they all have the wee whiny accents.... It doesn't matter where you go, scagheads all talk the same. ... They are usually quite gaunt, thin*

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<sup>31</sup> Scag is a common 'street' term for heroin.

*people, sweating all the time, especially in the middle of winter. You can tell a scaghead a mile away because he's sweating like f\*\*\* and its freezing', (Ron, 30's).*

The perspective that 'career' heroin users are different from other users of drugs was supported by most of the participants who had not tried opiates. Opiate users were described as easily identifiable, not only by their mode of dress of wearing long sleeve shirts and jackets, which helped cover the 'track marks' on their arms from regular injecting but also by their constant sweating. Ron also describes something interesting about the highly visible addicts that Scotland produces: the tendency to sound the same. This of course cannot be explained simply by the power of pharmacology (as Ron surmises) but is partially explained by the climate of moral and legal censure, and the illicit economy in which the contemporary addict criminal must operate. In being visible, they are vulnerable; however the fact that they are recognisable by how they look, and how they sound (Ron describes their 'wee whiny accents') means that they are seen as part of a deviant sub culture, instantly recognisable by others, and instantly rejected by most. Nevertheless, by wearing the addict uniform, and by using the addict patois, they are seen as unthreatening to other users. Their identity suggests that they are career addicts not undercover policemen, or social workers, or even researchers. In being 'like an addict' they have a group who will not judge them as other non addicts will. This explains, from a sociological perspective rather than from a pharmacological perspective, why addicts eventually learn to sound dress and act the same. The same participant however later expressed a more considered opinion on the aetiology of addiction by stating that it depends on the drugs:

*"Depends on what kind of drug user that you're talking about...I've not come across a decent heroin addict yet, they would rob you blind. Crack-heads as well, would rob you blind, stab you in back...." (Ron, 30's).*

However in stating this view, he reveals that two drugs in particular are more likely to result in problems, heroin and crack cocaine. The literature reveals that these two drugs are

considered to be addictive, one physically and the other psychologically. However there is also a considerable literature that has found users able to control the use of such drugs (Shewen and Dalgarno, 2005, Ditton and Hammersley, 1994) and therefore the drugs as causal factor in addiction, while a common and accepted rationale for addiction, is not supported by the available evidence. However this evidence is clearly not known by the participants in this research who repeat the views disseminated via 'drug talk'.

Ms M states that in her view there is only one drug that she thinks of when thinking about addiction:

*'When I hear of an addict I always sort of jump to smack. I associate that word with addict or junkie, not with any other drug', (Ms M, 40's).*

It is interesting to note that heroin was not the only demon drug. It is certainly a finding (discussed more fully in the chapter on accessing drugs) that drug availability and drug experiences are a crude shadow indicator of acceptability of that drug. Those users, who had never experienced GHB, or ketamine, had negative views about its use, and on the identity of the users who had experienced it.

## **Social structures as causal factors**

As discussed in the review of the literature, several theories from sociology have challenged 'drug talk'. Such research suggests that addiction may be in part a social construction, and that trying to locate the cause of habitual drug use in the user or in the drug is fruitless. There appears to be statistical relationships between dislocation and social problems such as alienation, anomie, drug addiction and crime. One of the participants, who currently worked in media, Millie, is a daily user of cannabis (in the evenings and weekends), recently stopped smoking, had tried opiates, and had, prior to her current job, conducted some research working part time for a rehabilitation project in Ayrshire. She describes her

experiences of interviewing young service users on their views of 'recovery'. As a result of having taken part in this, it is her opinion that the problems these young people faced were more than simply drug related. She explained her views on what she perceived to be the principle cause of treatment seeking and drug addict identities:

*'Part of that project (in Ayr) was interviewing kids...in prison because they'd stolen because of their drug habit. It just broke my heart...I just think it's really sad. Not that it isn't a drug addicts fault, if those people had been taken out of poverty and taken out of those fucking villages and be given some bus services and some jobs, you know', (Millie, 40's).*

This was a view expressed by a small minority of the participants. The vast majority tended to see the cause of addiction in biological, psychological explanations, and ignored environmental or structural factors. Millie views addiction as the result of pain and suffering. This pain she explained is not necessarily medical pain, located in a specific suite, but pain suffered due to inequality:

*'... There's a big part of me that sees addiction as just an inability to deal with pain and suffering; not wanting to deal with that', (Millie, 40's).*

Bruce Alexander (2008) has argued that addiction in contemporary capitalist society is caused as much by inequality, consumerism and globalisation, than the addictive properties of drugs.

That there were several competing explanations for addiction stemming from the research participants highlights the complexity of the debate in academia about what addiction might be, what government policy might best address it, and what treatments or interventions might prevent drug related problems. Ms Abby expresses the opinion that addiction to drugs requires a multi-faceted explanation:



*'There are so many functioning alcoholics just like there are functional drug takers as well', (Abby, 30's).*

The opiate experienced held views which directly challenged addiction discourse. Ms Y, a single mother of two young children, had lived with a drug dealer and had experienced heroin on at least six occasions. She was with five others, three of whom became 'addicts', they had injected, and she had smoked the heroin. Ms Y found the experience pleasant, but not at all like the mythical drug that was instantly addictive. She described her experiences:

*'It (using heroin) was pants'. 'It wasn't as good as I was told it would be. The experience wasn't as good as it was made out to be. I would rather have a joint'. 'I just didn't think it was that amazing, I don't know. It was alright but it wasn't, I thought a joint was better, but that was just my own opinion. I think they all believed it was the drug to be, and the drug to have, and the drug to use, at the time', (Ms Y, 20's).*

She was then asked: what did you expect? She stated:

*'I don't know I just expected something more like when you take E and you feel wonderful and great and it wasn't. I suppose it was a nice feeling but it tasted a bit like freshly plucked chickens which I didn't like. It just wasn't just that great a feeling. I mean it was a nice feeling, it just wasn't great', (Ms Y, 20's).*

Ms Y was asked why she did not become an addict and others in her social circle who had used heroin had, she said:

*'I don't know some people just get greedy or something. I've only ever done it when there wasn't something more important to do', (Ms Y, 20's).*

She was then asked: what would be more important to you than taking drugs?

*'Work, friends, kids; I probably enjoyed the drug experience more but in the long term the work was more beneficial...Just for my own sanity', (Ms Y, 20's).*

This participant is suggesting that in her opinion, other things of importance in her life made drugs subordinate in her life. Such factors described as 'social capital' by Biernacki (1986) were the factors of importance ensuring that that drugs had not become the most important thing in her life and by extension her identity. She had other interests, other elements in her life that were more important, such as her job and her children, and as she states such factors resulted in, 'her sanity'. Six of the twenty four participants had experienced heroin. Several described it as 'nice' and 'very pleasant', and one (Rob) mentioned it being 'his wee thing', a drug he only used on very special occasions. One (Mr R) had used raw opium, which he mentioned he had sourced<sup>32</sup> from a 'bent chemist in Bayswater (London). While all considered the drug to be pleasant, it was not described as so pleasurable that they stopped all other activity to pursue that particular drug experience. Findings supported by the literature on controlled drugs use.

The negative identity associated with problem users of controlled drugs was firmly rejected. One participant epitomises this by stating that:

*'I contribute very positively to society. I pay an absolute fortune in tax every year. I've had a good sporting career...I think I'm a good role model. But if you look at the popular press, as a drug user, then I'm just a hopeless addict who's a danger to everyone in society, who contributes nothing', (JJ, 40's).*

This statement highlights several issues that will be addressed: those users do not contribute to society and are a drain on its resources. That they are not tax payers, because the stereotypical problem users is on benefits, and that drugs users are unfit and unhealthy. He points out that he is not only healthy, but remains active and healthy.

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<sup>32</sup> The theme of where drugs are sourced will be examined more fully in the chapter titled 'sourcing drugs'.

## Identity exchanges

Ron explains that drugs are not just pleasurable and functional in his life, they also allow him to experience a temporary 'loss of control', but on his own terms, setting his own boundaries and limits on the extent of risk he is willing to tolerate, and more importantly put on public display to other users. He explains his rationale for using drugs to achieve a temporary loss of control:

*'I'm just searching for oblivion; it's why I do drugs to get that (laughs). Usually the whole point of taking drugs with me is I like to get really high to a point, where you're not coming down for a while and you feel great', (Ron, 30's).*

Ron was not the only participant to use this type of language, whereby they temporarily exchange the contingent identity of controlled sensible risk assessor for out of control hedonist. Most participants were keen to use language to describe their drug taking as responsible risk assessment which actively rejected stereotypical descriptions of hedonism, chaos and irresponsibility. As a result of this temporary loss of control, Ron did not risk his 'master-status' as a responsible risk assessor in his group. By making his loss of control about hedonism and fun, he temporarily exchanges one identity for another, with risking his status as one who has mastered being 'in control'.

Several participants were keen to describe themselves as creative risk takers, rather than irresponsible hedonists. Mr K for example exemplifies this position by stating that users of drugs are:

*'Not a straight peg...your drug taker is usually more of an interesting sort of person', (Mr K 40's.)*

This opinion shared by most of the participants rejects the boundaries imposed on them through addiction discourses of being out of control, at risk of addiction. Mr K in using terms

such as 'not a straight peg' is declaring that using illicit drugs does not necessarily make him at risk of developing a problem with drugs, but it does mean that he is at risk of condemnation. Therefore insisting that he is 'more of an interesting sort of person', he protects his self-identity as a controlled sensible user of drugs (Parker et al, 2005). Most had to subordinate any desire to engage in risk and had to be responsible most of the time, and as a result, drug taking was viewed as personal 'me' time, and time where one could catch up with others. It signalled the end of the working day, when children were in bed, or when they could catch up with partners or loved one. The use of drugs for several participants was not just about hedonistic pleasure, although this was important on occasions, but about signalling when they were 'off the clock' and relaxing. Ms S explains:

*'It (drug taking) is a reward and a kind punctuation, a knocking off...'* (Ms S, 40's).

Almost every event of any significance in our lives is marked with some sort of ceremony or celebration – and almost all of these rituals, in most cultures, involve alcohol. Alcohol is used to differentiate between work and play. Mandelbaum (1965) observes that:

*"... The act of drinking can serve as a symbolic punctuation mark differentiating one social context from the next. The cocktail prepared by the suburban housewife for her commuting husband when he returns in the evening helps separate the city and its work from the home and its relaxation."*

Gusfield (1987) has described the ways in which alcohol 'cues' the transition from work time to playtime in North American culture. In this society, alcohol is a suitable symbolic vehicle for the ritual transition from work to play because it is associated with 'time-out', with recreation, festivity, fun, spontaneity and the dissolution of hierarchy: it possesses a meaning in contrast to organised work. Thus the stop off at a bar on the way home from work, institutionalised (and commercialised) as the 'happy hour', or the drink taken immediately on crossing the threshold of the home, embodies the symbolism of a time period between work and leisure. Gusfield (1987) is stating that this time out enables one to

engage in liminal time<sup>33</sup>; a way of passing from the ordered regulation of one form of social organization to the less-ordered, deregulated form of another. In the same manner, drugs are used to symbolically create atmospheres and environments that are leisurely, relaxed, and relatively class free insofar as like in all other human activity, there are serious users, with a high degree of knowledge, intermittent users, and 'drug tourists', who come and go, but do not actively identify with the 'native', or regular users group functions and norms. That said the use of drugs also symbolise a boundary between work time and leisure time, as does alcohol for many. However while the risk from alcohol<sup>34</sup> can be calculated, there are several harms arising from the use of drugs that are beyond the control of even the most experienced drug adept. These will be explored later in chapter five. We are happy with ritual, and engaging in the familiar is more comfortable than doing anything that might be fraught with risk or difficulty. The contrast between searching for oblivion and the pleasure of mild intoxication is one aspect of drug taking; another is the social and fun aspect, the relaxation, the hedonism, and the negotiated 'me' time that the participants described. The next section will explore those aspects of the drug users' identity that were necessary to be concealed, to protect them from social affronts and stigma.

### **Identity concealment.**

An interesting point emerges from the narratives of the participants in relation to their reasons for first trying drug and the reasons they continued taking drugs. There was little change; reasons for using drugs were to aid sociability and enjoyment in being with like-minded others. This is in contrast to the typical service user narrative of the typical drug careers of 'addicts'. So the reasons given by the hidden populations do not fit with the typical 'career trajectory' of addicts who started as recreational experimenters, and descend

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<sup>33</sup> Liminal -Situating at the threshold; a liminal person or character is at the threshold between two societies or cultures.

<sup>34</sup> The strength of alcohol is regulated by the manufacturer, unlike the purity of illegal drugs.

into a life of addiction and crime to fund their use of drugs. As this narrative is distinctive this becomes an important factor or mechanism by which to separate 'recreational' from 'problematic', and through which status is achieved and communicated. The purpose or function of the narrative is to create a separate identity, functional insofar as it distances the participants from the stereotypical problem user, concealing from others aspects of their identity which do not 'fit' with sensible risk assessors. Five distinct identities emerged from which it was necessary to conceal their identity but also from which they derived their sense of normality and inclusion: parent, worker, music fan and petrol head, and the sports enthusiasts who enjoy the thrill of hill walking, climbing abseiling, paragliding and mountain biking.

All of the participants recognised the dangers of drugs; however as their use was potentially damaging to their reputations if discovered, they had developed elaborate techniques to create aspects of personal identity that allowed them to manage risks. They would describe other users as 'out of control', but not themselves, unless it was noted that this was 'on their terms', such as Ron and his temporary 'identity exchange'.

Kay describes herself as a daily user of cannabis in her thirties and acknowledges that drug use patterns exist on a continuum, and shares the view along with several of the participants, that drug taking is essentially normal, and that addicts are atypical. She like all other participants was asked to use her own words to describe what it means to be a drug user:

*'Drug user is a pretty vague term for a pretty broad spectrum. Which end of the spectrum should I pick...I would call myself a habitual user of recreational things', (laughs), (Kay, 30's).*

By asserting that drug taking is normal, Kay is stating that there is no 'line' that is crossed which separates the boundaries between drug user and drug 'addict'. However she is a

daily cannabis user, and by describing drugs as 'recreational things', she is merely holding the view that drugs are important, but not as important as other things in her life. Kay's drugs are not 'addictive' drugs; by describing her drug taking as 'things' she constructs drugs as just another commodity in her life. In so doing she separates herself from potential condemnation and stigma, apart from the atypical problem user of drugs. Expressed in her opinion is that drug taking was neither abnormal nor dysfunctional. It was merely something that she does with others.

The research participants were at pains to describe how important, and yet unimportant drug taking was to their sense of self. Mr R summarises by stating that:

*'I'm just a normal functioning human being. I've got friends ... some of them are very successful and run really successful businesses and they take drugs like myself, just as and when, it's not something they are doing every day', (Mr R, 50's).*

By referring to friends who are successful in business, Mr R assigns himself to this category of responsible risk assessor. Mr R describes himself as a 'normal functioning human being', who is an intermittent user of drugs. Problem users are daily user of drugs, as he does not use daily, he is 'normal'.

The idea of taking drugs to excess and that some users have gone too far was expressed in how addicts were labelled (by certain groups in society) and by some of the research participants. However there were types of drugs, and types of use that users clearly did not identify with, as in doing so they would increase risk of stigma and condemnation. The differences between types of drug, routes of administration, in particular injecting, as potential sources of shame and stigma will be discussed in the following chapter. Intermittent users were normal, and in describing themselves as normal, they described

other 'normal' activities that they engaged in, such as being a parent, and being in employment, distancing themselves from problem users of opiates, who they largely refer to as unemployed, chaotic and out of control.

### **Drug users with children**

'Child protection' social policy is underpinned by belief that drug using parents are significantly more likely to be poor parents, and put their drug wants before the needs of their children. These beliefs, explored in the review of the literature stem from temperance dogma. This is clearly highlighted in William Hogarth's 'Gin Lane', where the central protagonist in his etching is a woman intoxicated after her use of gin and snuff. Hogarth indicates that being so intoxicated she allows her baby to fall to its imminent death due to her neglect. The use of gin among the working classes was perceived to be a massive problem, setting in motion the Gin Act, in 1751, and the first formal attempts at regulating alcohol use in the UK. Such temperance thinking, that the 'demon drink' and in particular powerful distilled spirits caused poverty and infanticide echoes still in current media debates and government policy<sup>35</sup>. As this theme is an important issue for the identity of the research participants, it is now examined. Ten participants were parents, and five had children under the age of 16. One participant explains that as a daily user of cannabis, she limits her use to evenings when her son is in bed, or to weekends when her son is with his natural father who does not live with them. She explains how her drug user identity is a source of tension and potential shame and stigma to her social identity as a parent:

*'... the biggest part of my life when I've taken drugs is when I've been a parent, which is possibly the opposite way round for a lot of people...I'm very thought-out*

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<sup>35</sup> see 'Getting our Priorities Right' (2003, 2008) and 'the ACMD's (2003) report titled 'Hidden Harm: Responding to the needs of children of problem drug users' UK policy documents as examples.



*about how I'm going to take my drugs, so that I make sure that my son is away', (Ms H, 30's).*

She describes various situations where she worried that her son would smell cannabis, or notice drug paraphernalia, and was concerned that this would increase her risk of discovery. In order to minimise the risk of discovery, she created a rule that she does not use drugs unless her son is out of the house. Her son (aged 8) was getting older and she became increasingly concerned that he or his friends might talk at school, and thus reveal and spoil her hidden social life as a user of illegal drugs. She identifies with others who juggle work and drug taking and who view themselves as productive citizens, in direct contrast to the labels used by government. She firmly rejects any identification with problematic users of heroin who she terms 'wasters'. This was a view consistent with most heroin naive participants. However, Ms H, a non-user of opiates had a more balanced view:

*'Mostly I kind of think they are people like myself actually, you know, people who take recreational drugs when they've got the chance but they're probably holding down jobs and are possibly parents... ', (Ms H, 30's).*

She describes people who use drugs are just like her. She also as an intermittent user mentions that she takes drugs 'when she has the chance'. As a parent, these chances must be negotiated with the father of her son, who does not live with her. She mentions that this delayed onset of drug taking had an impact on her attitudes to drugs. She states that:

*'I got married very young so I feel I kind of missed out on a certain amount of partying so I think when I got to 30 I made up for it slightly (laughs) (Ms H, 30's).*

Those participants, who were parents, scrutinised their use more closely than others without such responsibilities. Ms I helpfully explains her rules:

*'With a young child in the group that we socialise with, I always take less than them and am always aware that I've got to leave. If they are going to start taking an E pill usually to their one, I take half ... I've got to get home and be responsible and all that', (Ms I, 30's).*

Her choices based on how she strongly identifies with being a parent first and a drugs user second are explained:

*'I stopped taking drugs when I had a child and didn't start again until long after breastfeeding', (Ms I, 30's).*

The ever constant threat of discovery weighed heavily on all of the research participants; however those who have children express the strongest guilt at their use of drugs. However Mr R is quick to point out that even though his children are now fully grown, he does not want his drug use exposed. He expresses concern about what 'message' this would send to his granddaughter. He explains:

*'All of my family is grown up; I've got a grandchild, with another couple on the way. I'm a regular family guy so I don't want to set bad examples to my kids', (Mr R, 50's).*

Don is keen to keep certain parts of his identity secret, having other responsibilities and other demands on his time means that he does not identify with problem users of drugs.

*'I have responsibilities. There's a responsibility to myself, to my kids, to my employers, family, all that kind of thing. I've always worked. What I have, I've earned. I don't have a mind-set of sitting about on benefits and stuff like that', (Don, 50's).*

This statement from Don explains clearly that having competing interests in his life, as a parent and as a worker, means that he cannot actively choose to retreat from society in the

manner that he believes addicts and service users can. These competing elements of his social identity may act as a protective factor by regulating his use patterns. He is a daily user of cannabis (in the evenings and after shift work as a fire-fighter).

Ms S also delayed onset into drug use as she had two young children to look after and support:

*'I had left school at 16 because I got pregnant and had two children to bring up and I was kind of busy focusing on them', (Ms S, 40's).*

She did not use drugs until her children were born and could be looked after by others. It then became necessary for her to conceal that part of her identity which could have stigmatised her. While it is not necessarily new that drug users who are parents are also responsible risk assessors, the fact that they are potentially more at risk of condemnation must not be overstated. Several drugs users, who were not parents, expressed their ability to be able to explore controlled chaos and abandon.

### **Drug use and employment**

Don suggests that in his social network, he struggles to think of people who are not users. He mentions that in his workplace (he is a part time fire-fighter) up to one third use illegal drugs.

*'Most folk I know take drugs, illegal drugs of one sort or another. I struggle to think of people that don't take drugs and every single one of these people all work, probably a quarter to a third of the people that are in the fire station take drugs', (Don, 50's).*

Don's view that drug taking is essentially normalised is at odds with how drug takers are described in government policy documents, and often perceived by others. He is indicating that in his workplace, he struggles to think of people who do not take drugs. This situation

may be unique to his place of work, and it may also be an exaggeration, however there is no reason to believe that he is being untruthful. If he is indicating that about one third of the workplace use illegal drugs, this may in fact be representative of the numbers of drugs users who remain hidden. There may be drug taking going on at his place of work and users may acknowledge each other's drug taking, but it is concealed from others. He states that:

*'I mean one of the lads; his wife does not know anything of his coke use', (Don, 50's).*

He refers to his friend who uses coke on a regular basis as 'Escobar veneer'. He is called 'Escobar' because he uses so much cocaine and 'veneer' because a significant other does not know of his regular cocaine use, and his life is described as being a 'sham'. This of course highlights the fact that this social world is very much concealed, stigmatised and viewed negatively by 'outsiders', i.e. those who do not use illegal drugs. This of course raises the issue of who is in the 'know', who is classed as an 'insider' and who is categorised as an 'outsider'. Ms J highlights who can know about her hidden social world, and who can't. She explains her 'rules':

*'People that you just tell about your night, it's an unwritten rule; they don't talk about anything in front of my manager. One of my best friends in work has never used drugs', (Ms J, 20's).*

Ms J explains that societal attitudes to drugs and drug users means that she cannot even tell one of her best friends she uses drugs:

*'We have so much in common; I could talk to her all day. But I would never bring her on a night out that we went to, as I've heard her comment on people taking drugs, she has never been around it, she's never been exposed to recreational drugs. She would just change in an instant. Because I think she is so against them, she believes it's a bad thing. Although we are friends she is so against it so I choose not to tell her anything', (Ms J, 20's).*

Her best friend is anti-drug, and therefore Ms J cannot share this part of her life with her.

Her partner Mr B explains why:

*'It is illegal, it's not normal to do that, so society says. Some people have been brought up that way and it's their views. People that have never been around it have totally different views. Society says it is wrong to go out and take drugs', (Mr B, 20's).*

Ms J had stated that her best friend thinks it's wrong to take drugs. This highlights well the reasons why she and the rest of the research participants remained hidden from others who publicly denounce drug takers as irresponsible risk takers. There is a great deal of risk attached to disclosure, as Ms C explains:

*'You couldn't just talk about this to anybody, like people in your work or whatever', (Ms C, 20's).*

These responsible risk assessors require safe places where they can express this aspect of their personal identity with like-minded others, where there appears to be a group cohesion, as those who 'use' and those who are not part of the social worlds of the intentionally unseen. The element of who is 'in the know' also raises the issue of identity and what is valued. Concealing ones drug use breached class boundaries. Mr HM explains:

*'I met a lot of people through it (MDMA) as well too, clubbers, people that I would probably not normally have a great deal in common with, from very affluent backgrounds, when we were doing the club thing... (Mr HM, 30's).*

Mr HM indicates that in general, social class is not one of the factors that would generally operate to make distinctions between users. Drug taking environments for the research participants were described and perceived as classless environments, where social

distinctions are created through having knowledge about drugs, which serve to create several aspects to the controlled sensible drug using identity.

Several participants were keen to point out that drug taking was a positive influence in their lives. It enhanced their enjoyment of music, and identifying with certain types of music and fashion, they were making a statement about who they were in relation to others. Mr HM states that:

*'I was always 'alternative', black clothes, everything was black', (Mr HM, 40's).*

He discusses what tempted him to change his appearance, and pursue another that rested firmly on the use of MDMA, and the music that accompanied it. He went to a Glasgow concert venue to see a band called 'James' and it was their support act that totally changed how he viewed himself, and his drugs of choice. He describes himself as a drinker up to that point, and afterwards, he discovered MDMA, which opened up an alternative world to him. He explains:

*'The Happy Mondays just totally blew me away...The band was having a ball on the stage ... I heard obviously they were all taking E and all the entourage had taken E... I thought, I pretty fancy a wee bit of that', (Mr HM, 40's).*

MDMA by the early 1990's had become widespread among some groups of young people who had never considered using cocaine or cannabis, or opiates, prompting the 'normalisation' thesis from Parker et al (1998). Several participants managed to find like-minded people who used illegal drugs in a particular music scene:

*'I'm into northern soul; I like scooters, into the mod side, drugs have always been part of that culture, and so is drinking. It's a ritual, like a social thing, sitting round the table having beers, listening to music, having a laugh...'* (KT, 50's).

The clothes, music, lifestyle all interact to create aspects of an identity that allows a sense of belonging, where drug taking is not condemned as irresponsible, but chic and even essential to the enjoyment of music. Drugs are a part of this, and accessing them was easier for some, and difficult for others. How this relates to identity and identification will be explored more fully in the chapter 'sourcing drugs'. The themes of bartering commodities for drugs, including other drugs and precursor chemicals that can manufacture controlled drugs will be discussed more fully in the chapter 'sourcing drugs'. What they used, and what they could buy was important for many of the participants, especially those who accessed large quantities of cocaine, an expensive drug, which still symbolised success and risk, despite policy documents condemning it as unhealthy and dangerous. KT was able to source large quantities of drugs and because he could, he was able to use that to get something from a DJ at a music festival. He explains:

*'Some of the DJ's record collections run into several thousands of pounds. 'One guy offered to put £10,000 records from vinyl onto my laptop but I won't take a penny off him for drugs, even though he offers. Because I couldn't buy what he put on my machine, I mean for the pleasure they give me', (KT, 50's).*

Participants indicate that a large part of their social identity is in the music scene they identify with, the drugs that enhance the music and the social aspect of drug use.

Another interesting aspect of some of the participants' identities was the love of biking, in particular scooters and fast bikes, by groups who had no connection; that is they were not recruited into the research by the same gatekeeper contacts. This is a risky pastime that enhances their reputations as responsible risk assessors; however it also creates another set of risk. Some of them clearly drive their bikes and scooters after taking drugs. It became clear that sometimes, in order to get home from a social situation, such as a party where drug taking had gone on for several days, they had to make difficult decisions. The rules

and sanctions they created to make this as safe as possible is explored more fully in the following chapter on managing use.

Five participants were 'petrol heads' and KT discussed the drug use that takes place at the rallies for mods, scooter enthusiasts, and lovers of the music from the era of the late sixties and early seventies, and the early eighties, represented in the release of film 'Quadrophenia', driven largely by the music of the Who and other 'mod' bands. Several participants from all geographical areas represented in this research describe how riding bikes is a pleasurable experience, and one of the reasons that this group uses drugs together in social situations. It is not inconceivable that they enjoy the thrill of engaging in an adrenalin fuelled sport like biking, and this also is the reason they choose to use illegal drugs. However this may not be significant, and is a chance occurrence.

Ms S insists that drug taking is less risky than other pursuits; however, in doing so she reveals that perhaps the desire for risky experiences is what bonded her social group of drug using peers:

*'Most of the people in my social circle will take other risks, like for example; most of them drive fast bikes', (Ms S, 40's).*

She argues that these risks are managed and context dependent. She states that:

*'I know that my partner would drive his bike way faster when he's on his own than if I was on the back. That risk is managed, and is managed by the gear that we wear when we get on it. I wouldn't get on without wearing a helmet', (Ms S, 40's).*

This statement clearly is intended to infer her identity as a responsible risk assessor. She has clear rules of engagement that define her identity. Interestingly as well as being a lover of fast bikes, Ms S is also keen to maintain an active lifestyle, and maintain her levels of fitness, despite using drugs that she and others had described as unhealthy and potentially damaging to their health.



## Drug use and health

The impact of drug use and health, and how a healthy lifestyle can be used to counteract some of the negative consequences of drug use are explored in chapter five. However sport and health were important aspects of the identity of several of the participants, and this issue is now explored. Five of the participants were sports enthusiasts, and this element of their identity was at odds with the treatment addict seeking identity disseminated via mass media, alluded to in policy documents as typical, suffering from physical health problems, mental ill health, and regular intoxication. Three of the health conscious drug users were in their fifties, (Don, KT and Mr R) all of them describing the importance of hill climbing, mountain biking, and also the sport of paragliding. Don is a scooter enthusiast like KT (a hill climber and hill walker), and sailing, Mr JJ is a judo expert, and all attempt to maintain high levels of fitness. Mr R summarises how drugs fit into his lifestyle, and why he chooses illegal drugs rather than alcohol:

*'...I hate anything that gives me a hangover, in any shape; it doesn't suit what I do with the rest of my life if you know what I mean', (Mr R, 50's).*

KT a long term regular user of drugs in his early fifties explains how drugs fit with his lifestyle, and with his personal and social identity:

*'Me and my best pal were into climbing and rock-climbing and hill walking and we were coming back from weekends, totally knackered and we used to drink in a boozier and we heard about sulph or wiz (amphetamine sulphate) that gave you a bit of a buzz. It meant you could drink more and you were wide awake and we thought it would match our weekend's hill-walking, climbing, so I went and bought it', (KT, 50's).*

These participants enjoy risk, and used stimulant drugs that are functional, to suit their particular lifestyle. The use of the stimulant amphetamine allows KT to pursue his energetic pastimes, and at the same time is functional in allowing him to stay awake and use more

alcohol than he would have had he not used this drug. Several participants indicated that drugs were functional, not just the social nexus on which part of their identity and people they identified with revolved. Drug taking was identified as a powerful group activity to be engaged in, and as the use of drugs was a potential source of shame, being with like-minded people who tolerated their use and made it safe to do so was important to them.

## **Discussion**

Despite the lack of coherence in the available literature on what is typical in regards to the use of illegal drugs, some wide-ranging conclusions can be drawn from the participants in this research. The primary function of drug taking for these research participants appears to be the facilitation of social interaction and social bonding. Where drugs are demanded, there are dedicated environments created where they can be consumed relatively safely; and these participants have demonstrated that they can create places of safety. Places where drugs are consumed are usually distinctive environments, representing a separate sphere of existence, a discrete social world with its own laws, customs and values, and where identities of control and abandon co-exist. Drug taking places tend to be socially integrative environments in which status distinctions are based on diverse criteria from those operating in the outside 'straight' world, such as social class. More importantly is the necessity to bond with like-minded others who understand the 'rules' and rituals required to keep potential stigma hidden from others. They created liminal identities which were contingent identities that could be altered, concealed and revealed as the context demanded.

The participants' responses suggest that the functional and instrumental value is the 'nexus' around which a significant part of social life revolves. The functional value of drug use was characterised by a number of expectations on the effects, the 'utility' of taking drugs and of resolute attitudes to drugs in their social networks. None of the participants in this study

considered themselves to be addicted despite some being regular, even daily users of drugs, in particular cannabis. Consumption of drugs was often confined to weekends, social occasions and the use of stimulants in particular were considered purposeful insofar as they allowed many of the users to stay awake and/or consume larger than normal (for them) quantities of alcohol without succumbing to its depressant properties and falling asleep.

Participants constructed narratives that allowed identification with social identities they perceived as positive, which served to neutralise stigma associated with addiction. As users of illegal substances, the participants generally viewed alcohol users negatively, while at the same time actively used them as a source of social camouflage to fit in while 'on drugs'. They demonised the 'typical', Scots binge drinking style, and expressed a general disapproval of aggressive drunken comportment suggesting that this was an important reason for not identifying with 'straight' alcohol users. The research participants were keen to position themselves as active members of their communities, which dominant addiction discourses clearly did not.

Participants were acutely aware of the identity boundaries and risk contingencies that separated certain types of drugs as potentially being more damaging to their status and identity. Being identified as out of control, chaotic; being labelled as unproductive and a drain on the resources of society put them at risk of condemnation. Just being identified as an illegal drug user is clearly a great risk for social affronts and stigma. It was recognised that being around like-minded people (other drug users who were intentionally unseen) was a source of comfort and safety.

Research has indicated that on problem users tend to congregate together when they had accepted their primary deviance as a source of the identity or their 'master' status. They adopted the lifestyle, habits, mode of dress and even accent and colloquialisms required to fit in with this 'addict' identity. In like manner the intentionally unseen participants in this study actively sought out like minded individuals in which to seek comfort and safety. In so

doing their use and status was accepted and delineated their notions of sensible and safe use from problem use. This sense of 'us' and 'them' allowed the research participants to position themselves as normal, sensible and controlled and not as a cause for concern.

If a significant proportion of Scotland's population have experienced drugs, or know people who have, who did not become addicts, then it is time to reconsider our view of drug users as 'offenders in waiting'. In a now decidedly anachronistic sense, a 'drug-user' was easily definable as a member of a distinct deviant sub-group, with definite implications for their social identity in the wider 'mainstream' social world (Becker, 1963). Whilst this still remains arguably the case for some users of heroin or cocaine, when drug taking becomes normalised without necessarily being accepted, an account of that behaviour as non-deviant is required. There has been some reluctance to accept this as reality however. Instead there have been efforts to re-label or redefine drug users in ways that manufacture a large "normal" group of people who have tried drugs in their past but are not "really" users and a small, potentially deviant, group of 'problem users', who were once sensible and recreational users.

It is without doubt that adopting the 'addict' identity is a radical shift in individuality, which is highly stigmatised (Radcliffe and Stevens, 2008). Elaborate theories that infer personal deficits in certain 'deviants' dismiss drug taking in politicians, media celebrities and sports personalities as mere youthful experimentation, or temporary lapses in personal judgement, or falling in with the 'wrong' crowd. Previous research into drug taking constructs an identity based on drugs of choice, (cannabis users for example) or on their route of administration (injecting drug use for example), or their type of crime (traffickers, dealers etc.). If drug taking has indeed been normalised (Parker et al 1998; 2005) it is no less stigmatised. We require explanations for drug taking that move away from simple constructions of deviance and labelling, or identity (Jenkins, 1996). If biological explanations are insufficient to explain drug taking, and psychological explanations which imply pleasure as a 'primary reinforcer' are also rejected as simplistic, we must ask what drugs mean symbolically to those who

choose to use them, or associate with people who do. As drug taking is essentially normalised for certain types of drugs, if it is accommodated, explanations must account for this. It is no longer appropriate to label drug users as 'outsiders' (Becker 1968), as this is only a small part of their personal and social identity. The management of an aspect of identity, which must be concealed to protect self-esteem and status as 'normal', is required, (Goffman, 1963) insofar as being a law breaker is at least in part, an act of rebelling against an unjust law (prohibition). As psychology infers a rather deterministic aspect of drug taking as it relates to identity, one must turn to sociology to explain this.

Identity theory has attempted to treat identity as a variable which can be measured and analysed (Stryker, 1968), in terms of the salience or significance of perceived differences between individuals and groups (Woodward, 2004), and is often the reaction to being oppressed by a dominant social force, the police for example. This is a view of identity that tends to concentrate on the margins or boundaries, where certain aspects of a personality or identity (heroin use for example) are synonymous with minority status, and the conflict that emerges from this. Most studies concentrate on the young, and their drug 'career', and essentially construct 'youth' as a category of deviance (Pearson 1983). This means that we understand relatively little about the hidden drug taking of users who do not come to the attention of treatment agencies, or criminal justice agencies. Identification for the participants in this research therefore is characterised in terms of protecting esteem and managing potential social affronts. Users construct positive identities by rejecting negative aspects of identities that are potentially stigmatising (being a heroin smoker, but rejecting emphatically the identity of an injector). An alternative sociological view is that identity is constructed in the on-going intersection of similarity and difference between one group and another, and between members in a group and others (Jenkins, 1996). This is little more than a refinement of labelling theory (Hammersley et al 2001). If drug takers construct their identity in terms of how they are different from non-drug takers, or other types of drug users, alcohol users for example, by the same process they will be identifying with other people

they perceive to be like them. The social construction of identities is thus an on-going process of assertion, imposition and negotiation between actors and institutions, with varying degrees of salience between them. This process will be fluid and never ending, if constructed as non-static (Bauman, 2001). Strategically concealing and denying what one sees as central to one's identity is not unusual. If identification is an on-going process, heavily dependent upon setting, attention is required to three important aspects of identification: signification, negotiation and categorisation (Jenkins, 1996).

Drug use crosses the class barrier, age barrier, and the gender gap. Drug taking may also be more a signifier of the type of social setting than the identity of the participants: perhaps drug use generally signifies "time out" (Parker et al., 1998), a relaxed and playful or recreational setting, apart from achievement-oriented conventional life. In this respect, what drugs signify is of central importance, its "illegal but somewhat condoned" nature perhaps rendering it more alluring symbolically due to its illegality and risks.

While some drug users may signify their identification to a specific 'scene' by the clothes they wear, and the music they listen to, others will be keen to downplay this identification, or at least only dip into it now and again. These 'drug tourists' are not keen to identify strongly with certain types of drugs or types of user, and act to deliberately conceal their transitory identities for fear of their principal identity becoming stigmatised and spoiled.

As drug use denotes contingent identity boundaries, drug taking environments are constructed as safe spaces and within these spaces, certain types of user will congregate together. Illicit drug use may serve as a marker of identity boundaries in a way that is potentially misleading. Judgements of similarity to, and difference from, others, which are constructed on this basis, may not work outside the small-scale settings of drug use.

Hammersley et al., (2001) states:

*"Although cannabis may no longer be widely regarded in many social circles as stigmatising of itself, it can still result in stigmatising conflicts with authorities,*

*including parents, police, educational institutions, and housing providers. While many people, even those in institutional positions of authority, take liberal views as private individuals, punishment and exclusion remain potential - and not uncommon – public responses to cannabis use when officially “discovered”, (Hammersley et al., 2001: 143).*

So we have the tensions described by Hammersley (2001) of what one does in private and expected norms in public. For example a police officer may smoke cannabis, however if she discovers several plants in a private house while on duty, she will be expected to bring charges against the offender. Informally, the legality of the drug use is unlikely to be the key issue, since similar sanctions - in particular a spoiled reputation and exclusion from social networks are applied to many legal but negatively signified activities such as drinking at work or having affairs, and similar excuses have to be offered to minimise the potential shame and stigma.

The notion of categorisation emphasises that processes of identification are always two-way processes, at least. Social actors identify themselves internally, but they are always also categorised externally, by significant others. The social construction of identity is the outcome of both processes, a dialectic interaction. External categorisations may be internalised, they may be resisted, they may be partly incorporated, or there may simply be congruence between internal identification and external categorisation. These processes previously highlighted by the labelling model in the sociology of deviance (e.g. Becker, 1953); are also central to Goffman’s interactionism perspective and are useful in the study of identity (Jenkins, 1996). Nonetheless, there has been an increasing merging in the ways in which drug users understand and identify themselves as non-deviant, ordinary citizens and how they are externally categorised. Signification, negotiation and categorisation are likely to combine in different ways to produce a range of potential identity constructions. The participants were keen to portray themselves as responsible parents, in full time employment or education. As their drug taking was potentially stigmatising, who was ‘in the know’ and

who was 'out of the loop' became not just an exercise in creating 'in groups' and 'out groups', but had important implications for their standing in their communities. Who they identified with in public, what they did in private, was not that surprising, given the cultural cachet associated with being drug naïve, or abstinent, and the stigma associated with drug use, and its links to pathology, and criminality.

Many of the participants discussed the use of alcohol, and described problems associated with its use, constructing 'typical' i.e. non problematic users of a dangerous drug alcohol users as similar to their controlled sensible use of illegal drugs. Several participants noted that alcohol was a cause of a great many problems, and acknowledged that while dangerous it could be used safely. Having rejected the concept of the 'problem or addict drug user' as a deviant minority, the idea that drug use interacts with the ins-and-outs of social identification appears useful for capturing the nuances and complexities of contemporary illicit drug taking. It is particularly useful because it moves beyond the polarised dichotomies that have tended to direct both discussions of drug use and the research agenda. That drug taking is no longer "deviant" - at least in some circles - does not make it "normal" either. Rather, drug use occurs in, and serves to define, a range of social settings, as well as being chosen by different people for a range of social purposes other than simply hedonistic. Moreover, arguing that prohibition is indefensible - which many participants believe is the case, - does not mean proposing that society should be as casual about illegal drugs as tea or coffee. Drug taking is unlikely to be either eliminated or universally accepted. However, without developing an understanding of how drugs fit in contemporary society, it is impossible to have the informed discussion that is so necessary about how it might fit, or not fit, into the social world of the future.

People who have never experienced illegal drugs see themselves as very different from those who have experienced them. In addition to this dichotomy between users and abstainers, within the drug experienced category, some drug users see themselves very differently from some types of users (the heroin junky, the celebrity cocaine user, the



cannabis user, the binge drinker). The cannabis users view themselves as different to users of heroin. In addition to these categories of identity related to drug of choice was the use pattern as mediator of identity, which ranged from a continuum between the extremes of abstinence to regular and on occasions excessive daily use. Having clear regular access to drugs was easy for some, and difficult for others. Many of the participants who had never experienced opiates had potential access to them, and had been in the company of regular users who were not seeking treatment. Not only did abstainers have access to drugs, but daily users of cannabis had access to other drugs, indicating that exposure to drugs due to wide availability (the key component from which drug policy is derived) combined with an inherited or acquired vulnerability leading to problems was challenged. This is only a cautious finding, and these attitudes may not be typical of other hidden users of controlled drugs not in contact with any treatment agency.

This chapter has demonstrated that there are tensions between policy representations and people's realities about drugs use in Scotland. While public support for drug prohibition is high in Scotland, much of the support is built upon certain myths about the power of drugs to remove volition and ability to control ones actions. Whilst there are sensible policy guidelines for safe alcohol use, nothing formal exists for safer drug use. All drug use is condemned as irrational, unhealthy, criminal and immoral, creating a source of tension of those participants whose ethical preferences do not fit with expected norms defined in policy documents as being drug free, abstinent, or 'in recovery'. The dominant discourse explains prohibition as a costly but necessary measure required to delineate boundaries of acceptable conduct. While it appears ineffective in preventing drug use, the climate of moral censure that exists in a climate of prohibition results in dissonance between users groups and between users and non-users. The findings also support the literature that explains drug taking as essentially normalised among certain sections of society, and that distinctions between types of user exist on moral and ideological grounds rather than on scientific

evidence. Participants are acutely aware that drugs are harmful, however they are also aware that prohibition creates conditions whereby being 'outed' and revealed to be a drug taker creates very real risks of condemnation and stigmatisation, with damaging consequences. Therefore they used a range of sophisticated techniques to identify, create and maintain boundaries of risk and acceptability. They describe their own use as 'acceptable' and sensible, while at the same time condemned others with whom they did not identify. In light of these discursive gaps between policy documents, politicians, the police, medicine the wider public, and the research participants, it would be constructive to have regular discussions about illegal drug taking in Scotland, and recognise that a great deal of it must be sensible and controlled, rather than problematic and chaotic. This would foster conditions that might better inform the public about the actual dangers and the perceived dangers of drug taking and the tangible dangers that result from defending, and funding drug prohibition.

Some studies find that users who view drugs as a large part of their lives struggle to maintain or develop other aspects of their social identity, such as parents (Taylor, 1993), students (Brewer & Pierce, 2005), masculine men (Caceres & Cortinas, 2005) or non-addicted, successful drug dealers (Bourgeois and Pearson, 1995; Schensul et al., 2005). Bauman (2000) helpfully summarises the complexity of this situation by stating:

*"perhaps instead of talking about identity, inherited or acquired, it would be more in keeping with the realities of the globalising world to speak of identification, a never ending, always incomplete, unfinished open ended activity in which we all, by necessarily or by choice, are engaged" (Bauman, 2000:152).*

These participants manage clandestine identities by disclosing their drug use *only* to others who would not condemn them. The dominant theme emerging is how important drug use is to personal identity, that status loss that potentially results from losing control and learning the ability to regulate and control intoxicated behaviour was a key aspect of the reasoned,

responsible risk assessor. They expressed frustration at how their lifestyle choices were perceived by 'other' drug users (alcohol users in particular), and in government policy documents and in the drug talk which underpins addiction discourse, and supporters of drug prohibition. Despite being 'normal', the use of drugs was rarely without consequences. Notwithstanding the multitude of reasons why drugs were used, many of the participants, while open about the positive experiences they had with drugs, were at pains to state that taking drugs was not a risk free activity and it is to this aspect of managing risk that that the next chapter explores.

## Chapter five: managing use

This chapter explores how the participants informally learn and transmit knowledge that regulate risk, using informally agreed sets of rules, regulations and sanctions that challenge certain privileged views about the negative consequences assumed to occur after exposure to certain drugs. The participants demonstrate that initiation into the illicit social world of illegal drugs was invariably with friends and family members they trusted. Not one mentioned the narrative regularly given by 'addicts' in treatment setting that drugs were pushed on them as unwilling victims, or that they inevitably *lost control* after experiencing intoxication, setting up a compulsion to use, characteristic of drug addiction. Over time a set of informally agreed rules and rituals were learned that, if followed and monitored, reduced risks to them. These skills once mastered were often passed on to others in order to maintain boundaries they themselves defined between safe controlled and sensible use, and problematic and chaotic use. Three techniques used by participants to neutralise risk are discussed in this chapter relation to the three crude categories of drugs effects, and several sub sets of rules are explained on managing the use of stimulants, depressants, and hallucinogenic drugs.

(1) Rule boundary recognition: the identification of boundaries of risk that delineate 'moderate' from 'compulsive use' patterns. The participants identified several risks, which included overdose, craving and withdrawal, drug tolerance, and intoxication. (2) Rule boundary creation: the creation of rules to manage intoxication and its after effects. Three techniques were utilised to manage and control risk arising from the use of drugs. Managing a healthy diet and regular periods of exercise helped them to cope and counteract the perceived and actual health concerns they had about their use of drugs. Finally (3) Rule boundary maintenance: the maintenance and management of risk boundaries, indicating that maintaining control of intoxicating experiences was a key element in maintaining or enhancing status in user groups, and to this end several participants regularly took drugs on their own to regulate their tolerance and to participate more fully and sensibly in the social

gatherings where drug taking was taking place. Negative experiences of drug taking generally took the form of frustration at being too intoxicated to take part in the sociable aspects of their drug taking environments. The frustration at not being able to engage with others was described as errors in judgement, and not engaging the skills they had learned from others, or learned on their own to create the conditions necessary for a positive experience. Some drugs users in social gatherings, labelled 'drug mentors' took on the important but informal role of helping and teaching the less experienced to manage risk factors in-group was reported often enough to be discussed as a theme in its own right.

Three crude factors that influence the drug experience, the 'drug', 'set', and 'setting' (Zinberg, 1984) have been discussed and this chapter will utilise these concepts to help outline the risk users experience and manage when using drugs. Three techniques used by participants to neutralise risk refer to the recognition, creation or maintenance of rule boundaries will be discussed in this chapter; the identification of boundaries that separate 'moderate' and 'compulsive use' patterns, the creation of rules to manage intoxication and its after effects, and the regulation of supportive environments to manage risk.

The **drug** factors include the effects of drugs on the central nervous system (CNS), the route of administration, the adulterants<sup>36</sup> that might be present.

The **set** factors include the anxiety users feel at managing the powerful intoxicating effects of drugs, the risk of temporary effects that could mimic mental illness, including paranoia and acute anxiety. Drugs produce real physiological changes (changes to heart rate for example) and cognitive experiences (creative ideas) that can be alarming to novice users.

These effects are for the adept the main reasons that they use them. Once the skills

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<sup>36</sup> Cutting or adulterating drugs with dangerous chemicals is largely a media fuelled myth. Forensic analysis is rarely able to support any such claim, what forensic analysis does reveal is that some drugs can be 'cut' or diluted. Many powdered drugs can be bulked out with other powders to increase profits, often these will be inert substances such as mannitol, an industrial sugar, however in this unregulated market, this is an area that requires systematic research to reduce preventable harms to users. Finally as the next chapter will reveal, the participants who supplied drugs to others invariably believed that it is bad for business to kill ones customers.

necessary to master the powerful effects of drugs are learned, the anxiety is replaced by confidence and anticipation.

The **setting** factors include the criminal justice apparatus, built on the drug laws that put users at risk from legal penalties, stemming from Temperance ideology. The environment also includes the culture where drugs are used. If the environment is supportive, then risks could be reduced; if the environment is hostile, and potentially stigmatising, then risks could be increased.

There were several drug risks that participants identified, which they could do little to control. The strength or purity of a drug can only be realised once it is taken, and sourcing drugs safely required the development of sets of skills to manage such risk. The participants needed to be able to gauge the purity and strength of unknown drugs and certain techniques and paraphernalia allowed this to be carried out safely, using a dispensing device known as a 'bullet' device was one measure routinely used. The users had to decide on a route of administration that allowed drugs to be taken safely. Breaching a boundary of risk, for example moving from smoking to injecting, or from sniffing to smoking cocaine, was potentially stigmatising. After exploring the drugs of choice as risk factors, over which the users exert little control, this chapter focuses the techniques and rituals used to manage other risks, over which the participants have a degree of control, those aspects of use such as their mind set and the environment or setting.

### **Drugs of choice as risk factors**

A small qualitative study with illicit drug users aged 50 and over was carried out in the north-west of England in 2008 (Beynon et al., 2009). They reported no common pattern in terms of the drugs consumed and participants used whatever drugs were available. However, given the qualitative nature of the study and the small sample size, the authors were unable to make any broad generalisations from the results regarding patterns of drug use amongst

older drug users. The participants tended to follow one of three patterns: some had used drugs on a near continuous basis for over 30 years; some had brief periods of abstinence followed by intermittent drug use; and others had abstained from drugs, three of the twenty four for up to four years at a time. Such findings challenge the accepted wisdom that drug users become chaotic after repeated exposure to drugs, and that once problem drug use becomes the norm, it is irreversible.

The next section explores briefly the common patterns of use described by the participants in this research, and the drugs are categorised by the main sought after effects: stimulants, depressants and hallucinogenic drugs. It is accepted that some drugs do not 'fit' neatly into such crude categories.

## **Stimulants**

The drugs described in this category included ecstasy or MDMA, cocaine, and mephedrone or 4MMC. These drugs were used for several functional reasons: to stay awake, aid sociability, and perhaps, with the use of cocaine in social situation, to identify with its more glamorous image as a drug used by the rich and famous.

### **MDMA**

In 2008, the ACMD reviewed the harms related to the use of 3, 4-methylenedioxy-*N*-methylamphetamine, commonly known as MDMA and ecstasy (ACMD 2009). The ACMD found that evidence on extensive chronic use and mental health harms is currently ambiguous and that, unlike amphetamines and cocaine, MDMA is infrequently implicated in significant episodes of paranoia. A web-based questionnaire study (Carhart-Harris et al., 2009) using estimates of sleep quality found some subjective support that lasting sleep disturbances are a possible consequence of ecstasy use; however the sample size was

small, and the results were speculative. Selvaraj et al., (2009) found that there was no significant difference in neuronal serotonin transporter (SERT) binding between former MDMA users, drug naïve individuals and poly-drug controls that had never used MDMA. The results indicate that serotonin depletion is temporary. This finding was important because serotonin depletion had been reported by some newspapers, law enforcement agencies and government policy documents as proof that ecstasy was causing 'brain damage'. Rogers et al., (2009) carried out a systematic review of observational evidence on the harmful health effects of recreational ecstasy. They found that evidence provides a fairly consistent picture of deficits in neurocognitive function for ecstasy users compared to ecstasy naïve controls. However deficits did not significantly impair the ecstasy user's everyday functioning. The authors conclude that despite ecstasy being associated with a wide range of acute harms, it remains a rare cause of death when reported as a sole drug.

The research participants in this study were asked about their typical MDMA use pattern and preferred route of administration. They were also asked about the amounts of this drug they could tolerate in a single session. The following respondents discuss the amounts of MDMA they consider tolerable:

*'the most I have ever taken in one night I think would maybe be probably about five...I don't think I've taken more than seven in a 24 hour period though', (Kay, 30's).*

*'...Usually 5 or 6 pills is fine ...', (Jim, 20's).*

*'Actually when I first started I was using maybe 1 to 2 tablets and at the height of it I ended up I think the most I ever took over a 2 day session was about 13 tablets', (Rob, 40's).*

*'take between 5 and 10, maybe even a couple more, depending if you go to an after party which can tend to be the full next day sometimes...', (Chris, 20's).*



There may be several reasons why the use of MDMA increases after initiation. All users reported that it was rare for them to take drugs of an unknown purity without gauging its effects first, and then taking higher doses as required to achieve the level of intoxication they were seeking<sup>37</sup>. It could be that reductions in average levels of the active compound per pill are becoming commonplace, hence increased levels of use, or it could be due to short term user tolerance to this drug. The reported use of MDMA by participants ranged from what they might use at initiation (often one or two) up to 10 in a single session. What is being described in terms of typical patterns of use of MDMA in pill form could be explained by several factors. That purity has decreased with price, or that regular users become tolerant to the effects and require larger doses for desired levels of intoxication. As a result of the inconsistencies in purity of MDMA pills make them less desirable for regular users who report sourcing other more concentrated forms of this drug. Don believes tastes and fashions explain the preference for MDMA powder to pills:

*'In a party situation pills aren't what folk want to take...it's changed really, quite dramatically over the last two or three years, in terms of drugs that are available, and what we're taking', (Don, 50's).*

Some users now choose not to take pills sold as ecstasy for various reasons. One major reason is quality, another is that the fact that they are so cheap that it has changed their status (perhaps one reason why cocaine is becoming more in vogue); purity is also a concern. MDMA powder is becoming the drug of choice for many:

*'I would rather take MDMA than take ecstasy because I know that you are going to get a good hit off it and you are not going to feel shit the next day. I am more reluctant to do pills now and I'd rather opt for MDMA', (Mr G, 20's).*

After describing several negative experiences using pills he thought were MDMA, the inconsistency of the purity and quality made Mr G stop his use of MDMA pills and purchases

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<sup>37</sup> However there were occasions where such simple risk reduction rules were breached discussed in chapter five

only the powdered drug. One participant suggests that it is subtle marketing that changes what drugs are purchased. He explains his position on MDMA pills versus powder debate:

*'No, I'm probably cynical...the (ecstasy) powder is purely a marketing ploy...people who are over 25 up to about 45 don't want to spend £1 for a pill because there are kids running about paying £1 for a pill. So they'd much rather have 2 pills crushed and pay £30 for it and tell themselves that they're buying a better quality of drug', (Don, 50's).*

Users tend to switch to the more expensive MDMA powder, which was considered by several participants to be a product of higher quality and purity than pills. However the quote reveals the complexity in this debate of whether pills or powder are 'best'. It is Dons view that some dealers are merely crushing pills and marketing them as MDMA powder, which is perceived to be a higher purity commodity. The MDMA content of ecstasy tablets seized by police appears to be reducing in the short term according to the EMCDDA, based on data supplied by enforcement agencies (discussed more fully in chapter seven on prohibition and drugs policy). In 2008 the average content (mean mg) of MDMA per tablet was 33 mg compared to 52 mg in 2007. As fuel and other transportation costs have increased since 2008 those who distribute these drugs on a commercial scale have few ways to maintain profit margins. It is not inconceivable that options available to them were to increase price or decrease average purity per pill. That said selling poor quality drugs may not ensure repeat business, a factor discussed in the chapter investigating how participants sourced drugs.

## **Cocaine**

Participants were mindful of certain parameters to be considered before they could work out how much of this stimulant drugs were to be used in a typical session. Mr B explains some of the complexity:

*'When I first started taking coke, me and my friends used to buy a gram and it lasted all night but obviously you get immune to it and you end up buying 3 grams each for a night, you can go through, the sky's the limit really 3, 4, 5, 6 grams you will snort them, because it's very 'moreish', (Mr B, 20's).*

So Mr B had to consider who he was with, how long he expected to be using, and how he would cope with the negative consequences, as well as calculating his tolerance to the drug, relative to the purity of the product he typically purchased. He was fully aware that as he really enjoyed cocaine, he would always use what he had in a single binge session, no matter the amount. The amount of drugs consumed in a single session is also dependent on access to a source, and the monies available:

*'If we're paying for it, it's usually about 3 or 4 grams. If there was a more generous host and we have seen ourselves working through as much as is there and sometimes I've seen that being 28 grams and will just keep taking it until it's not there. ... but we are quite capable of taking 2 or 3 grams between us of an evening', (Mr K, 40's).*

Note that this pattern of consumption is only possible when several factors are in place: the resources to pool together to purchase a large amount to secure a high quality product, that others will be around to aid in the enjoyment of the experience, and that there are others to help should any negative situation arise.

## **Depressant drugs**

Several of the participants used depressant drugs, the most common being alcohol. This category of drugs include GHB, and ketamine recognising that there are hallucinogenic properties associated with the use of both of these drugs, depending on dose, and route of administration.

## Alcohol

Alcohol was the ubiquitous drug, used in conjunction with most illegal drugs with few exceptions. The reported use of alcohol has increased among young people who also have experience of the use of illegal drugs (EMCDDA 2010); there appears to be an age difference in patterns of consumption. The older participants who used MDMA in the late 1980's and early 1990's rarely used this drug with alcohol. Several of the older participants describe using MDMA without alcohol, which they believed counteracted the stimulant effects they were seeking. The younger participants who had only ever experienced MDMA in corporate dance club environments where events were commonly sponsored by alcohol companies regularly used alcohol with other drugs. Mr B (25) explains why he believes alcohol and drugs go together:

*'...Millions of people out there take coke regularly and alcohol seems to go hand in hand with it... (Mr B, 20's).*

The typical binge style of drinking in Scottish culture was understood, and this was largely the experience of many of the participants. Several had used alcohol in social situations, and often while using drugs too. Mr HM explains that he enjoys being intoxicated by alcohol, leading to a temporary a loss of control, but did not necessarily seek this type of experience with illegal drugs:

*'I've used alcohol like that, I just thought fuck it I'll get pissed. But I never ever used drugs like that', (Mr HM, 30's).*

As will be discussed later, the role of alcohol was most often to counteract the use of stimulants and prepare users for sleep, rest and recuperation.

## **Gamma-Hydroxybutyric acid (GHB)**

GHB was the drug of choice for those users who sought to achieve a rapid alcohol-like intoxicated experience; however, it had to be used under controlled circumstances, and only when others were around to manage the risk of intoxication and overdose. The negative connotations of the typical Scottish drunken comportment may be an important factor in choosing GHB:

*'I wanted to try (GHB), was just very wary of it because I'd heard nothing but horror stories...I only had a wee bit that night and it was lovely. It was like having ten pints in a 'oner' without the aggression', (Rob, 40's).*

Here Rob explains why he chooses GHB. He likes to fight the depressant power of the drug, and in mastering the skills necessary to cope with its powerful effects, it boosts his self-esteem and gives him great pleasure. Ron explains that achieving mastery over the power of drugs is a source of great pleasure and satisfaction. He explains his most recent use of GHB:

*'My latest one (drug taking session) was on Friday so it was a sort of fool about with friends, GHB, alcohol type of thing, just get wasted for a Friday night because there's nothing better to do and just really wobbly, and takes the legs from you and if you can fight it then all the better...That's pretty intense', (Ron, 50's).*

However while the use of GHB is enjoyable, the dose must be carefully judged to achieve the required level of intoxication. Ms M explains:

*'Again it's got its place hasn't it...in small doses it's excellent, too much and you're no good to anybody', (Ms M, 40's).*

Regulating dosage is an ever present exercise in risk management. Ms M prefers small doses to achieve the level of intoxication she is seeking. In larger dose she explains that 'you're no good to anybody'. Sociability is extremely important; not engaging with others

defeats the purpose of attending social events where drugs will be used. Not interacting with others is not the function of drug taking for her. However her partner, Mr K, mentions that there are circumstances where it is normal for them to use on their own, when they are alone during intimacy. Mr K explains how GHB is managed in this situation:

*'All our peers seem to have different tolerances to it ...It's not a thing I will take on my own. She will take it on her own, (looks over to his partner M) but I never would. We'll take it for sex, it's great for sex', (Mr K, 40's).*

Mr K explained that his partner, Ms M, used GHB in social situation, where dose is very important. However when on their own, they use as much as they can tolerate, which for them enhances the sensual experience.

## **Ketamine**

Some research indicates a correlation between ketamine use and urinary tract problems (Cottrell et al., 2008), and link its use to cystitis (Hoskins 2009). What is most interesting is that these anecdotal reports are often considered typical consequences of mere exposure, rather than being the result of prolonged heavy use, which is atypical. Morgan et al., (2009) compared frequent, infrequent and ex-ketamine users with poly-drug and non-drug using controls to see if there were differences in cognitive functions and psycho-pathological symptoms. They found that Ketamine users performed better than schizophrenia patients and no different from controls in memory tests. A study by Moore and Measham (2008) found that the use of ketamine was largely playful and fun; their participants, young users recruited from clubs and pubs, positioned themselves as recreational controlled users who had created informal rules to manage intoxication, at odds with the discourse which stigmatises them as hedonistic and irresponsible risk takers. Griffin, Measham, Moore, Morey, and Riley (2008) explored the social and cultural uses of ketamine as a source of

intoxication, and the value nexus upon which consumption was based. Loss of control was both sought after and condemned by some users, challenging accepted notions of risk (Tackett Gibson 2008). They describe a continuum between the more experienced adepts and the novices, labelled 'candy users'.

Ketamine required strict rules for its use, which when transgressed had potential negative outcomes. Mr G explains:

*'... Ketamine, that can be one of the best drugs in the world if taken in the right environment with your friends but equally it can be one of the worst drugs in the world if you take it in the wrong environment with people you don't know', (Mr G, 20's).*

Ms I explains the reasons why she chooses not to use ketamine in any type of situation. She describes herself as a sociable partier, and does not enjoy the anxiety and paranoia that can accompany certain intoxicating experiences:

*'...I don't do a lot of Ketamine ... I get paranoid so it's not conducive to partying. I'm a sociable partier and I find some of the drugs that everyone does aren't sociable', (Ms I, 30's).*

This attitude to ketamine was rare however; several participants report enjoying the fun aspect of the ketamine experience. Mr K states that he does enjoy taking ketamine, but only in small doses, as he has a tendency to binge, because this type of powdered drug makes him wish it were cocaine, his first drug of choice. Therefore he has a tendency to overdose in an unplanned experience if he does not follow certain rules. He explains:

*'If you take small lines then you will get a nice little sparkle but then all it makes me think about is I wish it was coke. If I take too much of it then I go into a K hole and as much as I like going into a K hole it's very wearing....It just gets a bit samey...', (Mr K, 40's).*

Ms M describes how she manages doses to achieve the desired experience she seeks from her use of ketamine:

*'I used to enjoy the K hole and enjoy the little lines as well because it felt like there was dose for every occasion, but now I find the smaller lines, instead of giving me that nice little buzz and chatty feeling it makes me feel like I've been hit with a stupid stick. It just makes me unable to do things, or deal with things...'* (Ms M, 40's).

Several of the participants describe their experiences of using ketamine and learning how to achieve the 'K-hole'. This relates to the dissociative anaesthetic and mild hallucinogenic properties, an experience that is sought after by drug adepts. Ms M likes to interact socially with other users in a social situation, and regulates her dose to limit the risk of unplanned intoxication, and the 'K-hole'.

Ketamine is most often purchased in a powdered form; the common route of administration is nasal insufflation. Two of the participants had injected this drug for two main reasons. To experience what they describe as a smoother high, and to use less after increased tolerance due to regular use. Renee injects the drug in order to make the experience 'softer' as she describes it, and to make this drug go further:

*'...It does seem that you need less to get more of a hit and I find that often when I'm snorting it, it's quite an angular and harsh sort of drug. When I'm injecting it, it seems a bit smoother, a more 'floaty' kind of feeling'...*, (Renee, 30's).

Injecting ketamine requires a smaller dose to create the desired sought after effects. Renee understands that should her friends discover that she and her partner inject, this would be damaging to her social standing. She explains:

*'Most people don't know that we inject as well because a lot of people look badly on that',* (Renee, 30's).



Parkin and Coomber (2009) have described the symbolic violence that drug injectors experience because it is a route of drug administration that is highly stigmatised. Symbolic violence refers to 'non-violence' by means of social and cultural control that is premised upon domination, complicity and misrecognition. The impact of this stigma puts injecting drug users at greater health risks (including death) by having to stay out of sight as they use their drugs, leading to injecting drugs in inappropriate and unsafe environments, and the health risks associated with this. The language used to demonise users of drugs who inject increases the potential for stigma should this become known. Most people believe that users who inject do so because it is more pleasurable, leading to their condemnation on two counts, for being wilful hedonists, and for breaching boundaries of acceptable risk on health, and risking blood borne viruses; while this may be subjectively the case, it is well known that smoking drugs is the fastest route to the brain. The misinformation surrounding the reasons why people inject has been widely disseminated in films like 'Trainspotting' fuelling the myth that injecting is carried out for pleasure rather than functional and financial factors, further increasing potential for stigma. Renee explains she injects to use fewer drugs, which for her is a functional risk reduction measure. Renee states that 'people look badly on that', referring to the stigma and potential loss of her identity as a responsible drug taker and risk assessor should her secret be discovered.

## **Hallucinogenic drugs**

Several participants in their drug career had used several types of drugs that could fit into this category. The most commonly reported hallucinogenic drug among the majority of participants was cannabis. Several of the participants used this drug daily; however use was confined to set periods in the day, with strict rules. Use after work, before bed, to enhance relaxation or aid the enjoyment of music or reading was commonly reported. LSD 'acid' and psilocybin or 'magic mushrooms' were the next most common drugs in this category.

## Cannabis

Ms H uses cannabis every day, purchasing a ¼ ounce (7 grams) per week which is around an ounce (28 grams) per month. However, constant use throughout her day is not feasible; an experience she explains that becomes boring and expensive:

*'... smoking a lot of pot can get very boring after a while. You become very insular I think. You don't really go out and see your friends and you don't necessarily do very much with your time...I think you realise it's not that sustainable', (Ms H, 30's).*

Kay had developed a rationale for her daily use of cannabis by suggesting that she required using it prior to going to bed to aid relaxation and sleep. She explains:

*'...I can't sleep at night, my head's always thinking about stuff so I smoke. It cuts down the noise, the traffic, the burble, burble, burble...'* (Kay, 30's).

Millie explains that she uses a key strategy or 'ground rules' to limit her use of cannabis to just a few joints per day.

*'I am laying ground rules for myself definitely in order to make sure because if I got down to just a couple of joints a day then I would just leave myself alone and be happy but at the moment it is more than that', (Millie, 40's).*

Ms H, similar to Mr K, suggests that while she enjoys her daily use of cannabis, she prefers the milder cannabis resin to strong 'skunk' leaf cannabis:

*'...I'd rather it wasn't skunk actually, because I find that kind of just knocks you out a bit and you just can't function for a couple hours...'*, (Ms H, 30's).

Ms M and Ms K prefer cannabis resin as it is milder in its effects and leads to a more sociable experience. Ms M explains that overdosing is not that functional for her:

*'... suddenly you just slouch in the corner rather than actually interact. What's the point in that?' (Ms M, 40's).*

Several cannabis using participants mentioned that sometimes becoming intoxicated with cannabis results in anxiety and paranoia. The drug induced paranoia mimics the perceived effects of mental illness, and has led to the widespread belief that cannabis causes mental illness. Frisher et al., (2009) tested the hypothesis that cannabis leads to schizophrenia. They noted that, with an increase in cannabis use over the past 30 years, there would be a corresponding increase in schizophrenia/psychosis diagnoses. Looking at the annual incidence and prevalence of diagnoses of schizophrenia and psychoses in general practice, the authors found a decrease in diagnoses in the United Kingdom between 1995 and 2005. This finding is further supported by evidence from inpatient hospital statistics and household surveys. The authors conclude that the study provides little evidence for a causal link between cannabis and schizophrenia/psychoses.

Several participants reported using cannabis on a daily basis. However as all of the daily users were in employment, some had children under 16, they confined their use to periods of their day when it was convenient to do so, such as evenings or after work, or before going to sleep in the evening. Two participants had used cannabis in a work situation and experienced anxiety and paranoia. They did not experience these negative effects when they used alcohol at work. The legal status of the drug, the environment where they had taken it, all appeared to have an impact on the reported consequences of use. This of course is an interaction between the drug, the user's mind set, and the environment in which the drug is taken, an interaction that Zinberg (1984) describes in his classic work 'Drug, Set and Setting'.

Ms H explains how she regulates her cannabis use depending on the occasion, and her mind set, or mood:

*'When I'm smoking weed well that just really depends on how my day is, what on earth I'm doing... then at the end of the day, you have your tea, put the kids to bed and then I usually have a spliff after they've gone to bed and then a spliff when I go to bed and read my book...'*, (Ms H, 30's).

For Ms H, her use pattern depends on whether her children are at home or not. When her children are at their father's place, her use of cannabis has a tendency to increase. She explains:

*'But if the kids were away, it would be as soon as I got up really (laughs)! It kind of depends...'* (Ms H, 30's).

Millie, a daily user of cannabis who had recently stopped smoking tobacco, explains how she manages her daily use of cannabis:

*'...my latest thing...is not to smoke in here (her lounge where the interview took place) ... I'm sick of spending money on it and my house smelling'*, (Millie, 40's).

Here Millie is describing that her strategy for reducing her cannabis use was tied to her desire to stop smoking tobacco, which she had recently given up, describing herself as a 'non-smoker' of tobacco, but acknowledged that she did still use small amounts of cannabis in the evening. That however did not make her a smoker in her opinion.

## **Rule boundary recognition**

There were several risks that the participants identified, which linked to the themes found in the literature. However one point should be made. The research chosen to be included in drug policy documents invariably focus on negative aspects of drugs use, concentrating in particular on negative health consequences. For example research into the use of ketamine

concentrated on linking it to acute hospital admissions for urinary tract infections or sub pubic pain (Shahania et al., 2007). As a result of continual repetition, repeated anecdote becomes constructed as a 'risk norm'. There was no mention of the reported sensible use of this drug (Moore & Measham 2008) or the controlled use of any illegal drugs in drug policy documents.

Several participants were attracted by the illegality of the drugs they chose to use. Abby explains that it is precisely the illegality of drugs that provides a symbolic allure. She explains why she is drawn to the social world of the drug taker:

*'...I think there is something nice about something being risky...There is definitely appeal because it's something illegal. We like to be naughty; we like to be bad; we like to have fun ...' (Abby, 30's).*

For Abby the thrill of engaging in an illegal activity that only a minority engage in is for her the attraction. Were drugs made legal; they might lose their symbolic value. It was recognised that all drugs were dangerous, and that several dangerous drugs were widely used with minimal problems. Many participants stated that alcohol is a dangerous drug, and yet it can be used safely. There is no such acknowledgement in government policy documents. Don explains his position:

*'...Alcohol can be really dangerous, it can be really fun, and so can some drugs',  
(Don 50's).*

Don is acknowledging that dangerous drugs can be used safely, and the outcome is not necessarily negative. Several participants expressed considerable frustration at this not being acknowledged in policy discourse, or portrayed as potentially safe as well as dangerous in mass media.

## Drug risk factors

Several participants highlight the common risks associated with illegal drugs:

*'...with illegal drugs there is no way to tell what you are taking and things can be cut with all sorts of things so one time you might get a gram of something and it might be very weak because it's been cut and the next time it could be very strong...If you buy a bottle of rum it tells you the percentage on the label', (Renee, 30's)*

While others suggest that drugs risks are comparable with other risks:

*'I don't consider drugs harmful if taken in moderation. If you take too much of one thing it can be bad for you. Too much water can be bad for you, it can dilute your sodium and you can die. Too much of anything is bad for you', (Mr G, 20's).*

Two participants fully understood that solvents, such as glue or butane gas, which can be found in many households, are extremely dangerous as their use results in more deaths per user, than any other drug, legal or illegal. In contrast, the use of MDMA widespread, and yet is a factor in very few deaths. His argument is that ecstasy is relatively safe given the numbers of deaths relative to the large numbers of people who use it regularly.

*'There's probably 5 million E's taken in the UK every year<sup>38</sup>, how many die every year? Less than 20, how many die of sniffing solvents or petrol, probably about 60. So statistically they can be safer', (Don 50's).*

This argument was raised by Professor David Nutt, while chair of the ACMD<sup>39</sup> who argued that horse riding is more dangerous than using ecstasy. The argument arose when Professor Nutt argued that Class A drugs are perceived to be extremely harmful, however

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<sup>38</sup> E's refer to MDMA or ecstasy.

<sup>39</sup> Advisory Council on the Misuse of Drugs. The committee was plunged into controversy in 2009 when its chairman, Professor David Nutt, was sacked after clashing with the government over its decision to reclassify cannabis from a class C to a class B drug, and on the dangers of ecstasy (MDMA) being relative to its use, safer than some risky activities, horse riding for example. The then Home Secretary Alan Johnson had called for him to resign.

research indicated that ecstasy is not as dangerous as some controlled drugs, and is safer than some drugs which are not controlled, such as solvents. This challenged the use of the legal classification system as a deterrent rather than its original purpose of informing sentencing guidelines if convicted of an offence within the confines of the Misuse of Drugs Act 1971.

## **Overdose**

The word "overdose" implies that there is a common safe dosage and usage for a drug, and that using in a dose over this limit is dangerous; therefore, the term is commonly only applied to drugs, not poisons, however certain poisons are harmless at low doses. Several participants agreed that drug overdose was a risk and had to be understood and managed:

*'...overdosing (and) not being aware of what you are doing, what you are taking',  
Abby (30's).*

Abby, like others, makes the clear point that not knowing what drugs contain and their levels of purity was a risk factor that was difficult to gauge and manage. Although drug overdoses are sometimes caused intentionally to commit suicide or self-harm, many drug overdoses are accidental. Overdose is a term that can also describe the intentional increase of dosage in a controlled knowledgeable manner can produce euphoria and a dreamlike state. Using illicit drugs of unexpected purity, in large quantities, or after a period of abstinence can also result in overdose. The term 'overdose' is often misused as a descriptor for adverse drug reactions or negative drug interactions due to poly drug use. That said several participants used the term to describe their experiences. Renee used the term in this manner:

*'With ketamine, I've overdosed. I don't mean like overdosed as to have to go hospital or anything like that but the line between having a bit of a sparkle and a bit of*

*fun ...there is a fine line between that and sometimes I get caught out', (Renee, 30's).*

Renee describes that she on occasions she becomes more intoxicated than expected, and as a result the involuntary, non-volitional experience was not desired. She explains how she manages risks from ketamine, and powdered drugs in a party situation to reduce the risk of negative experiences due to overdose:

*'...at a party situation I'm there to interact with my friends. I'm not there to go off on my own world and I don't ever want to put my friends in a situation where they have to look after me or are worried about me and all of that', (Renee, 30's).*

The risks of overdose are overcome by the use of a drug dispenser that dispenses a set amount, which is easily regulated. Renee and other intermittent users of powdered drugs describe using a bullet shaped device that dispenses powdered drugs in small measured doses. The use of this device means that users can regulate their consumption. Field notes indicate that several participants used this drug dispenser when there were several powdered drugs in circulation, which allowed a distinction to be made between ketamine, cocaine, 4MMC and a powdered form of GHB. However when Renee and her boyfriend are on their own, there is no need for the bullet drug dispenser. Renee explains the distinction:

*'The inhaler would generally just be used for parties and stuff', (Renee, 30's)*

The user of ketamine requires a dose large enough to create the sought after 'out of body experience' generally known as the 'K-hole'. Ms M and Mr K (interviewed together) regularly used the drug individually and in party or social group situations; however they had decided that the K hole was best achieved together. They explain:

*'We do go in K holes together and it's best trying to talk to each other all the time and you really can get each other through it'...You couldn't just do it with sort of anyone', (Ms M, 40's).*



Research conducted by Griffin et al (2008) challenges popular discourses which describe the use of ketamine as inevitably problematic and dangerous. They found that the enduring search for pleasurable intoxicating experiences drove the participants in their study to use this drug sensibly and recreationally, and the perception was that even at large doses, this drug was relatively risk free. A planned overdose helped achieve a state known as the K-hole. In the absence of any credible harm reduction messages emanating from government sources, their research is important in disseminating information that produces a safer drug experience, rather than merely condemning all use as dangerous.

Moore and Measham, (2008) interviewed 12 current and regular users of ketamine and found that narratives of 'fun' and 'pleasure' dominated the users experiences. For their participants, the use was distinctly 'playful' and users sought a 'childlike' state as a source of fun and recreation. Some users preferred mild intoxication; however some users planned an overdose to create the K-hole experience. Some participants had the K-hole experience individually. But on occasions it was experienced together by couples in a strong pair bonded relationship. Dose control to manage the intoxicating experience was a paramount concern for the participants.

GHB was a drug described as enjoyable by experienced users, who saw it as a fast route to intoxication; however there were risks from unplanned overdose that had to be managed.

Jamie explains:

*'I seen some folk who were on it who were just a total mess; they've just keeled over on the floor waiting to get raped', (Jamie, 20's).*

This loss of control, much sought after by some, feared by many, is described by Ms J:

*'It tends to make people pass out and when you take it you call people GB f\*\*\*-ups. You go to clubs and you see them all congregated together, you would see them together, all unconscious. Your face all drops and they go under. Then they get this*

*amazing buzz; don't get me wrong, the buzz is amazing. Unconsciousness is not fun', (Ms J 20's).*

While being intoxicated with high doses of GHB was described as pleasurable, planned or even unplanned overdose (the K-hole) was not the common sought after experience. Those participants, who could control and manage their behaviour while intoxicated, displayed status behaviours that were much sought after in a social situation. Those who had not yet mastered these techniques were looked down upon; such people were designated 'GB fuck ups' by Ms J. This pejorative term is used as a sanction to regulate use patterns of those users who do not have the experience to manage the risk of overdose, potentially risk a loss of status.

## **Craving**

Craving describes a real if ill-defined urge or desire to take drugs. An all-consuming desire to use drugs in the face of repeated negative consequences is called 'abnormal craving' and is a 'cornerstone' of a disease-based concept of addiction. It is this concept 'craving' and the belief that drug taking inevitably leads to a 'loss of control' that much addiction discourse rests. Some participants use these terms such as craving, tolerance and withdrawal borrowing from a medical discourse, however these terms could also be used to describe normality, without invoking the inevitability of ill health abnormality or pathology. Some describe experiencing craving for cannabis leading to the creation of rules to minimise the risk of uncontrolled daily use. Ms H explains how she manages cannabis craving:

*'I used to very much take it or leave it and I discovered that I now can't do that and if I had in the house I would just smoke it', (Ms H, 30's).*

Ms H, recognising that having more than she required for a single drug using session resulted in increased use, and had to take steps to minimise the amounts she was using and

purchasing. She set rules for herself, and used only at set times in the evening, and only when her son was out of the house. Other participants understood the term craving borrowing from a medial discourse:

*'There must be a physical addiction to nicotine. I understand there is not a physical addiction to cannabis, don't know if that's true or not', (Don, 50's).*

Don recognised that he was dependent on the nicotine in tobacco, and had a choice to make: keep increasing his dosage of cannabis *and* tobacco, or use tobacco on its own, intermittently to satisfy his craving for nicotine. He describes using cannabis only when it is safe and convenient to do so, in the evenings, and only with very close trusted associates that also use cannabis in his preferred intermittent pattern. He avoids daily use, and satisfies his cravings by smoking tobacco, thereby minimising the risk of discovery associated with cannabis use, and attendant intoxication. However his use of tobacco was causing him health concerns. Five participants engaged in regular and daily use of cannabis, at time of interview, and they created several rules to manage craving. Purchasing only in small amounts, using only in the evenings, or when their children were out of the house, or using cannabis only after work. It is also interesting that nicotine is used as a substitute for cannabis, explaining that he satisfied his cannabis cravings using tobacco, as he had become 'addicted' to nicotine. It is interesting that craving for cannabis is not identified as a problem, but craving for nicotine is.

In contrast cocaine has been described as 'a very greedy drug' (Ditton, & Hammersley, 1996); several of the participants who enjoyed using cocaine described the tendency to binge on this drug in patterns of use which could only be described as 'chaotic'. Therefore users of this drug had created several informal rules to regulate their intake, and manage craving. Several users of this drug explained that if cocaine is around they must use it:

*'Coke is 'moreish' ... I could quite easily do a gram by myself', (Ms I, 30's).*

Ms I explains that she usually has plenty of other types of drugs around her house, particularly MDMA; however she finds it difficult to manage her use of cocaine. Once she starts using cocaine, the craving to keep dosing results in her using all that she has in a single session. In this sense cocaine is unmanageable for her because it is 'moreish'. She minimised a tendency to binge and lose control by purchasing only what she can use on her own, in a single session. She does not purchase in bulk, something that is regularly reported by other purchasers of cocaine, referred to more fully in the chapter 'sourcing drugs'. However once supplies of cocaine are exhausted, the participants had choices, source more or use alcohol to come down from the stimulant high. In contrast to Ms I, who minimised craving by purchasing only enough for a single session, Mr B explains his preferred strategy of 'craving' management:

*'... make sure you have plenty of beer to take away the craving afterwards...'* (Mr B, 20's)

However not all participants who use cocaine described a tendency to binge, or experience craving. One participant in particular states that the hype surrounding cocaine is inaccurate and misleading. He explains:

*'...I don't really get anything out of coke; I think it's one of the most over rated drug that is out there... I could get a better effect from a £10 bag of speed',* (Mr HM, 40's).

This may just reflect his personal preference; however it may also be that he had other reasons to denigrate cocaine. It remains an expensive drug, and it is, weight for weight, more expensive than other types of powdered drugs, in particular amphetamine, 4-MMC and MDMA powder. It may also be the case that certain attitudes reinforce a personal belief that cocaine is not for them, a belief that helps minimise consumption, thus reducing risks of unplanned binges.

The 'set' and 'setting', appear to be important in craving management. When Ms I reports using cocaine with her boyfriend, she describes the experience as less enjoyable than when she used it in a social situation on her own. She explains:

*'...my boyfriend doesn't do it (cocaine) so it's no fun doing something with somebody that doesn't do it. He doesn't get it', (Ms I 30's).*

Her partner was a regular user of MDMA and an infrequent user of opiates. It is not inconceivable that given Ms I's tendency to binge on an expensive drug like cocaine, her partner was merely attempting to create a boundary to protect her from her tendency to binge. He had already mastered the techniques necessary to use heroin in a controlled manner. The experiences of those drug users for whom cocaine was not as pleasant or as enjoyable as the hype suggests indicate that controlled use is possible, a finding regularly reported in research, but not widely disseminated out with academic debates.

## **Tolerance**

Over time, users describe experiencing drug tolerance, usually interpreted as requiring more of a drug to achieve the pleasure or outcome desired. The rate that one may become tolerant to the effects of a drug is contingent on the drug, dosage, route of administration, and frequency of use. With alcohol, over time we learn what our limits are. We learn what levels we can tolerate to achieve desired levels of intoxication; and we learn what to expect if we overdo it, resulting in a hangover, called the 'comedown' with certain drugs. There are several factors that interact to regulate tolerance. The belief stemming from a disease concept of addiction is that tolerance is a fixed state after prolonged exposure to drugs; however research indicates that tolerance is a process of learning and adaptation, regulated by several factors and is a fluid concept (Weinberg, 2002, Hammersley & Reid, 2002; Peele,

1985). In general terms the amount of drugs one can tolerate will depend on several factors. The drug factors include its purity, the 'set' factors rest on the affective state experienced during consumption, and the setting, i.e. the environment the drug is taken in, will also be influenced by other users in a social context. The experiences of the research participants construct tolerance as a reflexive process, and not at all like a fixed state. The participants describe being able to manipulate tolerance levels, detoxing and re-toxing themselves; to create the intoxicated state they sought. Several participants recognised that they were using too much cocaine, too often, and were purchasing and using more than previously. As a result tolerance had to be managed:

*'After you've been on it (cocaine) a couple of weekends your tolerance is up, you recognise that', (KT 50's).*

KT explained that he understands that when his use begins to escalate, there are two explanations for this: the quality and purity of drugs is less than he would expect from his trusted sources, or his increased tolerance is a signal for a temporary period of abstinence, in order for his tolerance to reduce. He explains:

*'...it's not the gear is rubbish, your tolerance builds', (KT, 50's).*

### ***Managing tolerance: Instrumental abstinence***

KT and Renee, and several other participants describe periods of instrumental abstinence as functional, and result in pleasurable experiences using fewer drugs in a single session. KT clarifies that given his tendency to binge on cocaine, he has to manage his tolerance. He explains:

*'I tend to binge ...but I do get bored with it after a while. If I'm not getting the same rush, then it's time to chuck<sup>40</sup> it', (KT, 50's).*

Tolerance here is defined as a process of escalation where larger amounts than could previously be tolerated become necessary to achieve desired levels of intoxication. KT has learned that periods of temporary volitional abstinence result in rapid lowering of his tolerance, and that he can safely use smaller amounts, reducing his risk, and his consumption of expensive drugs.

Renee explains the situation regarding her use of ketamine.

*'...about a month ago I found that my ketamine use had got to a stage where if it was in the house I would take it and even if it was just a couple of lines every night it would be enough to make me a bit out of it and not very able to get on with anything else', (Renee, 30's).*

Renee states that cutting down and stopping temporarily to manage her tolerance had little effect in terms of withdrawal or discomfort:

*'... going for 3 weeks without having any, ok it was fine, I was functioning, not really having withdrawals or whatever; so; starting having little bits and trying to get back to where I can have it sitting in the house and not want to take it. It (regulating her tolerance) seems to be working fine at the moment', (Renee, 30's).*

Periods of chaotic use are described by several participants and after a period of abstinence, drugs are reintroduced at a level and rate that are practicable. Renee explains that the regular use of ketamine and other drugs help her cope with repetitive tasks, and explains her regular use as functional, rather than beyond her control. The regular use of drugs increases tolerance, requiring a period of temporary enforced abstinence. Renee and KT

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<sup>40</sup> This term 'chuck it', refers to stopping behaviour, in this case it refers to stopping his use of cocaine.

describe how they reintroduce drugs at manageable doses to minimise health and other risks.

## **Intoxication**

Howard Becker's (1953) early sociological work on deviance indicated that one must learn to become a cannabis smoker. Several participants describe learning to cope with the intoxicating effects of drugs in the company of others. Not being able to cope, being seen as a 'noob', i.e. a newbie, is potentially damaging to status in a drug-using environment. Status is achieved or maintained by being a drug adept, and a drug mentor, as one who has demonstrated mastery of the intoxicating power of drugs, hold a conversation with others, and not pass out or sit in a corner unable to engage or interact with others. Renee explains how she learned to manage the intoxicated experience:

*'I really like GHB by myself or if I've got a day at home by myself, have a coffee and put on some music, and potter around, tidy the house and clean. I find that really enjoyable as a drug to take on my own', (Renee, 30's).*

Renee explained that using certain drugs on her own resulted in several benefits. Her tolerance increases and she can function socially while intoxicated, while learning to manage intoxication also reduces boredom when on her own. She explains:

*'Compared to some of my friends who take 'G' (GHB) regularly I seem to have quite a high tolerance ...I find G for me is a really good drug to take on my own because it just heightens things. I have no worry of overdosing ...I would have to try pretty hard to overdose on it', (Renee, 30's).*

GHB is regularly described as dangerous in certain policy documents. However research described earlier indicates that it can be used safely with the minimum of knowledge, and



following some simple rules to manage the potential for harm. Some participants were aware that overdosing on this drug was a potential risk. Renee regularly used it on her own, something that would be extremely risky were she not adept at recognising her levels of tolerance.

## **Withdrawal**

The after effects of taking some drugs are similar to a hangover after ingesting alcohol to intoxication. These 'come downs' can be relative to the subjective effects of mind set, and setting, and of course to the type of drugs taken, whether stimulant, depressant or hallucinogenic. The after effects of stimulant drugs that act to make the user feel more energetic and reduce fatigue require that the body sources energy that would otherwise not necessarily be available. Therefore like the overdraft facility in bank when one is overdrawn, paying back the loan (of energy) can be taxing, and even on occasions, perceived as 'painful'. Several participants referred to the after effects of drugs, effects of which had to be managed. The comedown could also relate to lack of sleep and fatigue, lack of vitamins and nutrition, and a depletion of various feel good chemicals, in particular serotonin. However the debate in the field is whether these effects of drugs are temporary or permanent. Inferring that some use patterns can be described as 'controlled' challenges the drug talk that underpins addiction discourse. The subjective effects of the consequences of using drugs are now explored. The negative effects were described as being physical and psychological. Abby explains how she perceives the negative effects of drug use:

*'It's when you need a really big joint ...you feel so low, you feel so depressed. The world is going to end, the bank manager is going to take the house off you, everything is going to happen, and it's awful. You just feel really low after a massive high that you've experienced with the drugs', (Abby, 30's).*

Abby describes the comedown as 'suicide Tuesday'. This affective state describes the subjective effects of feeling low physically and mentally after the high experienced by using stimulants (her drugs of choice). She describes feelings of being overwhelmed by normal everyday tasks that she would normally perform routinely. However as with a hangover after a heavy session of alcohol use, the comedown or after effects of drugs are just as difficult.

Mr K took time to describe the anticipation of both the enjoyment of taking drugs, and the realisation that there will be a cost in terms of a comedown which for him means that he described getting nervous prior to a social situation. He explains:

*'I sometimes actually get really nervous about going to parties...I get quite wound up about them because I know that I'm in store for a bit of a come-down afterwards ...'*,  
(Mr K, 40's).

Mr K knows that his drug taking will result in an inevitable low after being intoxicated. Others describe such situations as physically and emotionally painful. Mr K experiences physical symptoms from the comedown describing his state as a sense of temporary depression and feeling of profound disappointment. He describes having to take on the mundane world of work as the price he had to pay for the social enjoyment he experienced. He describes how he interprets the comedown:

*'For me personally I think it's the realisation that the party is over and it's back to work ...'* (Mr K, 40's).

His partner Ms M realised that there are certain times when it is not in her best interests to use drugs, thus avoiding a negative after drugs experience. She is self-employed and at the time of interview recently taken on a mortgage with her partner (Mr K) and therefore when things felt as if they were getting on top of her, she realised that taking drugs might actually heighten the potential for negative subjective states. As a result of her previous experiences, and careful consideration, based on her expertise of dealing with the come down and the

potential negative effects of drugs. She explains why she does not always use drugs when the opportunity is present:

*'... for me anyway, unless I'm happy, stable then it's probably not a good idea to take drugs. For that reason I missed the next party', (Ms M, 40's).*

Mr K explains his strategy for managing the comedowns:

*'... I know what works for me, and it's definitely 2 days isolation. A drugs binge for me then forced to interact with Joe public is a fucking penance, I'd rather not...'* (Mr K, 40's).

It is the knowledge of what he must do ritually after taking drugs which protects him. He, like other participants, uses a variety of techniques to limit the negative effects of drug taking. He knows that he likes to binge on his drugs of choice (cocaine, MDMA, 4-MMC, ketamine and GHB). He explains that he does not like to miss work and take time off; however his statement clearly indicates that this is something that had happened, and he would rather it didn't.

Several participants used diazepam (trade name Valium) to aid sleep after long session of using stimulant drugs. Mr K describes his use of diazepam:

*'I like Valium from time to time...I just enjoy fighting the sleep thing and bouncing about the hallway..., (Mr K, 40's).*

Ms M explains that she does not enjoy seeing her partner Mr K take benzodiazepines:

*'... I like to have it around the house to take sometimes to help us sleep, but I find he had a wee spell of taking a handful of them for instance for the hit and I just find it's such an ugly drug. I just hate seeing anybody on them. When I see him on them, it's just horrible, it's disgusting. It's not nice at all so I had to put the foot down at one point and say 'stop taking them'.*

Ms I, an intermittent user of stimulant drugs, explains that she uses diazepam to help with the comedown:

*'I will only take one Valium...It's just purely as just to make sure I come down and relax enough to get to sleep because I'm a bad sleeper anyway', (Ms I, 30's).*

The functional use of benzodiazepines, GHB and alcohol to get a sleep after using stimulants was commonly reported.

## **Rule boundary creation**

Two techniques were regularly reported to manage and control risk arising from the use of drugs. Creating rules, which had to be adhered to allow the participants to use drugs, and manage the negative consequences that result from rule breaches. Creating rules, within set boundaries such as managing a healthy diet and regular periods of exercise counteracted the perceived and actual health concerns they had concerning the use of drugs. The stereotypical problem user is constructed as unhealthy, with its attendant and inevitable loss of control. This construct would of course make the typical drug user unable to think about their health. Ms S explains why she manages her diet and uses exercise:

*'Occasionally I go on health drives...about four months ago I was biking and running twice a week and wasn't smoking and was drinking maybe two, three times a week and wasn't taking any drugs because I was concentrating on getting fit', (Ms S 40's).*

KT is a self-confessed binge user of MDMA and cocaine in his early fifties, who has used drugs for thirty years; he balances his 'unhealthy' use of drugs, with an exercise routine that keeps him active and healthy. Despite an accident that prevents him from hill climbing, he is still active, regularly engaging in hill walking. He explains:

*'I had an MOT recently (health check)... my bloods and pressure were perfect and my cholesterol was low, and I was doing coke every weekend! .... I live quite a healthy lifestyle, when I'm not; it's due to taking drugs. But being healthy allows me to do that', (KT, 50's).*

KT is suggesting that after using drugs, periods of healthy eating and regular exercise counteract negative effects of drug taking. Other participants manage the risk associated with drugs use in a similar manner:

*'...I always like to be healthy; eat and drink well, exercise and then party hard at the weekend. ... Sort of counteracts it, in my head anyway', (Chris, 20's).*

Mr R, an associate of KT, a 51 year old male, uses cannabis and MDMA intermittently, enjoys being on his mountain bike, even when suffering the after effects from drug taking. He explains his experiences after a drug binge:

*'... I'm always cycling a bit slower for the first couple of hours...It takes a couple of hours for you to be back firing on four cylinders again', (Mr R, 50's).*

This suggests that participants actively plan for the comedown, and having an active lifestyle for some, helps them counteract negative consequences.

During his interview, Mr R described a situation where he had been paragliding, while suffering a comedown, had misjudged the wind direction and crashed suddenly to the ground, breaking his wrist. He had some cannabis resin in his pocket, and ingested it orally, which dulled the pain sufficiently to walk to get help and attend hospital for treatment. While this experience occurred after a drug taking session, he was at pains to explain that he was not intoxicated when the accident occurred.

## Managing drug risks: long term abstinence

After a particularly hard time, or after a series of negative consequences, several participants had long periods of abstinence. This appeared different to the short periods of abstinence used to manage and regulate tolerance. Ron stopped using all drugs, with the exception of tobacco, for four years. At the time of interview he was a daily user of cannabis, and intermittent user of other drugs including cocaine, MDMA, and 4MMC. He explains why he stopped:

*'I had a bad experience... stopped everything, didn't even smoke hash, or drink alcohol...smoking cigarettes, but that was it. As far as drugs went that was it, I'd had a scare and I wasn't interested in being scared again', (Ron, 30's).*

In asking why he decided to use drugs after four years of abstaining, he states:

*'Things changed, new friends and stuff, people wanted to go out clubbing again. That's how I got back into it again. Four or five weeks later, it was like I'd never left. ...suddenly I was back there again, in full swing.'* (Ron, 30's).

Ron explains that he remained abstinent by not being in the company of drugs users as he did not wish to be tempted to use drugs. Eventually, however, his attitudes changed, he had a new job, and a new reference group and he entered voluntarily into the social world of drug use. He explains that after around a month, it was as if he had never stopped, and he continues to use drugs on a regular basis. One participant stopped using drugs in order to achieve his goal of obtaining his master's degree in engineering. He explains:

*'... I did a Master's Degree at University so I knew that was time I had to stop completely in order for me to be able to study properly', (Mr G, 20's).*

These periods of enforced long term abstinence were necessary for several reasons. For some it was a goal, to achieve something. For others it was to reduce their intake to more

manageable levels. Mr B was a former daily user of cannabis; however he is now abstinent, the reasons for this are:

*'...What made me stop was that I was living with a guy who had been doing it a lot longer than I had and I just looked back one day, and I just saw where his life was going and knew I would end up like he was if I kept smoking every day. I've never touched it since', (Mr B, 20's).*

On being asked why he stopped his daily use of cannabis, he explained his reasoning. He could see himself becoming more and more like his friend, a situation he wished to avoid.

## **Rule boundary maintenance**

Once risks were identified, and rules created, they had to be maintained to reduce the risks associated with drug taking. Other users in social situations were a ready resource, imparting knowledge, and keeping a watchful eye on their own and others use of drugs. Dictionaries define mentors as wise and trusted counsellors or teachers, influential senior sponsors or supporters, stemming from the Greek 'Mentes'. Mentors assume the informal but important role of drug adept guiding the novice through high risk situations imparting and displaying the skills necessary to neutralise risk. Participants describe how some drug users took on the informal but important role of mentor to minimise the risk to other users. This role served several functions. Being out of control was potentially stigmatising. Therefore disseminating the skills necessary to reduce the risk of unplanned overdose and minimise other negative consequences were important. Some participants describe taking on such a role willingly, while others did not. Ron describes the role of a mentor:

*'Somebody to keep you right and make sure you are not doing too much or stepping up a level when you are not really ready to go up to the next level..', (Ron, 30's).*

Having someone in the company who would use less, or remain temporarily in control until others were safe was regularly reported by participants, particularly in parties and informal social gatherings and in clubs and other drug taking environments. Sharing and pooling of knowledge and skills were common features of the social groupings drug adepts created. Being guided by a mentor was most commonly reported when users were initiated. Ms I explains how friends helped her when she used LSD for the first time. She explains how she was taught to enjoy the experience:

*'...I had suddenly 8 people looking after me so I couldn't have had a better first experience... I saw really weird things like snakes but it didn't freak me out or anything because I still knew it was just my imagination', (Ms I, 30's).*

Ms I describes several experienced users passing on their knowledge to her as a novice user. She said that she 'could not have had a better first experience', with the benefit of having experienced adepts reassuring her during a novel experience with LSD. She was reassured that her experiences were drug related, temporary, as a result of this support she learned how to manage the potential risks associated with the use of hallucinogenic drugs, and how to manage her fear of losing of control. However not all first experiences were as positive. Some mentors were less than helpful. The first illegal drug Mr HM tried was cannabis. This resulted in an unpleasant experience. The main reason was that he had not learned what he could tolerate and felt pressure to use more than he wanted to. Although this was still a supportive environment, his mentors were less helpful than he would have liked:

*'...the company I was in were older people at the time and they kept telling me to take a bigger draw and not be shy. I was never a 'stunt smoker' and that sent me a wee bit over... Eventually I was ok', (Mr HM, 30's).*



Mr HM explains that his mentors believed that achieving intoxication as fast as possible was desirable, similar to the Scottish view of the main function of alcohol, is rapid intoxication and a 'binge' style of use. After this experience at initiation however, he settled quickly into his preferred use pattern for cannabis. He explains that the pleasure of drug taking is about learning to cope with the powerful effects. Once achieved, he further explored the pleasure associated with differing levels and states of drug intoxication. While there were differing types of mentor, some more positive and more helpful than others, the first experience was often described as positive. Drug mentors serve several functions: to aid others, including the mentors who may require looking after if they were intending to experience a managed loss of control; and to maintain a positive social and caring environment where the outcome and consequences of drug taking can be regulated. If the environment is supportive, and drug users feel looked after, the experience is generally positive, and even if it turns negative for whatever reason, more experienced users guide them through the temporary negative experience and make sure that they learn to interpret the intoxicated experience as drug induced. Support networks of informal mentors were commonly reported to manage rules, and police boundaries were they breached.

*'... If we do get out of control then we are slapped on the hand, but the support network is there to help. There is one or two that don't take the help at times and they just disappear, you can't help them', (Abby, 30's).*

Research conducted by Beynon et al., (2009) accessed problem drug users. They found that some formed reciprocal alliances with younger drug users out of practical necessity. The climate of moral outraged directed at drug users create the conditions for hostility. Therefore creating a supportive environment is necessary to reduce the risk, and produce the conditions necessary for an enjoyable experience. Adept mentors mentor the less experienced in order that all remain safe. Conditions are created that reduce risk to everyone. No one is chosen to take on this role; being a mentor appears to happen organically, without anyone

necessarily being in charge. The conditions are created where some deliberately remain less intoxicated than others, often taking it in turns. These informal roles taken on by some members of the social groups appear functional and necessary reducing the risks of drug taking in potentially hostile environments that result from drug prohibition.

Participants describe when humour can be used to put across a serious point. Don describes how friends with whom he tends to use drugs cope with getting someone to recognise that they are not managing risk as well as they ought. He explains:

*'We sent one of my pals a 'plan your own funeral' leaflet and that. We told him he was going to keel over one of these days and that he needed to get a grip of himself. We deal with humour, kind of quite harsh humour possibly', (Don, 50's).*

Having adepts around taking on the informal role of expert reduces potential risks, and is described by most of the participants as clearly an important method of risk identification and management. Several of the participants drove after taking drugs and this risk had to be managed, particularly those who attended rallies where scooters were part of the scene. Working out when it was safe to drive was a factor that had to be calculated, and risk managed. Don explains:

*'...you can't drive scooters if you are mashed on benzos or opiates, you fall off', (Don, 50's).*

This was potentially stigmatising, and several participants were at first reluctant to discuss this aspect of drug taking. While keen to discuss their mastery over drug risks by describing the rules and regulations they had created to assess and manage risk while intoxicated, they were less keen to discuss the risk associated with drug driving.

## Discussion

Drug taking is a social experience, some participants describe using drugs on their own to test limits and build tolerance, in order to function and maintain an identity of 'being in control' when intoxicated in a group or party situation. Others use drugs in pair bonded partnerships, and enjoy the experience only achieved through trust and negotiation, in particular the users of ketamine. Two ketamine users express concerns that being discovered as drug injectors would result in shame and a loss of status in their social groups with whom they regularly used drugs. The stigma associated with uncontrolled use, creates the potential for conditions that could lead to status loss in a group. This was apparent in how the participants described and responded to problem users in their social world who transgressed informally agreed rule boundaries.

Participants indicate that rituals function in four basic and overlapping ways to create and maintain rule boundaries to manage the drug risk. Informal rules regulate use patterns that operate to compartmentalise drug use and protect against use patterns that are condemned. In such cases participants used informal methods to learn such rituals, in particular the use of 'drug mentors', an informal role taken on by the more experienced to aid and guide users to reduce risks to the individual and to the group. Users create environments that are intended to ensure positive outcomes, and reduce the risks associated with a hostile environment.

First, learned rules define moderate use and condemn compulsive use. Controlled opiate and cocaine users have sanctions limiting frequency of use to levels below that result in addiction. Many describe creating special sanctions, such as 'don't use every day', or 'never inject drugs'. Labels are used as sanctions to regulate norms regarding the use of opiates or cocaine to weekends or special occasions. Also rules such as purchasing set amounts, or using at set times regulate and manage risks of overdose, and protect users from extreme negative consequences such as the 'come down', described as 'Suicide Tuesday' by Abby.

Second, rules limit use to physical and social settings that are conducive to a positive or 'safe' drug experience. The maxim for drugs that can result in mild hallucination is, 'Use in a supportive environment with like-minded people', at least one of whom must be sober or at least sufficiently experienced as an adept to care for others should any difficulty arise. Two rituals consonant with such sanctions are the selection of a pleasant friendly setting for the use of Ketamine, GHB, MDMA, and 4-MMC and the timing of use to avoid driving while still under the influence of drugs.

Third, rules identify potentially negative drug effects. Rituals symbolise the precautions to be taken before and during use. Unplanned overdose is avoided by using only a portion of the drug and waiting to gauge its effect before increasing the dose, or by regulating use by means of specialist equipment (such as a bullet device) for titration of powdered drugs such as Ketamine. Becoming intoxicated in an unplanned manner unable to contribute to the social milieu is frowned upon, and sanctions are applied.

Fourth, rules and rituals operate to compartmentalise drug use and support the users' non-drug-related obligations and relationships. For example, users may consume drugs only in the evenings (especially cannabis) or at weekends (particularly cocaine and ecstasy) to avoid interfering with work performance, or family commitments.

How controlling rituals and sanctions are adopted varies from participant to participant. Most individuals come by them gradually during the course of their drug-using career. Without doubt, the most important source of the tenets and practices for control is the social group they choose to belong to. Virtually all of the participants were assisted by mentors in constructing appropriate rituals and sanctions out of the practices or 'folk pharmacology' circulating in their drug-using group. These mentors informally provide instruction in and reinforced appropriate use; and despite the popular image of peer pressure as a corrupting force pushing weak individuals toward drug misuse, the participants explain and demonstrate that many sections of the drug subculture avoid the chaotic patterns of use by

active risk avoidance, and learning harm reduction techniques from others. It was regularly reported that being a source of worry or anxiety produced sanctions from others in their social groups, in particular being spoken to, or taken to one side and gently persuaded to better manage their drug taking. One participant described the situation where they sent a potential problem user a 'plan your own funeral' leaflet, which with humour sent a clear message of what they considered acceptable risk norms within their social group.

Some participants expressed concern about their physical and mental health, and this may be partly due to the negative effects reported by service users, and described in drug policy documents. The strategies implemented to manage risk ranged from avoiding drugs, limiting personal supply, using diet and exercise, to engaging in periods of short and longer term abstinence to help them recover from negative effects and to return to previous use patterns. Short term periods of instrumental abstinence was regularly reported by users of cocaine. This had the functional value of allowing positive effects of drugs to be experienced using fewer drugs, resulting in cost and health benefits. Finally the practice of testing one's limits using drugs alone to find a level of tolerance and to practice the management of intoxicated experiences in order to more fully function in a group situation was regularly reported.

There has been the belief, put forward by several Home secretary's in the UK government, that the legal classification system is an important factor in deterring the use of controlled drugs: that when penalties and risks are greater, that acts to deter use. With few exceptions, most of the participants knew of the legal classification system underpinning the Misuse of Drugs Act 1971; however most did not care about the legal class of drugs they chose to use, or know of the actual legal penalty associated with possession. They 'knew' that MDMA, a class 'A' drug was not as dangerous as alcohol for example, and that GHB and ketamine were relatively safe, even if used alone, even at high doses. All drugs while potentially dangerous were perceived to be safe, given the right skill set, and environment. What the users had little control over was the purity of the illegal drugs they purchased, especially pills and powdered drugs.

Given the wide range of views that drive much of the addiction literature, experts on drug use appear to be a long way from knowing how to understand or agree on the dynamics that interact that lead to problematic drug use. This may in part be because the current UK law on illicit drugs prevents any research of their use in the field, or in controlled laboratory conditions. Even minor changes to drug policy could greatly increase knowledge of how, why, and where people use drugs, and why some people become regular excessive users of drugs, and others do not. By documenting techniques used by the participants to regulate their use, establish patterns of controlled chaos and loss of control, the use of mentors, and the informal and effective use of devices such as the 'bullet' dispenser, as well as exploring how drug users learn to cope with intoxication all signify that risks are recognised, techniques are learned, and appear to be effectively disseminated to new users. Also important are the techniques used to encourage problem users to re-establish patterns that safeguarded continued group membership, the management of intoxication, displaying patterns of use that demonstrate skill and mastery over dangerous substances, and the intoxicated experience. Having established ones status within an informal group; norms are regulated in a variety of ways. Having explored how risks are managed, how drugs are sourced in a climate of prohibition is what the next chapter will now focus.

## Chapter six: sourcing drugs

The links between illegal drug use and crime are the subject of much controversy (Hammersley, 2008). The aims of UK drug policy are to eradicate or at least reduce the supply of drugs, increase the numbers of problem users in treatment, and reduce offending believed to be related to addiction to drugs. However the links between drugs and crime may not only be an artefact of the drugs laws themselves (possession of drugs being the most common crime) but that crime may for many users, precede drug taking (Hammersley, 2008). Despite crime reducing in real terms since records began, the fear of crime is a prominent theme to emerge from surveys of local communities affected by drug markets (Cyster & Rowe, 2006:2). The fear of drug related crime appears to be influenced by media stories that concentrate on linking drugs use, drug dealing, and acquisitive crime together. The participants in this research were a hidden population who hid their drug use, and feared having their identity spoiled should they be discovered as a drug user, or branded an 'offender'. This fear of discovery was not linked to actual experiences, but to a generalised fear of detection that underpins drug prohibition in Scotland, which creates a climate of moral as well as legal condemnation.

This chapter explores how the participants understand risks associated with purchasing illegal drugs. The overall impression created by the responses of the participants was that prohibition creates stress of being discovered by the police, and more importantly being labelled negatively as an addict or offender. The participants developed several strategies to manage these identified risks. Chapter two indicates that drug discourse, or 'drug talk' constructs stereotypical dealers or pushers whose motive is largely profit, unconcerned about the quality of drugs they distribute, or the health of consumers. However in contrast to such populist views of how drugs are accessed at 'street level', many of the participants sourced a steady supply of drugs from close friend and kinship networks of suppliers, who informally supplied drugs to help out their friends, and with whom they would often be using

the drugs. Challenging the profit at any cost motive widely disseminated by drug talkers, those who engage in such 'drug talk'.

Participants' views of who a dealer is created several categories of identity, friends as sources, partners as sources, dealers as party facilitators, and six participants identified themselves as current or former dealers. Some had merely supplied very close friends and family, while others described being at a level slightly above being a supplier to one or two friends, and had extended their network on occasions to include others introduced to them through friend or kinship links. Within the confines of the Misuse of Drugs Act 1971, all of the participants were drug dealers, having given or sold drugs to their friends and associates, risking prosecution had they been discovered. However there were two participants who had sold drugs at a low level commercially and their insights relative to the typical dealer stereotype are explored in some detail. Some of the participants categorised dealers by the type of drugs they sell, and whether they were operating in a closed market, or an open market. Preble and Casey (1969), in their seminal work on heroin use in the USA 'Taking Care of Business', describe strict hierarchical structures of drug supply chains, and define the top down 'career' structures necessary to maintain a steady supply of illegal drugs. They describe drug dealers as a community bonded by common interests and cooperative partnerships with other users which served to maintain such pyramid like structures. The intentionally unseen participants in this research formed bonds to protect each other from the risk of problematic use and becoming visible when at all possible, as well as remaining part of a moral community with whom risk of discovery would damage their reputation and standing in their communities. Some participants reported cooperating to share risk of drug purchases on a rota basis. This is a view that challenges the construction of the addict as slaves to drugs, or the dealer largely concerned with profit, increasing their market share by pushing drugs onto unwilling victims.

The participants describe several techniques used to manage risks associated with purchasing drugs. Often drugs were not available when required, or the participant had few



sources. Several participants created informal supply networks that meant that they had a surplus of drugs which were then given out in social situations similar to sharing alcohol or tobacco, or described surplus bartered as commodities for other drugs. Several participants mentioned travelling to other locations outside where they lived, mainly England, but one had travelled to the Netherlands to source MDMA in bulk. One female participant had refused prescription drugs from her GP, preferring to continue to take cannabis rather the prescribed SSRI<sup>41</sup> Prozac which she felt the GP was 'pushing' on her. Several participants sourced drugs from the Internet, and in particular 4-MMC, commonly known as mephedrone. When this study began collecting data, between late 2009 and mid-2010, this drug had not been made illegal to possess and this study allows some evaluation of users' patterns of use of this drug, prior to it becoming illegal in April 2010.

## **Defining the market for illicit drugs**

The illegal drug economy is a business. It provides an informal source of income to certain members of various communities, and can give meaning and status to some social actors who cannot easily access legitimate employment and education opportunities (ACMD, 1998). The illicit drugs trade can also have a negative impact on quality of life issues for local communities, undermining community confidence, damaging neighbourhood reputations and hindering regeneration efforts (Lupton et al., 2002). In a review of the literature in this area Ritter (2006) observed that there is no single working definition of a drug market. May and Hough (2004) concluded it possible to conceptualise two types of organisational or distribution system: a pyramid or top down organisation and a more fragmented, non-hierarchical and entrepreneurial free market. However, it proves difficult to judge which system is dominant in the UK (May and Hough, 2004: 556). Pearson and Hobbs (2001) have argued that:

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<sup>41</sup> SSRI = selective serotonin reuptake inhibitor. In general such a drug prevents the reuptake of the neurotransmitter serotonin, a drug known to affect mood.

*“There is not so much a national drugs market, as a series of loosely interlinked local and regional markets” (2001: vii).*

May and Hough’s (2004) classification of retail markets distinguishes between open, semi-open (pub and club-based) and closed kinship and friendship markets. May and Hough also observed how these different markets adapt and respond. For example, they noted how during the 1990s heroin and crack markets evolved from open street-based markets to closed phone-based ones. Social network markets are primarily based around friendship and social networks (gaining access to drugs through family connections or through friendship networks). Participation in these informal networks serves to insulate or distance drug purchasers and drugs sellers from the risks posed by more overtly criminal drug markets. This type of drug selling has little to do with commercial gain, (May et al., 2000; May and Hough, 2004; Duffy et al., 2007). The pyramid type structure, described by Preble and Casey, (1969) is believed to involve large-scale importers and traffickers operating at the apex, filtering down to street dealers who operate on the lowest tier (May and Hough, 2004; Cyster and Rowe, 2005). Samantha Coope et al., (2004), conducted similar work in Scotland, and came to similar conclusions. The illicit drugs trade is described by the UK government as having three levels: an international trafficking level, a local retail level, and between these a loosely defined ‘middle market’ at national/regional level. However, the lines between the different levels in the supply chain are far from clear and the various roles within them are often fluid and interchangeable.

### **Sourcing drugs – open and closed markets**

In an open market, a dealer will supply to anyone whereas in a closed market dealers only conduct business to friends and well known associates whom friends introduce. There is some considerable overlap between these two extremes, and for brevity these are the

definitions referred to in this study. The Home Office study 'Disrupting Crack Markets (2003) defines crack markets as 'open' or 'closed'. An open market is one where a dealer will see anyone. Open markets can be: (a) On the street, where several street dealers can congregate offering drugs or wait to be approached, (b) Off the street at premises which can be approached by anyone, for example in clubs and pubs and cafes. A closed market is one where a dealer will only sell to users who are known or introduced to them. Closed markets can be: (a) on the street, at meetings arranged via mobile phone, (b) off the street, at premises from which drugs are sold only to known or introduced users.

Premises may differ in terms of whether buyers may also stay and consume drugs after purchase. The available evidence suggests that dealers and operatives at all levels of the market tend to display a fair degree of adaptability and responsiveness to changing market conditions (Seddon 2011). Enforcement initiatives at a local or regional level are usually led by the police, sometimes in partnership with statutory and voluntary sector agencies. While these activities can achieve perceived success (e.g. in terms of drug seizures, street drug price calculations and arrests) there is rarely any independent assessment of their impact on how the market functions and operates, on the subsequent availability, price and purity of illegal drugs, or on broader harm reduction outcomes<sup>42</sup>. The Home Office<sup>43</sup> estimates that there are approximately 300 major importers into the UK, 3,000 wholesalers and 70,000 street dealers (Stevens and Wilson, 2007). However due to the illegal nature of the market, and the difficulty in accessing various loosely organised networks of supply, this is largely a data free environment.

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<sup>42</sup> See McPhee et al., 2012 for an overview of how street prices are calculated and used as performance indicators by the police in Scotland.

<sup>43</sup> See report 14 of the Beckley Foundation Drug Policy Programme (BFDPP)

### **Sourcing drugs: the users view**

All of the participants were asked how many sources of drugs they thought were selling drugs in their area, or the areas in which they most often travelled to source drugs. The answers ranged from 5-50, indicating that the ease of obtaining drugs was in part a function of where the respondent lived. Another explanation is that the more experience drug takers had of using drugs, the greater their knowledge of sources of drugs.

In general the participants tended to source drugs from closed markets to reduce risks to themselves and others. Several gave valid reasons for choosing only to purchase drugs from a closed market, saying that, if no trusted sources are available, they would do without:

*'...where I used to live there were lots of people who were dealing that I wouldn't go to because they were slightly dodgy. They weren't careful; they would be indiscrete so I would avoid them...I have to know someone incredibly well and for them to have come through a very reliable source in the first place', (Ms S, 40's).*

The language used by Ms S is interesting: she avoids places and dealers she views as 'dodgy', and 'indiscrete', indicating strongly where her preferred boundaries of risk begin and end. She has strict rules that operate to protect her when she is sourcing drugs, and this position was distinctive of the intentionally unseen. However some participants had numerous sources, all of whom they knew, and accessing drugs was not a huge source of risk, or anxiety. Some of the participants grew up in areas where dealing was commonplace, and therefore knew several sources of drugs. Mr G explained that selling drugs was a ready source of income in an area of high unemployment with few opportunities for legitimate training or education, and that dealing drugs can be a source of status and a meaningful occupation:

*'The area that I was brought up in, the employment is relatively low and a lot of people buy and sell drugs as way of making money...so it's quite easy to actually find or to obtain them', (Mr G.; 20's).*

Mr G is an intermittent user of MDMA, and ketamine, and on rare occasion's cocaine. He purchases drugs regularly in bulk, and shares or sells the surplus with others, whom he will invariably be using them; hence profit was not his reason for 'dealing'. Mr G explained that he is now in a profession that allows him to earn enough to live in an area that is affluent. He accesses drugs with relative ease because he grew up in an area characterised by deprivation, low employment, and poor educational attainment. This is in contrast to the opinion of another participant who believes that the affluent area of Glasgow he lives is consistent with the use and supply of cocaine. For this participant, where one chooses to purchase drugs can be a reflection of social standing, and purchasing power. He explains his reasoning:

*'...this is the kind of area, the demography for 'coke' users. This is not a demographical area for heroin users or crack users. This is a very affluent part of the West End of Glasgow and I think that the people who deal here will deal in a certain kind of drug more realistically than another', (JJ, 40's).*

Availability was an issue for some participants. The number of sources of drugs they had in their network indicated several things: knowledge of the market, tolerance to risks within these markets, length of time using drugs, and drugs of choice. Social class, changing fashion and social attitudes appeared to be important factors in sourcing illegal drugs with relative ease. Some of the older participants, in their 40's and 50's refer to situations when they first began sourcing drugs, in the 1970's and 1980's where it was described as 'all cloak and dagger', with people acting very nervous. Drugs were not described as normalised or their use accommodated until the late 1990's. Prior to drugs becoming commonplace in certain settings, among certain people, the 'war on drugs' that had defined drug policy in the

1980's had created several stereotypes. Several of the older participants described occasions where the dealer was a typical 'hippy type', middle class and stoned, or a working class nervous dealer in amphetamines, or a habitual junkie using heroin. One participant describes the first time he tried to source drugs, the experience was not at all positive. He explains the situation:

*'...you went to some estate and you went in and it was all very cloak and dagger', Mr (HM, 40's).*

The situation prior to drugs becoming 'accommodated' by many types of young people were typically described as 'cloak and dagger', typified by paranoia, and acute nervousness, where dealers 'grilled' purchasers about who they were, where they were from, with the result that the situation was not at all comfortable. However when drugs became in his words 'more mainstream', the market changed:

*'...When the E thing came on and the club scene came out, it became more mainstream and people decided they wanted to go and buy drugs...They didn't want to stay and be grilled about who they were, where they were from...', (Mr HM, 40's).*

Mr HM describes the change when drugs became normalised. During the 'rave' scene, and the dominance of dance music in music charts, young people attended environments that had previously been characterised by the use of alcohol and amphetamines. An increase in drug demand required an increase in drug suppliers. That was to eventually result in several unexpected outcomes:

*'When I saw people taking drugs it was always the underclass but I think the E boom just blew that out the water...', (Mr HM, 40's).*

Mr HM described the situation in the 1980's being typified by several types of user: controlled sensible users, who accessed recreational 'soft' drugs such as cannabis, and amphetamines, LSD and magic mushrooms, and another type of user with a dedicated

market characterised by the regular and problematic use of opiates. When the dance scene became associated with ecstasy (MDMA), this had an impact on who accessed illegal drug markets. Friends purchased ecstasy and as a result became informal sources of drugs, and eventually drug availability increased to meet increased demand. He explains:

*'...I saw people being with each other on dance floors that would never normally be that way and I thought it was fantastic to see that but like anything else like that, you get a shelf life on it...after that somebody decided there was a shit load of money to be made out of this and that's when all the trouble came into it', (Mr HM, 40's).*

Mr HM explained that in his opinion organised crime changed the market parameters, and ushered in the conditions that changed his views of drugs, and his rationale for using them. He has since stopped taking drugs, and has been abstinent from all drugs for over two years with the exception of cannabis, of which he was an intermittent user.

Several regular users of cannabis were experienced market users and the daily users in particular required a number of sources to maintain their daily use pattern. All of the daily cannabis users with one exception had several sources of their drugs of choice:

*'I never have just one dealer; I have hundreds of dealers because they are all my friends. If it has run out I can always visit somebody else'. It's a buyer's market, so little or so few people realise that', (Rob, 40's).*

Rob is indicating that as a daily user of cannabis, his drug of choice means that he has several sources of drugs, all of whom he considers to be his friends. He indicates that it's a buyers' market. He explained that if there are several sources of drugs in an area, prices are kept low, and drug quality is generally high rather than low. This perspective challenges the dominant view that dealers control every aspect of the market and purchasers merely passively purchase what is available, without influencing price, purity, or quality. In a market with multiple sources of illicit drugs, buyers can exert influence by only giving repeat

business to users with whom they perceive to purchase quality commodities. Therefore those sellers who remain in the market maintain a tolerable boundary between making profit and keeping their customers happy. Those who do not consider the customer's requirements quickly go out of business. Several of the older participants were experienced market users and describe the ease with which they access drugs:

*'Sometimes you can phone a taxi, and the taxi will go get it, by just paying the taxi fare...It's almost as easy as getting it in the supermarket, it's just illegal', (KT, 50's).*

### **Sourcing drugs: The dealers view**

Defining a dealer was something that Mr K and his partner Ms M took a little time to explore and explain. He suggested that the term conjured up two images. He explains:

*'...I was a dealer myself for a considerable number of years myself and I didn't see myself as a dodgy geezer at all. I was a purveyor of fine goods if you like. (Laughs) I don't see dealers in a bad light at all', (Mr K, 40's).*

He maintains his level of esteem and manages the potential stigma of the public perception of a dealer by insisting that he was not a dealer per se but a 'purveyor of fine goods'. Several participants supplied drugs on occasions, although describe themselves as drug users who shares surplus in a sociable manner. Rob explains his perspective:

*'We are not dealers; it's a very sociable thing. If some guy in the street asked if I could get him some hash I would tell him to f\*\*\* off because I'm not a dealer. If any of my friends asked me for hash I would buy them hash, or pills, it's not a problem, because it's a sociable thing. Nine times out of ten they are going to be taking it with me or with people I know so it's cool', (Rob, 40's).*



Supplying drugs to others without necessarily making a profit has other benefits as Rob explained, 'nine times out of ten'; they will take the drugs supplied by him with him, as it is a sociable 'thing'. He goes on to highlight the boundaries between commercial and non-commercial dealing:

*'... selling sizes like 9 bars and spending a couple of grand here and there, that's when it starts to get cut-throat; anything below that is very sociable', (Bob, 40's).*

The cut off point for Bob is a 'nine bar' of cannabis. This is street slang for nine ounces, or a quarter kilogram. So anything below a quarter kilogram or nine ounces is for Bob still sociable, and is within the realms of purchase for personal use. There are no such thresholds operating officially in the UK. Portugal the only EU member country to have formally decriminalised all drugs, have a threshold set at ten days supply being classed as personal use. Amounts above this are considered to be trafficking offences. That there are no official cut off points in Scotland to distinguish between personal use and drug dealing and trafficking means that users are at risk of being prosecuted for trafficking offences if they purchase more than could be argued is reasonable for personal use. These amounts are determined arbitrarily by the police.

A common misperception by the public according to the participants was the association of being a dealer and selling drugs to children. Several participants' sourced drugs from friends, who do not fit with such a stereotype, of tempting vulnerable youths with 'free samples', to get them 'hooked', something that no participant described as a reality they had experienced, or understood to happen. For Mr HM dealers did not stand around:

*'...outside schools and wait for school kids to come out... I don't see the guy outside with the dealer t-shirt outside the school waiting for the school kids coming out - that's a myth', (Mr HM, 40's).*

Several participants described dealers as essential, for if they did not supply drugs to those who wanted them, social situations would not be as much fun. Ms C explains that for her, dealers are:

*'... People who sell it and they come to parties. If they weren't there (drugs) would run out so sometimes it (dealing) a good thing', (Ms C, 20's).*

Several participants had been regular sources of drugs, and often described situations where they purchased drugs in large quantities, selling them to friends for a profit. This was not without difficulty. Managing the risks between being a supplier for friends, and branching out semi-commercially to make some money, put some participants at great risk of moral condemnation by their friends. One participant in his early 50's was a supplier of amphetamines in the late 1980's, initially for friends and close associates. He would purchase amphetamine in ounces, and then sell it at the same purity he purchased it, guaranteeing a solid reputation as a supplier of good quality drugs, which ensued repeated business. He explains how he began his 'career' as a dealer with a friend with whom he used to hill walk and mountain climb with:

*'...we decided to buy an ounce...and within I would say a month, a month and a half it was 2 ounces, and then within a year it was 3 ounces and we were selling it over two weeks. We were measuring it exactly, never ripped them off, we gave them one gram exactly. It was good marketing', (KT, 50's).*

Here KT is indicating that he fully understood the power of the 'street drug' market, which is largely driven by perception of quality. If the quality is good, and one builds a reputation for selling good quality commodities, repeat business is assured. However after building a reputation as a seller of quality drugs, he was also aware that he was being drawn into a world of commercial dealing, where he could increase his profits. He understood the risk this entailed:

*'...I was getting mixed with people I didn't want to get mixed up with...Selling drugs became a hobby and once it started infringing on my everyday life I thought this is not a road I want to take; probably the fear of getting caught too', (KT, 50's).*

KT describes the profits he made selling amphetamine to his friends and family enabled him to purchase an expensive motor bike. After achieving this aim, he then had a choice. Stop or continue. He did not enjoy mixing with criminals, and he realised the increased risk he was facing being a supplier of drugs to friends to becoming a 'dealer'. However he still sources cocaine in ounces, but will only sell or supply at cost to those users who will be using drugs with him. He has clear boundaries, he does not sell to those whom he does not trust, know or use with him. This small role as supplier to his friends only ensures his positive reputation with friends; however this does increase risk of discovery by the police.

### **Partners as dealers**

As has been discussed the participants were keen to distance themselves from potentially stigmatising identities, and used techniques to construct distinctions between their friends as sources of drugs, and the commercial dealer with ties to organised crime. Some female participants had been in relationships with dealers, and were at pains to point out that the relationship was not based on them as a source of drugs.

Despite attracting a large slice of the drugs policy budget in Scotland, the police have finite resources. Countless people are sources of drugs, numerous people every weekend use illegal drugs; the police cannot target them all and must focus on drug users and drug dealers they consider to be the biggest problem for their community. Therefore small time dealers and users are potentially less at risk of discovery than the highly visible 'street addict', and distressed small time dealer of heroin, albeit similarly potentially stigmatised. The police are also more likely to target areas of deprivation where drugs associated with

problem use such as benzodiazepines; heroin and methadone are bought and sold. This type of police activity has much public support. The former partner of one participant was purchasing drugs in bulk and supplying his friends and family only. Ms Y explains why he did not receive unwanted police attention:

*'The police knew him, the police knew he was a drug dealer, but he was never a big enough, big time drug dealer I suppose ...' (Ms Y, 20's).*

The ex-husband of one participant was part of a music and social scene which allowed him to sell drugs in a relatively risk free manner, in a closed market:

*'People like my ex-husband just do it because they are just out in the scene a lot. They are in the clubs, they know lots of people, they take drugs themselves and they are looking for a way to make a bit of extra money and I guess it's a kind of social thing', (Ms H, 30's).*

This type of informal dealing engaged in by several of the participants, and partners of the participants, is typified by several factors which reduce risk of detection and discovery by the police. The types of markets described here were closed or partially open markets and they would only sell drugs to close friends or to those they were introduced to by close friends or associates. Such practices and rituals allowed them to remain undetected and free from the gaze of state surveillance agencies. They also sold drugs as a side business, and had other jobs or occupations that meant they had a reason for having money.

Abby explains that her former partner was a drug dealer who sold drugs to people he was introduced to through friends and close associates, a practice which reduced his risk of detection. His commercial dealing in a semi closed market allowed them to fund what she described as an 'affluent lifestyle'. However his activities had come to the attention of the police and the increased risk of arrest acted as a deterrent of becoming a commercial dealer.

*'...My ex-boyfriend used to be a dealer in his twenties and had a very affluent lifestyle but could no longer run the risk, so just stopped doing it', (Abby, 30's).*

The police actively target areas of deprivation, and those dealers in the types of drugs perceived to be the most dangerous and addictive, such as heroin, Temazepam and methadone. However several participants indicated that police activity concentrated on groups and individuals who had expanded their networks from closed to semi closed markets, which clearly acted to deter supplying to friends becoming a commercial operation. Creating a distinction between being a source of drugs for one's friends, and being classed as a dealer, or worse a pusher, just 'in it for the money' was not status enhancing. Ms I describes the boundary between being a source of drugs and a pusher of drugs:

*'Generally we are all getting it for each other....a pusher would be different; I think that's the seedier side where I think you're trying to get people onto it and stuff...', (Ms I, 30's).*

Ms I constructs a sophisticated argument creating a clear moral boundary between someone who supplies drugs as a commitment to a social network and friendship, and someone who is trying to make a profit from selling drugs. These boundaries serve to create several categories of dealer who were friends who took risk for several reasons: to be part of the group, because they enjoyed the risk, and because being 'one who dared' was status enhancing. However distinctions between selling drugs to be part of the group, and selling drugs with the express intention of making a profit, were sources of some tension. Ms J explains the distinction. Drug pushers are in her opinion:

*'...too involved in the cash, they get higher up the cash ladder. They get away with it for so long, get used to the lifestyle...'* (Ms J, 20's).

Ms J views the distinction between non-commercial and commercial dealing as a continuum, where the line between selling for friends and selling to support a lifestyle are blurred. Ms H

describes the distinctions that separate the boundaries between being a friend who supplies a need, to becoming a person who is defined by their activity and the aim becomes profit. She explains that the distinction is based on being a non-user:

*'I guess you get the people that actively want to make money from it. A lot of dealers don't a lot of the time and it's very marginal, the profit, especially if you are taking them as well. Then you get ones that actually want to make money and therefore usually don't take the drugs', (Ms H, 30's).*

Ms H describes what separates the commercial dealer from the friend as informal source of drugs. To make a profit there are several factors that must be taken into account. The public perceive the low level market to be a source of great profit for drugs suppliers or dealers. This is not the case according to these participants. To make money one must sell large quantities of drugs in bulk to several associates, and these associates must sell the drugs and not use any of the profit. This type of semi commercial operation brings unwanted criminal and police attention, which acts as a barrier. However despite such barriers one participant explains that in the area he resides so great is the demand for drugs, that anyone willing to take the risk can have the opportunity to make money. He explains:

*'...if you send someone down to Manchester to buy a kilo; you can double your money. I mean someone who is having problems paying their mortgage, can make easy money', (Mr HM, 40's).*

While money can be made, dealing drugs is fraught with danger and is not an easy source of profit. Such a view is actually challenged by the economist Steven Levitt in his book 'Freakonomics' (2007) in a chapter titled 'why do all crack dealers live with their moms'? A hilarious account of the reality of the low level drugs market, where profit was only achieved by those at the very top, and others in the market hoped one day to ascend the ladder and

'make it' as a dealer, which in reality was seldom if ever possible. Levitt & Venkatesh<sup>44</sup> state that:

*'...a crack gang works pretty much like the standard capitalist enterprise: you have to be near the top of the pyramid to make a big wage...the gang's wages are about as skewed as wages in corporate America. A foot soldier had plenty in common with a McDonald's burger flipper or a Wal-Mart shelf stocker', (Levitt & Venkatesh, 2000: 781)*

Drug talkers have managed to convince the public that vast profits can be realised, a situation that is far from reality for most sellers of illicit drugs who took part in this research.

### **Sourcing drugs from open markets**

While Mr K and Ms M were risk averse, there was an occasion where they accessed drugs from an open market, and describe the risks associated with this:

'Actually there was once in Prague', (Ms M, 40's).

Mr K interjects and continues, after being told to by Ms M:

*'... It was on the street which we would never do normally. We spoke to some 'chavvy'...He wanted me to buy his 'E' and I wanted to test them. He gave me a bit to test and I said 'that's not E mate'. Next minute he had a knife at my throat and it got a wee bit messy at that point...that was breaking all the protocols we always put down for ourselves', (Mr K, 40's).*

This highlights the dangers in breaking the rule boundaries set in place to monitor risk and keep drug users safe when sourcing drugs. Trying to source drugs in an open market in a

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<sup>44</sup> Levitt SD, Venkatesh SA. An economic analysis of a drug-selling gang's finances. Quarterly Journal of Economics. 2000; 115(3): 755-89.

foreign country from a seller with whom they have little knowledge or affiliation put them at great risk. One participant describes as situation where he was intimidated accessing drugs in an open market from someone he only knew of, but had never actually met. He describes this experience:

*'...One of them had a hand gun and I wasn't comfortable there. I got my grass and I was gone. I'd never get anything from them again regardless', (Mr R, 50's0.*

Mr R explains that he views a clear distinction between some commercial dealers. Some he calls entrepreneurs and other 'nasties', ruthless criminals who he finds intimidating and avoids:

*'...There are quite a lot people I'd call entrepreneurs as opposed to criminals', (Mr R, 50's).*

Mr R explains that he prefers to source from friends, who may have criminal contacts, but accessing drugs through this third party significantly reduces risk of being identified as a drug user, or unwanted attention from the police. One female participant describes her experience of accessing drugs from an open market. As a daily user of cannabis she often purchases in ounces or at minimum in half ounces. On one occasion when buying cannabis she was tempted to purchase cocaine. She explains the situation:

*'one dealer was very pushy, very, very pushy...I think because he made a lot of money on coke... £50 a pop and I was a single mum, and really I could not afford it...', (Millie, 40's).*

Millie explains the dealer in her words 'got a bit sleazy'. This created a dilemma that was not an issue for the males who took part in this research. She explains the situation:

*'...the dealer did get quite heavy with me... he offered me some coke one time I went round there. ... I had some and he got a bit sleazy and heavy and I left and*



*then his wife pulled me up ...I felt quite intimidated about the whole thing', (Millie, 40's).*

She then had the trouble of trying to find other sources of drugs, in a part of town that she was unfamiliar. She had just recently moved to a part of town that was closer to her place of employment. She had tried to find other sources, and luckily after briefly considering asking her children (discussed later), whom she knew had been users of MDMA and cannabis, decided to ask another friend, and was duly offered another source, which she now uses regularly. She did not feel at all comfortable accessing drugs from an open market. As a result she explained that her decision led to not being able to source drugs at all for a time. She explains:

*'... in the end, I did have a period actually of not, of having hardly any dope, finding it quite hard to get ...' (Millie, 40's).*

Commercial dealers are also able to operate in a partially closed market. One participant in his fifties explains that he knows and trusts several sources, but, some of these sources may be known to the police. He regularly purchases drugs in large quantities or in bulk. Doing this on occasions puts him in contact with the types of criminal that he would rather not associate. Other participants explain why they rarely use an open market, because there is a greater risk of being sold poor quality goods. KT explains that he does purchase drugs from a known criminal with whom he has a prior purchasing history; however as this source is known to the police as a commercial seller this is not without risk. He states:

*'...One of them came to my house four weeks ago and I felt uncomfortable with the fact the he was there... because he is a major dealer. If he's coming into my house people are going to click that I might be using', (KT, 50s).*

One participant a daily user of cannabis regularly purchases in ounces explains the reasons that he does not like buying cannabis from unknown sources who are often involved in commercial selling of drugs:

*'...they will rip you off to the extent that they will sell you stuff that's wet so it's like grass that's never been dried and its soaking wet. They probably get a bag and stick it over the kettle and steam it and put more moisture into it so it bulks the weight out, it's heavier, so they can sell even more bags, and get even more money', (Ron, 30's).*

Ron is indicating that buying cannabis from whom he termed a 'random' from the street readily results in poor quality 'wet' cannabis. This refers to herbal cannabis being deliberately left in a 'wet' condition in order to increase its weight; similar to how meat is sold commercially. A certain amount of water is tolerated in meat because manufacturers and processors argue that it prevents meat going off and increases its shelf life. This has the added benefit for the commercial seller insofar as they actually sell water which is hidden in their products. Ron indicates that several 'new' commercial drug dealers in his area (in east Scotland) were selling 'wet' cannabis to increase their profits. However as this was a short term operation, they were unconcerned about repeat business.

Mr R explains how he perceives the problems associated with commercial dealing:

*'...There are lots of so called legitimate businesses run by criminals and they are not good people to work for. They are not a good team to be in opposition against; they've got a lot of power because they have a lot of money...'* (Mr R, 50's).

The statement highlights clearly that these sources of drugs are not people that one can complain to, or that one can return goods that one is unhappy with.

There were some complexities to the markets, and there were rules being operated. Several participants explained that some sellers of drugs sold drugs during set times only to trusted

customers, who knew that to access good quality drugs they had to purchase before ten in the evening. Afterwards they were liable to be sold poorer quality drugs. KT explained this situation:

*'There are guys who are selling superb gear, whose shop will be open until ten at night, and there are guys whose shop is open all night but they are selling shit gear, but if you want it, you'll get it, at any time of night; if the need is there...'*, (KT, 50's).

Here KT is indicting that closed markets operate to a set of rules that guarantee good quality commodities; they operated at strict times, closing at ten in the evening to minimise risk. After ten in the evening, if someone had not been 'sorted', i.e. purchased the drugs they required, they were forced often to access a semi open market, which was characterised by poorer quality drugs, and greater risk. Mr G a user in his twenties highlights that there are semi commercial sellers of drugs who will not sell their products to known associates because the quality is poor knowing this would damage their relationship and their reputation. This appears to be a regular occurrence, and a key feature of an open, or semi open market. Mr G explains:

*'I know dealers who wouldn't sell me some of the stuff they've got because they know it's poor'*, (Mr G, 20's).

Mr G is suggesting that he has an affiliation with certain sellers of drugs from whom he regularly purchases large quantities of MDMA for him and his friends. Several participants including Mr R, KT, and Don describe two types of closed market: one open all night, which sell poorer quality drugs, and one that opens at set times to manage risks of detection, closes early, has repeat and known clientele, and sells high quality drugs. This highlights the flexibility and complexity of the closed market for illegal drugs. One of the risks associated with prohibition is that the market is regulated by organised criminals who may have no interest in repeat business. These types of sellers can on occasions sell drugs and

do so because they are only selling for short opportunistic periods. The dealer who wishes to keep a good reputation, and encourage repeat business, even in a closed market selling only to friends and associates, does not want to eradicate his consumers and or discourage repeat sales.

### **Sourcing drugs: Bulk buying**

Several participants were willing to travel to source drugs, and those who had become in part commercial dealers had travelled great distances, most often down south to England, Manchester being the most common destination, then Newcastle, and then Glasgow. Mr K, a resident of the Scottish borders area had travelled to Amsterdam to source large quantities of MDMA. He explains:

*'...I took a hire car, filled the car with E's and brought them back and got away with it, fortunately.'* (Mr K, 40's).

The risk that Mr K had engaged enhanced his status among his drug using social group. However while he enjoyed the status that taking such a risk had conferred upon him, he was not entirely risk averse. While some users will purchase in bulk, some users do not wish to take these risks indiscriminately. Mr K describes the boundaries of risk he tolerates:

*'I no longer get quantities of drugs for individuals. I will certainly have a capped limit on what I'm prepared to go and collect and to be honest I now won't collect drugs for people. I just won't do it.... Now, I'm really cagey'* (Mr K, 40's).

However two female participants had described the dangers of going too far in trying to bond and fit in with the larger group by taking risk others would not tolerate to enhance their status and fit in. Abby sums up this situation stating:

*'Personally a friend of mine who has children was not selling drugs on, but going to collect drugs for her friends and in massive quantities; she has a little child. I think the risk that was taken there was absolutely appalling', (Abby, 30's).*

Abby is indicating that a minor player in a larger social group was willing to risk sourcing large quantities of drugs to fit in, to be part of the larger established social grouping.

Many participants purchased drugs in bulk with some friends from a trusted source. These sources had little interest in making a great deal of money by selling small amounts to large numbers of people. This fact ensured a good relationship for several of the participants and ensured repeat business:

*'...one guy, he only deals in ounces so that's quite a quantity for an individual to buy. Generally when I do it there are usually 2 or 3 or 4 of us involved. Again he will only deal with people that he knows. I asked to deal with someone else and he said he didn't want to do that. He said he was dealing with enough people and just wanted to keep it at that. ...He's obviously taking a risk, obviously I take a risk bit I'm a consumer as opposed to a dealer', (Mr R, 50's).*

several participants users of cocaine and MDMA, explained that purchasing a large quantity in bulk meant that they only had to put themselves at risk one time, as opposed to several times, by buying only when they needed to:

*'... We used to buy about 500 ecstasy tablets a few years ago, we bought in bulk and had them in our safe, this reduced our risk; you know not getting them every weekend or that reduced our risk...', (Don, 50's).*

This 'just in case' purchasing as opposed to the 'just in time', demonstrates that participants purchase what they need, when they need it in bulk most often. However in contrast several participants tended only to purchase drugs in small amounts to regulate their intake and minimise their consumption, and this was typical of the cocaine users. This strategy helped

regulate their use, as discussed in the chapter on managing risk; however for some participants every time they sourced drugs was potential risk, and therefore when they purchased drugs in bulk, they believed this one risk event was preferable to multiple instances of risk. Nevertheless this purchased on a bulk quantity of illegal drugs also put them at greater risk had they been caught by the police at any stage of a transaction, and being charged with a drug trafficking offence, which carries a greater penalty than simple possession of illegal drugs for personal use<sup>45</sup>.

Often the friend who was the source of drugs did not require money, up front. However some participants were not that keen on building any debt with someone who could potentially be drawn into, or was already part of a criminal organisation. Chris explains his position on being offered drugs by credit:

*'... A lot of people take tick<sup>46</sup> which means you get them and pay later. I'm not a big fan of that, I don't like the idea of being in debt to a drug dealer whether he's an old friend or not because they tend to be pretty heavy users themselves and you don't want to have any reason for them to think you're needing money', (Chris, 20's).*

Ron a daily user of cannabis knows that purchasing in bulk allows him to realise savings in both risk and costs. He explains:

*'It's cheaper to buy in bulk and you're saving yourself loads of hassle. I get someone I know; you know its good stuff and you just buy a big lump. It probably saves around £60-70', (Ron, 30's).*

Sourcing drugs from friends who purchase in large quantities can ensure a cheap high quality product. As Don explains:

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<sup>45</sup> See McPhee, et al., (2012) on the practices of the Police in Scotland in determining what is and is not a 'dealers' quantity of illegal drugs.

<sup>46</sup> Tick refers to purchasing a commodity on credit.

*'A couple of the guys we know end up buying lots and punting it. They punt it to their pals. I suppose like most things there is a market, so they buy their ounce, £750 or £700 divvy up their grams and all that. So they say we can get it for about £27 a gram if we all chip in', (Don, 50's).*

Don suggests that buying in bulk from closed markets has become the norm for him and his associates. He explains:

*'...There is nobody I know goes up to scheme<sup>47</sup>s and deals with shady's<sup>48</sup> to buy wee grams of this and that. I don't know anybody that does that', (Don, 50's).*

### **Alternative sources of drugs**

Millie describes a recent experience of feeling rather depressed about her life. She describes seeking help for this problem at her GP's surgery and was offered Prozac, a SSRI<sup>49</sup>. She had not heard great things about the effectiveness of this drug, or its side effects, and declined this from her GP. Her GP was not happy. Millie had made her decision primarily because she wished to continue smoking cannabis, which for her had known and manageable risks. She explains:

*'I have sought help for depression and my doctor got really pissed off with me because I wouldn't go on Prozac and I realised then that actually I didn't want to stop smoking dope because at least with dope I could smoke it and when I was depressed it could relieve me, relieve how I felt. I was in complete control of the quantities', (Millie, 40's).*

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<sup>47</sup> Housing estate

<sup>48</sup> A criminal, or untrustworthy person

<sup>49</sup> SSRI: Selective serotonin reuptake inhibitor, which acts to increase levels of the hormone / neurotransmitter known to affect mood.

She explains her rationale for not taking prescribed drugs, and her desire to maintain her daily use of cannabis:

*'...I certainly don't think there's anything a professional could do for me that I couldn't do myself because I know what it would take. The only thing a professional could give me is some kind of substitute drug and there doesn't seem to be much point in that, you know? (Millie, 40's).*

Millie had heard such bad reports from other users of Prozac that she did not believe that the GP was acting in her best interests, and refused the prescription. There are several points to make here. Firstly GP's have little time to deal with complex issues, and do not have the time to adequately deal with relationships, housing and employment issues that can affect everyone at some point in their lives. Secondly GP's are closely tied to the prescription of powerful drugs, supplied by pharmaceutical companies that market products directly to medical personnel and these products are in the main prescribed to more women than men, indicating a gender divide. Finally some users of illicit drugs, who are adepts and have used for several years, know what to expect when using these drugs, and trust them more than the powerful medications pushed on to them by the brokers of the companies that manufacture, market and distribute them.

Don describes the other link in this chain: when GPs prescribe powerful medications to alleviate the stress of living, the chemists have become the profession that dispenses them directly to the consumer. Indeed Don does not see any distinction between the chemist, the GP or the 'street dealer':

*'... I look at the chemist in the same way as someone who deals....' (Don, 50's).*

Abby suggests that purchasing illegal drugs can put her at a level of risk she cannot now tolerate and she had recently started sourcing legal highs from the internet.



*'...I tend to not take the banned drugs anymore; I tend to take more herbal...I (usually) take it with GHB and it was quite superb..... You get a coke high, ecstasy high; any kind of high really...'* (Abby, 30's).

At the time of interview mephedrone, described as a 'research chemical' or a 'legal high', usually labelled 'not for human consumption', or as 'plant food' to circumnavigate the legal controls put in place to prevent their purchase and use. This served to create a situation where illegal drugs could reasonably have been described as safer because their effects long and short term is relatively well known. The situation with legal highs is that no one knows the long or short term dangers of their use. Don summarises this situation:

*'These legal highs are punted on the internet and we don't know a thing about them',*  
(Don, 50's).

Don is suggesting, and this view was expressed by most of the users of 'legal highs', illegal drugs are in fact safer to use, as the risks are relatively well known and understood. The long term dangers associated with drugs sold as legal highs, put users at potentially great risk.

Other participants found another way to source a regular supply of drugs. They made or grew their own. Several participants from one geographical location describe a situation where they started growing their own cannabis to ensure a steady supply, and to minimise risk.

*'... I've grown weed in the cellar because I've got a cellar here and one of the things that actually worried me about it is when it starts budding it's really, really smelly and with all of my sons friends coming to the door and asking if he wants to go out and play football and going 'your house really stinks of weed' and then saying that to a parent or a teacher or something',* (Ms H, 30's).

However she stopped after one growth cycle because of the very strong smell associated with herbal cannabis. She was worried that as her son was getting older the risk of his friends coming round to her house, smelling something unusual and telling a teacher caused her some anxiety, so she stopped. She then had to find other sources, and stated that she usually sourced drugs in closed friendship networks:

*'I usually find it through friends of friends...so I guess I don't think the risks are that high because if they are taking the risk to come with it then the risk is just as great to them', (Ms H, 30's).*

However, she also stated that many of the sources of drugs were at work indicating that her boundaries defining closed networks and friends of friends were actually regularly transgressed and permeable. She explains:

*'It's not something I discuss openly at work, although bizarrely most of my drug connections are at work', (Ms H, 30's).*

The previous chapter on managing use highlighted that talking about drugs, what happened at work, and tentatively using conversation to find out whether someone was a user or not was fraught with difficulty. For some users asking about the use of drugs was easy to initiate, and therefore could potentially increase sources of friends, informal supplies of drugs, and aid sociability, by creating opportunities for social events where drug taking could safely take place. While this hidden social world was often a source of anxiety about the risk of discovery, the cooperation and friendship that some users described and displayed, including their ingenuity, were interesting indeed. As sources changed constantly, some starting, some stopping, regular users who required a steady source of drugs but wished to minimise risk had fewer choices. They travelled and purchased in bulk, because they were suppliers themselves, or they engaged in bartering with others. The next section explores these factors of the illicit drugs market.

## Exchanging and bartering drugs

Ms H describes the situation with her social circle of drug using friends. They have a system whereby they all try to source drugs, and bring supplies of their drug, hoping to barter for other drugs in a social gathering. She explained that some of her friends are known for accessing a particular drug in bulk, and thus having a surplus means that they can use this surplus to bargain and barter for other drugs. She explains the situation:

*'...quite a lot of my friends bring it, especially with K. They are all there, co-ordinating; getting it brought up from London or flown in (names particular country) ...I guess a lot of it is just because there is no other way of getting hold of it and so they actually work out how to do it themselves. It's not something that I've ever done...'* (Ms H, 30's).

In one social group of drug users, there were a small group who access large quantities of certain types of drugs which are then bartered in a social situation. One in particular explains that she and her partner can access ketamine in bulk, which they then exchange as commodities for other drugs:

*'... With most of the parties I go to everyone sort of brings stuff to share. If we bring along a bunch of k (ketamine), someone else might bring 'm', 'mephedrone'; some might bring pills so there is usually not that much running around trying to sell drugs to take',* (Renee, 30's).

Cooperation and bartering were common currencies in several social groupings interviewed for this research. With each group having responsibility for accessing drug of particular type, they acquired skills that were useful to their social group, enhancing their status, but also enhancing the social aspect of their lifestyle. One group accessed high quality cocaine, high quality ketamine and others accessed the precursor chemicals required to manufacture

GHB<sup>50</sup> and made it themselves. One pair interviewed together from this social group describes how they contribute to the social gathering by taking along precursor chemicals that allow them to create their own drugs. By purchasing legally available chemicals, they can make the drug GHB, which allows them to circulate these drugs for the enjoyment of others, or use it as a commodity to barter for other drugs. :

*'...GBL is the ingredient to make GHB...Its' mixed with caustic soda and water and you test the pH to make sure it's the same pH balance as your tongue and if it is then you are good to go. We enjoy taking that, it's good fun', (Mr K, 40's).*

## **Discussion**

Some of the participants recalled sourcing illegal drugs from open markets, and explained the additional risks this entailed. However sourcing drugs from a closed, or semi closed market was the most common source. Techniques to avoid detection included travelling to locations outside of their area of residence to source drugs from a link introduced via a trusted friend. Most had purchased more drugs than they could use in a single session, called bulk buying. There were several benefits associated with this type of purchase, however it was recognised that there were potential risks too. The police tendency to describe drugs seizures in terms of what drugs were 'worth' on the street, known as 'street prices', had created a set of dangers whereby even a small amount of drugs could be argued from a police perspective to be a 'dealers amount'. The police perspective on 'street prices' were described as having little basis in reality to the prices participants paid when drugs were purchased in bulk, and as such were considered by participants to be a myth, and as such were regarded as another example of 'drug talk'.

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<sup>50</sup> GHB (gammahydroxybutrate) and GBL (gammabutyrolactone) are closely related drugs with similar sedative and anaesthetic effects.

The participants knowledge of markets in their areas were typified by the types of drugs they chose to use, how often they used them, daily, intermittently, or were abstinent, and how much risk they were prepared to tolerate. Some participants had little tolerance to risk, and if they could not source drugs from a trusted associate, they would do without. This view challenged the stereotype of drug users as foolish risk takers. Some participants who were using drugs for a long period, described the changes they had witnessed in drug markets, from small numbers of sellers, characterised by a 'cloak and dagger' style of market to the friends as dealers that supports the normalisation thesis, where drugs have become accommodated, even if their use, and their users are not necessarily accepted as normal. Defining a dealer was a source of much tension. In policy debates and in the discourse engaged in by drug talkers, dealers are dangerous people, who push drugs onto unwilling victims, and who define the parameters of the 'street' market. Such discourse was challenged by the research participants who describe several types of market, where the suppliers of poor quality drugs did not stay in business long, characterised by competition where many people were willing to supply on very small scale in closed markets to close family and friends. What became apparent is the suggestion that the illegal drug market could in part be more *demand* than *supply* led. It was clear that while on occasions there were difficulties for some participants to source drugs, there were choices from whom and from where to source them. From the participants' point of view, sellers of these commodities had to either sell a quality product or lose repeat business, challenging accepted views on the nature of low-level drug markets, and the primary purpose of 'dealing'. This may only apply to the use of 'recreational' drugs such as ecstasy and cannabis; and more research into the consensual nature of these markets is required.

There were few participants, who would describe themselves as dealers, although it was clear that several had engaged in small scale commercial enterprises. They described the activities they engaged in, and how they managed to avoid detection. Several female participants had relationships with dealers, and one described having an affluent lifestyle

funded by drugs. However this was uncommon and was not the experience of most of those who had sold drugs.

The participants preferred to access drugs in a closed market where they an established relationship. Several of the participants had travelled to access drugs such as cocaine and Ketamine, and discussed their views on dealing drugs to friends, an illegal activity, which, while fraught with danger, they engaged in readily, challenging accepted social constructions of the stereotypical 'dealer' or 'pusher'.

Only one of the participants reported someone hassling them to buy drugs, one reported that drugs were being pushed on them against their will. Some participants indicated that drugs were often difficult to obtain, while others suggested that it was easy. While some did report accessing open markets to source drugs, this was fraught with difficulty and risk. These risks were fear of being 'ripped off' and of being caught in possession of illegal drugs as part of a police drug enforcement operation.

Buying more drugs in bulk than was needed for immediate personal use enabled them to help friends in a social situation, and some did this to realise a profit. From their point of view this was an illegal act and was risky, however they were prepared to share these risks and the rewards were often that their personal drug costs were paid for. Some participants took great risks sourcing drugs because they actually enjoyed the risks and the status they gained from being a source of drugs, in tolerating the types of risk others shied away from.

When these participants were interviewed, several of the legal highs that have since become illegal such as 'spice' and 'mephedrone' were available from Internet sources, and several participants had purchased such 'legal highs' on a regular basis. When these drugs started to become the focus of media attention, two of the participants had sourced large quantities of 4MMC or mephedrone. And were stockpiling it for their personal use, or were bartering it for other drugs. Some participants had begun growing their own cannabis on a very small scale indoors using hydroponic systems, for self-sufficient use; others had acquired the

knowledge to obtain precursor chemicals necessary to make their own GHB, the surplus used to barter for other drugs. Three others described how they were able to source large supplies of ketamine from outside of the UK, and used the surplus in social situations to barter for other types of drugs. As this was regularly reported, this may be a key feature of how drugs are exchanged in *closed* market situations.

Tough enforcement which seeks to reduce the supply of drugs may do this successfully for a short period. However temporary reductions in drug supplies does not automatically increase prices for any long-term period, or indeed lower purity for any length of time either (see Pearson and Hobbes 2001; Casey et al 2009). According to Pearson and Hobbes all other factors being equal, if those who deal drugs are making rational decisions, increased enforcement (risk) would lead to increases in selling cost (reward), and a reduction in potential for profit, often considered to be the primary reason for engaging in supplying drugs to others. The prices of drugs have been falling (ecstasy and cocaine) or remaining constant (heroin) in the last decade or more, and purity has remained relatively stable in the same time period (Casey et al 2009). This is a situation unexplainable by the available evidence and neglected by Pearson and Hobbes. One participant, Don, knowledgeable about drug enforcement agency activity, stated that high level drug sellers could be absorbing some of the enforcement costs which would otherwise be passed on to the consumer. The implication is also that the high cost of drug enforcement is not realising any decreases in the availability or increases in prices of drugs. Don Weatherburn (2002) states:

*'The preference of policy makers to invest in 'evidence free' policies worldwide may bring short term sound bites and political plaudits, but have demonstrably failed to regulate effectively this large market'.*

The next section examines how drug enforcement policy is implemented and how the participants perceive the activities of politicians, the police and how mass media report the activities of drug users and drug enforcement agencies.

## **Chapter seven: drug policy**

This chapter begins by exploring what the participants think drug prohibition seeks to achieve and then moves on to discuss reasons why prohibition continues. Finally the participants discuss policy reform and provide examples of alternatives to prohibition including the regulation of drugs and how policy might develop if drugs are truly normalised. It is also argued that if politicians who have experienced drugs take on important offices in local and national government, then policy will at some point be reformed, although this view was not shared by all.

Erich Goode (1972) has argued that prohibition is underpinned by the widespread belief that drugs cause addiction which drives crime due to craving and a loss of control. Supporters of prohibition argue that policy reform would lead to increases in drug use, increased criminality, and a reduction in the moral fabric of society. Goode has argued that there are five basic functions supposedly served by drug laws and their enforcement: 1 deterrence, 2 rehabilitation, 3 public safety, 4 vengeance, and 5 symbolic representation. The first three are instrumental goals, and processes can be measured, albeit with difficulty, and little agreement on definitions of success. The last two functions of drugs laws are symbolic or ideological, beyond the reach of empirical measures, and are not falsifiable in the sense Popper (1963) used the term.

### **Defining prohibition**

Over the past five decades, prohibition has been primarily a politically driven policy. This politicisation has according to several researchers skewed drug research towards demonstration of drug harms, in order to justify punitive responses to the 'drug threat' (Goode, 2006; Levine, 2001). Popular support for drug prohibition is perhaps rooted in the uniquely 20th century faith in the capacity of the state to control many aspects of daily life for



the 'common good' (Levine 2001, 5). The language of anti-drug rhetoric has been politically and financially useful to politicians, the police, and treatment agencies. For Levine the situation exists to exert power on individuals and subordinate groups:

*“Drug prohibition is a worldwide system of state power. Global drug prohibition is a ‘social fact’; it is a ‘thing’ (to use the terms of the great sociologist Emile Durkheim). Drug prohibition exists whether or not we recognise it, and it has real effects, real consequences” (Levine 2001:6).*

The view that prohibition and drug enforcement can be effective in preventing drug use and problem drug use is widespread. One theme that emerged consistently from the data on this theme was the linking of prohibition of alcohol in the USA, and current drug policy of prohibition. A study by Smith and Smith (2005) considered prohibition policies to be a problem for users of 'hard drugs', defined as heroin and methamphetamine. They conducted 20 semi-structured interviews in Australia probing the ramifications of a context of illegality for those who routinely engage in illicit drug use. Prohibition was found to have negative consequences for users in financial, legal, social, and personal spheres. Drug research typically explores the pharmacological risks of drug use and the collective impacts of drug taking on health and social functioning. However the impact of prohibition on drug problems is rarely considered in estimating drug harms (Winnick 1991:12).

Several participants in the research being discussed held the view that criminalising drug possession merely made it attractive as a source of untaxed income, created an illicit economy, resulting in the creation of a police force dedicated to stifle the supply of the commodities that were viewed as dangerous and corrupting. The participants express the view that current drug prohibition is similar to alcohol prohibition. One participant encapsulates this view by mentioning 'bootleg liquor'.

*'Prohibition makes me think of bootleg liquor in America in the 20's when they banned alcohol and it just made everyone make their own and hide it rather than stop it', (Renee, 30's).*

A key feature of high demand and low availability during alcohol prohibition in the USA created the conditions for someone to act to meet this demand. It was not lost on Renee however, that such a view justified her participation in an illicit economy. The participants understood that current drug policy in Scotland made the possession of certain substances illegal, and made supplying and possessing them a criminal act within the confines of the current drug law:

*'...the system has made us criminals because it's illegal', (Ms I, 30's).*

Such a statement challenges a law believed to be unjust. Most participants considered alcohol to be a dangerous drug, which could be used safely. Ms I explains her position on drugs policy in Scotland:

*'...I don't think having it illegal controls it all. If anything it makes it worse. If kids are going to get hold of it they're going to get hold of it. If it was controlled then in theory you could control who got it and how often. I think the classifications are ridiculous as well', (Ms I, 30's).*

Several views are articulated here: a belief that the law is unjust, which creates many of the problems attributed solely to drugs; if young people were given information about, and not against drugs, then drugs could be used safely. She also ends with the suggestion that, 'the classification system is ridiculous'. Here she is expressing the view held by the former chair of the ACMD, Professor David Nutt, that the classification system widely used by the government as a deterrent is unfit for that purpose, and the classifications system is currently informed by a 'faith' in its utility to deter the use of drugs. The original purpose of the classification system was to inform sentencing guidelines. Ms M expresses such a view:

*'...The laws are nonsense, all the 'hoo-hah' about Prof Nutt and his opinions. The government just won't listen to these advisors; it's all about votes and nothing to do with the risks', (Ms M, 40's).*

Several participants understood that the law criminalised their lifestyle choices; however this did not deter participation in illicit economies. Most participants did not feel like criminals, even if the law made that distinction:

*'But I don't feel like a criminal at all...but, f\*\*\* that, you know, no more than parking on a double yellow line...I myself don't feel at all like a criminal and I don't think my children are criminals either', (Millie, 40's).*

It is interesting that Millie is basing her point of view on challenging the irrationality of the law. She states that if we consider that illegal parking is an offence that most drivers will have committed, and that even if the law makes certain behaviours illegal, it does not prevent them from happening. She also stated in her interview that her children were intermittent users of cannabis and MDMA. She did not think they were criminals either, but understood that within the law, such behavioural choices were criminal. Participants held strong opinions that governments had no right to involve themselves in what goes on behind closed doors, in the privacy of their homes.

*'...I don't care what you're doing in your home, your life, so why the f\*\*\* should they care about what I'm doing in my life or in my home', (Rob, 40's).*

The often quoted maxim from 'On Liberty' (1859) by the 'utilitarian' John Stuart Mill is cited when the issue of freedom is raised. Several participants were extremely critical of the government's position, and did not see how it could reasonably be justified. They understood that historically, drugs were once viewed less negatively than they are now, and that a mass hysteria has taken place in recent years regarding what can and cannot be put into one's body:

*'...I think it came from the far right Christians...Self-righteous people tell other people how to live ... its other people telling other people how to live their lives', (Mr R, 50's).*

Many participants believed that prohibition meets the needs of ambitious politicians and agencies of social control that use the symbolism of the 'drug problem' for their own ends:

*'... I guess at some point something happened with some government who decided this (prohibition) was the best way to win an election and so decided to put it in their manifesto...'', (Ms H, 30's).*

Several participants express anger and resentment at the paternalism that underpins drug policy. This creates several themes in this discussion, and in particular drug use by celebrities and sports personalities can establish drug harms, and being labelled as a danger or at risk of becoming or being a problem linked to the use of drugs they perceived to serve as a punishment and a warning about what happens when norms are violated. When celebrities are the target of media intrusion, Ms M believes that this is intended to serve several purposes, to entertain, and to reduce the demand for drugs:

*'...its horrific isn't it when they pin on some poor sod that's maybe only taking a few ecstasy tablets or something and they make them into the baddie... It is so irritating...the way some papers sensationalise that kind of thing', (Ms M, 30's).*

At the time of Ms M's interview, Amy Winehouse was alive and recovering from a failed marriage. She was photographed on several occasions when it had been alleged that she had been using drugs. This focus of much media attention in particular was a real source of tension between how the participants saw drug users as normal and sensible and how Amy Winehouse was being portrayed as typical of drugs users by being described as chaotic, out of control and hedonistic. Ms M was incensed at the media attention Amy Winehouse had been receiving:

*‘...they photograph her with her tits hanging out, nudded on her way out of a club... it doesn’t paint a fair picture whatsoever’, (Ms M, 40’s).*

The construction of Amy Winehouse as a typical ‘drug casualty’, aimed to strengthen the position that drug taking is always problematic, legitimises the intrusion into her private life, in the interest of the public. Another theme developed in describing how ‘drug talk’ is disseminated through school books, anti-drug literature, public service announcements, and in popular fiction. Several authors have given accounts of the effects of drugs, and one in particular was mentioned by a participant who was given the book by her mother when she was growing up in Australia. The book was intended to prevent experimentation with drugs. ‘Go ask Alice’ is an account of the descent into hell when ‘Alice’ uses LSD. The book is written in the form of an autobiographical diary.

*‘My mother gave me a book called ‘Go Ask Alice’<sup>51</sup>. It was supposed to be real; I don’t know whether it was real or not but she took a lot of acid and would have these bum trips ...and to this day I have never taken hallucinogenic drugs...I don’t want to see things. I can’t handle seeing life as it is let alone seeing life as it isn’t (laughs), (Millie, 40’s).*

Another participant describes a demand reduction strategy which has the aim of preventing drug use in students. She explains that in her workplace - she works in a University on the East coast of Scotland - had ran an anti-drug strategy, based on a ‘know the score’ anti-drug campaign, which linked environmental and ecological concerns with drug taking. She explains:

*‘...There was a statistic that they were trying to advertise to students...it was every gram of coke taken in Scotland, 2 square metres of rainforest is destroyed. It was to try to get to the students who care about the planet’, (Ms H, 30’s).*

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<sup>51</sup> This is the work of Beatrice Sparks, a lurid account of a teenage drug addict, written in the style of an autobiographical diary. It emerged that it was entirely fictional. The middle aged author hoped it would act to deter drug use, and defended it on that basis.

These statements highlight the participants' attitudes to anti-drug messages. The participants were challenging the portrayal of drug taking as negative, and asked why positive drugs stories rarely ever made the media. If balance was the objective of reporting, then one positive drugs story should be sufficient to demonstrate balance and objectivity. It was this obvious bias that created much resentment about how such issues were portrayed.

Scotland's current drug policy of prohibition is underpinned by several beliefs historically disseminated by the late Temperance Movements. The movement eventually disseminated the view that universal abstinence was a way of solving social problems. These moral entrepreneurs did not just want to change society; they wanted to improve it by having everyone behave in a manner considered moral. One participant an ex-Naval Seaman explains quite forcefully that he thinks it is wrong of government to lecture him about the dangers of drugs, when he is put in danger living close to Faslane and Coulport, where Britain's nuclear submarines and armaments are located. He explains his position:

'... don't tell me what's bad for me then plant nuclear weapons 2 miles up the road',  
(Don, 50's).

Several participants held the view that supporters of prohibition must be uneducated about drugs. One participant went on to explain that if politicians and other drug talkers could understand the 'facts' about the benefits of drugs, then policy reform should follow naturally. However such a stance merely echoes the position of 'drug talkers' who believe that giving people the 'facts' about the dangers of drugs would prevent their use. Both positions appear entrenched. Many participants held the belief that popular public support for prohibition is due to constant negative press attention focusing on police success, demonising use by focusing on the negative consequences of drug use.

*'...It's a country of Daily Mail readers and that's what the government always pander to, whatever government it is', (Millie, 40's).*

The media has long used sensationalism to sell its consumers to advertisers. Sensational stories create interest, and keep stories alive, and keep the public titillated and interested in the misfortunes of the rich and famous, or the latest celebrity casualty of drug prohibition. However, sensationalising the drug danger means that information which could be effective in preventing negative consequences is often lost in the populist anti-drugs posturing.

Several participants and in particular those who were in their 40's and 50's, had a more considered view about what caused problem drug use, rejecting the mythology that underpinned 'drug talk', and the representations of drug use, and drugs users as defective psychopaths or wilful criminals. Several thought that punitive policies served the interests of government. Mille explains her views on the function of drug policy:

*'...it's just a total distraction from the fact that we allow people to live in such poverty...there is a whole section in society that the government don't have to feel responsible for', (Millie, 40's).*

Millie's comments raise the argument of structure and agency, and how structural factors are hidden as causal factors in the development of drug problems. Research commissioned by government was also severely criticised by many of the participants. There was a widely held belief that research is commissioned to support a predetermined moral view on the use and function of certain illegal drugs.

*'I think drugs are illegal because research has all been one-sided and I'm not saying this because I'm sitting in front of you', (KT, 40's).*

Several participants expressed the view that there appeared to be no good news about drugs. Many even went on to suggest that the evidence that drugs cause few problems were being suppressed.

*'A good number of years ago there was a royal investigation, a commission, where they appoint people to look at that and their findings were that they actually*

*should legalise drugs with permission but was stopped at that point. Channel 4 actually broadcast it, brought all the people who were on the actual committee, it was on for a while, saying what their findings were and they said this should stop. But the politicians didn't really have the balls to continue with it'. (Mr R, 50's).*

Several participants spoke knowledgably about commissions which conclude that drugs are not as dangerous as drug talkers would have people believe. Commissions were used as rhetorical devices; useful to shore up the official view, that drugs cause crime, insanity, or degradation and ill health; if the finding from a commission cannot serve such purposes, they are quietly buried.

### **The activities of drug enforcement agencies and the police**

The participants were asked to comment on what impact they thought the police had on stifling the availability of drugs in their area, and how this might influence the use of drugs in a climate of prohibition. This section also elicited a discussion on the use of street prices as performance indicators by the police, and how the media reported and framed drug enforcement activity. Police enforcement interventions target drug related activity and can be wide-ranging and diverse. As most drug transactions occur at 'street level' the bulk of arrests of low-level users and dealers target problem users, however all drug users are potentially at risk of arrest. There is no conclusive evidence from the respondents' perceptions that police tactics have any long lasting impact on demand for drugs and on the activities of low level markets. Several participants discussed how enforcement agencies calculate the 'worth' of street drugs and considered these to be unrelated to their knowledge and understanding of the price and costs of drugs. Don explains:



*'Agencies will state how much money they're saving by working it out at street level and prices and stuff so that it sounds great to the public instead of being real', (Don, 50's).*

He and several other participants argue that the Scottish Crime and Drug Enforcement Agency received millions of pounds in funding, seize large quantities of drugs and yet the perception is that more drugs are available, and more people selling them. Don attempts to explain the complexity of the situation:

*Five years ago there was a hundred million tonnes of cocaine coming into Scotland... today there is five hundred million tonnes and you can capture 5% of that every year. They are going to capture more and they are going to appear to be on the surface doing better', (Don, 50's).*

This participant was arguing that if the police are seizing more drugs year on year, and yet drugs, at least in his opinion, remain relatively easy to access, then this must mean several things are occurring. If drugs are not noticeably less available, then the supply of drugs must be constant to meet the constant demand, despite the police seizing several large kilogram quantities per year. He stated that:

*'So you can't have more drugs on the street and have more drugs being captured without more drugs coming in. Or is cocaine being cut down so much? I would think it is that there are more drugs coming in...'* (Don, 50's).

His argument demonstrates the complexity of the drug situation, the role of drug policy, and the activities of drug enforcement agencies. He mentions purity levels may be being manipulated in order to meet supply, and that drugs are actually less available, suggesting that police activity is having an impact on supply. The reality of the situation is complex. The police have a vested interest in promoting the view that drugs are extremely impure at the point of sale. This allows them to maintain an influence on information concerning the

'street price' of drugs. If how they calculate estimates of 'street price' values can be based on drugs being typically sold which are low in purity, then seized drugs which might be above average purities can be argued from their perspective to be 'worth' more. Such pronouncements on values of street drugs mean that their activities are considered to be value for money. However the participants' views on poor quality drugs suggested strongly that they tolerate impure drugs for only short periods of time before they either move onto other drugs (at the time of interview in particular legal highs) or source another supplier with a better reputation for selling higher quality commodities.

Drug enforcement performance indicators include numbers of successful prosecutions, which are intended to act as a deterrent, and the quantities of drugs seized calculated as 'street prices'. The participants expressed dismay at the myth of the huge values of the police version of 'street prices' used as outcome measures. When 'street prices' were discussed it was concluded that what was reported were maximum potential realisable values, which had little resemblance to what participants considered to be customary and normal practice when buying and selling 'street' drugs. This was expressed most clearly in the 'street prices' of ecstasy in particular with one participant suggesting that he could purchase them in bulk for around 25 pence per tablet. For Bramley-Harker (2001), the formula on which any 'street price' calculation is based can be misleading, subjective and arbitrary and as such must be treated with a degree of caution.

Several participants held the view that drug use continues despite it being illegal, and therefore certain individuals and professions who are tasked with preventing drug taking must also on occasions be aiding this illicit trade.

*'...You will never stamp out this drugs menace because the police are involved in it, judges are involved in it, the whole spectrum of life is involved in it', (Mr HM, 40's).*

One participant suggests that the only way that drug taking can be prevented is by increasing the level of state surveillance, a situation he likens to Orwell's book '1984', and 'big brother', with the constant threat of discovery, and constant manipulation of ideas, beliefs and behaviour by an all-powerful state political apparatus. At present policing levels he does not believe that drug taking could ever be stopped. He explains:

*'The police could never stop drug use. You would need to have 1984, with cameras in every single person's house. You would need to have mind police, thought police', (Don, 50's).*

In revealing alternative perspectives on the drug problem it is possible to begin theorising about drug discourse and that the war on drugs is not about drugs *per se* where chemicals meet receptor sites but about who has the authority, the legitimacy and power to disseminate a restricted analysis while at the same time render powerless views which challenge this privileged view. Social constructionist theories reveal the lack of substance to the themes which tend to fuel moral panics – Jock Young's 'the Drug takers' 1971; Stanley Cohen's 'Folk devils and moral panics' 1972; and Hall *et al.*, 'Policing the Crisis' 1978, and Shewan and Dalgarno's (2005) work on controlled heroin use in Scotland are notable examples. These and other studies centre on the representations of criminality and the manufacturing of ideologically dominant viewpoints. The central themes concentrate on revealing the myths, the lack of evidence which underpins media representations, which often exacerbate the social problems that drive criminality. Therefore these approaches obsessively demonstrate the incongruity between the real and the unreal, the myth versus the reality (Brown, 2007:15).

## **Alternatives to prohibition**

Alternatives to prohibition and policy reform were not a key question of the research interviews; however it was raised by several participants, who understood that other EU

countries had tried to resolve some of the potential harms arising from prohibition by concentrating on strategy known to reduce drug related harm. One such country is Portugal which is the only EU member state to enact a law which decriminalised all drugs for personal use in 2001. Ten days supply is seen as a reasonable amount to have in one's possession, and amounts over this are prosecuted as traffickers. Millie explains her understanding of how Portugal has begun to see the results of its policy of decriminalising drugs:

*'...Obviously there are examples of where prohibition has been lifted where they are having really amazing results. In Portugal the reports are starting to come out now...it's just really putting resources into the right thing; I think putting resources into prohibition is just ridiculous', (Millie, 40's).*

Don believes that an increase in regulation rather than outright prohibition would be beneficial. He cites the example of the selling of illicit cigarettes which occurred in his town to make his point:

*'...there was a huge market in cartons of cigarettes coming across the channel, so they changed the amounts that were allowed. The cigarettes stopped coming in', (Don, 50's).*

The belief that concentrating less on the stifling of availability, which puts resources and power into the hands of law enforcement agencies, could help regulate an unregulated drug market. The participants typically stated that drugs will always be used, but that they could be more efficiently regulated and sold with advice which aims to minimise risk.

*'Sell the drugs and tell them what the risks are, then we won't have cops running around schemes busting people. It's not rocket science...'* (Don, 50's).

There were often statements that demonstrated a degree of optimism regarding drugs policy. As drugs become essentially normalised, and thus more people have experienced drugs, who then take up positions in politics, media and the arts, policy will be influenced by

their collective views on drug taking. Mr K best expressed this theme in the analysis of the data:

*'All the older generations who have been brought up to believe in draconian drug policies, they are getting older and they are dying off ...There are a lot more people now who are casual drug users.. They must now know that it's nonsense...'* (Mr K, 40's).

The participants expressed frustration at successive government inactivity and are keenly aware that with only a few notable exceptions, few people in a powerful position advocate for their point of view. The actual and perceived harms arising from drugs are regularly disseminated through mass media, positive drug messages or harm reduction information is rarely made widely available.

Supporters of prohibition often oppose the aims of harm reduction – the reduction of harm without requiring abstinence. Several participants expressed the view that government should be doing their utmost to make drug taking safe:

*'...they should make it (drugs) safe for people to take and actually wake up and see it isn't going to go away and something has to be done about it',* (Mr HM, 40's).

Those who support prohibition, and dismiss harm reduction are merely expressing a moral position based on their ethical preference for abstinence. Mr G explains:

*'The people who are reluctant to try drugs are the ones that are in government...I don't understand why drugs are perceived in the media as being so bad when alcohol is by far much worse',* (Mr G, 20's).

Alcohol is described as a dangerous drug, and that making 'danger' the rationale for making drugs illegal is unjust and without evidence. A view shared by many of the participants. It is this position that being drug naive, or making a virtue out of being abstinent from drugs, actually serves the needs of the few, over the needs of the many.

## Discussion

The participants largely held the view that several stakeholders support prohibition, particularly law enforcement and politicians, make use of the fear surrounding drugs and drugs users for their own ends, in particular to secure funds, or votes. Law enforcement agencies in particular were accused of engaging in empire building, rather than trying to seriously reduce drug harm. Simplistic performance indicators, such as numbers of arrests for drug possession, and 'street prices' of drugs meet the needs of drug enforcement agencies, and keep the public alarmed and misinformed. Erich Goode (1972, 2006) has argued that drug laws create more harms than they attempt to reduce. Drug laws are passed, enforced and evaluated independently of whether they actually accomplish their stated goals of deterrence, rehabilitation and public safety. They are supported not for rational reasons but to fit with a predetermined moral view which valorises the currency of abstinence and ignorance over knowledge of the drug experience. He argues that prohibition laws should be repealed given that several performance indicators based on its enforcement are a failure. He argues that

*'In sum, the view that laws are passed and enforced as a result of 'objective' danger presented to society by the prohibited behaviour is not only extremely naïve but fallacious', (Goode, 1972, chapter 7).*

The review of the literature demonstrates that it is typically 'street' level enforcement or low-level enforcement that much police activity tends to concentrate on as it helps them achieve the targets set in terms of numbers of arrests, and more controversially, the calculations of street prices of drug seizures considered to be performance indicators. The links between vigorous enforcement and supply reduction are tenuous at best. It should be noted however that:

*"Whenever there is a fall in the cultivation, trafficking, availability or use of drugs, politicians are quick to claim that this is due to the success of their own policies and*

*proof that the huge sums of money invested in supply reduction is well spent. This is good politics, but poor analysis: invariably the real picture is more complicated".*  
(Roberts, Trace & Klein, 2004:3).

Prohibition is a form of global drug policy upon which international treaties and the drug policies of many countries have been shaped (Blackman 2004).

The attitudes, beliefs and behaviours of the research participants' suggest that prohibition does not deter drug use. As responsible risk assessors they do not require rehabilitation, and are not seeking treatment. Many pointed out that alcohol creates as many if not more problems of public safety than illicit drugs. How drug policy acted symbolically as a justification to punish behaviour which has become unlawful was an issue that was raised consistently.

While there has been an attempt to examine the impact of opiate drug markets and police interventions on communities<sup>52</sup>, to date no research has been undertaken that examines the impact and the effectiveness of policing responses from the non-dependent illicit low level drug market users' perspective in Scotland. Drugs are considered a danger to the individual and a threat to our sense of community. Illegal drugs are defined as unhealthy and prohibition seeks the complete eradication of drugs from society. A key theme revealed by the participants is their understanding that prohibition is about the exercise of state power. Supporters of drug prohibition consider their objectives to be based on scientific evidence and rationality; however like temperance dogma, such drug talk rests on a moral view that taking drugs is wrong, which in itself is a justification for eradicating them, at any cost.

The views of the participants reveal a belief that the government and a large percentage of the public are opposed ideologically to drugs because they believe that exposure to drugs causes problems inevitably. Such drug myths are powerful rhetorical devices for the ambitious politician or agencies of social control, because they are act as ciphers for many

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<sup>52</sup> Cyster, Rowe, Hanson & Chalk for EIS 2005

other social problems that are condemned. Examples include people trafficking, pornography, particularly child exploitation, and terrorism. The medico determinism which underpins drug talk (chemicals meeting biology results in loss of control and criminality) is added to the moral and ideological sentiments to make prohibition appear a rational policy which aims to improve society and reduce deviance. When launching the UK ten year drugs strategy in 2008, 'Drugs: protecting families and communities', the Home Secretary Jacqui Smith stated:

*"Drug misuse wastes lives, destroys families and damages communities. It costs taxpayers millions to deal with the health problems caused by drugs and to tackle the crimes such as burglary, car theft, mugging and robbery which are committed by some users to fund their habit. The drug trade is linked to serious organised crime, including prostitution and the trafficking of people and firearms. Drugs remain a serious and complex problem that we – along with all modern societies – must face", (Home Office, 2008).*

It is the views of the research participants that drug prohibition is causing as many problems as it seeks to eradicate. The premise of prohibition policy rests on the assumption that a chemical change in the drug user makes them 'objects' in relation to their drugs due to the biochemical properties of the drugs themselves, or susceptibility within the users to addiction. The participants in this research are 'subjects' making active choices and understand that drugs do not have magical properties that result in the enslavement of the user. They use drugs for several reasons, and use them regularly not because they are dependent, but because drugs are functional for many reasons discussed in previous chapters of this thesis. However there may be other symbolic reasons why drugs are used by those participants who believe prohibition to be unjust. Robin Room (1987) suggested in the late 1980's that there are good reasons why drug use occurs in a society that has legislated to prevent it:



*“Questions that need to be asked of any control measure, beyond the short term effectiveness, include how much it is supported or opposed by popular sentiment and how much of a target it offers for symbolic protest” (Room 1987:82).*

From this perspective then, many people consider the drugs laws to be something that can be challenged, negotiated, and even bypassed altogether as a risk that accompanies their lifestyle choices. Writing on the attempts to control the per capita consumption of alcohol during the Great War (WW1), Shadwell (1923) warned that:

*“There are limits to the compulsory suppression of drinking, and when carried beyond these limits it defeats its own objective by tending to promote more injurious forms of drinking and the evasion of the law by common consent”, (Shadwell 1923:149-152 cited in Room, 1987:82).*

It would seem that evading the law by taking part in illicit drug taking is a lifestyle choice that, while hazardous, appears clear that legislation is not deterring the use of drugs. This failure to account for viewpoints that some people can use drugs without any problems or coming to the attention of any state institution does not accurately reflect the principles on which prohibition rests.

Drug discourses are complicated and difficult to explore rationally because they produce such passion between those who are pro-drug and those who are anti-drug. It is an arena marked by rigid moral boundaries characterised by exaggeration, hyperbole and stereotypes. The media reinforce certain drug stereotypes and identify problem users as the foolish prey of drug dealers, or innocent victims of biological destiny. In a field built on frequent moral panics, governments and enforcement agencies are keen to impose some semblance of rationality. However the measures chosen to determine the success of prohibition are believed to justify an expensive war on drugs. Whether the sensational and saturation coverage that drug use and activities of the drug enforcement agencies now

routinely receive in the mass media justifies being termed a moral panic is a moot point. As this is not a thesis on mass media specifically, this issue could not be addressed fully. However it is evident that the coverage the drugs problem receives does bear many of the hallmarks of a moral panic. Hall et al (1978) helpfully explains how this may be defined:

*'when the official reaction to a person, groups of persons or series of events is out of all proportion to the actual threat offered, when 'experts' in the form of police chiefs, the judiciary, politicians and editors perceive the threat in all but identical terms and appear to talk with one voice of rates, diagnosis, prognosis and solutions, when the media representations universally stress 'sudden and dramatic' increases in numbers and events and 'novelty' above and beyond what a sober, realistic appraisal could sustain, then we believe it appropriate to speak of the beginnings of a moral panic", (Hall et al, 1978:13).*

As drug talk becomes increasingly hegemonic, so other more plausible narratives that challenge these interpretations get filtered out. People who are regarded as 'experts', the police, the grieving parent of a dead drug user, the recovery champion, the law and order politician are rarely challenged about their level of knowledge, their 'objectivity', and their tendency to reuse the 'script', that underpins drug talk. 'Experts' are consulted on their support or otherwise of the drug strategy believed to address the problem, launched by a law and order politician, or discussed in the media by researchers seeking the next government grant. Rarely do we hear from ordinary, unremarkable, controlled, sensible drug users.

## **Chapter eight: discussion and conclusions**

This thesis explores how hidden illegal drug users maintain their resistance to problem drug use, defined as addiction or dependence, and discusses how and in what way they are active agents in this process. The sentence 'resistance to drug problems' refers to those who have never attended treatment, or been processed as a 'drug offender', and who actively identify and manage risks, including the risk of being identified as an illicit drug user. By referring to these groups as the 'intentionally unseen', it sets the participants analytically separate from the highly visible group who identify or are identified as addicts, and the lifestyle assumed to underpin such a stigmatised identity. How the intentionally unseen maintain a clean non stigmatised identity, hidden from view, and manage the drug risk and the risk from drug policy is the largely unexplored theme that forms the basis of this thesis.

Research into hidden drug use tends to situate such populations as apart from a visible treatment population and is assumed hidden for several reasons related to their illegal and illicit use of drugs. The euphemistic term 'hidden population' often refers to those who are stigmatised by their use of certain drugs but other factors which further label them as drug offenders, which if visible would risk putting themselves and others at risk, for example the children of drug using parents, in particular female drug users with children. This thesis challenges such a view of hidden populations, and theorises the intentionally unseen as socially competent users of illegal drugs engaging in several illicit behaviours, which if discovered would damage their reputation as members of several communities.

Jock Young (2004) has argued that the study of deviance disregards three major problems in its measurement. These are the problems of representativeness, of the plurality of definition, and claims to truth based on the previous two categories. The term 'drug user' is a signifier saturated with meaning and symbolism immediately brought into play when this label is used. In one single concept, that of the 'addict offender' and the perceived inevitable 'loss of control' that results from exposure to drugs, we find embedded a simple convenient thesis about what drugs are, and the power they have to remove reason and

rationality. The pejorative terms used to denote drug problems such as 'abuse' and 'misuse' and the complications associated with drug consumption by social actors signifies not human beings, who choose to do something that is condemned, but as others, a force that terrifies by contaminating a good ordered society. Drug addict, junkie, problem user, offender, 'waster', 'poor parent', and numerous other terms within this lexicon render into thought drug users as different and outside of a moral community. Drug talk provides simplistic but plausible enemies in users of illegal drugs that to resist classifying them as such is challenging, and potentially itself a source of stigma, as one who is 'for' legalisation, and thus by deduction 'for' dangerous drugs, and its associated illegitimately derived pleasure. The addiction concept links drug taking to offending, and health problems, particularly mental ill health. However the issue relates to the objects of research, and the *a priori* assumptions underpinning questionnaires administered to minorities of drug takers and treatment seekers, and to the methods elected to study them. Research into drug use from the beginnings of the twentieth century onwards concentrated on the addict as different and linked drug use to crime and pathology (Glassner and Loughlin, 1987). The large body of social science research which challenges 'dope fiend' mythology is little known by the public and is available only in specialist texts, and in academic institutions. However access to such material via the Internet may serve to address this lack of understanding.

Research placed within government policy documents can be used to place drug users outside of society, and as a result confirms prejudice, that drugs inevitably result in health and legal problems. Constructing *a priori* assumptions that drugs cause problems, research methods confirms prejudice by linking statistical variables, and concluding that such relationships infer causality. This 'governance' is merely scientific prejudice and chauvinism. The use of 'voodoo statistics' described by Jock Young (2004) highlights how drug talk, disseminated by drug talkers merely confirms pre-existing biases, and atypical research findings linking drugs with inevitable negative consequences.

The review of the literature discussed the historical links between addiction and temperance discourses, revealing the moral underpinnings of the concept, and the work of Foucault exposed the power exercised through these 'discursive formations'. As such new terms are added to the lexicon in this thesis. 'Drug talk' refers to the discourse which links drug use uncritically to mental illness, criminality and other social problems. 'Drug talkers' are those who uncritically disseminate such discourse.

The section on the sociology of deviance discusses the shift that has taken place from conceptualising drug users as passive objects, driven by a compulsion set in motion by pharmacology or inherited biology towards conceptualising them as agents, active subjects. The context of a hidden community of controlled sensible drugs users remains relatively unexplored. This thesis therefore marks itself out by considering contemporary identity with its attendant agency, in respect of drug users and their maintenance of a clean untainted hidden identity as normal sensible controlled drugs users, rather than 'addict-offenders in waiting'.

This thesis introduced four themes which emerge from the analysis of the data: the issue of identity and identification, how the participants engaged with their community as hidden users of illegal drugs, how they sourced drugs, and their understanding of drugs policy. This thesis introduces a new concept into the lexicon of social research, that of the 'intentionally unseen'. Such a term gives power to those drug users labelled deviant due to their choice to use illegal drugs. It describes the active decision of these research participants to remain part of a community that rejects the use of drugs as immoral and criminal, and how they manage to maintain a clean identity by intentionally concealing deviant activity by veils of respectability and selective conformity. The data indicates that illegal drugs have become normalised for these participants however they are still stigmatised, and problem users, most often accumulated in pockets of deprivation in the UK, are particularly vulnerable to be caught within the criminal justice system and processed as 'drug offenders'.

The contradictions that drug users experience in a social world that condemns their behaviours as criminal, anti-social and pathological on the one hand, and as normal and acceptable on the other hand create disharmony and the conditions for creating a binary category constructed as opposite of the norm, that of the 'other'. This allows the construction of the outsider, the 'offender in waiting', and the illicit, illegal drugs user. If we begin as a society to study drug users with *a priori* assumptions that drugs are at the heart of social problems such as crime, gang culture, terrorism and public disorder then invariably one will find that suppression of the cause is the preferred solution to this problem, even if there are numerous social problems that cannot be directly attributable to drugs.

The model developed by Fine & Asch (1988) described on page 54 of this thesis, described stigma associated with disability. The four assumptions based on the stigma of disability were easily applied to drug users who are similarly marked and stigmatised for their assumed difference. The analysis of the data revealed the techniques the participants utilised to remain intentionally unseen to avoid such 'disabling' labels, social affronts and stigma. Three themes of identification were discussed in chapter four (1) Identity rejections: refers to how the participants viewed themselves as essentially normal, and rejected the addict identity using several arguments with which to delineate identity difference: biological arguments - addicts were born not made; that some drugs, such as heroin, inevitably caused problems although this was only true of the opiate naive; and structural factors as causal. (2) Identity exchanges: the participants were able to voluntarily engage in a temporary loss of control, which as volitional separated them from problem users (3) Identity concealments: refers to the necessity of concealing an identity as functioning drug users to preserve an untainted identity. Several participants were parents. This thesis discovered three techniques used by participants to neutralise risk (1) Risk boundary recognition: the identification of boundaries that separate 'moderate' and 'compulsive use' patterns. The participants identified several risks, which included overdose, craving and withdrawal, drug tolerance, and intoxication. (2) rule boundary creation: the creation of rules to manage

intoxication and its after effects. Several techniques were identified, learning the rules from mentors, and teaching these skills to others. Three techniques were most often utilised to manage and control risk arising from the use of drugs. Managing a healthy diet and regular periods of exercise helped them to cope and counteract the perceived and actual health concerns they had about their use of drugs, and periods of temporary abstinence served several functions. Periods of instrumental abstinence signalled control to themselves and others which could be status enhancing. Such behaviour allowed tolerance to reduce to manageable levels and had additional health and economic benefits. Fewer drugs were required to achieve sought after levels of intoxication. (3) Rule boundary maintenance: the maintenance and management of risk boundaries. The data revealed that rituals function in four basic and overlapping ways to create and maintain boundaries of risk. Informal rules regulate use patterns that operate to compartmentalise drug use and protect against use patterns that are condemned. First, learned rules define moderate use and censure compulsive use. Second, rules limit use to physical and social settings that are conducive to a positive or 'safe' drug experience. Third, rules identify potentially negative drug effects. Learned rituals symbolise the precautions to be taken before and during use. Overdose is avoided by using only a portion of the drug and waiting to gauge its effect before using more, or by regulating using specialist equipment (such as a bullet device) for titration of powdered drugs. Becoming intoxicated and being unable to contribute to the social milieu was frowned upon, and sanctions were applied. Fourth, rules and rituals operate to compartmentalise drug use and support the users' non-drug-related obligations and relationships. For example, the use of drugs at specific times of the day or week (particularly cannabis) and on weekends (particularly cocaine and ecstasy). Such intermittent use served to avoid interfering with work performance, or family commitments.

The techniques the participants utilise to reduce risk and harms arising from the use of illicit drugs allowed the creation and management of certain informal rubrics that separate controlled use from problem use. The participants in this research had used drugs in many

use patterns from chaos to control. They ranged in age from their early twenties up to mid-fifties. Several of the participants in their fifties were regular users of cocaine, MDMA and cannabis, and two out of the four had been users of opiates, including heroin. One quarter (6) of the participants had used opiates, benzodiazepines, and alcohol, the drugs most commonly associated with problem use and treatment seeking. The research literature on patterns of drug use indicates that the most common patterns of use are controlled and intermittent, with periods of abstinence, and occasional periods of regular heavy use, especially after initiation, until a pattern of controlled use that fits with their lifestyle is achieved. They accomplished this in several ways. Some of the participants reported learning to use drugs on their own, to find the levels of intoxication they were willing to adopt. The knowledge they learned on their own and with others was passed on, informally as part of social interaction. They utilised several techniques that condemned certain behaviours that could lead to problems, and shared and lionised patterns of behaviour and attitudes that maintained controlled sensible use. Their status in groups as 'those in the know', who had developed techniques to maintain their clean identity, while also allowing certain times to be set aside for recreational drug taking with others. Such behaviour maintained group norms characterised by controlled loss of control, and planned chaos, often supervised by others, who are labelled 'drug mentors', and this thesis introduced another term into the lexicon of the controlled drugs user. The responsibilities of the mentor role did not rest with any one individual, and appeared to rotate, based on keeping watch in turn on levels of intoxication in social groups. Such behaviours served to minimise risk, in particular the use of bullet devices to regulate consumption of certain types of drugs. Some of the social groups that the participants belonged to would 'police' order and regulate group norms underpinned by control, and where loss of control was negotiated, and ordered. Deviance from group norms was challenged subtly, often with humour to 'bring the deviant' back into the fold, or cast them out as scapegoats that would lead to changing negotiated groups norms that regulated and normalised controlled sensible use of drugs.



By presenting problem drug users as typical, and assuming that the career path of drug users begins from recreation to desperation (Yates, 1979), the addiction thesis conceals structural factors which may lead to problem drug use, and micro interactionism factors that protect users from problems. By discounting the global factors which link an accumulation of problem heroin use within areas of deprivation, and connecting drug use to addiction and criminality, drug policy is presented to the public as an antidote to the problems of inequality characteristic of globalisation and neo liberal economic policy, (Alexander, 2008). However globalisation is not necessarily an economic phenomenon, it is also cultural (Young, 2003). The visible consumption of illicit leisure activities, explained in the normalisation thesis, explains how drug users create and establish identities, (Abes & Jones, 2004; Bauman, 1988), and conceal sources of potential stigma by a veil of respectability. However consumption of illicit leisure activity is not confined to any one subculture. Young (2003) has argued that even socially excluded groups, such as problem drug users, can embrace consumption as a way out of their economic and social situation; in such a way drugs and crime are rational responses to a culture that views those who do not conform to the 'norms' of abstinence from illegal drugs, and in particular heroin users as unproductive, irrelevant, and disposable.

If pharmacological properties of drugs are the primary cause of drugs problems one would expect to have compelling empirical evidence that drug exposure, routinely measured in several types of surveys, would result in large numbers of users who develop drug problems. The review of the literature on drug use in the UK in general and Scotland in particular indicates that problem users are less than one per cent of the population in Scotland (Hay et al, 2008; Casey et al, 2009), and largely reside in areas of extreme deprivation, characterised by several enduring structural inequalities. However, defining what constitutes the drug problem has remained a consistent issue in policy formation and evaluation.

In the phrase 'speak truth to power', there is embodied a critical discourse that infers that power can be brought to justice were truth revealed about the misuse or abuse of power. However perhaps there is neither knowledge nor power than can be revealed in 'truth'. Power is revealed in the knowledge and disciplinary practices from various institutions dependent on both governments for funding and the public for support, the drug enforcement agencies for example. However hospitals, asylums and other 'caring' institutions also form part of a carceral continuum that Foucault described (Foucault, 1977, 1990). Foucault studied sexuality, the prison and the asylum to reveal how power is exercised through knowledge. Certain institutions utilise certain discursive practices that discipline and govern the populace, in particular the child protection agenda that rebukes deviations of approved parental practices. The participants who had children particularly feared discovery. Several noted that alcohol can be used and is not claimed to unduly affect the ability of the parent to look after children. However certain illegal drugs are not approved and their use is linked to neglect, criminality and ill health. An identity constructed and disseminated via policy documents and mass media was an identity the research participants were understandably keen to reject, and feared being labelled as such should their drug use become public.

We are all subject to intrusion, moulding, and regulation by certain domains of knowledge. Consider Ms H's fear of discovery by her young son, or his school friends who could alert his teachers perhaps innocently to the transgression of his mother's use of cannabis for example, and thus triggering an entire social control apparatus that would lead to intrusion by the police, social work, education and medicine. One can see this in the dissemination of anti-drug education underpinned by the belief that abstinence is equated with normality, and that drug use must be prevented lest it lead inevitably to pathology and criminality. Thus is revealed how and in what way knowledge and power govern, regulate and discipline conduct and that seek to maintain approved 'norms'. In many ways such insights from Foucault imply that all modern states have become police states, attempting to address the drug

problem. Those unfortunate enough to become caught within the gaze of medicine, social work or law enforcement due to their known use of illegal drugs use are subject to such discipline.

## Conclusion

This thesis explores how a hidden heterogeneous population of drugs users in Scotland resist being categorised as drug offenders, and drug addicts. The use of illegal drugs is most often researched in the context of criminology or medicine. This thesis, by situating the intentionally unseen analytically adjacent to recreational and problem drugs users has moved from conceptualising the research participants as addicts in waiting, with its attendant loss of control to skilled competent active agents.

Choosing a somewhat unusual focus, a study of non-addict drug users rather than drugs offenders, has revealed complexities and paradoxes, which arguably defines the human condition. In keeping with a qualitative methodological approach, the aim has been to take these complexities as the starting point for understanding the common shared experiences of drugs users in maintaining and resisting an addict lifestyle rather than ignore them. The focus on drug users resistance to stigmatising labels, and their ability to maintain their use of illegal drugs while remaining part of several communities has added a further dimension to this thesis, that of *re-presenting* the drug user. People who use, and often those who have experienced illegal drugs are routinely presented by drug talkers as offenders, or 'offender-addicts in waiting'. The public are concerned by such media presentations. So prevalent are the links between drugs use and offending, potential death, disseminated uncritically via media that it is unsurprising that the public believe the hype.

'Drug talk' extends beyond adopting inefficient treatment interventions and policy. The major concern is that it colonises the political imagination and hinders policy reform. It does

this by a tendency to perverse fixations. What drug talkers collude in producing is a collective discourse that situates users of illegal drugs outside of 'civil' society. This thesis repositions them actively within it.

It must be accepted that drugs cause problems, and some people develop drug problems and others do not. It must also be accepted that people who use drugs in a habitual manner to the exclusion of all other activities do appear, and often consider themselves to have 'lost control' of the ability to stop. The stigma linked to drug use and its related problems makes the practice of the powerful language associated with the addiction concept useful as a method of explaining bad behaviour, and also excusing it. However, the problematic use of drugs was not the focus of this thesis. The roots of problem drug use are manifold and to study and understand these it is important that we look beyond the 'addict' to find them. This entails bringing into the research gaze the complex totality of social networks of the intentionally unseen, a group of people whose who use substances that are illegal, and who risk stigma and condemnation for choosing to use drugs that are not approved, as well as the usual participant in drugs research, the easily contacted, visible treatment seeking substance user.

Obviously, as is common with most research, this work raises a series of additional questions. The study was modest in that it was done in retrospect with a relatively small sample of drug users recruited via chain-referral methods. The work represents only a beginning in understanding why long term users of drugs resist drug 'careers' as negatively stigmatised 'addict' stereotypes, a set of processes that are important enough to warrant further research.

The majority of the data used in the analysis were gathered subsequent to the events in question. The use of retrospective materials has both advantages and disadvantages. Problems stem from the vulnerability of human memory, including the inevitable reconstruction of past events on the basis of new experiences and vocabularies.

Consequently, it is recommended that longitudinal studies be conducted with intentionally unseen drug users as they progress through their 'careers', not as addicts or addicts in recovery, but as sensible controlled users of dangerous drugs, able to employ learned knowledge to resist the very real risks of social affronts and stigma. These should be ethnographic studies done 'up close' that focus on the difficulties illegal drugs users face when they negotiate the moral and legal risks associated with their behaviour.

The participants revealed in this research a strong belief that those with the power to make policy ought to be more critical and sceptical of those who support the continuation of drug prohibition, especially the motivations of individuals and agencies who engage in 'drug talk'.

Axel Klein (2011) has argued that the symbolic and ideological functions of drug policy triumph over scientific objectivity. Some researchers are sceptical about the aims of drug policy (Seddon, 2010; Berridge and Thom, 1996, 2005; Duke 2001; Ashton 2006). Such critics describe the tendency to play down value conflicts and power struggles that occur between various agencies of social control, particularly medicine and law enforcement, which create factions and opposing stakeholder interests. Several researchers have challenged the tendency for policy makers for their macho posturing (Brown, 2008; Stimson, 2000), and vulnerability of key stakeholders and research institutes dependent on government for funding to remain objective, (Thom, 2005).

The politicians and others who engage in drug talk collectively known as drug talkers, create and reproduce representations of drug use which are at odds with the drug realities of the participants in this research. Drug talk, and the language drug talkers use to represent drug use required a methodology to deconstruct and interpret it. Drug talkers use symbolic terms to create mythical drug users, who are on self-destructive paths to hell. The representation of drug users, drug markets and the criminal gangs believed to distribute drugs are fictions, requiring deconstruction and criticism. Drug talk refers to a utopian future underpinned by temperance ideology that universal abstinence from illegal drugs is achievable. Such is the

power of temperance ideology that anyone may proclaim knowledge of the 'inevitable' career trajectory of drug users, underpinned by addiction, criminality and death. Drug talk taps into our deepest fears of several archetypes. Drug talk is a technology of state power; it lends itself to repression of certain 'othered' minority groups, who are easily stigmatised and scapegoated. Drug users have no voice from which to challenge drug talk and drug talkers. The drug practices of the participants in this research refer to what drug users actually do in terms of the rituals, rules and sanctions they have created to minimise risk and protect their identity. As such they embody a challenge to the representations of drug use that occurs in policy documents and mass media narratives.

Policy makers require to be more careful to ensure than when they allocate the resources for a prevention strategy they allocate them in ways that do not concede to the issue of the supply of drugs, or concede to service users and those who have 'recovered' from drug problems an importance their perspective may not necessarily possess. If the drug problem is not specifically situated with the drug this also entails developing theories that explain negative consequences as not necessarily drug specific. It means looking beyond and behind the mystification surrounding drugs and drug users, and being extremely wary about the labels conferred on drug users, principally the uncritical use of the term 'drug abuse'. The voices of the intentionally unseen may simply be neglected because such hidden users are difficult to find. With this in mind, I conclude that there are important lessons that can be disseminated. For too long, we have heard the voices of the atypical, the unrepresentative, and those users of drugs who have not employed knowledge that is 'out there', that serves as a technology to help protect users from drug problems. Further research that explores hard to reach populations will continue to reveal how and in what way these users have learned to remain part of the intentionally unseen. Listening to the voices of intentionally unseen drug users may deepen our understanding of the causes of collective problems that appear impervious to prohibition policy and abstinence based treatment.

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Serial No:



UNIVERSITY OF  
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## Exploring risk & identity in a non-treatment population of illicit drug users in Scotland

### Research Information form

#### Contact details of researcher

**Iain McPhee**

University of the West of Scotland  
Institute for Applied Social and Health Research  
Paisley campus  
High street  
Paisley  
PA1 2BE.

#### Contact details of supervisors

**Ian McIntosh** Tel: +44 (0) 1786-467737

**Rowdy Yates** Tel: +44 (0) 1786-467699

Department of Applied Social Studies

University of Stirling

Contact mobile number: 07876127222

**You are being invited to take part in a research study. Before you decide to take part it is important to you to understand why this study is being carried out. Please take time to read this before making any decision. Please ask if there is anything that concerns you or is not clear to you. Thank you for reading this far.**

#### Why have I been chosen?

You have been chosen because you are either a current user of illicit drugs, or a former user, and have never been in treatment or prison related to your use of drugs.

**If have been in prison due to drug use, or attended treatment for your drug use, you will not be able to take part.**

#### What is the purpose of this study?

The study aims to understand the experiences of drug takers who have never had any formal contact with treatment agencies. Most drug research access users from a treatment agency, this means that the experiences of non-service users are absent from research, and therefore do not contribute to policy and treatment responses.

#### Who is organising this study?

This study is being organised by a researcher who lectures in alcohol and drugs studies at University of the West of Scotland, and who is a PhD student at the University of Stirling. Supervisors are Ian McIntosh and Rowdy Yates, based at University of Stirling.

#### Do I have to take part?

No there is no obligation, and it is your decision to take part. If you do decide to take part, you will be given this information sheet to keep and you will be asked to sign a consent form. **Even if you agree, you can still withdraw at any time, and if interviewed, can stop the interview at any time, without giving any reason.**

#### What would I have to do?

You will be asked to be a participant in an interview with myself (Iain McPhee). This interview will be recorded on an MP3 recorder, and will be typed into a word document to aid understanding. This recording and the word document will be accessed by the researcher only.

#### Will my answers be kept confidential?

Yes you do not need to give me your real name, and if you do this will not be used in any word document. This document will be used to form part of PhD thesis to be written by the researcher. You will not be identified.

**If you think you need help concerning your misuse of drugs you can call this confidential helpline:**

**National Drugs Helpline 0800 667700 – this is a free phone number, staffed 24/7.**

**Appendix b**



CONSENT form

Exploring risk & identity in a non-treatment population of illicit drug users in Scotland

**Contact details of researcher**

**Iain McPhee**  
**University of the West of Scotland**  
**Institute for Social and Health Research**  
**Paisley campus**  
**High street**  
**Paisley**  
**PA1 2BE.**

**Contact mobile number: 07876127222**

**please circle as appropriate**

I have read and understood the research information sheet and I am satisfied that I know about this study and my involvement in it. Yes / No

I have had the opportunity to ask questions about this study, and am satisfied with the answers I have been given Yes / No

I understand that the interview will be recorded so that it can be properly transcribed and analysed. Yes / No

I understand that the data obtained will be kept in confidence and that when any data is presented all personal details will be removed. Yes / No

I understand that the interview is confidential / anonymous. Yes / No

I understand that I have the right not to answer any of the questions asked. Yes / No

I understand that I have the right to stop the interview at any time without giving a reason. Yes / No

I agree to take part in this study Yes / No

Signature or mark of participant.....

Date.....

Initials of researcher and serial number of interview.....

Date.....

**Appendix c: Interview schedule** (must be attached to consent form)



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Serial No:

**SURVEY QUESTIONNAIRE**

This is a researcher-administered questionnaire

Gender

Male:

Female:

Age:

Have you ever had any type of help/treatment for drug or alcohol use?

Yes

No

Encounters with the criminal justice system;

Have you ever been in trouble with the police due to your drug use?

Have you ever been in prison related to your use of drugs?

## Employment, Education and achievements

What age were you when you left school?

Are you in employment?

What was your previous job?

What is your highest educational qualification?

Are you in full or part time education?

## What are your main drug(s) of choice right now?

Drug/	Last use this drug?	how much / often you use	How long have you used this drug?	Age first used?	Route of administration

## Where you live

10	During the past 6 months, where did you live most of the time?	
11	Who do you live with?	
12	How long have you lived there?	
13	Do you rent your property?	
14	Do you own your property?	



## **Semi structured interview**

### **Exploring risk and identity**

Where or from whom did you first find out about illegal drugs?

Can you describe your first drug experience?

Who introduced you to drugs?

Where did this take place?

Why were you keen to experiment with drugs?

Can you describe your most recent drug experience?

What words would you use to describe a drug user?

What words would you use to describe a dealer?

What words would you use to describe an addict?

What words would you use to describe yourself?

Have you ever tried to stop or cut down your drug use?

Do you consider using drugs harmful? In what way?

Are you able to regulate or control your intake of drugs?

How do you limit harm to yourself or others who use drugs?

What are the greatest risks to users of illegal drugs?

What does the word prohibition mean to you?

Why do you think drugs are illegal?

Are all drug users' criminals?

## **Obtaining drugs**

Can you tell me about a typical day? (Prompts: what do you do; where; alone or with others, when do you use?)

How far do you travel to buy your drugs?

When obtaining drugs, have you ever suffered or been threatened by violence?

Can you tell me what you do if the dealer does not have what you want?

How many dealers do you think are in your area (define locality / area)

Is this more or fewer than five years ago?

Have you ever sold or given drugs to others?

What happens if someone in your drugs using circle does not have drugs on them in a social situation?

What would happen if this was a regular occurrence?

### **Police and mass media**

Do you think the police can stop drug use? In what way?

What are your thoughts on how drugs and drugs users are portrayed in newspapers, film and TV?

**Thank you for your participation.**