ECSTASY USE AMONG YOUNG IRISH PEOPLE – A COMPARATIVE AND INTERDISCIPLINARY STUDY

Report prepared for Forbairt by:

Tim Murphy, Pat O'Mahony and Marie O'Shea

THE CENTRE FOR EUROPEAN SOCIAL RESEARCH
and
THE DEPARTMENT OF LAW

NATIONAL UNIVERSITY OF IRELAND. CORK

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GENERAL INTRODUCTION

The aim of this research report is to provide information about Irish patterns of Ecstasy use. As a first step in initiating the process, it is useful to look at the international context, and consider what the wider social scientific research community is revealing about recreational drug use patterns amongst young people; identifying the principal areas of concern; and considering ways in which responses are being implemented to the new challenges emerging within youth cultures. In order to arrive at an informed understanding of the relationship between frequency and types of drug use within society and the means by which effective and rational responses can be made to significant problem areas, it is important to consider, in as far as possible, the picture which emerges from macro-level analysis. From this basis, it will then be possible to draw detailed information from micro-level analysis in the Irish context, which in this report consists of qualitative data from interviews with Ecstasy users and former users. The merger of macro and micro horizons will serve to reveal interfaces between lifestyle, motivational factors and drug use patterns of Ecstasy users, and action strategies emerging from within the Irish institutional spaces of law and order, education and health, public debate and government, with the objective of highlighting problem areas and considering available models of response.

It is the objective of the **first chapter** of this report, to provide a general overview of patterns of recreational drug use, through reference to a selected section of the research literature emanating from England and Scotland and Ireland, with reference to other relevant literature and key points of information. It is felt that examination of the extent and patterns of drug use at this general level will serve as a useful initiation to the substantive matter of this report, which is an exploration of patterns, contexts and institutional and cultural implications of Ecstasy use in Ireland. Given the fact that the

research base from which significant analysis can be drawn in the Irish context is still relatively narrow, it was decided to introduce a comparative dimension to this chapter, in order to present an extended discussion of issues relating to drugs and young people. The decision to select the comparative research literature referred to within this chapter, primarily from studies undertaken in the UK, was influenced by a number of criteria. First, given the fact that Britain was one of the first countries to be affected on a mass scale-by the-phenomenon of new types of recreational drug use, and given the close cultural similarities and points of reference between youth cultures in Ireland and Britain, and also the close physical proximity between these countries, consideration of drug-related trends in this context promises to have a particular resonance in the Irish case. Second, within the constraints of the present study, it is not possible to provide an exhaustive review of new developments in the entire European drugs research field, so a reasonable attempt has to be made to limit this initial review of literature in a coherent and rational way.

The **second chapter** of this report considers the historic development of the drug Ecstasy, from the time of its synthesis in 1912 as an intermediate chemical in the preparation of other drugs, through its uptake by the psychotherapeutic community, and its subsequent widespread popularisation as an integral element of a transnational sub-cultural configuration broadly termed 'club culture'. It is contended that in order to understand motivations which underlie use of the drug Ecstasy, it is necessary to situate the phenomenon of drug use within the broader system of values, norms and experiences available within club culture. The present study hypothesizes that through the combination of drug use and dance within rave, the promise of the 'transcendent embodied experience', captured by Frank's model of the body in communication, is tantalisingly available.

Whilst the body in communication is the desired end state of the rave experience, it shall be argued that due to the complex nature of the relationship between the variables drug, 'set' and 'setting' (i.e. the individual and social circumstances

in which drug use takes place), the drug/club experience does not deliver on the promise it holds out, at least not in a consistent and continuous manner. The shadow side of the model of the communicative body, potentially available through rave, is the model of the 'anxious body', fearful of psychological and physical trauma. Dimensions of the anxious body are explored with reference to the risks deriving from use of Ecstasy. Whilst it is not within the scope of the present research to deal extensively with medical issues, an attempt is made to represent, in general terms the underlying themes of the current medical debate about Ecstasy. Given the close association between use of drugs such as Ecstasy and the broader youth cultural experience, particular emphasis is placed on specific risks associated with selecting and using Ecstasy and other drugs in social venues the chapter concludes with a review of types of responses that are emerging at an institutional level to the contextualised risks of use of Ecstasy and other drugs.

The **third chapter** discusses the policy and legal dimensions to the macro-level analysis referred to above. It sets out the development of Irish drug and Ecstasy policy and then goes on to place this development in contrast to policy in two other European Union states. One is the Netherlands, which has adopted the most liberal and tolerant drug regime in Europe since the early 1970s. The other is Sweden, which bases its currently extremely repressive policy on the perceived failure of harm reduction strategies in the 1960s. These two countries represent the headquarters of two warring ideological camps in the EU and. because the ideological rhetoric in that particular 'war' often tends to be overblown and/or incorrect, the chapter aims to present a more measured account of the situations in these states vis-a-vis the Irish situation.

The aim of the **fourth chapter** is to provide specific information about levels and patterns of Ecstasy use in Ireland.[1] Generally, in terms of accessing information about

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[1] Although drug consumption of all kinds is a perennial human activity (see generally. Weil, *The Natural Mind: An*

drug use in a given society, a number of channels are available which supply specific types of information. In conjunction these channels provide an overall picture of the current state of knowledge about the object of inquiry. These channels or sources can be conceptualised as forming three levels of information about drugs. The levels progress from general contextual information about incidence of particular types of drug-related phenomena such as crime, addiction, and deaths (supplied by state agencies dealing directly with the processing of such types of information), and progresses through level two which supplies indications of levels and types of drug use patterns amongst representative samples of the population. The second level of information is supplied by survey type methods which target sections of the population and ask specific questions about individual drug use. Whilst survey-based research supplies valuable information about issues such as the incidence of drug use amongst a chosen sample of people, there are certain limitations to this type of research method. Commenting on methodological problems encountered in compiling data about drug use at a European level, the European Monitoring Agency for Drugs and Drugs Addiction (EMCDDA) report that 'cultural differences and diverse health, social, legal and administrative structures influence results to such a degree that they become meaningless unless seen in the light of the systems from which they were derived'.[2]

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investigation of *Drugs* and the *Higher Consciousness* (Boston, 1986) and McKenna, *Food of the Gods: The Search for the Original Tree of Knowledge* (New York, 1992)), any quantification of consumption, historical or contemporary, is highly problematic. This is particularly the case in relation to present illegal drug use: 'In general, it can be assumed that the less illegal the use of a drug is, the more complete the picture will be which the authorities and researchers have of such use' *(Continuity and. Change, infra,* p. 8).

[2] EMCDDA, *Annual Report on the State of the Drugs Problem in the European Union* (Lisbon, 1997) p.10.

A third level of analysis within the drugs research field can be identified as those types of study which employ qualitative methods which attempt to supply in depth information about the specifics of drug use, including issues such as motivational and lifestyle factors. Typical modes of enquiry within level three analysis include participant observation, in-depth interviews, focus group interviews and case studies. It is the contention of this report that, in the substantial debate which has developed around the issue of drugs in Irish society, the voice of drug users as a significant group of stakeholders has been consistently ignored. The present research project has offered the opportunity to engage with this group and to directly address their experiences, concerns, and to offer an alternative construction of drug use which represents a broader spectrum of drug realities than has traditionally been addressed in the Irish context. The fourth chapter reports on the findings of the interview process, exploring users' attitudes towards Ecstasy, patterns of drug use, motivational and lifestyle factors, and the short and longer-term effects of the drug.

The **fifth chapter** provides, by means of an analysis of selected media texts on Ecstasy, a brief commentary about the way in which recreational drug use is contextualised in Irish society, identifying in particular cultural barriers to new policy paradigms and initiatives.

CHAPTER ONE

YOUNG PEOPLE AND DRUG USE – AN OVERVIEW OF PATTERNS, TRENDS, AND ISSUES

Introduction

One of the first points to note about current trends of drug use is that the incidence of drug use amongst young people seems to be on the increase,[3] Given the recreational nature of most Ecstasy use, users largely do not come into contact with either the police or medical services and thus are not registered in state statistics. Official statistics do however set the broader parameters of the drugs issue by showing that the scale of problematic drug use has increased dramatically from 1990 to 1995. The first level of information about societal drug use is supplied by official statistics which in the English context comprise addict notifications supplied by GPs to the Home Office, drug misuse statistics compiled by the Department of Health, and police statistics relating to drug seizures and offences.

Opiate and cocaine addicts notified to the Home office:

1990	1995
17755	43372

Similarly rates of detected drug offences have also escalated in the same time frame:

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[3] Provincial surveys in Austria suggest that about 3% of 18-20 year olds have tried Ecstasy. This increases in the context of larger cities; for example, 6% of 15-18 year olds in Vienna have reported using this drug *(ibid.,* p.72).

Drug Offences

1990	1995
44922	93631

The 1997 report of the European Monitoring Agency for Drugs and Drugs Addiction has noted significant trends relating to the incidence of drugs and drug use amongst young people in the member states. Evidence from survey data across a number of countries shows that use of drugs associated with the club scene has increased significantly amongst young people in the last ten years.[4] Wright and Pearl comment on findings from two surveys conducted in Britain in 1989 and 1994. They report that 45% of 14-15 year olds in 1994 had tried an illicit drug, which represented a nine-fold increase from figures in 1989. Similarly, in 1994, 65% of-pupils indicated that they knew someone who had tried drugs as compared to 15% in 1989. The authors conclude that:

> an increasing proportion of young people are in contact with illicit drugs from their early teens; that a greater variety of drugs are more widely available both socially and geographically; and that young people expect to enjoy the pleasurable effects with minimal harm.[5]

In addition to overall increases in levels of drug use in

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[4] A 1995 survey of 462 disco goers conducted in the Netherlands showed that 52% of all young people who attend clubs or house parties had tried Ecstasy, and that 41% had done so in the last year; for LSD figures were 23% and 9%; and, for amphetamines, 34% and 20% *(ibid.,* p.75).

[5] Wright and Pearl, 'Knowledge and experience of young people regarding drug misuse, 1969-94' (1995) *British Medical Journal* 310.

society, a second major point that is revealed through general population surveys is that drug use is more prevalent amongst the younger age groups, particularly 16-29 years, than it is in older age cohorts. The British Crime Survey demonstrates that 46% of 16-19 year olds have tried an illegal drug.[6] Indications are that amongst this age group, young people who attend clubs and dance events are more likely to have direct experience of illegal drug use. Amongst young people aged between 14-17, a longitudinal research study demonstrates a steady increase in the use of drugs over a three-year period.[7] In the first year of the study, it was found that 36% of the sample of 14-15 years olds had tried an illegal drug. In year two, the percentage of this sample who had tried an illegal drug had increased to 47%, and by year three it had risen to 51%. It must be noted, however, that this rather high figure includes those who have used on a once-off basis and also infrequent users, so it does not give an accurate picture of sustained levels of use amongst this cohort. The ISDD summary of national drug surveys suggest that differences between drug prevalence rates and rates of regular use is pronounced in the case of 15-16 year olds who have tried solvents or illegal drugs, with regular use being confined to perhaps 2% for cannabis and below 1% for other drugs.[8]

Research indicates that in terms of the types of drugs used by young people, cannabis is the most common drug and that use of LSD, amphetamine and Ecstasy, has increased since the 1980s.[9] The incidence of polydrug use is high, with users mixing a

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[6] Ramsey and Percy, *Drug Misuse: Results of the 1996 British Crime Survey* (London, 1996).

[7] Parker, Measham, and Aldridge, *Drugs Futures: changing patterns of drug- use amongst English Youth* (ISDD Research Monograph 7) (1995), cited in Wibberly, 'Young People's Feelings About Drugs' (1997) 4 Drugs, Education, Prevention and Policy 65 at p.66.

[8] ISDD Drug *Misuse in Britain 1994* (London, 1995) p. 35.

[9] Parker et al, *op. cit.,* in Wibberly, *op. cit.,* at p.66.

coterie of drugs including alcohol, amphetamine, and Ecstasy and cannabis.[10] The age group most likely to start using Ecstasy are the 18-21 year olds.[11] Sustained patterns of frequent usage tend to be rare, with the most typical pattern being that Ecstasy use peaks in the late teens and early twenties and then declines. Evidence collated by the EMCDDA for their 1997 report suggests that use of Ecstasy transcends socio-economic boundaries.[12] In other words, Ecstasy is widely used by young people from a range of socio-economic backgrounds.

It is perhaps useful to qualify that socio-economic position does not appear to act as a disabling or enabling factor in terms of influencing the decision to use drugs, but that the onset of problematic or dysfunctional use patterns can be linked to disadvantage. More specifically, a range of risk factors have been identified which predispose certain vulnerable groups of young people to develop drug-related problems: these encompass variables such as early school leaving, family histories of substance abuse, and inadequacy of youth service provision.[13] It is recommended that in order to prepare more effective strategies to prevent drug related harm, it is necessary to explore in

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[10] Forsyth, 'Places and patterns of drug use in the Scottish dance scene' (1996) 91 Addiction 511 at pp.511-21.

[11] See Calafat et al., *Characteristics and Social representations of Ecstasy in Europe* (IREFREA and the European Commission) pp.68-9.

[12] EMCDDA, *op. cit.,* p.70.

[13] Mark Gilman clearly distinguishes between the social class profile of recreational users, and problematic drug users: 'Most recreational drug users play a full role in a society in which they have a very clear stake.' In contrast, 'addiction is highly discriminatory, recruiting from clearly defined sections of British society. Problematic drug use draws the vast majority of its recruits from all along the faultlines of our society.' 'Onion rings to go: Social exclusion and addiction' (1988) Drug *Link* (May/June) 14 at p 16.

detail the exact nature of the relationship between patterns of disadvantage and problematic drug use.

In attempting to understand the dynamics of controlled and uncontrolled drug use, there is evidence to support the hypothesis that drug cultures can exert substantial influence over users to use drugs in a controlled fashion.[14] Zinberg argues that drug behaviour is influenced by social control systems which operate both inside and outside the drug culture. Within drug culture, such controls are buttressed by rituals which are 'stylised, prescribed behaviour patterns surrounding use of a drug'. A dual structure of both sanctions and rituals constitute the parameters which guide usage of a particular substance. Using Zinberg's approach to the study of controlled and uncontrolled drug use, the emphasis on dysfunctional use shifts from targeting the dysfunctional user (i.e. the 'addictive personality') to exploring the inter-relationship between the properties of the substance, properties of the individual user, and examining elements in the setting or context in which drugs

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[14] See Zinberg, *Drug, Set, and Setting: The Basis for Controlled Intoxicant Use* (New Haven, 1984). Zinberg conducted a study on heroin use amongst American conscripts in the Vietnam war. He interpreted the high prevalence of heroin use amongst the army as an attempt to escape the harsh reality of social contextual factors. His feelings were that rates of heroin abuse would decrease if the users were taken out of the particular context in which dysfunctional patterns had developed. In a follow-up study, this feeling was validated as a large proportion (88%) of 'addicts' ceased to be addicted once they returned to the United States. These findings would seem to indicate that rates of addiction are highly influenced by social contextual factors. The significance of these aspects of drug-taking ('set' and 'setting') had in fact been recognised long before. See, for example, Becker, 'On Becoming a Marijuana Smoker' (1953) LIX *American Journal* of *Sociology* 235 and Leary, Metzner and Alpert, 'Psychedelic Sessions' [1964] in Miller and Koral, *White Rabbit: A Psychedelic Reader* (San Francisco, 1995) p.129.

are taken which lead to either controlled or dysfunctional usage.[15]

If it is the case that the setting is a significant factor in shaping use patterns, why then is it that certain people exercise more control in their drug use than other people in the same context or setting? Grund et al suggest a refinement to Zinberg's theory.[16] They describe a peer-based social learning process through which users learn to regulate their use of intoxicants. These learning processes apply equally to legal drugs, such as alcohol and nicotine, as to illegal drugs. Learning processes are implemented on the ground through the types of stylised rituals which Zinberg speaks of. They include such behaviour as passing around a 'joint' in the case of cannabis, or sharing 'works' in the case of heroin, or not drinking and driving in the case of alcohol. The purpose of such rituals is both symbolic and pragmatic. They serve to enforce a sense of commonality and identity amongst drug-using networks. They also function as enactments of methods which have been subculturally proven to maximise the 'high' and to prevent the types of negative effects and secondary problems which detract from the experience.

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[15] *Young People Now* (Issue 84, April 1996). Research into young peoples attitudes about drugs was conducted in Liverpool. The research findings indicate a high degree of concern and strategies adopted to minimise harm. The latter include: buying only from trusted dealers; not using drugs at times they consider inappropriate; using certain drugs (particularly LSD and Ecstasy) only when trusted friends are available to ensure safety and support; using only sufficient quantities of a drug to achieve the desired effect; not mixing drugs; imposing internal sanctions against anyone within their group using 'hard' drugs, such as heroin, crack and methadone.

[16] Grund, Kaplan and De Vries, 'Rituals of Regulation: Controlled and Uncontrolled Drug Use in Natural Settings' in Heather, Wodak, Nadelmann, and O'Hare (eds.), *Psychoactive Drugs and Harm Reduction: From Faith to Science* (London, 1993).

The effectiveness of rituals and rules in exercising control is, however, subject to a number of variables. In attempting to specify these contextual variables, Grund et al develop a three-fold model of controlled usage. They argue that the three determinative factors are rules and regulations, life structures and drug availability. Together these factors constitute what they call an 'interactive feedback circuit' which is constantly adapting to external social influences. For instance, it is arguable that if a person's life structure is quite regulated, it is likely that more control will be exercised in relation to drug intake than otherwise. Applying Zinberg's basic drug, set and setting model and the modifications suggested by Grund et al to the case of Ecstasy use facilitates the development of an understanding of the inter-relationship between the range of variables which underlie motivations, and consequences, both individual and social, of drug use.

Young People's Views About Drugs

An initial review of the literature indicates that public discourse about drug use amongst young people has been heavily ideologised. The pervasiveness of what shall be termed the 'negative model' of drug use, and its widespread diffusion into public culture, has been accompanied by a resultant withdrawal of the drugs issue from critical reflection. It shall be argued that the dominance of the 'negative model', both as a reference point for information and as the basis for a cultural understanding of the issues, has suppressed rational debate and effectively silenced the significant minority of the population who do choose to use drugs. (See Chapter 5 of this report.) In the absence of authentic communication, a polarisation has taken place between those who use drugs and those who do not, between youth culture and adult culture, and ultimately between institutional cultures and sub-cultures. Evidence suggests that the views young people hold about drug use are very different from the views of institutional actors. Indeed many argue that one of the weaknesses in the development and delivery of drugs

policies is that young people are being excluded from the processes of deliberation:

> young people are excluded, being defined as the object of change, not subjects with knowledge, views and ideas about the use of illicit drugs.[17]

In terms of redressing this imbalance, a move is discernible in the research community towards a more direct engagement with young people, exploring issues such as motivational and lifestyle factors, as well as knowledge and attitudes. In terms of assessing young peoples experience of drug use, knowledge of drugs, attitudes to drugs and drug use, and views of drug education, extensive work was undertaken by the Scottish Schools Survey which was conducted in 1996. The sample used in this study consisted of 9496 young people throughout Scotland, and was constructed so that half the respondents were drawn from first-year students at secondary level, and half were from fourth-year students. The survey showed that 8% of the sample used illegal drugs on one or more occasions per week. The mean age at which illegal drug use commenced was 12.5 years. In terms of presenting reasons for engaging in drug use, the factor which seemed to be of most significance related to identification with social groups or peer related factors. The reasons for using drugs are believed to be mostly

> group factors to do with maintaining or improving one's standing within the peer group: in other words, because of the role of drugs in society rather than their chemical effects.[19]

One of the outcomes of the research was evidence of a pronounced need for improved education about drugs. 52% of the overall

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[17] Parker, Measham and Aldridge, *op. cit.,* p. 6.

[19] Buzz, *Scottish Schools Survey conducted by Fast Forward Positive Lifestyles Ltd.* on behalf of Scotland Against Drugs p.2.

sample felt that their knowledge about drugs was insufficient. However, amongst regular users there was less demand for drugs information than amongst infrequent users and non-users. Regular users were also more likely to answer correctly questions which required prior knowledge about issues such as legality. Certain gaps were apparent in terms of overall levels of knowledge about drugs, particularly in relation to health risks associated with pain killers and solvents, and concerning the legal status of recreational drugs. In terms of attitudes about drugs, there was a pronounced difference between the views of the first-year students and the views of the fourth-year students with the point of difference being that views became increasingly liberal as age increased. For instance, in response to a question about whether drug use could be perceived as a normal part of growing up, 10% of first-year students agreed that it was, whilst 24% of fourth-year students agreed with this perception.

Girls demonstrated lower levels of drug use than boys for all drugs except tobacco. Additionally, males tended to have higher rates of experience of violence and arrest as a result of drug use than females. In relation to gender, age and locality variables, there emerged differences in use patterns, drugs knowledge and attitudes about drugs which

> reinforces the importance of careful targeting of interventions according to both the needs of the target group and the social context in which that group operates.[19]

The research conducted by Parker et al showed no substantial differences in terms of numbers of men and women who took drugs; however, it was suggested by the authors that women may take drugs for different reasons than men, and that they may demonstrate different patterns of use, using smaller quantities

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[19] *Ibid.*

and using less frequently.[20]

The gender variable has also been raised by Kellie Sherlock who conducted a survey for the dance magazine, *Mixmag.*[21] The survey targeted Ecstasy users through the medium of a widely popular club magazine. This approach to selecting a target group utilises what Sherlock terms as 'peer approved' sources for questionnaire distribution, and has proved a valuable way of contacting large numbers of Ecstasy users. On the basis of this study, it was apparent that male respondents demonstrated heavier patterns of use than female respondents in terms of frequency, quantity and duration of Ecstasy use. Whilst males demonstrated higher patterns of use, it was reported that they were less likely than females to seek advice or information about Ecstasy. The implication of this finding is that specific ways need to be devised to increase the uptake of drugs information amongst the population of male users.

Given the established link between Ecstasy use and the club scene, and the significant difficulties encountered by drug researchers in accessing 'hidden populations' of drug users, a shift has occurred in the strategies of some organisations working in the prevention field, towards using the night club as an access point for conducting drugs research and for targeting drugs education and information messages. A recent example of use of the 'peer approved' source approach is contained within the 1997 Release drugs and dance survey, which provides information based interviews conducted across eighteen dance venues in London and the South East.[22] The purpose of the study was to examine

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[20]See Henderson, *Young* Women, *Sexuality and Recreational Drug Use – Final Report (Lifeline)* (Manchester, 1993) for discussion of the themes of gender and recreational drug use.

[21] Sherlock, Unpublished PhD Thesis. See 'The Ecstasy Questionnaire', *Mixmag,* Volume 2, 1997. Issue no. 59.

[22]Release drugs and dance survey, An *insight into the culture* (London, 1997). Release is an organisation based in London which provides drugs and legal advice to drug users. Its services include the provision of a dance outreach service giving

the socio-demographic characteristics of people attending dance events; to look at patterns of drug use amongst this sample; and to consider the opinions of clubbers to a range of issues relating to the institutionalisation of drug laws and policies.

A very high percentage (97%) of the people interviewed for this study had experiences of illegal drug use, with 87% of the sample planning to use drugs on the night on which they were interviewed. Whilst drug use was considered to be an important element in the overall entertainment of the evening, it ranked as the fifth most popular reason for attending events; after music, socialising, atmosphere and dancing. In terms of drugs such as Ecstasy, amphetamines, LSD and cannabis, it emerged that the reasons why people chose to use was for enjoyment rather than for escapist or negative reasons. Use of 'hard' drugs such as heroin, crack and methadone was very low (1%) amongst this sample, which indicates, at least in this context, that the use of heroin as an aid to come down from the effects of Ecstasy is not an established pattern of use. Analysis of the results indicated that quality of Ecstasy was a substantial concern, and 97% of the sample favoured the introduction of drug testing facilities at clubs. The need for drugs information featured as a significant need amongst this group, with 41% indicating that they had sought information from a range of sources. The sample were also opposed to current drugs legislation with 93% recommending cannabis legalisation, and 83% advocating the decriminalisation of cannabis possession.

Research conducted in the North East of England during 1994, has looked at drug use trends amongst a sample of young people.[23] The authors differentiate between three different accounts of the phenomenon of drug use in society: media accounts, official accounts, and users accounts. It is argued that the accounts of both the media and officialdom serve to misrepresent the reality of drug use in society as understood by

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information and support at clubs, festivals and dance events.

[23] Coffield and Gofton, *Drugs and. Young People* (Institute for Public Policy Research) (London, 1994).

young people. In terms of the nature of misrepresentation, it is argued, first, that the issue of drug use is sensationalised through the media, and second, that drug reality 'on the ground' does not correspond to, nor is reflected by, the series of institutional responses which have been enacted by society.

Users' perceptions and experiences of drug use were explored through a series of discussion groups with users within three different age groups ranging from 12-18. The objective of this study was to provide an insight into users' motivations for drug use, patterns of use, and knowledge of drug types. Results from this study locate certain types of drug use firmly within a youth culture of uncertainty, tension, and unemployment. The research indicates that the motivations underlying drug use relate to the maximisation of enjoyment obtained through leisure time activities. Drug use is perceived as a valid and rational way to enjoy recreational time, rather than constituting an act of deviance or rebellion. The motivations which underlie use of certain drugs, is based on consumer rationale relating to the desired degree of intoxication, mood, atmosphere, etc.

The authors argue that there is a major discrepancy between the reality of drug use in post-industrial societies and the responses of policy makers, legislators and public commentators. The research report highlights the increasing normalisation of certain types of drug use amongst young. On the basis of these findings, the authors recommend a controlled experiment in the decriminalisation of cannabis, and a radical restructuring of drugs education based on harm reduction methods. Furthermore, they feel that more attention should be paid to the very real dangers posed by alcohol and tobacco.

Parker et al identify, as a key trend amongst people in the 15-20 age group in the UK, high use of the drug cannabis.

> The most popular drug is cannabis, which has been used by about a quarter of the young adult population, with rates around 40-50% in some urban areas and particular

cities.[24]

The implications, drawn from this and other surveys, is that use of cannabis and drugs such as amphetamine and Ecstasy, is becoming increasingly 'normalised' in society. Wibberly provides additional qualifying insights into the debate about the extent to which drug use has become a normalised part of adolescent experiences. He specifically addresses young people's feelings about drug use through a series of focused qualitative interviews with twenty groups of 14-16 year olds across three schools. On the basis of analysis of these interviews, it is apparent that the prevailing feeling was that certain types of drug use are quite common amongst young people. Groups were divided about the extent to which they 'approved' of illegal drug use, with some young people expressing the view that drug use was a matter of personal choice. However, even amongst those who expressed more negative views about drugs, it was noted that

> there is some evidence of an air of fatalism in accepting that illicit drug use is now part of the cultural milieu within which young people exist.[25]

There was a clear differentiation between the types of drug use which were deemed to be acceptable and those which were considered unacceptable. It was felt that use of such drugs as cannabis and speed were not likely to cause undue harm, but that the consequences of using 'harder' drugs such as cocaine were more serious. In light of the findings of this study it is perhaps more accurate to suggest a qualified version of the normalisation hypothesis, whereby certain types of drug use are generally accepted as part of social reality, but stressing that not all young people engage in or sustain patterns of drug use.

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[24] Parker et al, *op. cit.,* cited in Wibberly. *op. cit.,* at p.66.

[25] Wibberly, *op. cit.,* at p.77.

Irish Research Context

Until quite recently, effective assessment of the incidence, patterns and trends of drug use in Ireland has been hindered by a lack of available research. Fran Bisset, in a 1997 report on Ecstasy and young people, identifies three sources which have served as the primary references in providing quantifiable information about drug use: Central Statistics Office, Annual Reports of the Garda Siochana, and the National Drug Treatment Centres. Each of these sources indicate that there has been a substantial increase in use of certain drugs over recent years.[26] Whilst the above sources serve to provide essential information about the people for whom drug use has become obviously problematic, whether for reasons relating to health, drug dependence, death, or legal reasons; other methods are needed for accessing the hidden population of users, for whom drug use is not obviously or immediately problematic. The following is intended to give an overview of some of the findings that have emerged from levels one and two research which has been conducted in this field in recent years.

One of the key points emerging from level one research being

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[26] In relation to the data from treatment centres, the information may reflect factors other than levels of drug misuse, i.e. type of service available, differential uptake of services amongst social groups, number of treatment places available. Similarly, with regards to data on seizures and arrests, it has been remarked that these cases may reflect the level of Garda activity in different areas rather than actual levels of drug misuse. Furthermore, in relation to accessing information about exact numbers of deaths resulting from use of a drug such as Ecstasy, current recording methods utilised by the CSO are not sufficiently specific to yield this level of information *(ibid.,* p.13).

done in Ireland is the existence of significant regional differences in drug use patterns across the country. This finding is also supported from analysis emerging from level two:

> From schools and youth surveys, it is apparent that the drug experiences of young people in the west of Ireland are different to those of young people in the east of the country, with lifetime prevalence rates in Dublin being higher.[27]

Figures from the Garda Annual reports support the hypothesis that there is substantial regional variations in patterns of drug use.[28] In 1996, cannabis resin accounted for over half of all controlled drug offences, with heroin accounting for 15% followed by Ecstasy at 12%. Proportionately the rate of Ecstasy proceedings was highest in the southern region, accounting for 21% of the total drug proceedings, as compared to an average of less than 10% in all other regions.

Analysis of statistics emerging from drug treatment centres in Ireland has yielded valuable information about the profile of problematic users in Ireland. 1995 was the first year that statistics were compiled at a national level for treated drug misuse. Again regional differences between drug misuse are quite pronounced:

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[27] The Health Research Board, *1996 National Report on Drugs Issues in Ireland.* See Chapter 11.

[28] Garda statistics provide information about numbers of seizures and drug related prosecutions the quality of this information has been upgraded since 1995 with the introduction of drug prosecutions being broken down by drug type and Garda division.

1995	Greater Dublin Area	Other Regions
Percentage of total sample naming Ecstasy as their primary drug.	3%	22%
Percentage of first time clients naming Ecstasy as their primary drug	6%	25%

The 1996 national treatment statistics also show pronounced regional differences in patterns of drug misuse. 86% of treatment clients were living in the Eastern Health Board region, and in this region heroin represented the primary drug of misuse. What is particularly significant in the present context is the fact that rates of Ecstasy misuse are quite sizeable in the Southern and Eastern Health Board Districts, accounting for 39% and 38% of treatment cases respectively.

Unlike the heroin problem which is concentrated in Dublin (although recently becoming more prevalent elsewhere in the country), Ecstasy culture is a significant feature of contemporary youth culture throughout the county. Speaking on the incidence of people requiring drug treatment facilities, it has been noted that within the Cork context,[29] there has been a significant change in terms of the demographic profile of people referred for treatment, and this change seems to be associated with new developments in youth culture.

> The problems tend to be across the board. In fact, if anything, we seem to be getting referrals from areas which in the past would have claimed that they didn't have drug problems, on the South side of the city. We get a fair amount of referrals from outside the city

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[29] Data is drawn from an interview conducted for the purposes of this project with a representative from the Southern Health Board treatment centre at Arbour House.

> as well, and we are seeing more and more people coming in from the satellite towns of Mallow, Fermoy and Macroom.

The types of drug problems experienced by this burgeoning group of people needing treatment primarily result from polydrug consumption which includes drugs such as alcohol, Ecstasy, cannabis, cocaine and amphetamines. A change was noted in relation to profiles of age and consumption patterns:

> There is more use of Ecstasy now than there was five years ago, and we are also seeing people as young as thirteen and fourteen who have developed problems through using Ecstasy.

Evidence from level two survey data provides information about more general drug trends in Irish society. A study has recently been published by the Southern Health Board which conducted research on drug use amongst the general population in Cork and Kerry.[30] Analysis of the findings show that whilst a high percentage of the population currently drank alcohol, much lower numbers were recorded for the use of illegal drugs. Whilst the highest drug use in the region was concentrated in Cork city, it was apparent that drugs were spread across the geographical area represented in this study, with 25% prevalence across the total sample. In terms of socio-economic variables, use of illegal drugs was found to be distributed across all social classes, and did not demonstrate significant connections to indicators of social exclusion.[31] The typical profile of drug use which

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[30] Jackson, *Smoking, Alcohol And. Drug- Use in Cork And. Kerry* (Southern Health Board) (Cork, 1997) pp.6-9.

[31] An important distinction has to be drawn here, between use of drugs which is not obviously or immediately problematic, and problematic forms of drug use. In the case of the latter, there is an established link between drug misuse and social disadvantage. The Health Research Board, *1996 National Report on*

emerged from this study was that users tended to be young and male and from urban areas.[32] Amongst the younger teenagers (15 – 16 year olds), it was found that 22% smoked cigarettes, and 33% drank alcohol. The main type of illegal drug used by this cohort was cannabis, which had a prevalence of 18%.. Use: of other drugs such as Ecstasy and amphetamines was significantly lower, standing at 2-5% prevalence. The lower prevalence of Ecstasy amongst this age group is in line with findings from other research which shows that initiation of Ecstasy use mainly occurs in the 18-21 age group. People who used illegal drugs recorded earlier experiences with legal drugs such as alcohol and cigarettes than people who did not use illegal drugs, which has implications for targeting drugs information at younger age groups. In terms of other relevant social information, it was noted that users of illegal drugs demonstrated high frequency of pub and disco attendance, and low frequency of attendance at church.

In terms of exploring drug-taking trends specifically amongst young people, the following pieces of survey research have produced some important information. The European School Survey on Alcohol and other Drugs (ESPAD), which carried out research amongst 50,000 young people in 26 countries in 1995, provides comparative information about drug-taking trends amongst young people aged between 15-16. The report indicates that there is quite a high prevalence of drug use amongst the Irish cohort of this sample.[33] In relation to legal drugs such as alcohol,

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Drugs Issues in Ireland. See, also, Gilman (*op. cit.*) for discussion of these issues.

[32] Men in Cork under the age of 35 years demonstrated a lifetime prevalence of 40%, whilst recent use stood at 20%. Jackson, *op. cit.,* p. 7.

[33] The European School Survey Project on Alcohol and Other Drugs (ESPAD), *Alcohol and Other Drug Use among Students in 26 European Countries* (The Swedish Council for Information on Alcohol and Other Drugs, CAN; Council of Europe; Pompidou Group) (Sweden. 1997).

66% of Irish students said they had been drunk in the past year, as compared to an average of 48% of the total sample. In relation to illegal drugs, 37% of Irish students said that they had tried cannabis, as against the European average of 12%. Use of illegal drugs other than cannabis stood at 16% as compared to a European average of 4%. Compared to the findings of an earlier study conducted in 1989 on smoking, alcohol and drug use amongst a random sample of 3000 pupils aged between 12.5 and 18 in the greater Dublin area, the ESPAD study shows some increase in prevalence of certain types of drug use.[34] The authors of this earlier report conclude that the biggest drug-related problem amongst young people at this time was cigarette-smoking, followed by alcohol abuse. It is apparent from the evidence emanating from the Irish context and other national contexts that there are currently additional reasons to be concerned about drug taking trends amongst young people.[35]

A recent National Drugs Survey conducted by the USI used a sample of over 1,000 students from forty campuses in Ireland. The study found that 53% of this sample felt that drugs were part of their social lives, with 80% reporting that Ecstasy was a part of the current club scene. The majority of the respondents had tried an illegal drug between the ages of 14-18. 47% of the sample said that cannabis was the first drug that they had tried; however, for 3% of the sample, the first drug of use had been cocaine, whilst 1% of the sample indicated that their first drug of use had been heroin. The fact that 5% of the sample stated that they had first used an illegal drug whilst in primary school has implications for implementing earlier introduction of drugs

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[34] See Morgan and, Grube, 'Drug Use in Irish Schools: A comparison with other countries' (1989) *Oideas* 34. Prevalence for cannabis use quoted in this earlier study stood at 13.2%.

[35] Compared to the Southern Health Board Study, the findings of ESPAD indicate a much higher lifetime use amongst 15-16 year olds of cannabis, LSD, amphetamine and Ecstasy, a fact that may reflect the Dublin population weighting of the latter. Jackson, *op. cit.,* p.72.

education to younger children. Commenting on the results of this survey, a USI representative points to

> a gaping hole between the level of information on drugs provided by the Government and the 1eve1 of information required by students and young people.

To date, that there has been very little research undertaken in Ireland which has specifically focused on use of the drug Ecstasy. A notable exception is a small scale survey undertaken in 1996 which focuses on Ecstasy use amongst young people in two Dublin schools.[36] The schools used in this study were chosen so that they represented areas broadly categorizable as middle class and working class. In the case of the former, it was found that 10% of fourth-years had taken Ecstasy, whilst in the case of the latter, 20% of third-years, and 33% of sixth year students had used this drug. Three broad bands of user types were identified within the study: regular, occasional and experimental. Of the 86 users surveyed, it was the case that 44% fell into the category of regular use or weekly use, 34% fell into the category of occasional or monthly use, and 12% were experimental users. Whilst the sample included in this study was necessarily quite small, it is felt that these figures give a good indication of patterns of Ecstasy use throughout the rest of the country. In terms of identification of areas of potential concern, the author notes a high incidence of mixing Ecstasy with other drugs. 70% of the sample regularly mixed Ecstasy with a range of other drugs, the most popular being cannabis, speed and alcohol. Additionally, a significant proportion of the sample were using more than one Ecstasy tablet at a time, which is an added cause

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[36] O'Keefe, *Ecstasy in Ireland* (Unpublished Masters Thesis). Research into Ecstasy use amongst young people is currently being conducted by Queen' s University, Belfast. Contact Karen Me Elrath, Queens University, Belfast.

for concern.[37]

[37] 66% of the sample of 86 users had taken more than one tablet at a time, and 16% of the sample were taking three or more tablets at a time.

CHAPTER TWO

DIMENSIONS OF ECSTASY WITHIN CLUB CULTURE

Introduction

'Ecstasy' is often thought of as the popular name for MDMA (3,4 – methylenedioxymethamphetamine). MDMA was first synthesised in 1912 by the German company, Merck. Although it was patented at that time, it was not put on the market. Its original function was as an intermediate chemical for use in the preparation of other drugs. Little is known about its early use. It came to light during the 1950s when it was resynthesised by US Army chemists, assessing any potential military value the drug might have. During the 1960s, it was again resynthesised, first by drug researcher Gordon Alles, then by a Californian chemist called Alexander Shulgin.[38] During the 1970s, MDMA was used extensively by psychotherapists in the US with great success:

> [The therapeutic community] would give their patients MDMA in the course of psychotherapy sessions to break down mental barriers and enhance communication and intimacy. The patients might be suffering from post-traumatic conditions, phobias, neurotic disorders, drug addiction, terminal illness or marital difficulties – a large proportion felt that the drug sessions helped them, eased their ailments or improved

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[38] Collin, *Altered State: The Story of Ecstasy Culture and Acid House* (London, 1997) p.25. Shulgin's most widely-known book is entitled *PIHKAL:* A *Chemical Love Story* (Phenethylamines I Have Known And Loved); this was followed by a book on trypatamines – *TIHKAL: The Continuation.*

their self-esteem.[39]

In tandem with this psychotherapeutic use, there also developed a limited recreational use. As a new music ('house') emerged from the black and gay clubs of New York, Chicago and Detroit during the 1970s and early 1980s, so too did the association between Ecstasy and dance culture.[40] It was while the drug was at this stage of distribution that a tension, almost traditional in the case of psychedelic drugs, emerged. The dispute between 'drug elitism' and 'drug-populism' had already been witnessed in the disagreements about LSD between author Aldous Huxley and Harvard professor Timothy Leary during the 1960s. In the case of MDMA, there was a similar division among those who were aware of the drug: a minority, believing the drug would have positive effects on people generally, advocated 'mass distribution';[41] the majority, on the other hand, believed it should be kept underground, for use only in therapy and by so-called 'adepts'.

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[39] Collin, *op. cit.,* p.28.

[40] 'Black and gay clubs have consistently served as breeding grounds for new developments in popular culture, laboratories where music, drugs and sex are interbred to create stylistic innovations that slowly filter through to straight, white society.' *Ibid.,* p.12.

[41] One campaigner. Rick Doblin, proposed an Ecstasy project to the UN entitled 'Shaping a Global Spirituality While Living in the Nuclear Age'. He extolled the virtues of the drug as follows: 'The religious experience, the sense that people get that they are part of the same community which is very diverse but includes everybody, that insight about humanity has incredible political consequences because it will lead you to try to understand people rather than consider them the enemy… People will be more willing to settle disputes and more willing to pay attention to environmental issues.' Quoted in Collin, *op. cit.*, p. 33. As Collin remarks: 'Such subtleties were naturally lost on people who made a career out of the slogan 'just say no', and now had a new drug to vilify' (*ibid.)*.

At any rate, in 1985, following a wave of aggressive marketing in Texas that alerted the Drug Enforcement Administration (DBA); to the drug,[42] it was placed, amid widespread publicity, on Schedule 1 of the US Controlled Substances Act.

The next major development was the entry of Ecstasy into Europe, a move that is often associated with the followers of the controversial Indian mystic, Bhagwan Shree Rajneesh (also known as Osho), and in particular with their base on the Balearic island of Ibiza.[43] Ibiza subsequently became the European source of the new dance culture. The first report of MDMA to reach a broad audience in the UK came in 1985 in an article published in a club magazine, *The Face*.[44] The combination of Ecstasy with house music during the 1980s resulted in 'the most vibrant and diverse youth movement Britain has ever seen'.[45] Against a

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[43] '"Ecstasy" was distributed openly in bars and nightclubs in Dallas. There were pyramid sales structures, 800-numbers and credit card purchase options. It became a "phenomenon" among Dallas yuppies, college students, and gays, who would go out "X-ing" on Friday and Saturday nights. Distribution grew and recreational, as opposed to the more therapeutically oriented, use increased dramatically.' Rosenbaum and Doblin, 'Why MDMA Should Not Have Been Made Illegal' in Inciardi (ed.) the *Drug Legalization Debate* (Newbury Park, 1991) p.137.

[43] The gay club culture of New York was another important conduit for the entry of the drug into Europe, 'primarily via European musicians working or holidaying in the city'. Collin, *op. cit.,* p. 36.

[44] Naysmith, 'Ecstasy (MDMA)', *The Face*, 66 (1985).

[45] *Ibid.,* p. 4. Almost accidentally, MDMA was made illegal in Britain in 1977: a raid on a clandestine laboratory had resulted in the seizure of formulae for MDMA and its derivatives. *Ibid.,* pp.40-41. Common to the experience of transition to the mainstream is the commercialisation of aspects of the culture. Collins speaks of rave's influence as being so considerable that

background of a certain amount of home and other recreational use,[46] this youth movement initially involved thousands of young

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it has led to a reshaping of the leisure industry, with the food, drinks, music and the book trade being particularly affected.'; *Ibid.,* p.273. A survey by The Henley Centres for Forecasting found that attendance at rave events was over fifty million a year in Britain, with each person spending an average of £35 on admission charges, soft drinks and recreation drugs (Music and Copyright (10 November 1993), in Thornton, *Club* Cultures: *Music, Media and Subcultural Capital* (Oxford, 1995) p.15.

[46] The use of Ecstasy outside the rave or dance scene is not well-documented. Collin does provide some details about the 'London Ecstasy circle' between 1982 and 1986 *(ibid.,* pp.40-44). In the Netherlands, the CVO reported that the drug 'appeals to a very wide public: not only [disco regulars], but also old hippies and "wheeler-dealers", ... New Agers and Yuppies, football supporters and fringe youth groups.' *Ecstasy in the Entertainment Circuit,* p.5. 43% of the respondents to the Utrecht survey at house parties *(infra)* had used their first Ecstasy pill elsewhere than at those parties (p.68). The validity of the proposed connection between Ecstasy use and the club scene has been empirically tested in a study undertaken by the Centre for Drug Misuse Research at the University of Glasgow. The objective of this study was to demonstrate whether a relationship exists between adolescent drug use and identification with styles of music linked to specific youth cultures. The research was conducted with a sample of 1,523 secondary school students from the areas of Dundee, Perth and Kinross District. The sample was constructed so that it represented adolescents of mixed educational ability, and from differing socio-economic backgrounds. The results from this project confirmed that a relationship existed between drug use and musical style. Adolescents who identified rave music as their favourite type of music were more likely to be substance users than those who did not like rave. This identification was prevalent across class and ability boundaries. Moreover, rave music was positively related

people attending ‘house parties’ or ‘raves’ in factories and warehouses which were often lacking in elementary facilities such as electricity, ventilation and toilets.

From this point in the late 1980s, the most distinctive feature of Ecstasy culture has been its diversity. One obvious example of this relates to substances: Virtually all commentators note that Ecstasy culture is no longer driven by MDMA alone and has become what drug experts call a ‘polydrug’ scene, with cannabis, amphetamines, LSD and heroin also playing significant roles.[47]

It is apparent from interviews conducted with cultural commentators for the current research project, that the Ecstasy/club formula emerged in Ireland, broadly at the same time as elsewhere in Europe, from the mid to late 1980s, gaining widespread popularity in the early 1990s. Uptake in Ireland, in the initial phase occurred in the distinctly political arena of the gay community:

> At this time clubs were serving a very political purpose in the gay community. This is previous to the decriminalisation of homosexuality when club culture

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to legal drugs such as alcohol and tobacco as well as illegal drugs. See Forsyth, Barnard and Mc Keganey, ‘Musical preference as an indicator of adolescent drug use’ (1997) *Addiction* 1317.

[47] Collin describes the more general diversity of the culture in postmodern terms while at the same time attacking the prevalent notion that it is ‘apolitical’: ‘[Ecstasy culture] is a culture with options in place of rules … The idea that [it] has no politics because it has no manifesto or slogans, it isn’t saying something or actively opposing the social order, misunderstands its nature. The very lack of dogma is a comment on contemporary society itself, yet at the same time its constantly changing manifestations ... serve to dramatise the times we live in. Ecstasy culture offers a forum to which people can bring narratives about class, race, sex, economics and morality.’ *op. cit.,* p.5 (emphasis in original).

gave gay communities a sense of identity and solidarity.[48]

From this minority base, dance culture became increasingly popular as an element of mainstream culture: a fact which is reflected in the increasing sales of 'dance music'.[49] One of the first public references to the developing dance culture focused on drug use in night clubs in Co. Donegal in 1992. Reporting of the Garda drugs operation 'Rave in the Cave' supplied the public with incidental detail about the lifeworld of rave:

> Parents reading about this case were to learn of bizarre rave practices, including dancers who use Vicks inhalers or who sniff avidly from their Vicks covered gloves in the throes of wild, drug inspired dancing.[50]

A significant aspect of dance culture is its trans-national appeal. Whilst there are marked national, regional and local

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[48] Comment by club promoter, Shane Curtain, at a public meeting to discuss 'Ecstasy and Club Culture' organised by Praxis in Cork (Spring 1997).

[49] '[D]ance music is now one of the biggest sellers in music stores. Dance acts have become some of the most frequent and biggest selling events in Dublin's Point Depot and top dance bands and DJs also figure prominently in the mainstream charts.' Cormac O'Keefe, *The Irish Times* (November 19, 1996). A person working in a dance music shop interviewed for this project comments, 'When I started in the shop seven years ago, there was hardly any dance music in Cork. In the space of six years, we were totally independent. We had indie bands and guitar bands, and one little section for dance music, and now its the exact opposite the alternative section died down, and the dance section took it over.'

[50] O'Mahony, *Criminal Chaos: Seven Crises in Irish Criminal Justice* (Dublin, 1996) p.46.

differences in specific enactments of the culture, there are strong connective elements which lend coherence to rave as a distinct international youth culture. Within this transient, ephemeral culture, the value placed on the 'new', is considerable: new ways of dressing, dancing, mixing music – all fuel the appeal of this culture the compatibility between the pharmacological properties of certain drugs and the values of dance culture has been noted by various authors.[51]

Speaking of the relationship between dance culture and Ecstasy use, Haslam comments that:

> the entry of Ecstasy into house clubs gave the scene a huge boost, loosened the crowds, fed the atmosphere and contributed to the staggering rise of house music.

The fusion of drugs and music, acts as a powerful sensory stimulus:[52]

> The rhythms and textures of jungle, trance, garage, etc., each make you move through the world in a different way, recalibrate and recondition your body.

The psychoactive effects of Ecstasy on the individual include 'altered time perception, suspension of fear, an increased ability to interact with others, partly due to the suppression of the insecurities and fears which normally modify behaviour'.[53] It has been noted by various researchers that users accounts of the experience of taking the drug demonstrate a common formula. Solowij et al conducted a study on recreational

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[51] Specifically noted in the 1997 report of the EMCDDA, *op. cit.,* p.70.

[52] Haslam, 'DJ Culture' in Redhead, Wynne and O'Connor (eds.), *The Clubculture. Reader: Readings in Popular Culture Studies* (Oxford, 1997) p.175.

[53] 'Bad Medicine', *The Face*, June 1998.

use of MDMA in Sydney.[54] Comparisons with a similar study undertaken in America[55] indicate that a number of factors are consistent across the two studies. 'These include the motivations for use, patterns of use, mode and context of use, the nature of the experience itself including effects, side effects and issues of tolerance'. Differences were, however, noted in relation to typologies of users with an absence of New Age spiritualist type use in the Sydney context. Ravers' accounts of Ecstasy use typically stress the sensation of bodily and emotional liberation which the drug produces. Accounts of Ecstasy use, collated by Nicholas Saunders,[56] emphasise sensations of bodily weightlessness, an ability to enjoy bodily fusion with music through dance, heightened emotional energy, and increased empathy.

Mc Robbie argues that traditional gender relations are changing within rave. She points to the fact that the dance floor, once the preserve of women sub-culturalists, has within rave, become the rationale for the entire culture. In this space, stereo-typed images of masculinity are being transformed in and through dance:

> They undergo a conversion to the soft, the malleable and the sociable rather than the anti-social, and through the almost addictive pleasure of dance they also enter into a different relationship with their own bodies, more tactile, more sensuous, less focused

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[54] Solowij, Hall, and Lee, 'Recreational MDMA Use in Sydney – A Profile of Ecstasy Users and Their Experiences with the Drug' (1992) 87 *British Journal Of Addiction* 1161.

[55] Beck, Harlow, McDonnell, Morgan, Rosenbaum and Watson, *Exploring Ecstasy: a description* of *MDMA users* (Report to the National Institute on Drug Abuse) (San Franciso, 1989).

[56] Saunders, *Ecstasy-Reconsidered.* (London, 1997) pp.254-285.

around sexual gratification.[57]

Reynolds similarly speaks of the abolition of the traditional sexual narrative 'in favour of an infinitely sustained pre-orgasmic plateau'. He views the freedom from the gendered uniformity of mainstream culture as an authentically subversive aspect of the culture. Users' accounts of Ecstasy experiences, collated by Nicholas Saunders, support the hypothesis that perceptions about gender relations in the drug/club context differ substantially from mainstream constructions.[58] It is apparent that at the experiential level the sensation of participation in dance events, combined with use of psychoactive drugs is considered by many to be the optimum setting for pleasurable use of the drug Ecstasy.

Frank develops a model of the differentiated roles which the body plays in society. He attempts to relate the development of self-identity to the achievement of embodied consciousness. The model which he develops establishes a relationship between the three categories of institutions, discourses and corporeality.[59] He argues that social interaction requires actor reflection upon

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[57] Mc Robbie, *Postmodernism and. Popular Culture* (London, 1994) p.168.

[58] One user speaks of 'the almost childlike pleasure of being able to meet people without the usual barriers we put up to defend ourselves in normal situations. This applies (for me) to being able to meet other men for the first time without any trace of initial hostility, and being able to approach women without it being perceived as a sexual advance.' Saunders, *op. cit.,* p.275.

[59] The categorisations are not experienced as rigid, they are rather action orientations or 'heuristic guides through which to order empirical behaviours and understand something of their flips and relations'. Frank, 'An Analytical Review' in Featherstone, Hepworth and Turner (eds.) The *Body: Social Process and Cultural Theory* (London, Newbury Park, New Delhi, 1993) p.53.

four problematics of embodiment. These are the dimensions of control: desire, relatedness to others and self-relatedness. These dimensions each require resolution in the action context. From each of these dimensions, an ideal type of style of bodily use emerges which attempts to resolve, in different ways, the questions posed by the above mentioned action problems. He suggests that four ideal types of bodily use are: disciplined body; mirroring body; dominating body; and communicative body. Of interest in the present context are the Utopian possibilities offered by the model of the communicative body/which is, presented as 'less a reality than a praxis'.[60] The resonance of the model of the communicative body within the context of rave becomes apparent in the following reflection by Frank:

> Dance appealed to me as one site at which communicative bodies might by found. Dance is producing in its expressiveness, and the dancer must be associated with her or his body. Dance evolved through the contingency of the body, this contingency being dance's source of change and inspiration. Most important, dance is communal. Dyadic relation with others who join in the dance implies an associatedness which goes beyond one's own body and extends to the body of the other. Finally dance may be no more a metaphor for the sexual joining of bodies than sex may be a metaphor for dance.[61]

The model of the communicative body is one of bodily liberation, of freedom from external pressures, and ultimately the realisation of individual expression. It is the promise of Utopian bliss in a broader culture which many young people perceive to be uncertain, competitive, and hostile. The present study hypotheses that through the combination of drug use and dance within rave, the promise of the 'transcendent embodied

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[60] *Ibid.,* p.79.

[61] *Ibid.,* p.80.

experience',[62] captured by Frank's model of the body in communication, is offered. Whilst the body in communication is the desirable end state of the rave experience, the 'transcendent moment' would seem to be governed by rules of diminishing returns, being contingent upon the drug experience and the conditions of cultural institutionalisation and commodification. Too often, the rave experience does not deliver on the promise it holds out. The shadow side of the model of the communicative body, is then the model of the 'anxious body' fearful of psychological and physical trauma.

Reynolds draws an analogy between the structure of rave culture and the properties of MDMA. He argues that rave culture is fundamentally postmodern in so far as it lacks objective and direction. He describes it as a culture of acceleration without destination; as having no goal beyond its own propagation. Like MDMA, the culture typically demonstrates a cycle of buoyancy; the honeymoon period, followed by a phase of disenchantment and burnout. He refers to certain musical developments within the culture, as constituting a 'dark side' of rave:

> a style that appeared to reflect long term effects of Ecstasy and marihuana use: depression, paranoia, dissociation, creepy sensations of the uncanny.

The point that emerges from the preceding discussion is that the relationship between Ecstasy use and participation within dance culture is not an inevitable or a static one, as each of the variables has the capacity to impact upon the other variables

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[62]One user describes the physical and emotional experience of using ecstasy in the club context as follows: 'When the first feelings, both emotional and physical, hit, I literally felt stunned. I felt so joyful, so loving and everything was so utterly, painfully beautiful. Eventually I got around to dancing, but my dancing was more of a trance spiral in the middle of the floor – spinning, twirling gently and gazing into the mirrors with much curiosity.' Saunders, *op. cit.,* p.264.

in a more or less positive manner. Whilst the relationship between social setting and drug use can serve to enhance the user's perception of pleasure, so too can the trajectory of use of the drug on the physical body influence the value which individuals place on continuing participation within the culture: Rosenbaum and Doblin argue that in the case of 'Ecstasy': the tendency to develop excessive use patterns is countered by properties inherent within the drug itself:[63]

> MDMA is a drug that promotes self reflection, can only be used enjoyably every few weeks, and is unpleasant to overuse. It is not likely to be attractive to classes of individuals whose life options are so limited that they feel they need to use anaesthetising drugs on a daily basis'[64]

Mathew Collin draws a distinction between physical addiction and psychological compulsion in the case of Ecstasy. He links the compulsion to take Ecstasy to the attractiveness of the wider cultural experience. Again, he advances the argument that Ecstasy has, what he terms, a 'built in pharmacological limiting factor' that deters long term abuse.[65] If it is the case that a positive drug experience can heighten the cultural experience of rave, then it follows that the trajectory of the effects of drug use on the body will influence the way in which the culture is adhered to and maintained over time. One user describes the

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[63] Rosenbaum and Doblin, *op. cit.,* at p.143.

[64] Results from a study undertaken in Sydney indicate that 70% of a sample of 100 users found that the effects of ecstasy varied over time with reduced pleasurable effects and unpleasant side effects. Solowij, Hall and Lee, *op. cit.*

[65] As against these arguments, accounts of drug use given by young people in drug treatment show that in problematic cases Ecstasy is being used in large quantities on a daily basis in conjunction with a range of other substances with seriously adverse consequence.

experience of ongoing use of Ecstasy:

> After a couple of years, I found that the honeymoon period was drawing to a close. What was missing? After talking to lots of disenchanted clubbers I came to the conclusion that Ecstasy feeds on excitement and novelty. After a while, the brain assimilates a lot of experiences, and comes up with an 'ideal' which must be met in order to have a good night ... Many now only use amphetamine because they get too disappointed compared with the euphoria of their first few times.

Disappointment at the qualitative decrease in experiences at rave is a common reaction to prolonged 'raving' and generally leads to a phasing out of participation in the sub-culture. However, for some users the effects of use of the drug over time are more profound, leading to severe depression and psychological disorders.

A particular area of concern related to the normalisation hypothesis, is that if 'soft' drug use becomes increasingly embedded in youth culture, there may be a risk that it will lead young people to experiment with other 'harder' types of drugs.[66] The idea that certain types of drugs act as a gateway which lead to potentially problematic forms of drug use has been evoked as a cause for concern in recent debates about Ecstasy. Particular focus is placed on the period of time when the effects of the drug are wearing off. The 'coming down' phase can be difficult to negotiate, and it is at this time that some users are inclined to use other drugs to ease the transition. The most widely reported problem associated with coming down is inability to relax and sleep. Some users do not encounter significant problems with this phase, but amongst those who do, supplementary drug use is not uncommon. A drug which is widely used as an aid to come down is cannabis. However, there is strong evidence to support the contention that heroin is used in certain context as a means

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[66] See also Chapter Four of this report.

of negotiating the unpleasant after-effects of Ecstasy. Whilst it is the case that some people who use Ecstasy will go on to use other 'harder' drugs, the circumstances under which this progression occurs must be looked at carefully before conclusions can be drawn about the general applicability of the gateway hypothesis.

Support for the gateway hypothesis tends to be strongest from actor groups most closely associated in working with problematic drug users, particularly in the fields of drug treatment and counselling. Whilst evidence of progression from soft drugs to harder drugs is abundant in the context of treatment, there are questions about whether this high risk pattern of use is established, emergent or marginal in the wider recreational arena. Evidently, it is the case that a substantial number of users of 'hard' drugs have previously used less dangerous drugs, but is a position of reductionist logic sufficient as a basis for claims that soft drug use necessarily leads to use of harder substances? Mark Morgan et al argue that it is not: 'Cannabis seems more often to be a closed gate than a gateway in that its use signal the terminus of illegal drug experimentation.'[67] Evidence from recent studies would seem to support this contention. The study conducted by Christopher Wibberly clearly shows that young people drew distinctions between what they considered to be acceptable forms of drug use, and use of harder drugs such as cocaine and heroin, which were considered to be unacceptable. Similarly, Coffield and Gofton comment that in terms of how users view their own use patterns, it emerged that this behaviour was widely seen as non-problematic. It was felt that a substantial gulf separated patterns of recreational and dependent use:

> Young adults do not picture drugs as being on a continuum from soft to hard nor do they see themselves

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[67] Morgan, Riley and Chesher, 'Cannabis: Legal Reform, Medicinal Use and Harm Reduction' in Heather, Wodak, Nadelmann, and O'Hare (eds.), *op. cit.*

on a slippery slope to cocaine and heroin.[68]

The major point of differentiation identified by users in the Coffield and Gofton study would seem to hinge on the question of control; with certain levels of drug use being viewed as acceptable, whilst other types of use are viewed more negatively. The case has been made by various authors that under certain conditions, moderate drug use does not appear to be problematic. Stanton Peele attributes this phenomenon to the inculcation of value systems compatible with management of consumption. He refers to evidence that suggests that in the US, the higher a person's social economic status, the more likely a person is both to drink at all, and to drink without problems. Low socio-economic status and minority racial status make people both more likely to abstain and more likely to require treatment for alcoholism.[69] The inference from this evidence is not that certain social groups are more prone than others to use drugs, but that patterns of controlled usage are more readily established in certain groups. These patterns of controlled use fit into a wider framework of values and lifestyle choices. The following section explores, in general terms, with reference to accounts from medical experts, some of the physical and psychological risks associated with use of the drug Ecstasy. It proceeds to look specifically at the area of risk in the social context of dance culture, and reviews the types of responses that are emerging at an institutional level to the contextualised risks of use of Ecstasy and other drugs.

Dimensions of the 'anxious body': Ecstasy and risk

MDMA belongs to a class of phemylethamines that have a chemical structure showing similarities with the structure of the central

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[68] *Op. cit.,* p.36.

[69] Peele, 'A Moral Vision of Addiction: How People's Values Determine Whether They Become And Remain Addicts' (1987) 17 *The Journal of Drug Issues* 187.

nervous system stimulant, amphetamine, and the hallucinogenic; substance mescaline. [70] Most commonly referred to as an 'empathogen' (empathy-generating), stimulant effects are felt after consuming MDMA and a sensation of euphoria and emotional intimacy with others develops. However, 'Ecstasy' may also be considered as a generic term that applies not only to MDMA and MDMA-analogs such as MDA (methylenedioxyamphetamine) and MDEA (3, 4-methylenedioxy-N-ethylamphetamine), but also to, other substances, of various, types, that can be and are, sold as Ecstasy.

MDMA appears to act on two of the brain's neurotransmitters, serotonin and dopamine.[71] Both of these chemicals play a role in regulating the body's temperature. The disturbance of the normal process of regulation, whereby messages of discomfort are sent by the neurotransmitters to alert the body that it is overheating, can place the user at risk if adequate precautions are not taken. The risks of overheating are increased by prolonged dancing, dehydration, overcrowding and inadequate ventilation. As such, the risk of overheating can be exacerbated within the context of the night-club, if adequate safety features

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[70] Despite these similarities, it should be noted that MDMA is not a true 'designer drug'. That term applies to substances derived from existing illegal drugs, with producers initially seeking to avoid existing prohibitive legislation.

[71] According to Collin, the drug "affects the chemistry of the brain in ways that are not yet fully understood, although current wisdom suggests it works on the neurotansmitters - chemicals in the brain like serotonin or dopamine – that affect pleasure.' *op. cit.,* p.27. 'Serotonin is a neurotransmitter which acts on the pleasure/reward centre in the brain. Serotonin regulates feelings of calm and well being. Subsidiary effects relate to cognition, appetite, movement and body temperature.' 'Bad Medicine', *op. cit.*

are not in place.[72] Whilst extreme reactions to Ecstasy are uncommon, they do occur, and in a number of cases have proved fatal.

> 'The most severe reactions include hyperthermia, convulsions, blood clotting and severe kidney failure. Other deaths have been attributed to users drinking large amounts of water in an attempt to counter overheating.'[73]

The degree of unpredictability concerning the triggering of severe reactions has alerted public concern about the drug; however, equally worrying are the less publicised dangers of long -term risk of liver and heart damage[74] and mental illness.[75] A

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[73] Typical features of 'safer dancing' campaigns include: information and advice about drugs; supply of condoms; support to those experiencing mental or physical health problems; liaison with organisers and licensing authorities over health and safety. Some also provide: a chill-out environment; free massage; free chilled fruit, ice lollies and water; on site testing and pill identification; collection of information on the current availability of drugs within the scene. EMCDDA, *op. cit.,* p.78.

[73] Bad Medicine, *op. cit.*

[74] See, for example, 'Permanent damage by ecstasy use discovered' the *Irish Times,* November 29, 1997.

[75] 'The "Dance drug" Ecstasy is exposing teenagers to the risk of long-term psychiatric illness, according to a leading psychiatrist ... His warning underlines the fear that the threat of mental illness has been overshadowed by highly publicised tragedies, such as the death of Leah Betts. On the current evidence, Dr Morgan's "best case" scenario is that ecstasy users will react less well to stress than if they had never taken the drug. His "worst case" scenario is that his findings will turn out to be the tip of a "neuro-psychological iceberg" of severe mental problems.' Illman and Pool, 'Ecstasy has sown mental

feature of the research into the physical and non-physical effects of Ecstasy is that it has been characterised by uncertainty and disagreement. A serious problem with much of the discussion about long term effects of Ecstasy use is that it is often vague as to what exactly constitutes regular use and also, even more significantly, that it is vague as to over what periods of time such use must take place for there to be these concerns about non-physical health. Further, this lack of precision must be viewed in the context of a wide variety of use patterns.

Alisdair Forsyth highlights a significant area of concern in relation to the use of drugs commonly associated with the club scene (amphetamine, nitrates and Ecstasy).[76] He argues that with the dramatic upsurge of use of the drug Ecstasy in recent years, much attention has been focused on the risks associated with Ecstasy in the dance scene. He suggests that the result of the sensationalisation of Ecstasy-related deaths in the media has resulted in 'the equation that dance drugs equals MDMA; therefore any drug related harm at dance events must be due to Ecstasy'. He argues that whilst the traditional coterie of 'dance drugs' may be used on the dance scene, there is evidence to suggest that these users may use a range of other drugs in other settings, either independently of, or in association with the drugs which they have used on the dance scene.

Data collected from 135 participants in the Glasgow dance scene indicates the range of drugs which are being used in the club setting.[77] Amongst the sample there was a high incidence of polydrug use. A clear distinction emerged between drugs which were used in the club scene and those which were not. The research suggested that certain drugs tend to be used in specific

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illness seed' the *Observer,* December 15, 1996.

[76] Forsyth (1996), *op. cit.*

[77] Respondents were selected through purposive snowballing using key contacts. The average age of the respondent was 24 years old, and there was a predominance of male over female respondents (62%).

settings. Broadly speaking, pharmaceutical drugs were more likely to be used in the respondents home; solvents and psilocybin were used outdoors more often than indoors; stimulants such as Ecstasy and amphetamine were most widely used in the dance scene; and alcohol was most commonly used in the pub setting. It was noted from the research that the practice of mixing drugs often took place simultaneously, increasing the risk of drug related harm. The author recommends that health messages designed to encourage 'safer dancing' should take on board the reality of polydrug use and its associated risks,[78] rather than targeting a single substance such as Ecstasy.

Attention is also drawn to risk factors associated with perceptions frequent amongst club goers that they themselves are immune from danger. Following from analysis of the Mixmag survey,[73] Sherlock highlights the fact that respondents who engaged in moderate patterns of use tended to be unconcerned about the adverse health consequences of their particular use patterns. Sherlock argues that this finding has important implications for health education:

> Since Ecstasy users were often defensively optimistic about their use of Ecstasy, many respondents may be unresponsive to health education advice since they will feel that the advice does not apply to them. Health education materials should aim to clarify that although Ecstasy-related injury appears to be rare compared to the numbers thought to consume the drug, Ecstasy injury could theoretically strike anyone, since the predictors of harm are not well understood.

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[78] An associated short-term risk of Ecstasy use is outlined in the article: 'A second study shows that the drug, used by an estimated 500,000 Britons every week, triggers "mid week blues" a few days after weekend use in people who are not normally depressed' *(The Observer,* December 15, 1996).

[79] 'The Ecstasy Questionnaire' *Mixmag,* Volume 2, 1997, Issue no 59, -72.

Forsyth also draws attention to the fact that Ecstasy is a term that does not represent a single pharmacological 'product' in the way that some other drugs do. Pointing to the wide variety of products on the market which are being sold as Ecstasy, he suggests that it may be more appropriate to view Ecstasy as a label rather than a nickname for MDMA. Because of the wide variety of brands available on the market, there is some concern about the contents of these various tablets. Issues relating to the quality of drugs such as Ecstasy, in part, derive from the fact that because of its illegal status, there is no attempt to impose quality control within this market. In addition to the very real possibility that Ecstasy may be cut with other substances such as ketamine, heroin, etc.,[80] there is also a widespread belief that the drugs sold as Ecstasy are frequently cut with other drugs.[81] This is fuelled by sensationalist type media reporting.

> A belief or myth (exists) that the quality of Ecstasy has reduced over the years. Whether this decline in quality is real or simply due to tolerance is a myth unknown ... Even if Ecstasy has changed, it is not known whether this is qualitative, as a result of the changing brands of Ecstasy, or quantitative, reflective of a general reduction in the strength of

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[80] Haugher, 'Warning on drug mix sold as ecstasy', *The Irish Times*. In the Irish context it has been noted that the drug ketamine is being used: '[it] is not being sold in its pure form in the Republic. Instead, it is mixed with the drug ephedrine and passed off in tablet form as ecstasy. My suspicion is that the people who are using the tablets think they are E. Whether they have a different effect on them, we don't know.'

[81] 'Despite stories of Ecstasy being cut with everything from rat poison to brick dust, the vast majority of tablets contain a mix of amphetamine, hallucinogens and MDMA, or MDMA substitutes such as MDA or MDEA.' 'Bad Medicine', *op. cit.*

Ecstasy.[82]

Forsyth highlights one important difference between the pattern of Ecstasy use in Glasgow in the mid-90s and other types of drug use patterns. In the case of cannabis, heroin and LSD, differences in brand names tend to reflect quantitative differences in the substance, whereas brand differences between Ecstasy tends to reflect qualitative differences. Research undertaken amongst 127 participants in the Glasgow dance scene, showed that users could identify 106 different brand names for Ecstasy. Users felt that the different brands contained a range of different substances, and that depending upon the particular mixture contained in the tablet, the drug experience would also vary. In this environment, it is difficult for the user to have a clear concept of exactly what is being bought. Brand names tend to vary over time and place, and do not provide a reliable indicator of what is contained in a given tablet. Even across tablets from the same batch, there is evidence that there can be substantial variation in terms of proportions of ingredients contained in individual tablets. Tablets which are embossed are generally seen to be of better quality than those which are not. The embossed detail can take varying forms, but the dove emblem is perhaps the most widely recognised Ecstasy symbol.

The implications to be drawn from this study are two-fold. Forsyth argues that the degree of tolerance for the widespread variation identified both in relation to tablet contents and drug effect indicates that 'Ecstasy was more important as part of a night out in the dance drug scene than as a drug experience for its own sake.' In this respect, the motivations for using Ecstasy lie less in the quest for a specific type of drug experience, and more in terms of participating in the wider dance culture. Forsyth observes that Ecstasy users are 'buying into a concept rather than a single pharmacology'.

The fact that users believe that Ecstasy tablets contain more than one drug type is also an area of concern. Forsyth

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[82] Forsyth, *op. cit.,* at p.200.

argues that the implications of this are, first, that it may encourage increased drug mixing during drug taking sessions, and second, that users may feel predisposed to use the individual substances (ketamine, heroin, speed) which they believe to be contained in Ecstasy tablets. In terms of developing public health policy, he argues that it is necessary to provide users with information about what substances the different brands of Ecstasy actually contain. He suggests two particular means by which this may be realised: release of more forensic testing results – a move which would necessitate on-going updating. An alternative means, which is currently being used in the Netherlands involves exploring the option of provision of on-site drug testing facilities in clubs.[83]

New challenges: new responses

Dance Outreach and Peer Involvement

At a European level, it has been noted that the official drugs services have been slow to respond to the needs of the large, ephemeral population of young people who can be categorised under the umbrella term of recreational drug users. Whilst this group traditionally do not present for drug treatment and so in many ways are invisible to state agencies, they are subject to developing particular types of drug-related harm; some of which have been highlighted in the above text. In looking at ways in which public health bodies construct and implement health education messages, it becomes apparent that in recent years there is an increasing awareness of the need to accept the challenges emerging from drug-taking youth cultures and to work within their structures and self-understanding. Perhaps the major catalyst in heralding this realisation is the fact that many types of drugs interventions whose aims lie within the sphere of primary prevention simply do not seem to have been effective, as evidenced by the fact that increasing numbers of young people are

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[83] For further discussion of drug testing in the Netherlands, see Chapter Three of this report.

using drugs.[84] Speaking of the failure of the 'just say no' approaches in the Scottish context, the authors of the Buzz Scottish Schools Survey conclude that:

> 'Just say no' failed precisely because it started from a pre-ordained decision, thus pre-empting the very debate needed to legitimise any decision to say no.

The impact of peer pressure as a factor which influences young people to experiment with drugs has been highlighted as significant in leading to the initiation of drug use. Indeed, within the field of drugs education, resistance training emerged as a favoured strategy in the late 1980s and early 1990s. Bukoski argues that previous educational approaches had failed specifically because they placed 'too little emphasis on the direct acquisition and mastery of those social skills necessary to increase personal and social competency, particularly those skills needed by youth to resist peer pressures to begin using drugs'.[85] Resistance education strategies thus attempted to address these issues through an approach which built on a two-fold model of, first, identifying and labelling social influences and pressure situations, and second, developing behavioural skills to resist such influences. The peer pressure model of drug use has however come under criticism in recent years. The findings of Wibberly's study are supportive of what Coggins and Mc Kellar term as a 'peer support' model, whereby drug use takes place in a socio-cultural environment of acceptance, tolerance or encouragement of drug related behaviour rather than in one of

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[84] Buzz, Scottish Schools Survey, *op. cit.,* p.20.

[85] Bukoski, 'School-based substance abuse prevention: a review of program research' in Djorn and Murji, *Drug Prevention: a review of the English language literature* (1996) p.19.

coercion or pressure as indicated by the peer pressure model.[86] Cripps similarly makes the point that the peer pressure model of drug initiation may be flawed:

> We talk of young people facing "peer pressure" to take drugs whereas we should really be talking about "peer preference". Young people don't have to be pressurized to take drugs, they choose to take them. They see other people having fun and want a piece of the action.[87]

In terms of the delivery of drugs education and information messages, a favoured approach in some contexts has been the peer-led model. The rationale behind peer-led approaches is the contention that there is a significant gap between youth and adult cultures, and that the most effective means of delivering a health education message is to use young people as the messengers. There has been substantial debate around the issue of peer-led interventions, with question marks around the efficacy of peer-led strategies in preventing drug use.[88] Part of the contentiousness of peer-led approaches is the concern that because they use young people who have not received formal training in the principles and techniques of education, they run the risk of being ineffective. Cohen argues that it makes more sense to integrate drugs education into the normal school

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[86] Coggans and Mc Kellar, 'Drug use amongst peers: peer pressure or peer preference?' (1994) 2 *Drugs: education, prevention and policy* 16.

[87] Cripps, 'Workers With Attitude' (1997) *Druglink* May/June (Institute for the Study of Drug Dependence).

[88] The Scottish Health Board make the point that such strategies may prove 'more effective with those young people who would experiment, even dabble over a period of time, but who are not likely to become problem drug users'. 'Drug Education Approaches, Effectiveness and Implications for Delivery', *Health Education Board for Scotland Working Paper No. 1,* Section 3, p. 7.

curriculum, thereby using the proven educational skills of teachers, than to rely on the supposed credibility factor of untrained young people. Again, it is suggested that in order to be effective, peer approaches must be carefully tailored to suit the specific needs of the target group. Thus, Cripps argues that it would be useless to use a young person experienced in heroin use to talk to a group of recreational users of cannabis and Ecstasy: 'The "peer" educators need to have come from the same environment, the same locality, to understand the local scene and how it operates. 'Additionally, scene knowledge on its own is insufficient; the peer educator must be trained in methods and techniques of education as well as receiving drugs training.

Whilst it is debatable whether or not pressure exerted by peer groups directly influences young peoples' decisions to use drugs, it is apparent that identification with peer groups is a significant factor in the lives of many young people. As a result, new approaches to the formulation and delivery of drugs education strategies are taking on board the positive potentialities of peer identification as a factor which can be used in the construction and delivery of health education. The development of alternative approaches to the provision of services for people involved in the club/drug scenes has been influenced by the work of Jock Young[89] and Norman Zinberg.[90] Both authors highlight the significance of socio-contextual factors in terms of exerting positive or negative influences on the behaviour of participants in that context. Young suggests that in order to deliver effective health and safety messages to target groups of young people, the most useful strategy is to encourage the development of values and norms within the subculture which are conducive to lowering risks of drug related harm, rather than attempting to control through censure or authoritarian means. The idea of producing sub-culturally or youth-culturally credible interventions lends itself to exploring methods which are not perceived as being authoritative, and

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[89] Young, *The Drug- Takers* (London, 1972).

[90] *Op. cit.*

removed from the reality of clubbers.

In terms of responding to the needs of new types of recreational drug use, the group Crewe 2000 have been very influential within the Scottish context. In response to perceived new needs emerging within groups who use drugs recreationally but are not accessible through general drugs services, they developed an innovative response, based on a coalition of young people who are active in the club scene. The coalition is supported, but not led, by drugs workers. The initiative commenced in 1992, and since then its work has included the development of a Safer Dance Outreach service providing harm reduction information and support at over 150 dance events in Scotland.[91] It has worked with the Scottish Drugs Forum in the development of 'Good Practice for Dance Events' the group also liaises with club promoters, owners, and staff connected with music events about safer dancing guidelines.

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[91] Crewe 2000, *Young People's Drug Use at Dance Events* (1997). In 1996, Crewe 2000 undertook a survey amongst a sample of 720 people at dance events in Scotland. The purpose of the survey was to evaluate the effectiveness of the dance outreach service which it provides, also to discern drug related trends at dance events. The results of the evaluation were very positive with 68% of the sample reporting that they now practiced safer drug use, as a result of exposure to Crewe 2000 interventions. It was widely felt that dance outreach was necessary at big dance events, and 90% of the sample felt that dance outreach should be provided at all dance events. In terms of identifying needs for information about specific drugs, 80% of respondents felt that they needed more information about Ecstasy, with speed and other drugs forming the second largest request. Additionally 47% of the sample felt that Crewe 2000 was the best source of 'good information' about drugs. Suggestion for ways in which the service could be improved included calls for provision for on site Ecstasy testing at clubs, and extended provision of services at more venues, including colleges and schools as well as dance venues.

Additionally, there has been a trend in recent years to provide drugs information through the format of peer approved sources. The *Face* magazine, which has a wide readership amongst the club going population, has used its appeal in this context to deliver information about drug-related risk. The caption on a recent edition reads: "Drugs: You are one of 2.5 million people in Britain who have taken speed, acid or Ecstasy. Do you have any idea what it's done to your brain? The bad news is inside."[92] The idea of utilising peer approved sources to deliver drugs education messages has been developed by a number of prevention agencies.[93] A favoured format has been to produce comic style booklets which target specific aspects of drug use, and construct health education messages around the issues which have been raised. Agencies which favour such an approach tend to exhibit a high reliance on peer involvement, at all stages of the project to ensure that in terms of content, language, style, etc., the booklet is pitched at the right level the aim of providing 'culturally attuned' information is to initiate behaviour changes in drug using populations. It is argued that through specific targeting of groups within a culture which is not homogenous or static, it is possible to reach young people who might otherwise slip through the traditional nets of drug educational provision.

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[92] 'Bad Medicine', *op cit.* (June 1998).

[93] The Lifeline Project in Manchester and Fast Forward in Scotland have widely used the comic book approach to producing drugs education for young people. See Sherlock, *Claire and Jose: An evaluation of three leaflets aimed at young women drug users*, Report produced for Lifeline (Manchester, 1994); Linnel, *Smack in the Eye: An evaluation of a harm reduction comic for drug users* (Manchester, 1993); and *Spark it up,* Evaluation Report of Fast Forward's Drugs Information Project (1993).

CHAPTER THREE

IRISH ECSTASY POLICY – A COMPARATIVE ANALYSIS

Introduction

Drug policy in Ireland has undergone substantial development, refinement and modification since the period of its inception in the decade of the 1960s through to the 1990s. During this time, the range of structures which have been created to respond to drug-associated problems have been challenged by emergent trends within drug-using communities, by public perception of appropriate levels of response and by changing terms of reference within the international debate. This chapter examines how this evolving policy has responded to the emergence of Ecstasy as a popular recreational drug during the late 1980s and the 1990s. In addition to providing some historical contextual detail about the moral-political climate in which the current public debate about Ecstasy in Ireland is situated, the chapter also has a strong comparative dimension. The first part will discuss the general drug policy, and the specific Ecstasy policy, of the Irish state. The next two parts will perform the same function in relation to the Netherlands and Sweden. These two countries, as indicated in the General Introduction to this report, represent opposite ends of the spectrum of drug policies in the European Union. The final part of this chapter will set out some brief concluding observations.

Irish drug policy and Ecstasy

Following the increase of illicit drug-taking in Ireland during the 1960s, when sporadic instances of amphetamine, cannabis, and LSD use came to the attention of the authorities, it led, in

1968, to the establishment of a special Drug Squad in the Garda Siochana. A Working Party was established under the Department of Health in the same year and the first major policy document to deal with drug problems was the *Report of the Working Party on Drug Abuse,* published in 1971.

The view of policy makers at this time was relatively complacent. It was generally considered that Ireland did not have a substantial drugs problem. Problematic use, where it existed, was largely seen as extraneous to the Irish context. It has been suggested that the 1971 report is in many ways a product of the complacency among policy makers: apparent is an absence of discussion on the appropriateness of available policy models emanating from America and Britain, and lack of critical reflection on possible implications for Ireland, and also in lack of precision about the actual definition of drug abuse.[94]

At the same time, one of the underlying themes of the report was the assumption that problematic drug use is a medical problem, 'to be treated with sympathy and understanding', whilst drug trafficking is a moral/legal issue and 'should be punished to the full extent of the law'. This differentiation, between the health and the moral aspects of drug-taking as bases for drug prohibition, takes place within what van de Wijngaart calls the deterrence perspective on drug use.[95] Traditionally, the drug policy of the UK has tended to be more in tune with the medical or public health model whereas that of the US has historically emphasised moral-legal prohibitionism.[96] In reality, of course, both models co-exist in some form of fused fashion as the reasoning behind any particular country's 'war on drugs'. Thus, in July 1998, on the occasion of the launch of a five-year 'anti-drug' advertising campaign in the US, President Clinton stated:

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[94] See Butler, 'Drug Problems and Drug Policies in Ireland: A Quarter of a Century Reviewed' (1991) 39 *Administration* 210.

[95] See *Competing Perspectives on Drug Use: The Dutch Experience* (Amsterdam, 1991) pp.99-104.

[96] See Murphy, *Rethinking the War on Drugs in Ireland* (Cork, 1996) pp.7-17.

> When young people turn on the TV, read a newspaper or surf the Web, they will get the powerful message that using drugs is wrong, illegal and can kill.[97]

There has also always been a combination of health and moral concerns in the Irish context. The differentiation in the 1971 report is reflected in the proposed solutions to drugs problems, which were seen to lie in controlling the supply of illicit drugs and, when this failed, to encourage drug users to become abstinent.

The Working Party reported in 1971 and the Misuse of Drugs Act 1977 was the (somewhat delayed) legislative result. This legislation remains as the basic legal framework for Irish prohibitionist drug policy.[98] The political rhetoric surrounding the enactment of this legislation often reflected the 'visceral fears, beliefs and instincts' that Nadelmann has suggested lie at the heart of much drug policy debate. Although most of this rhetoric, in the Irish context, strongly coincided with the

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[97] 'Clinton plea to turn the young off drugs' *The Daily Telegraph* July 10, 1998.

[98] It creates the category of 'controlled drugs' – any substance, product or preparation that is specified in the Schedule to the Act (which may be ministerially altered) (s.2). Possession of controlled drugs, except under limited circumstances (i.e. In the case of a medical practitioner or pharmacist), is an offence (ss.3-4). It is provided that the Minister for Health, for the purpose of preventing the misuse of controlled drugs, may make regulations regarding the manufacture, production, preparation, importation, exportation, supply, offering to supply, distribution, or transportation of controlled drugs, and also concerning the prescription of controlled drugs (s.5). Special procedures to prevent irresponsible prescribing are set out in detail (ss.6-12). A system of scaled offences was introduced, with cannabis offences relating to personal use subjected to lighter penalties (s.27).

moral-legal attitude towards drug use,[99] the legislation also reflected the public health perspective: it was provided that, in most cases, courts should place convicted prisoners on remand while a medical report was prepared; in certain cases, the court was to arrange for the medical treatment and care of such persons.[100]

It was not until the development of a serious opiates problem in Dublin in the early 1980s that policy makers were forced to reconsider the wider implications of the drugs issue.[101] A major report commissioned by the Minister for Health in 1982-83 (the 'Bradshaw Report') found that, in the north inner city, heroin use was alarmingly high.[102] The most immediate

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[99] See Nadelmann, 'Progressive Legalizers, Progressive Prohibitionists and the Reduction of Drug-related Harm' in Heather, Wodak, Nadelmann and O'Hare (eds.), *op. cit.* For an account of the political discourse around drug issues during the 1970s, see Butler, *op. cit.*

[100] Section 28. On the other hand, Butler also notes of the 1970s period that, within the Department of Health, responsibility for drug problems was assigned to the Food and Drugs Section (now renamed the Community Health Division) rather than to the Mental Health Section: 'the effect of this, consciously or otherwise, was to ensure an emphasis on drug control systems rather than care systems'. *op. cit.,* at p.231.

[101] The National Drug Advisory and Treatment Centre at Jervis Street in Dublin treated 55 heroin users in 1979, in 1980 this rose to 213, and in 1981 to 417. See Dean, O'Hare, O'Connor, Kelly, and Kelly, 'The Opiate Epidemic in Dublin 1979-1983' (1985) 78 *Irish Medical* Journal 107.

[102] Dean, Bradshaw and Lavelle, *Drug Misuse in Ireland 1982-1983: Investigation in a North Central Dublin Area* (Dublin, 1983). In the North inner city community which was the focus of this study, 10% of 15-24 age group had used heroin in the last year. Not only did the intravenous use of heroin increase dramatically in the early 1980s, petty theft to support expensive

policy response was to this report and to the work of a Special Governmental Task Force on Drug Abuse that had been established in the Department of Health in April 1983 was effected through the medium of the Misuse of Drugs Act 1984, which focused on increased sanctions for supply of drugs. This legislation reflected a shift, at the political level, towards the 'moral-legal' view of drug use: apart from the introduction of higher fines and harsher sentences for drug offences were introduced, the mandatory requirement in the 1977 legislation that the court remand certain convicted prisoners while awaiting a medical report was replaced by an optional arrangement, depending on whether the court considered it appropriate or not.[103]

However, the Bradshaw Report also raised the issue that misuse of drugs such as heroin was understandable in the context of socio-economic factors, such as lack of employment and social exclusion. The implications of this finding – which concordant with the implication of the significance attached by Zinberg to the concept of drug 'setting'[104] – were not, however, taken on

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drug habits as well as organised commercial drug dealing both became common as a consequence. See O' Mahony, *Crime and Punishment in Ireland.* (Dublin, 1993) pp.66-68.

[103] 'The political debate on the Misuse of Drugs Act 1984 reflected a preoccupation with law and order and drug control, rather than care for the health and well-being of drug users'. Butler, *op. cit.*, at p.221.

[104] See Chapter One of this report. It should also be noted that, although the Task Force report was not published, it was later leaked. It contained a section devoted to 'Community and Youth Development'; this was 'the clearest and most explicit acknowledgement ever made by Irish policy makers that drug problems in Dublin were largely explicable in terms of the poverty and powerlessness of a small number of working-class neighbourhoods'. Butler, *op. cit.,* at p.220. On this basis, it suggested the identification of 'Community Priority Areas' which would receive extra resources and services co-ordinated by a

board by policy makers at this time.

One of the major shifts in policy from 1987 was an acknowledgement that under certain circumstances, harm reduction measures such as methadone maintenance and needle exchange were merited.[105] Evidence suggests that methadone substitution can have a positive impact on stabilising social behaviour, reducing criminality and as a public health measure.[106] Adopting harm reduction measures represented an end to the 'abstinence only' model of dealing with drugs problems, which had been the preferred option up until this stage. There were, however, fears in adopting this course of action, that it may be perceived that society, in some sense, condoned drug taking the rationale behind implementation of harm reduction seems to have been prompted more by fear of the possibility of the spread of AIDS by intravenous drug users, than by ideological conviction about the merits of this course of action. These harm reduction measures, in other words, did not indicate a shift to the perspective on drug use that van de Wijngaart and others refer to as the normalisation perspective, which incorporates contextual variables in two further models of drug use, the

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'Youth and Community Development Forum'. As Butler notes, however, the Department of Health press release on the report completely ignored these aspects: 'It cannot, however, be too strongly stressed that in this area, above all others, it is the individual decision which counts most. The decision not to experiment with hard drugs is one which any individual can make before he becomes hooked.' 'Drug Abuse and the Task Force' – press release issued by the Government Information Services on behalf of the Department of Health, September 22, 1983.

[105] The National Drug Centre at Jervis Street Hospital first began to offer methadone maintenance programmes in 1987. Butler, *op. cit.*

[106] See, for example, Farrell et al., 'Methadone Maintenance Treatment in opiate Dependence: a Review' (1994) 39 *British Medical Journal* 997.

psychosocial and sociocultural models.[107]

Nonetheless, the consensus which appeared to characterise thinking about drugs in the decades of the 1960s and 1970s certainly fragmented in the face of new challenges in the 1980s and the ultimate outcome has been greater acceptance of normalisation principles. Community groups at this time were very critical of the way in which heroin problems in inner city areas were being managed. A major source of tension was the fact that policy makers were perceived to be implementing a centralised and ineffective response to problems which could not be understood outside of the local context of socio-economic disadvantage and lack of opportunity. Dissatisfaction with government action strategies led to the establishment of community initiatives such as the Concerned Parents Against Drugs which mobilised as a form of community self-policing in response to the drug problem and the perceived failure of the police and statutory authorities to respond adequately to it.[108]

Community groups were not the only group of social actors to express discontent with the direction government drugs policies were taking at this time: in the area of drugs education, tensions emerged around the formulation and delivery of appropriate types of interventions. Following the recommendations of the Working Party on Drug Abuse in 1971, a further Committee on Drug Education was set up to explore in detail issues relating to the provision of drugs education in Ireland. It was decided that the best way to tackle this issue was to set up a permanent Health Education Bureau which would include drugs education within a broader remit. The favoured method of the HEB was to adopt a life skills approach to drugs education which 'was negotiated rather than authoritative and

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[107] See van de Wijngaart, *op. cit.,* pp.104-116. This fourfold classification of drug models is also employed by Haes, 'Drugs Education' in Coomber (ed.), Drug's *and Drug Use in Society – A Critical Reader* (Greenwich) p.183.

[108] Mc Cullagh, *Crime in Ireland: A Sociological Introduction* (Cork, 1996).

individualistic rather than collective or public'. In the decision to implement this type of approach instead of embracing a more emphatic abstentionist model, the HEB attracted criticism from people opposed to its perceived liberal agenda, on the basis that it was 'fundamentally antithetical to traditional Christian methods of social and moral education'.[109] The role of the HEB in drugs education ended in 1987 with the closure of the organisation. What is interesting from the present point of view is the emergence of clearly polarised positions around the issue of how education about drugs should be devised. The degree of concern over the appropriate response to the provision of drugs education highlights a more fundamental uneasiness which exists in Irish society around the ethics of drug use.[110]

The 1991 *Government Strategy to Prevent Drug Misuse* can, to a limited extent, be read as a response to growing pressures exerted by community groups, in terms of redefinition of ownership of drug problems. In this respect the Strategy recommends the establishment of community drug teams, representing acknowledgement, on the part of policy makers, of the need to adopt a less centralised mode of operation. However, because of its continued emphasis on punitive sanctions, aimed at the reduction of supply, and its lack of deliberation about the wider implications and possibilities of effective drugs policies, it has been argued that the Strategy does not represent

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[109] Butler, 'Alcohol and Drug Education in Ireland: Aims, Methods and Difficulties' (1994) 42 *Oideas* Samhradh 125 at p.134, citing Manly et al, *The Facilitators* (1986) and McCarroll, *Is the School Around, the Corner Just the Same?* (1987).

[110] 'Disco Biscuits bite back", *The Cork Examiner* (March 6, 1997). 'As far back as the 1920s, the Archbishop of Tuam spoke out against foreign dances and the "craze for unlawful pleasure". De Valera later introduced state control over dance events at the behest of the Church hierarchy and, in submissions for these laws, clerical witnesses spoke of girls being drugged and doped at dance halls. How little has changed.'

a new departure from previous models of drug interventions.[111] Murphy argues that this report had been substantially shaped by the 'war on drugs' philosophy, but that aspects of a normalisation perspective are also apparent in strategies which deal with demand reduction and harm minimisation.

Certainly, subsequent drugs legislation, enacted in 1994 and 1996, further emphasise the importance of supply reduction as a key priority of the government, and respond to a high level of public concern about the linkages between drug use and crime. The Criminal Justice Act 1994 makes provision for the recovery of the proceeds of drug trafficking and the Criminal Justice (Drug Trafficking) Act 1996 introduces seven day detention for suspected drug traffickers. The latter piece of legislation, which was enacted in the aftermath of the murder of Veronica Guerin, has come in for substantial criticism from civil libertarians and one writer has suggested that, 'taken as whole, the 1996 Act has real potential to produce injustice, and indeed miscarriages of justice, rather than effectively addressing the problem of drug trafficking by major "drug barons"'.[112]

As indicated above, the war on drugs approach draws from the American model of responses to drugs issues. Following from the Harrison Act of 1914, ownership of the drugs problem was given to the criminal justice system, consequently US approaches to dealing with drug issues were framed by a law and order ethos. In Ireland, references to the war on drugs approach in the policy making domain and in public culture have been fuelled by a sense that society is under siege from the threat of drug use, and that

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[111] See Butler, 'Drug Problems and Drug Policies', *op. cit.* and Murphy, *op. cit.*

[112] Ryan, 'The Criminal Justice (Drug Trafficking) Act 1996: Decline and Fall of the Right to Silence?' (1997) 7 *Irish Criminal Law Journal* 22 at p. 22. For an account of how the 1996 Act reflects the general shift away from the accusitorial model of criminal investigation and towards an inquisitorial model, see Keane, 'Detention Without Charge and the Criminal Justice (Drug Trafficking) Act 1996' (1997) 7 *Irish Criminal Law Journal* 1.

strong measures need to be taken to curb drug use. In representations of drugs which lend themselves to this type of framing, drug use acquires a generic gloss, which ignores distinctions between levels, types, motivations and consequences of drug use.

Public culture in Ireland has particular sensitivity to linkages between drug use and crime.[113] Whilst this relationship primarily relates to connections between heroin use and associated patterns of crime, it is reasonable to suggest that uncertainties about the role which Ecstasy plays in youth culture, i.e. does it act as a gateway into use of harder drugs such as heroin?,[114] ensure that Ecstasy is negatively implicated in the general distrust that society has about possible implications of drug use. The nature of the relationship between drug use and crime has been specifically addressed in the 1997 survey conducted by the Gardai. Phase one of the research established a database of known drug abusers, in the Dublin metropolitan area. Information which fed into this database included custody records, district collators' records, local drug unit records and Community Garda unit records. Phase two of the project drew from this database of 4,105 individuals a sample of 352 people who were requested to participate in interviews. The interviews explored connections between drug use and crime. Based on the information from interviews and analysis of the drug database, an estimation was made of the percentage of total crime

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[113] For an expression of this sensitivity, see Charleton, 'Drugs and Crime – Making the Connection: A Discussion Paper' (1995) 5 *Irish Criminal Law Journal* 2. For a response, see Murphy, 'Drugs, drug prohibition and crime' (1996) 6 *Irish Criminal Law Journal* 1.

[114] 'There must be a risk that the use of "gateway" drugs, such as cannabis and ecstasy – which is a nation-wide phenomenon, particularly in urban areas – could in time lead to a heroin problem outside of the existing areas.' *First Report* of *the Government Task Force on Measures to Reduce the Demand for Drugs* (Dublin, 1996) p.8.

in this area committed by drug users.

Interesting from the viewpoint of the present project is the fact that the database showed that the principal drug abused, by perpetrators of crime, was heroin (91%), followed by Ecstasy which was significantly lower (4%). Commenting about the low number of Ecstasy users on the database, it is suggested that the number represents.

> an obvious underestimation of the general population using Ecstasy – Ecstasy users in general do not become involved with the Gardai ... Ecstasy itself is relatively cheap to buy and in general, users can afford to fund it from their own financial resources, without having to resort to crime.[115]

The implication to be drawn from this is that information about the sizeable population of people who do use Ecstasy, is not accessible through statistics relating to crime.

In terms of attempting to resolve some of the tensions which have emerged around the drugs issue, recent attention has been focused on the area of demand reduction. This trend signals an increasing acceptance of normalisation principles in that demand reduction is now often comprehended in a manner that acknowledges the significance of contextual variables in the drug-taking dynamic.

In July 1996, a government task force was established to address issues relating to the reduction of demand. In addition to measures which target reduction of supply, a need was acknowledged

> to implement policies and measures to discourage drug-taking – drug education and appropriate urban-environmental and socio-economic policies – and also

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[115] Keogh, *Illicit Drug Use and Related Criminal Activity in the Dublin Metropolitan Area* (Garda Research Unit) (Dublin, 1997) p.6.

to cope with the consequences of drug abuse – treatment of addiction.[116]

The report specifically acknowledges the significance of the role of socio-economic criteria in contributing to the development of problematic use of drugs. Additionally it provides for the setting up of structures designed to reduce the demand for drugs in areas which have established drug problems. The Task Force Model consists of a Cabinet Drugs Committee, a National Drugs Strategy Team, and thirteen Local Task Forces located in areas with a high prevalence of drug problems in Dublin and Cork. The ability of this model to combine 'bottom up' with 'top down' strategies has been remarked upon.[117] It is widely felt that the model encompasses the potential to deliver targeted and coherent solutions in which government policies reflect actual local level needs, rather than rhetorically serving divergent and conflicting elements of public opinion.

The first report of the Task Force deals with the issues relating principally to heroin use. This is followed by a second report which deals with non-opiates and youth culture and also the issue of drug use in prisons.[118] The report acknowledges the link between certain types of drug use and youth culture, and the fact that unlike the heroin culture which is mainly confined to areas within Dublin, use of drugs like Ecstasy, cannabis, amphetamines is now a nation-wide phenomenon. In terms of responding to the growing popularity of drug use amongst young people, the Task Force stress the importance of developing adequate prevention strategies beforehand, 'rather than relying

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[116] *First Report* or *the Ministerial Task Force on Measures to Reduce the Demand for Drugs* (Dublin, 1996) p. 7.

[117] See Butler, 'Review Essay: The War On Drugs: Reports from the Irish Front' (1997) 28 *The Economic and Social Review* 157.

[118] *Second Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs* (Dublin, 1997).

on treatment and rehabilitation afterwards'.[119] It is proposed that prevention strategies will encompass a number of levels which target particular groups of people. Level one targets young people who have not as yet taken drugs, through the means of education which is designed to prevent, or at least delay, the initiation of drug use. Level two targets people who are already using drugs and warns them of the dangers of drug misuse. There is specific acknowledgement at this level that consideration should be given to developing campaigns in Ireland, which 'replicate the "harm reduction" approach being adopted in countries like Britain'.[120] The third level relates to building structures which serve the needs of marginalised young people to actively participate in activities other than drug use. Particular emphasis is placed on the role of sport as a means of encouraging social integration, and recommendations are made for promoting greater co-ordination and integration of sporting activities in the context of communities. Additionally the role of the youth services as a means of accessing and working with young people at risk of developing drug-related problems is highlighted. Current measures aimed at facilitating youth workers in dealing with drug issues are outlined.[121] Further recommendations for ways in which the Youth services can be supported include the development of a substance abuse prevention programme specifically for the non-formal education sector. Such a programme would have particular value for young people who slip through the net of formal education provision. A second key priority is the establishment of a Youth Services Development Fund which would support the development of premises and facilities for youth in disadvantaged areas.

There has been a substantial level of concern about the

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[119] *Ibid.,* p. 43.

[120] *Ibid.,* p.46.

[121] A 'Youth Work Support Pack for Dealing with the Drugs Issue' (The National Youth Health Programme) is available as a resource to facilitate youth organisations to develop drugs strategy.

increasing prevalence of certain types of drug use in Irish society, as evidenced from research.[122] The issue about the extent to which drug use is becoming normalised in Irish society continues to evoke concern in many quarters. Yet the normalisation hypothesis, though contested by many, is supported by some community drugs workers, and people working in the area of treatment:

> Cannabis is available in every town and village in Ireland. Legalising it would not open the floodgates – they are already open. The challenge now is to cope with cannabis and drug use – not to stop it.[133]

At the centre of the debate about the normalisation of drug use lies the challenge of developing an appropriate level of response the nature of the response is in turn contingent on the way in which the issue is conceptualised or framed. Available models of response derive from a number of sources. Reference has been made to the moral-legal model, typically expressed in terms such as 'war on drugs' and reliant on imposing sanctions for possession and supply of drugs, and the medical or public health model. Both of these models have been used in the Irish context. So too has the psychosocial model, which is based on the idea that drug use (or misuse) would not persist unless it served some meaningful function for the individual user.

In conjunction with supply reduction measures, attempts have been made to reduce demand for drugs. Delivery of action strategies developed from the public health and psychosocial models has been undertaken by the Departments of Health and Education who broadly focus on encouraging the conditions for the

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[123] 'Mr O'Donoghue said it was "particularly alarming" that drug users tended to be relatively well-off students and young workers rather than from disadvantaged backgrounds' *The Irish Times* (November 14, 1997).

[133] 'Grass roots rebellion' *The Sunday Tribune* (October 5, 1997).

health and well-being of potential users, using education as a means of preventing the development of drug-related problems, and through the provision of a range of counselling and treatment services for people who are experiencing such problems. The fourth model of drug use is the socio-cultural model, which stresses the significance of social variables as contributors to the development of drug related problems. This model underlies many community-based drug initiatives.[124]

The development of each model has been subject to internal and external pressures for change, corresponding to processes of evolution in theory and practice. Historically, the objective of medical- and health-oriented interventions has been to prevent initiation of drug use. Whilst the 'just say no' approach has traditionally held wide credibility in the public cultural domain, there are significant moves towards developing initiatives which attempt to engage with the high level of 'relativism and ambiguity'[125] apparent in this field.[126] These moves embrace, to an increasing extent, psychosocial and sociocultural considerations.

One of the key issues in assessing the effectiveness of any educational programme is to look at the outcomes of the intervention. In the Irish context, as elsewhere, the evidence suggests that growing numbers of young people are using drugs,

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[124] It could also be said that the psychosocial model represents the intellectual shift from perceiving drug-taking as drug-centred – as is normally the case with the beliefs underlying contemporary versions of the moral-legal and medical models – by incorporating the concept of 'set', and that the sociocultural model takes this process further with its prioritisation of 'setting'.

[125] Butler, 'Alcohol and Drug Education in Ireland', *op. cit.*

[126] The 'Just Say No' is still the preferred option of some groups working in the drugs field. In April 1998, the Athlone Anti-drug group commissioned a special badge which was handed out to local students who took a pledge to remain drug-free. *(The Irish Times,* April 9, 1998).

which implies that interventions focusing on a 'just say no' message have had limited success. In response to the need to develop new types of approaches to the development of prevention programmes, there has been a move towards combining different strategies, i.e. knowledge, attitudes, decision making, social competence, in an attempt to maximise the positive impact of the programme across a number of fronts. Evaluation of the 'On My Own Two Feet' programme which is currently being used in post-primary schools[127] shows that this type of eclectic approach has been successful in the school context.[128]

However, in order to develop an effective level of response, many factors need to be taken into account, and Morgan et al caution that 'attention needs to be given to our expectations of what schools can reasonably be expected to achieve' the complexity of developing effective strategies in relation to provision of drugs education is compounded by changing social and cultural norms, and by emerging forms of youth culture.[129] It is in this context of heterogeneity and flux that Morgan et al's note of caution about realistic expectations must be read. At an

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[127] The prevention programme 'On My Own Two Feet' has been developed by the Psychological Service of the Department of Education in conjunction the Health Promotion Unit and the Mater Dei Institute.

[128] Students who participated in this programme had less positive attitudes to substance use, in comparison with a control group. See Morgan, Morrow, Sheehan and Lillis, 'Prevention of Substance Misuse: Rationale and Effectiveness of the Programme "On My Own Two Feet"' 44 *Oideas.*

[129] The effectiveness of educational programmes aimed at preventing young people from misusing drugs is currently being assessed under the Science and Technology Against Drugs initiative. Additionally, the results of the evaluation process will be used to inform the development of a new programme which will be piloted in the course of this project. Contact Ms Elizabeth Kiely and Ms Elizabeth Egan at the Department of Applied Social Studies, UCC.

institutional level, there appears to a growing awareness of, and commitment to dealing with a differentiated problem in differentiated ways. In this respect, the idea of specifically targeting groups with drug-related needs is being addressed through increased provision of services through the Local Task Force model, and through reformulation of the model of preventative drugs education regarding a second level of commitment to an extended model of the prevention of drug-related harm.

Ultimately, it is the acceptance, rather than the denial of complexity, which distinguishes the normalisation approach from other models of drug use.[130] Consideration of the Task Force Report in the context of previous policy documents, shows that the terms of the drugs debate have changed substantially since the 1970s. In a number of ways, recent government initiatives to reduce the demand for drugs can be seen to be moving in the direction of the normalisation model. What is apparent from the two reports of the Task Force on Measures to Reduce the Demand for Drugs is acknowledgement that drug use occurs at different levels, for different reasons, and has different implications. Because of the inherent complexity of this issue, responses must be reflexive, rather than dogmatic. Through the structures put in place by the Task Force, there is evidence of political will

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[130] As van de Wijngaart puts it, insofar as the two deterrence models are rooted in theoretical arguments (rather than being based on simple moral disapproval of drug-users), 'it tends to use causal models in which physiological mechanisms are the preferred mode of explanation. In contrast, ... the normalizing view does not believe in the possibility of simple causal generalizations where human behaviour and experience is concerned: predictions tend to be probablistic rather than deterministic, emphasising the many mediating factors which intervene between "cause" and "effect", and which make it impossible to say that a given substance will have a given effect on somebody.' *Op. cit.,* p.116. This difference is also a feature in the analysis of Nadelmann, *op. cit.*

to engage with complexity: apparent in attempts to understand problematic drug use in the socio-economic context, in recognition of contextual differences and implications between opiate use and use of other types of drugs that are associated with youth culture, and through a willingness to extend the provision of a harm reduction model from the area of opiate treatment to respond to the new challenges associated with drug use and youth culture.

Placing this framework directly on the development of perceptions of Ecstasy, the same trend towards harm reduction measures is evident since this drug was prohibited by the Misuse of Drugs Regulations, 1988,[131] the same year that the first mainstream Irish dance club opened in Cork. As elsewhere, dance music and Ecstasy 'combined to create a culture that enveloped the country within years'[132] and, although dehydration, overheating and heart failure have caused many of the estimated 15 Ecstasy-related deaths in Ireland, an exclusive focus on prohibition is gradually coming to be seen as unrealistic. As O'Keefe has pointed out:

> Many researchers warn ... against over-emphasising the risk of death. British Home Office figures show that Ecstasy deaths account for 0.0002 per cent of all users. Alcohol deaths, meanwhile, account for 0.5 per cent of all users.[133]

Official political discourse in Ireland, somewhat surprisingly, classifies Ecstasy as a 'soft' drug. The *Second. Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs* is the clearest example of this perspective. This is not the case even in the Netherlands, which, as the next part of this chapter will illustrate, has a policy that is

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[131] S.I. 328 of 1988.

[132] O'Keefe, 'Drug Hysteria: Ten years of E', *Magill*, August 1998.

[133] *Ibid.*

traditionally far more liberal and harm reduction-oriented than the Irish policy. Ecstasy was classified as a Schedule 1, 'hard' drug in that country. The viewpoint that Ecstasy should be considered other than as a 'hard' drug arises out of the idea that heroin abuse in Greater Dublin, and cocaine use throughout the country, constitute the only 'hard' drug phenomena. This means all other drugs, including Ecstasy, LSD and amphetamine, are referred to as 'the so-called "soft" drugs'.[134]

At any rate, this classification has probably helped to create an atmosphere where harm reduction measures, and the consequent shift in direction towards a normalisation outlook, could more easily be introduced than otherwise. The first major such measure has been announced just as this report was being completed (July 1998). The Dun Laoighaire Drugs Task Force and the Eastern Health Board have prepared a campaign which aims to regulate clubs and provide factual information to users as well as advice on how to reduce, rather than stop, the damage to themselves. Reflecting a perception of Ecstasy use that could well gain ground in Ireland, Steven Harding of the EHB stated: 'We would prefer if people didn't use these drugs, but they do, so we need to ensure they are as safe as possible'.[135]

Dutch drug policy and Ecstasy

A comprehensive overview of Dutch drug policy is provided by the 1995 government document. *Drugs Policy in the Netherlands:*

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[134] For this distinction, see *Second Report* p. 37. For a discussion of how the 'soft'/'hard' distinction could be seen as misleading and ultimately unhelpful, see n.143 below.

[135] Quoted in O'Keefe, 'Ten years of E', *op. cit.* This development took place after all of the interviews discussed in Chapter Four had taken place. In other informal interviews, however, users unanimously expressed approval of the Dun Laoighaire/EHB initiative.

Continuity and Change.[136] Since the recommendations of the Working Party on Narcotics (the Baan Committee) in 1972, Dutch policy has differed from that of the majority of other countries in that it is not based on the prohibitionist ideology of a 'drug-free society':[137]

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[136] Ministry of Foreign Affairs, Ministry of Health, Welfare and Sport, Ministry of Justice, and Ministry of 'the Interior, *Drugs Policy in the Netherlands; Continuity and Change* (Rijswijk, 1995) [hereinafter *Continuity and Change*].

[137] Baan, *Achtergronden en Risico's van Druggebruik* (Den Haag, 1972) the Baan Committee's report was of course prepared against the complex background of a particular political and social culture. This culture has been described as one that 'cherishes tolerance and openness, and celebrates the freedom of the individual. In Holland, government is seen to have little or no role in determining issues of [personal] morality, but to have a major role in meeting the needs of its people.' Whynne-Jones, 'Where the Grass is Greener', *The Independent on Sunday,* December 14, 1997. As Erik Fromberg has written, the two other reports submitted at this time – the Shafer Committee report in the United States and the Le Dain Committee report in Canada – reached similar conclusions to the Baan Committee but 'disappeared into oblivion and were [...] negated by their governments' (' Prohibition as a Necessary Stage in the Acculturation of Foreign Drugs' in Heather, Wodak, Nadelmann and O'Hare (eds.), *Psychoactive Drugs and Harm Reduction: From Faith to Science* (London, 1993) p.133). Fromberg also notes, on the basis of personal communication with the Dutch Minister of Public Health at the time, that the Dutch Ministerial Council at first voted by majority, on the basis of the Baan report, for the complete legalisation of cannabis. However, 'because of heavy pressure from the Ministries of Foreign Affairs and Economic Affairs ... this was not realized. Their argument against complete legalisation was that the Netherlands already had an isolated position with regard to the Israeli-Arab conflict (it was at the time of the first oil crisis) and could not afford an

> [G]iven previous international experience of tackling markets in illegal products or services it seemed likely that government intervention would have only a limited effect. It is partly for this reason that the policy pursued in the Netherlands has always had the, more modest objective of bringing or keeping the use, of dangerous drugs, as a health and social problem, under control.[138]

Also underlying Dutch policy is the refusal of successive governments to base policy on the idea that drug use in itself represents 'an unacceptable risk to society'; the Dutch view is that whether or not such a risk exists depends partly on the individual who uses the drug and 'partly on the circumstances in which the drugs were used and the extent of their use.'[139] In effect, this represents the incorporation into Dutch drug policy of the concepts of 'set' and 'setting'. Translated into practical policy, the pragmatic Dutch outlook means:

> that the government's role is to prevent young people in particular from unthinkingly starting to use drugs without knowing enough about them or under the influence of other people, and to make medical and/or social assistance available to drug users with problems, in order to alleviate their plight, (harm reduction).[140]

In line with this thinking, the Dutch Opium Act of 1919 was amended in 1976 so that a distinction is now drawn between two types of drugs. 'Hard' drugs, including heroin, cocaine, LSD and Ecstasy, are drugs where the level of risk involved in use is

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isolated position in another area' *(ibid.).*

[138] *Continuity and. Change* p.5.

[139] *Ibid.*

[140] *Ibid.,* p.6.

deemed unacceptable. These drugs are listed in Schedule 1 of the 1976 Opium Act. Schedule 2 includes hemp products such as hashish and marijuana (i.e. cannabis); these are designated 'soft' drugs.[141] While the production, trading and possession of all scheduled drugs is punishable, detailed guidelines setting out priorities have been published by the Dutch Public Prosecutions Department. The highest priority is given to the investigation and prosecution of the import and export of hard drugs; the

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[141] As mentioned above, and in contradistinction to the terminology employed in the Irish *Second Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs,* Ecstasy was classified in the Netherlands as a Schedule 1, 'hard' drug. It is appropriate to note here the line of argument which suggests that any distinction between 'soft' and 'hard' drugs is essentially misleading. Indeed, it could be said that the employment of the distinction represents one of the fundamental inconsistencies in Dutch policy. The significant role of contextual factors in any drug use (which, as indicated in the text, is central to Dutch policy generally) mean that it is really types of drug use – not drugs in themselves – that should be categorised as either 'soft' or 'hard'. The so-called 'hard' drugs, like the so-called 'soft' drugs, can be either used or misused. The use (as opposed to misuse) of heroin would be more appropriately termed 'soft drug use', whereas the misuse of cannabis, being dangerous to health, would be more appropriately termed 'hard drug use'. It should also be noted that the existence of this inconsistency, and indeed of several others (see *infra),* in no way detracts from the relative successes of Dutch policy. In addition, Dutch policy-makers possess a keen awareness of inconsistencies 'in some aspects of the policy'. Their outlook on this is again a pragmatic one: 'It should be borne in mind that drugs policy is an exercise not in logic but in controlling a persistent and multi-faceted problem which is subject to the influence of social and cultural developments at home and abroad which may change rapidly.' *Continuity and Change* p.69.

investigation and prosecution of user quantities of hard and soft drugs has the lowest priority.[142] These guidelines co-exist with the expediency principle in Dutch law. This is the principle that the authorities 'are not obliged to prosecute an offender but are required to weigh the importance of a repressive response against considerations of the general interest and special individual circumstances which militate against such a response.'[143]

These general principles operate in different ways with regard to different drugs. In relation to cannabis, the philosophy of 'separating the markets' for hard and soft drugs is outlined in the 1995 report as follows:

> Dutch policy on the use of cannabis is based on the assumption that people are more likely to make the transition from soft to hard drugs as a result of social factors than because of physiological ones. If young adults wish to use soft drugs – and experience has shown that many do – the Netherlands believes that it is better that they should do so in a setting in which they are not exposed to the criminal subculture surrounding hard drugs. Tolerating relatively easy access to quantities of soft drugs for personal use is

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[142] The Dutch are quick to point out that their system of 'priorities' is by no means unique: 'In almost all countries which suffer from drug problems the police and judicial authorities are forced to set priorities in the detection and prosecution of offenders who have committed drug-related crimes. Large-scale, cross-border trafficking in hard drugs has the highest priority everywhere, the lowest being assigned to small-scale trafficking in and the possession of soft drugs. This system of priorities is shared, for example, by large parts of the United States of America, Germany, the United Kingdom and France. Only rarely are people still prosecuted in these countries for the possession of small quantities of soft drugs.' *Continuity and. Change* p. 7.

[143] *Ibid.,* p.18 (n.25).

> intended to keep the consumer markets for soft and hard drugs separate, thus creating a social barrier to the transition from soft to hard drugs.[144]

Initially, during the 1970s, this idea, combined with the expediency principle, fostered an official toleration of the sale of soft drugs in youth clubs by bona fide house dealers. The commercial sale of these drugs in 'coffee shops', to people who are 18 years or older, has now become the norm.

The evaluation of Dutch cannabis policy contained, in *Continuity and Change* contains three important observations on the separation of the markets for cannabis and other scheduled drugs. First, the decriminalisation of cannabis in the 1970s did not lead to an increase in cannabis use in the Netherlands. Second, the extent and nature of cannabis use, including among minors, does not differ from the pattern in other western countries (a pattern which includes increased cannabis use during the 1990s). The total number of people in the Netherlands who regularly or occasionally use cannabis is estimated by NIAD to be around 675,000. This is about 4.6% of the population of 12 years and older. Patterns of consumption are overwhelmingly recreational.[145] Third, only a very small proportion of the young people who use soft drugs make a transition to hard drugs. This last point is crucial. As stated in *Continuity and Change,* it belies the so-called 'stepping-stone' (or 'gateway') theory and suggests that it should be regarded:

> as one of the many myths in circulation about the use of drugs, though one which under certain circumstances could become a self-fulfilling prophecy: by treating the use of cannabis products and hard drugs such as

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[144] *Ibid.,* p.7.

[145] Dutch cannabis policy incorporates such projects as 'self-control training' for cannabis smokers. A project in relation to responsible cannabis use is detailed in Dupont and Niewijk, 'Cannabis Project' (1996) 3 *Jellinek Quarterly* 11.

> heroin and cocaine in the same way may in fact make it more likely that cannabis-smokers will come into contact with hard drugs. Moreover, equating the one with the other undermines the Credibility of the information provided about drugs to young people.[146]

At the same time, as we have already mentioned, Dutch drug policy is by no means consistent.[147] For a striking example, consider that prior to the policy revisions in *Continuity and Change,* the Public Prosecution Department guidelines allowed that the amount of cannabis for personal use that was tolerated was 30 grammes, and the same amount applied to the sale of cannabis by tolerated coffee shops. Since 1995, the amount tolerated for individual coffee shop sales is limited to 5 grammes. However, coffee shop proprietors are necessarily in possession of much greater quantities, and the cannabis that is sold in coffee shops was once the target of law enforcement authorities' efforts to combat drug trafficking. This is referred to by the Dutch as the 'back-door/front-door dilemma'. In the words of one coffee-shop owner:

> It presents a lot of problems for us ... Someone comes to the front door and asks for [cannabis], we can supply them. Someone comes to the back door and wants to sell us some ... and we are breaking the law buying from them, they are breaking the law supplying us ... Of course they don't [arrest us], but the point is they could.[148]

Continuity and Change encapsulates the hallmark Dutch pragmatism which allows for the co-existence of technical legal prohibition with socio-political 'tolerance' by remarking that this inconsistency does not present any major problems 'given the way

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[146] *Continuity and Change* p. 9.

[147] See n.131 above.

[148] Quoted in Whynne-Jones, *op. cit.*

the law is enforced in practice'; as long as coffee shop operators adhere to municipal and statutory conditions and have 'supplies of no more than a few hundred grammes', no investigations will be conducted.[149]

As regards heroin and other so-called 'hard' drugs, the users are regarded – in accordance with the priorities referred to above – as patients rather than criminals. [150] The judicial authorities in the Netherlands have always followed the principle 'that drug addicts should undergo medical treatment rather than serve a custodial sentence'.[151] Harm reduction with regard to heroin tries to ensure the integration of users into society. Government harm-reduction expenditure (which, at NLG 160 million, is proportionately higher than other European countries) is directed towards providing a high standard of medical care, various kinds of day and night reception centres, needle exchange systems and methadone maintenance. However, in order to raise the threshold for the use of hard drugs as much as possible, even greater expenditure (NLG 270 million) is spent on tackling drug trafficking.[153]

The available evidence illustrates clearly the successful nature of Dutch heroin policy. *Continuity* and *Change* notes that all estimates suggest that the number of hard drug addicts in the

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[149] Continuity and Change p. 49.

[150] For a discussion of how this classification (despite the terminology) reflects the Dutch transcendence of the traditional tension between the 'medical' and 'moral-legal' models of drug policy, see Murphy, 'Drugs, Drug Prohibition and Crime: A Response to Peter Charleton' (1996) 6 *Irish Criminal Law Journal* 1 at pp.9-10.

[151] *Continuity and Change* p.6.

[152] The Public Prosecutions Department deals with an average of 10,000 cases involving infringements of the Opium Act annually. Over a further NLG 370 million is spent tackling the crime committed by drug addicts, usually property offences. *Ibid.,* p.7.

Netherlands is relatively low. It refers to 0.16 percent of the population as a reliable estimate, which compares favourably with a European average of 2.7 percent. This is also acknowledged by independent observers. David Downes, for example, reports the stabilisation of illicit drug consumption generally at levels which are below that of most European countries.[153] In addition, the number of heroin users under the age of 21 is relatively low, even among vulnerable groups, and has continued to fall in recent years. Nor has the use of cheaper forms of cocaine made any real inroads as was feared a few years ago on account of developments in the United States and elsewhere. Other positive indications regarding Dutch policy are the relatively small number of fatalities resulting from drug overdoses in the Netherlands, and also the relatively small number of people suffering from AIDS among its drug addicts.[154] One assessment of the effects of harm reduction programmes notes that the fear that these would discourage clients from making use of drug-free treatment services has not been confirmed:

> On the contrary, in the eighties the number of clients who made use of drug-free facilities had doubled, indicating that harm reduction programmes were not an obstruction to entering drug-free treatment and may even serve as a starting point for further treatment.[155]

Further, in terms of the costs and effectiveness of Dutch drug policy, Richard Stevenson notes that the Dutch government

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[153] Downes, Contrasts in Tolerance; *Post-War Penal Policy in The Netherlands and England and Wales* (Oxford, 1988) p. 127.

[154] See Engelsman, 'Drug Policy in the Netherlands from a Public Health Perspective' in Krauss and Lazear (eds.), *Searching for Alternatives; Drug-Control Policy in the United States* (Stanford, 1991) p.173.

[155] Buning and van Brussel, 'The Effects of Harm Reduction in Amsterdam' (1995) 1 *European Addiction Research* 92 at p.98.

'spends relatively far less than the UK government on law enforcement and more on services to drug users'.[156] He adds: The decriminalisation of possession removes large numbers of offenders from the courts, and sparing use of prison sentences involves particularly high-cost savings. Drug-related crime is minimal and in general terms, the social and economic cost of drug abuse seems much lower in Holland than it is in the UK'.[157]

As regards the future direction of drug policy in the Netherlands, one commentator observed in 1989 that successive Dutch governments have continuously felt pressure from two directions:

> on the one hand, there are domestic authorities that insist on the introduction of the same liberal laissez-faire policy with regard to hard drugs as the current soft drugs policy (which means leaving the. prohibitionist position in the fight against drugs); on the other hand, there are international treaties, international organizations for combating drugs and foreign governments, urging the Netherlands to adapt its different drug policy to international standards.[158]

In relation to the considerable domestic pressure to 'leave the prohibitionist position in the fight against drugs', drug legalisation, particularly cannabis legalisation, is discussed in great detail in *Continuity and Change*.[159] The document rejects the suggestion that the Netherlands should partially or

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[156] Stevenson, *Winning the War on Drugs: To Legalise or Not?* (London, 1994) p.47.

[157] *Ibid,*

[158] van Kalmthout, 'Characteristics of Drug Policy in the Netherlands' in Albrecht and van Kalmthout (eds.). *Drug Policy in Western Europe* (Max Planck institute, 1989) pp.262-263.

[159] See pp.15-18, 62-63 and 81-87.

totally legalise the sale of either 'soft' or 'hard' drugs on a number of grounds. While the coffee shop system is regarded as having justified itself as regards soft drugs, the document notes that current Dutch obligations under international law preclude cannabis legalisation. As regards hard drugs, the Dutch government, according to *Continuity and Change,* is not prepared to risk an increase in the number of hard drug users. It is also noted that domestic objections to various forms of drug nuisance have increased during this decade. However, it would seem that the major argument against legalisation is a sensitivity to the second pressure referred to in the quote above – the pressure from the international community and in particular neighbouring countries of the Netherlands. At the same time, in terms of the pressure to move substantially into line with prohibitionist ideology, *Continuity and Change* states clearly that there is no reason why Dutch policy should be radically amended and emphasises that the policy will therefore continue to be aimed at prevention of drug misuse and the provision of information about drug use. Ultimately, the discussion of legalisation leaves no doors closed:

> Both because of international obligations and the high level of mobility of people within the European Union, which continues to increase, the degree of availability of drugs in the Member states can only continue to differ within certain limited margins. The debate on the legalisation of drugs has thus become an intrinsically European one and one which must be pursued within the European framework. The Netherlands can of course play an active role in that debate ...[160]

The policy modifications subsequent to *Continuity and Change* are essentially the result of three 'complications' identified

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[160] *Continuity and Change* p. 17

in that document:[161] first, the nuisance caused, by a small number of hard drug addicts (for example, certain types of anti-social behaviour such as discarding used needles in public places) and, in relation to cannabis policy, by certain coffee shops which are frequented by 'drug tourists' from abroad and by establishments which, in contravention to local, authority licensing regulations, sell both alcohol and cannabis; second, the rise of criminal organisations involved in the supply and sale of drugs; and third, the effect Dutch policy has in other countries. In response to these 'complications', the document sets out proposals which include the following: a more flexible and more integrated range of prevention and care options (for example, attempts are being made to tie up methadone substitution programmes to a greater extent with projects relating to training, employment and housing); increased efforts to combat drug trafficking; a more integrated approach to tackling nuisance and drug-related property offences; the construction of a better administrative basis for coffee shops (incorporating: a strengthened ban on alcohol sales in places where cannabis is also sold; the reduction in the number of coffee shops generally, including the closure of all coffee shops near schools; and the reduction, referred to above, of the amount of cannabis that will be tolerated for sale by coffee shops from 30 grammes to 5 grammes); increased penalties for large-scale professional operations involved in the cultivation of cannabis in the Netherlands; the provision of heroin on medical grounds, on a pilot basis;[162] and the funding of increased research in the fields of drug use and drug policy. Implementation of these proposals has been underway since *Continuity and Change* was published. In addition to studies like the one which is discussed below (*Ecstasy in the Entertainment Circuit),* research into the

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[161] *Ibid.,* pp.11-14.

[162] A more extensive project of this kind is currently underway in Switzerland. See Shenk, 'Hooked on Dogma: US Drug Warriors Ignore Switzerland's Success With Heroin Addicts', *The Washington Post,* December 21, 1997.

effectiveness and efficiency of prevention work is also being promoted by the Dutch government. Bearing in mind that problematic drug use is closely linked to social deprivation, and in order to be able to reach new risk groups at an early stage, *Continuity and Change* notes that 'prevention work will have to focus its attention on a broader front and bear such social deprivation in mind more'.[163]

Turning then to the drug that is the particular focus of this report, it can first be said that following the increased recreational use of Ecstasy in the Netherlands since the beginning of the present decade,[164] there emerged a pattern that was typical of most other European countries: sensational media reporting of various incidents and accidents at these parties, a small number involving fatalities, led to subsequent public and professional 'confusion and concern'.[165] By comparison with its

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[163] *Continuity and Change,* p.29. In a paper ('Drug prevention in the Netherlands: an integrated approach') presented at a Dublin conference ('Substance misuse prevention education: International conference for exchange of information on best practice') in November 1996, this was expressed by Ernst Buning as follows: '[M]any things happen on a macro level, such as creating jobs, doing things to have intact families, working with the schools. These things may not be so visible, but they are extremely important in creating a setting in which young people feel strong, have self-esteem, have autonomy and prefer to participate in our society rather than becoming problematic drug users'.

[164] There are no epidemiological data on the scale of XTC use in the population of the Netherlands as a whole. Estimates by drug experts range from 20,000 to half a million people who have used XTC at some time, out of a total population of 15 million.' van Laar, van Ooyen-Houben and Spruit, *NIAD Report -Hard Drugs Policy: Ecstasy* (Utrecht, 1996) p. 1.

[165] van de Wijngaart, Braam, de Bruin, Fris, Maalste and Verbraeck, *Ecstasy in the Entertainment Circuit: Socio-epidemiological study* of *the nature and. extent* of, and the *risks*

neighbouring countries, the Netherlands had been late in prohibiting MDMA and MDMA-analogs when it placed them on the list of prohibited substances (Schedule 1) under the Dutch Opium Act in November 1988. The authors of *Ecstasy in the Entertainment Circuit* (a 249-page report commissioned by the Dutch Ministry of Health, Welfare and Sport) explain this with reference to the Dutch sensitivity to international pressure that was referred to above. They indicate that the primary consideration was 'not so much to limit the health risks for users, but rather to respond to comments from abroad suggesting that the Netherlands was becoming a center for the production and transport of the drug'. [166] After an initial harm reduction memorandum issued by the Ministry of Health, Welfare and Sport,[167] the same Ministry, in an April 1995 memorandum *(City Hall* and *'House'),* set out a detailed guide for municipal policy on house parties including three fundamental policy principles.[168]

Reflecting Dutch drug policy generally, the first principle estates that Ecstasy policy should 'be directed at the prevention of use on the one hand, and at the prevention of use-associated problems on the other'. While the provision of information is an appropriate instrument in this regard, it is also believed that 'damage control requires additional attention to be given to the

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involved *in, using XTC and other recreational drugs at house parties* (Utrecht, 1997) [hereinafter *Ecstasy in the Entertainment Circuit],* p.5.

[166] *Ibid,*

[167] Lower House 1993-94, no.23760. In this memorandum the Minister expressed her concern about the increasing use of Ecstasy. In addition to certain administrative measures, monitoring was introduced, and a public information programme and research into Ecstasy-related harm were both initiated.

[168] Ministry of Health, Welfare and Sports, City *Hall and 'House': Guidance for use by local authorities concerning large-scale manifestations and party drug use* (Rijswijk, 1995) [hereinafter *City Hall and 'House']* pp.6-7.

conditions in which the use of XTC may occur.' The second principle follows from this:

> In regulating large-scale dancing festivities, consideration should be given to the risks involved for the participants, to the risks associated with the use of intoxicants during such festivities, to the protection of public health and to the nuisance caused to those living in the neighbourhood.

Finally, the prohibition of large-scale dancing festivities is considered to be undesirable, unless unacceptable risks are involved. It is felt that this would '[negate] an important part of youth culture', and possibly lead 'to the emergence of an illegal circuit upon which the public authorities no longer have a grip because of its invisibility.' Crucially, reference is made to the fact that 'the municipalities do have possibilities to contain the most damaging consequences of the event and its impact upon public order and safety'.

In practical terms, the memorandum sets out procedural requirements applicable to the processing of authorisation applications by municipal authorities. The memorandum stipulates that responsibility for the safety of the event rests with the organisers. For example, they must ensure that proper security, First Aid facilities and free drinking water are provided, and that 'chill-out' rooms ('where no loud music is produced, so that participants may recuperate') are available.

In terms of protecting the health of participants, and recognising that searches of clothing at the point of entry may not be effective for detecting small quantities of drugs, it states:

> If considered necessary by the municipal health service, in consultation with the local institute for treatment of addictions, the organizer is obliged to provide a facility for expert testing of XTC and other

drugs.[169]

Before continuing, it is appropriate to address one obvious question: If, in 1988, the Dutch government placed the most widely-used 'house' drugs on the legislative list of prohibited substances, how could a Ministry of the state subsequently consider prohibition to be undesirable and actually make suggestions based on a tolerance of Ecstasy use? The answer to the question lies again in the inconsistent nature of Dutch policy and in the acceptance, on public health grounds, of that inconsistent nature. It is yet another example of legal prohibition co-existing with socio-political 'tolerance'.

Given that most of the research into Ecstasy use indicates the desire for on-site testing on the part of users,[170] this aspect of the 1995 memorandum deserves special attention. In the Netherlands, a 'Safe House' campaign has been operating during recent years. This campaign is a project of the Drugs Advisory Bureau in Amsterdam, supported by NIAD. Based in a small office in Amsterdam, the campaign has two main purposes: the prevention of AIDS in relation to sexual activity and the provision of both off-site and on-site testing of Ecstasy tablets in order to encourage safe drug use. The bulk of the campaign's work takes place at house parties and is accompanied by a large illuminated logo: 'Safe House'.[171] Folders with information about drug use

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[169] *Ibid.,* p. 16. This is referred to at the conclusion of the memorandum, as a matter 'which may be communicated but cannot be required as part of an authorization',

[170] See Chapter Two of this report.

[171] An information leaflet issued by the Drugs Advisory Bureau explains that, on the basis of experience from the world of advertising, the logo deliberately avoids 'the heavy tone of the words "safe use" and "safe sex".' It is claimed that the presence of the campaign is increasingly being 'seen as a mark of quality, like the Michelin rating for top class restaurants'. The leaflet also states that '[t]he XTC trend is closely related to the 60s revival of "love" and "peace" the name XTC (ecstasy)

and safe sex are distributed; at parties where condom machines are present, they are inspected regularly; and where no condom machines are present, condoms are supplied. In addition, the various forms of testing carried out by the campaign place it in a unique position to monitor developments in the nature and extent of drug use as part of the DIMS (drug monitoring) project.[172]

As part of the further research advocated by *Continuity and Change,* a highly significant study of Ecstasy use in the Netherlands – *Ecstasy in the Entertainment Circuit* – was published. It was prepared by researchers at the Utrecht University Center for Addiction Research (CVO) and constitutes the socio-epidemiological, part of a larger study which was designed to investigate the acceptability of the health risks involved in the use of MDMA and MDMA-analogs by party-goers, in particular at the type of large-scale house parties that take place in the Netherlands. In relation to the incidents and

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… has erotic connotations. This explains the link between safe use and safe sex information.'

[172] most advanced drug monitoring system in the European Union exists in the Netherlands. Since 1992, the Drugs Information and Monitoring System (DIMS) project of the Netherlands Institute for Alcohol and Drugs (NIAD) has been collecting data about drugs, including the results of scientific testing, with the aim of protecting public health by means of preventive and educational activities. During the first half of 1995, a sample of 1690 Ecstasy pills were tested at house parties: 53.51% consisted of MDMA, 26.8% of MDEA (a substance that :has a faster but shorter-lived (2-3 hours) effect than MDMA, with the stimulant effects being dominant), 1.2% of MDA (a substance that has a longer-lasting (8-12 hours) and stronger effect than MDMA, with similar effects), 12.5% of amphetamines, 4% of 'fake' substances, 0.1% of DOB (a strong, long-lasting (18-30 hours) hallucinogen) and 1.9% of other substances. van Laar, van Ooyen-Houben and Spruit, op. cit., p.3. Compared to other countries, these figures show a relatively high quality of Ecstasy.

accidents relating to Ecstasy which were referred to above, the authors of the Utrecht report note that their causes were not clear. In particular, the question is whether problems with Ecstasy use lie in the exogenous circumstances at large-scale events, the party-goers attending them, or in the substances they use. Hence, '[t]he analysis of the causes (etiological factors) of incidents at large-scale house parties [was] the most important objective [of the Utrecht study] ',[173] Not only did this objective lead to the following problem definition -

> What is the nature and extent of the use of MDMA and MDMA-analogs by party-goers at large-scale house parties, and what is the influence of exogenous factors on the effects of these substances?[174]

this was further broken down, during the period that data was being gathered, into four specific sub-questions. These questions can be paraphrased as follows: (1) whether the availability of testing of recreational drugs at the events encouraged their use; (2) how many party-goers drive a car after using MDMA or MDMA-analogs at the events and how many allow themselves to be driven by people who have used these drugs?; (3) what is the incidence of sexual activity between people who meet on the night of the events and how many take precautions against sexually transmissible diseases?; and (4) what is the nature and extent of the use of MDMA or MDMA-analogs by patrons of regular clubs and discotheques?[175] The last of these questions, therefore, extends the ambit of the Utrecht report beyond large-scale house parties.

In terms of methodology, much of the data was collected by means of traditional research methods: literature reviews, in-depth interviews with experienced former users of XTC (47), observations at house-parties (28) and regular clubs (24), and

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173 *Ecstasy in the Entertainment Circuit* p. 6.

174 *Ibid.*

175 *Ibid.*

interviews (10) with 'informants' such as First Aid workers, security staff and drugs experts; in relation to regular clubs, completed written questionnaires were collected from 197 patrons after house-evenings in sixteen different venues where observations had also been conducted.[176] However, the research methodology applied to party-going at large-scale house parties was particularly notable for its extensiveness. Between March and October of 1996, oral questionnaire surveys were conducted at the beginning and at the end of ten parties (seven of which were also attended by the Safe House Campaign). At each of the parties surveyed, the research team consisted of an average of thirty field workers and at least four study leaders. 1121 party-goers completed the questionnaire at the beginning of the party and 768 completed the follow-up questionnaire at the end of the party. In addition, urine sampling of 509 party-goers was conducted at the beginning and the end of three of the large-scale parties where questionnaire surveys had also been conducted.[177]

The CVO report first discusses the drug setting with which it is primarily concerned. The authors note that, apart from standard staff at large-scale house-parties (held in the Netherlands at such venues as exhibition and sports halls, skating stadiums, sheds, hangars, etc.), three other essential services are active in the 'circuit': security, First Aid and the Safe House campaign. In accordance with *City Hall and 'House',* all of the parties surveyed had a chill-out area, but some of these had insufficient sitting space. The majority of the party-goers were male (70%), a statistic that reflects the average gender ratio in the 'make-up' of dance culture. The average age was twenty, and people with the lowest and highest levels of education were the least represented. The period over which the

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[176] *Ibid.,* pp.8-21.

[177] The orientation of the Utrecht study is in line with a shift that has recently taken place within drug policy research generally, whereas there was a tendency within that research tradition to exclude the voices of users, direct engagement with users is now much more common. See Chapter Two of this report.

respondents went to house parties is usually about two years. Just over half the sample are described as 'regular house party-goers' (going to a party at least once a month), one quarter are 'recreational house party-goers' (seven to twelve house parties per year) and the last quarter went to parties 'sporadically' (at most six per year).

The main drugs that were consumed were tobacco, cannabis, Ecstasy (or, as the text of the report refers to this substance, 'XTC') and amphetamine. The median number of Ecstasy pills consumed per party was two. The main motive for the first use of Ecstasy was not peer-pressure, as the popular folk myth would have it, but rather curiosity. 6% of respondents were classed as 'excessive' users (more than once a week) and it was found that patterns of regular and excessive use were more common where there was a relatively low level of education. The greatest percentage of amphetamine users were also from this group, comprising mainly of part-time workers and the unemployed. The report confirms that Ecstasy is generally a substance that tends to be used intensively for a short period of time but then the use becomes more recreational in character. Amphetamines and Ecstasy were not among the top three drugs that respondents find it difficult to do without. Tobacco comes first, cannabis second, and alcohol is third. The in-depth interviews revealed that many people are able to integrate their XTC use and their everyday lives effectively. They are happy to accept the fact that they have less energy during the days after and feel some level of listlessness, and generally make allowance for this. This is not to say that ill-effects are not felt by the users:

> Respondents sometimes have temporary problems the day or days after a party. More than half the respondents occasionally suffer from insomnia, symptoms of exhaustion, loss of appetite, muscle aches, listlessness, or a bad mood after a house party. In the longer term, at least one quarter of party-respondents sometimes suffer depression, hearing impairments, loss of appetite, concentration problems

> or weight-loss. Almost half the party-goers occasionally suffer from forgetfulness. Fourteen percent of women say they (sometimes) have irregular periods.[178]

However, the report found that it is not the use of XTC at large-scale house parties that is a serious risk factor, but rather the combined use of XTC and amphetamines. As for the causes of the problems as perceived by the respondents:

> Of the respondents with problems, 44 percent blamed themselves (set factors), more than one-third said it was due to substance use, and seven percent cited exogenous factors. The rest attributed their problems to other factors or did not know the cause.[179]

With reference to the first (and arguably the most important) of the four specific sub-questions, the availability of Ecstasy testing at house parties was found not to encourage use:

> Both on the basis of the opinion of the respondents and the XTC prevalence figures on the night itself, the presence of the Safe House Campaign does not generally seem to have an encouraging effect on the XTC use of the party-goers.[180]

With reference to the other sub-questions: only a very small minority (6%) of party-goers drove a car after using MDMA or MDMA-analogs; slightly less than one quarter of the respondents had at some time after a party slept with someone he or she had met the same evening and more than three quarters of these practised safe sex; and patrons of regular clubs and discotheques

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[178] *Ecstasy in the Entertainment Circuit* p. 175.

[179] *Ibid.,* p.176.

[180] *Ibid.*

more often combine their Ecstasy use with alcohol or cannabis, but less often with amphetamines, than party-goers. (In comparative terms, a smaller number of the club patrons (31%) than of the party-goers (41%) believe they are running risks but, by comparison, the former attribute these more often to setting factors (6% as opposed to 3%)). The CVO report concludes as follows:

> [T]he conditions at house parties have little or no negative effect on the well-being of party-goers, and ... relatively few party-goers suffer from health problems or are at risk in the short term due to XTC use at large-scale house parties. One proviso in this respect is that the memorandum *City Hall and 'House'* remains fully effective in the future.[181]

Swedish drug policy and Ecstasy

At the opposite end of the spectrum to the case of the Netherlands, Swedish drug policy is based on the overarching principle that a 'drug-free' society, while it may not be 100% attainable in reality, should be the aim of all policy measures. This aim was legislatively articulated in 1977, the year that Swedish drug policy embarked upon its present 'restrictive' manner of dealing with illegal drugs. The Swedish equivalent of *Continuity* and *Change* is *Drug Policy: The Swedish Experience,* a document prepared by the Swedish National Institute of Public Health (NIPH) for the Ministry of Health and Social Affairs and published in the same year as the Dutch document (1995).[182] The meaning of 'drug-free society' is set out in that document as follows:

> A drug-free society is a high objective expressing

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[181] *Ibid.,* p.181.

[183] (Stockholm, 1995) (trans. Ordvaxlingen, Roger and Kerstin Tanner) [hereinafter *The Swedish Experience*].

> society's attitude to narcotic drugs: we do not accept the integration of narcotic drugs in society, and our aim is a society in which drug abuse remains a marginal phenomenon.
>
> A drug-free society is a vision expressing optimism and a positive view of humanity: the onslaught of drugs can be restrained, and drug abusers can be rehabilitated.
>
> Drug policy is part of social policy, the aim of which is to give everybody in Sweden a basic measure of security through a system of general benefits. The restrictive focus of Swedish drug policy is part of this general approach, of the idea that everybody is entitled to a decent life and that no groups are excluded from participation in society.[183]

While 'drug-free' here refers to the various drugs that are prohibited by the criminal law in most countries – notably cannabis, heroin, amphetamine, cocaine and Ecstasy (hereinafter 'illegal drugs') – there is also a tradition in Sweden of arguments for an alcohol-free society. This section will therefore first examine the historical background to Swedish alcohol policy before turning to the more recent development of policy concerning illegal drugs.

As in most traditional spirit-producing countries, the pattern of drinking in Sweden is not the same as in the wine-producing countries of central and southern Europe. Swedish alcohol policy has evolved 'against the background of intermittently heavy alcohol consumption and the Nordic tradition of drunkenness [drinking in order to become intoxicated]'.[184] As a consequence of the particular forms of social harm brought

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[183] *Ibid.,* p.11.

[184] National Institute of Public Health, *Swedish Alcohol Policy: Background and present situation* (Stockholm, 1995) p.5 (trans. Ordvaxlingen, Roger and Kerstin Tanner) [hereinafter *Swedish Alcohol Policy]*.

about by this pattern of drinking, the first temperance organisations were formed in the 1830s and this movement was strengthened after the emergence of the labour movement later in that century.[185] In addition to obtaining localised alcohol prohibitions in some areas, the influence of the movement led to the formation in 1917 of a State-owned company with a monopoly of imports, exports, wholesaling and production of alcoholic beverages.

In 1922, the temperance movement in Sweden forced a national referendum on alcohol prohibition which was only very narrowly defeated (49% for complete prohibition, 51% against). Instead of prohibition, a ration book system for the supply of alcohol was introduced and continued until 1955. (The promotion of such a scheme was a decisive reason. for the defeat of prohibition). Between 1945 and 1955, criticism of 'ration book suggestibility' – the view that the system increased rather than decreased consumption – brought about a reform of alcohol policy. The rationing system was abandoned and replaced with a policy based on the idea of 'liberty with responsibility' and characterised by positive measures, such as increased information and active prevention. The Swedish *Riksdag* (Parliament) substantially raised the price of spirit drinks and heralded the beginning of the use of the pricing mechanism as a principal instrument for controlling alcohol consumption. The relaxation of formal social controls (i.e. the ration book system) and the provision of alternatives to strong liquor led during the 1960s to the growth of a beer culture (based on relatively strong beer – at least 5.6% alcohol by volume) and also an increase in wine consumption.

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[185] In the Preface to the Swedish alcohol policy document *(ibid.),* Anna Hedborg, the Deputy Minister of Health and Social Affairs in 1995, stated: 'The harmful social effects of alcohol were a pivotal concern of the labour movement at the turn of the century. Wife-beating, cruelty to children and economic misery followed in the wake of alcohol. Vigorous action against drunkeness was demanded, not least, by women in the labour movement' (pp.3-4).

However, 'there was no corresponding decline in sales of spirits. New drinking habits were superimposed on the old ones'.[186]

A further reform of Swedish alcohol policy took place in 1977 as a consequence of the proposals of an Alcohol Policy Commission, which had been formed to address the continuing high consumption levels. Alcohol policy since 1977 has been based on the 'total consumption model', which became increasingly influential since its advocacy in a 1975 WHO report.[187] According to this model, there is a correlation between a country's total consumption of alcohol and the harm which alcohol causes. Thus, as the 1995 Swedish alcohol policy document states, 'the more difficult alcohol is to come by, the lower the consumption of it will be, in total figures, and the smaller the number of people suffering harm because of it'. [188] However (referring once again to the 'Nordic tradition of drunkenness'),

> The damage panorama ... varies according to the pattern of drinking in the population. In a 'wine culture', where people drink wine with their food every day, medical injuries, such as liver diseases, are common. In a culture dominated by drinking to intoxication (drinking in large quantities but on fewer occasions), there is a clear linkage with acts of violence and harmful social effects.[189]

In practical terms, the 1977 reforms meant that strong beer was removed from open retail sale, the advertising of alcoholic beverages was prohibited and heavier penalties for breaches of liqour retail laws were introduced. Alcohol policy continued to include an extremely heavy tax on alcoholic beverages and also

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[186] *Ibid.,* p. 8.

[187] Bruun *et al, Alcohol control policies in a public health perspective* (Helsinki, 1975).

[188] *Swedish Alcohol Policy* p. 9.

[189] *Ibid.,* p.9.

a state-controlled and limited off-licence supply. These public controls in Swedish alcohol policy have mostly come as reactions to popular demand. Currently, about 8% of the adult population belong to a temperance organisation. The 1995 document states that the tightening up of policy since 1977 has generally involved:

> a reduction of detailed regulation, at the same time as an extensive body of information, education and opinion formation has been created concerning various aspects of the alcohol issue in Sweden. In addition, resources for early response, after-care and coordination of the different aspects of alcohol policy have been augmented.[190]

It should be noted here that the restrictive Swedish policy regarding alcohol is under pressure following Sweden's accession to the European Union in 1995. Realisation that EU membership 'prevents Member States from universally protecting their national interests', as Siofra O'Leary has commented, 'may provoke shock and even anger at national level'[191] and this is illustrated with reference to Sweden's alcohol policy:

> The [Article] 177 EC reference concerning the compatability of the state alcohol monopoly in Sweden with the Treaty provisions on the free movement of goods has provoked fierce national controversy and debate at national level, with government ministers implying that a finding of incompatability by the Court might not be followed ... Sweden regards the State alcohol monopoly as an essential public health

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[190] *Ibid.,* p. 10.

[191] O'Leary, 'The Reciprocal Relationship Between Irish Constitutional Law and the Law of the European Communities' in Murphy and Twomey (eds.), *Ireland's Evolving Constitution, 1937-97: Collected Essays* (Oxford, 1998) p.301.

> measure. In [the relevant decision, the European authorities] interpreted [Articles] 30 and 37 EC as precluding such a monopoly and held that, taken as a whole, such a scheme could not be justified with reference to the protection of human health in [Article] 36 EC.[193]

Despite the intense opposition, however, there is little likelihood that the alcohol monopoly will survive. Prevention measures have been reinforced since 1994 (via special Parliamentary funding) given that, while the EU-forced changes may not be very dramatic in the short run, 'looking further ahead it is feared that commercialisation of the Swedish alcohol market and the more liberal import regulations may cause an upsurge of alcohol consumption in Sweden'.[193]

While current policy towards illegal drugs, in line with the above strong cultural attitudes towards alcohol, is extremely restrictive (in both absolute and relative terms), this has not always been the case. In fact, during the 1960s Sweden operated a socio-medical drug policy which was similar in some ways to the tolerance of current Dutch drug policy.

As in so many other countries, illegal drug use rose dramatically in Sweden during the 1960s. Cannabis was (and continues to be) the most widely-used illegal drug. However, despite this formal illegality, the official atmosphere was one of tolerant acceptance and the drug was relatively freely available. In relation to so-called 'hard' drugs, Sweden was unique in Europe in that the main form of intravenous drug use was (and continues to be) of amphetamine, not heroin or other opiates. As Leif Lenke has pointed out, the reason why amphetamine misuse became so dominant among Swedish drug misusers

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[192] *Ibid.,* (n.41).

[193] Swedish Alcohol Policy, *op. cit.,* p.11. For a detailed account of prevention work in Sweden, see *Prevention of Ill Health due to Drugs and. Alcohol – The National Institute of Public Health* (Stockholm. 1998).

has not been thoroughly investigated. His understanding is that amphetamine use began amongst bohemians and artists in Stockholm during the 1950s and spread from there to the criminal underworld. As a result, 'new recruits to drug abuse were persons connected with institutions such as prisons and juvinile delinquent reform schools'. However, previous to this, during the 1930s, amphetamine drugs were launched as slimming pills and stimulants and this was obviously a factor in developing patterns of use.[194]

The law enforcement measures with which the government responded to the growth in all forms of drug use were largely *ad hoc* and, particularly since some of these measures were perceived as discouraging drug misusers from seeking treatment, came in for increasing criticism. Against a background of inadequate care facilities, an experimental project was launched in 1965 for the legal prescription of drugs such as heroin and amphetamine.

> [The] idea [was] to limit the harmful effects of abuse, both on society and on individual abusers. Through the offer of legally prescribed drugs, the drug abusers would also receive offers of care and their social and medical staus would improve, partly because they would not have to commit criminal offences in order to finance their habit.[195]

The experience in Sweden of this liberal approach is the subject of much debate. The present restrictive policy is justified by the Swedish authorities as representing 'a conclusion drawn from … previous experience'.[196] They claim that the current 'Swedish model' was adopted after the failure of the more liberal and tolerant policy, a claim that is central to the Swedish campaign to introduce more restrictive drug laws throughout the EU. (In 1994, for example, Sweden was instrumental in forming

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[194] *The Swedish Experience,* p. 31.

[195] *Ibid.,* p.7.

[136] *Ibid.,* p.5.

'European Cities Against Drugs' (ECAD), an organisation which is funded by the Swedish state and active throughout the EU). As Lenke has observed:

> The official version can be summed up by saying that the liberal narcotics policies of the 1960s and 70s resulted in steadily increasing problems until a shift in policy in the direction of tougher laws around 1980 pushed back drug abuse on a scale that lacked precedent in Europe.[197]

The 'unofficial' version, on the other hand, explains things very differently. To take a leading example, John Yates' account of the transition from the tolerant approach of the 1960s to the present extremely restrictive drug policy is based on the activities of an almost fanatical prohibitionist movement, the *Riksforbundet Narkotikafritt Samhalle* (RNS – National Union for a Narcotics Free Society) ,[198] Yates likens the power of the RNS, particularly its connections in the government,[199] the police[200] and the media,[201] to that of MaCarthyite anti-

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[197] Lenke, 'The development of drug abuse in Sweden', *Oberoende,* 1/2, 1998.

[198] Yates, 'The Situation in Sweden' (1996) 7 *International Journal* of *Drug Policy* 88.

[199] Neither the RNS nor another powerful prohibitionist organisation, the FMN (Parents Against Drugs), make a secret of the fact that they have formal and informal connections in government and Parliament. Gould, 'Sweden's Syringe Exchange Debate: Moral Panic in a Rational Society' (1994) 23 Journal *of Social Policy* 195 at p.210.

[200] The report of a 'fact-finding mission' by G Van der Giessen (Chair, Amsterdam City Social Welfare and Health Care) and G van Brussel (Senior Medical Officer, Drugs Unit of the Amsterdam City Health Service) in February, 1996 (Sweden and *the* drug's *problem seen through Dutch eyes),* observed that '[t]he

Communism in the USA during the 1950s. Noting that it 'would be professional suicide for anyone in an official position to question the RNS publicly', Yates refers to the experience of Leif Lenke whose work has been cited above and who, as Professor of Criminology at Stockholm University, has raised questions about the alleged extent of dangers associated with cannabis and also regarding the rejection of syringe exchange schemes.[302] The subsequent official and professional negative reactions to Lenke reflect, according to Yates, a 'hysterical witch-hunt atmosphere'.[203] Jacob Lindberg, the Director of the NIPH, is

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police are 100% behind the prohibition policy'.

[201] While there is obviously no social consensus about drug policy in Sweden (or in any other country), there is undoubtedly a very strong political consensus. In an analysis of articles drawn from the country's four national newspapers, Arthur Gould has demonstrated the extent to which the press is part of that consensus, with the basic assumptions of the restrictive line coming through clearly in major articles. See 'Drug Issues and the Swedish Press' (1996) 7 *international Journal of Drug Policy* 91.

[202] For discussion of the debate in Sweden concerning the provision of clean syringes to intravenous drug users, see *infra.*

[203] According to Mats Hilte, 'There are many risks involved in not identifying with the politically correct position in narcotics policy. For politicians it means reduced credibility and less votes. Civil servants in national and local government risk losing their jobs or seeing their careers go down the drain if they express ideas contrary to the official policy. In the same way the careers and subsidies of researchers are threatened if they publish reports or articles that contain criticism of the politically correct position.' 'Drug Wars and the Open or Closed Society', *Oberoende,* January-February, 1998 (trans. John Yates). Hilte's discussion of the Swedish drug war describes the demise in that country of what Carl Popper called the open society – where proposals about, and criticisms of, existing social

quoted as responding to Lenke's situation as follows: 'Everyone should know that we are completely, fully and uncompromisingly against drugs. There is great unity on this in Sweden'.[204]

The experimental project of legal prescription lasted from 1965 to 1967 and was based on the practice of 'liberal prescription', i.e. the patients chose their own drugs and doses.[205] The number of patients taking part increased from about 10 in 1965 to 150 in 1967. According to *The Swedish Experience,* the 'extensive leakage' of legally prescribed drugs into the illegal market was one of the reasons for the project being called off.[206] The evidence supporting this view comes from the 'injection mark study' (IMS) of the extremely influential medical doctor and founder member of the RNS, Nils Bejerot. The IMS involved a check on the number of arrestees in a particular area who had needle marks and it registered a jump from 19% to 36% during the project and a flattening out after that. Apart from the fact that arrestees are hardly representative of the population at large, most official references to the IMS ignore the facts that the drugs taken by these individuals may not have come from the project and that there was an even sharper increase between 1974 and 1976. The number of individuals in Swedish 1960s project is so small that derived statistics of any kind are unreliable. Any increase noted during the 1960s was probably a reflection of the broader

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policies are freely expressed, thus contributing to reform processes and also serving to 'guard the guardians' by means of public dialogue and scrutiny – and its replacement with a version of the closed society – a society 'characterised by a magical and irrational clinging to traditions and habits instead of a rationally guided and critical questioning'.

[204] *Dagens Nyheter,* Stockholm, October 26, 1995, quoted in Yates, *op. cit.,* at p.89.

[205] This project included the self-prescription of amphetamine as well as opiates.

[206] *op. cit.,* p.8.

European trend and a result of increased supply. The evidence from a socio-medical study, allegedly demonstrating that the project had no effect on drug-related crime rates, was also a factor in the decision to abandon the project. Yet this study has also been heavily criticised by Swedish commentators (the study in only available in Swedish), particularly because, again, the number of individuals studied was very small.

The project was abandoned and drug policy took on a new direction from 1968 onwards the 'basic idea' of policy ever since, according to *The Swedish Experience,* 'can be described as close interaction between preventive measures, control policy and treatment of drug abusers'.[207] Yet this foundational idea still left scope for further restrictiveness after 1977. (As mentioned above, the recommendations of a government committee appointed in 1977 led to legislation which defined the aim of Swedish drug policy as being a drug-free society). During the 1970s, the prevailing view was that drug abuse was a consequence, first and foremost, of adverse social conditions the dominant drug policy measures were therefore demand reduction, care and treatment combined with general social improvements. Penalties for drug offences were also increased. A countervailing view – emphasising the addictive quality of the drugs and the importance of the drug market as a factor in the dissemination of drugs – took hold after a rise in heroin misuse during the 1970s. Bejerot's notion of a drug 'epidemic' – an infection-based theory – became popular.[208] The 'duty of society' to intervene led, after 1977,

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[207] *The Swedish Experience* p. 8.

[208] The comments of Sune Sunesson, Professor of Social Work at Lund University, on this theory are worth quoting at length: 'Nils Bejerot assumed that "narcomania" spreads like an infectious disease. The drug addict is the carrier who spreads the infection to others. In this way drug addiction can spread in a way comparable with any other infectious disease like the plague or influenza ... The measures to be taken against this infection are isolation of the source, the drug, the addict or group of addicts ... There is, however, no factual support from

to the prioritisation of supply reduction through punitive measures and the development of *abstinence-based compulsory* care.

In 1982, coercive care for adult drug misusers was added to a previously-existing system for young misusers. (The law in Sweden relating to the compulsory care of adult drug misusers is known as the LVM system). This was part of a more 'proactive' approach which came to be known as 'Offensive Drug Abuser Care'. This approach:

> put more emphasis on outreach activities and on efforts to motivate drug abusers for treatment, as well as on co-operation between the social services on the one hand and the prison and probation authorities on the other.[209]

As regards the extent of use and misuse, the Swedish authorities refer to a 1992 nationwide survey which estimated the number of heavy drug abusers at between 14,000 and 20,000 (out of a population of approximately 9 million). The age structure of the abuser population and the duration of abuse is said to suggest that most of the new recruitment occurred at the end of the 1970s and beginning of the 1980s, 'after which new recruitment appears to have fallen.'[210] Many commentators, however, take the view that there is wilful underestimation of drug use and misuse in Sweden. Lenke, for example, refers to the increasing experimentation with drugs in Sweden, particularly cannabis, 'and

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either research or other systematic documentation to assume that drug use or drug abuse spread like diseases caused by microbes or that drug abuse would be transferred to large portions of the population if action was not taken against the "infection carriers". Even in Bejerot's time, almost every tenth Swede had used cannabis or other illicit drugs but only very few became abusers.' 'The chemically controlled maniac and other everyday myths', *Oberoende,* January-February, 1998 (trans. John Yates).

[209] *Ibid.,* p.10.

[210] See *ibid.,* pp.14-15.

this is still most commonly found amongst young persons of low education living in larger cities'.[211] He also refers to increase rates of heroin and solvent misuse. In addition, the mortality rate amongst heavy abusers is, in the European Union, higher only in Denmark than in Sweden. Despite this, methadone maintenance is available only to very limited numbers in Sweden.[212]

Arthur Gould has commented that the essence of the restrictive approach 'is to focus upon the consumers of drugs, to outlaw their behaviour, to harass them, to intervene in their "drug careers" as early as possible and to take them into care compulsorily if necessary'.[213] In terms of law enforcement, the key measure was a set of revised directions from the Prosecutor-General, introduced in 1980 and still in force, concerning waiver of charges. Previously, possession of a week's supply of drugs had not entailed legal consequences. The 1980 directions rule out any waiver of charges:

> unless the amount possessed, for personal use, is so small that it cannot be subdivided – that is, at most one joint of cannabis or one dose of central stimulants. Where possession of heroin, morphine, opium or cocaine is concerned, charges, in principle, are never waived at all.[214]

Swedish cannabis policy is based on the assumption that the people trying cannabis during their school years constitute a recruitment base for those who later become 'heavy drug abusers'.

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[211] *Op. cit.*

[212] Interview with Dr. Gunnar Agren, Research Director of the Resource Administration for Schools and Social Services in Stockholm (May 1998).

[213] Gould, *op. cit.,* at p.197.

[214] *The Swedish Experience* p. 10.

(Heavy drug abuse is defined in Sweden 'as persons *either injecting drugs or using drugs in some other way daily or virtually every day*').[215]

A particularly vivid illustration of the nature of Swedish drug policy is to be found in the debate surrounding the spread of HIV through intravenous drug use during the mid-1980s. The 1995 policy document states that 'Swedish drug policy was put to a crucial test' at 'this time.[216] The focus of the debate was whether or not to adopt the WHO-promoted harm reduction measure – the provision of clean syringes to intravenous drug users (IVDUs). The widespread adoption of syringe exchange schemes (SES) was recommended by an official report, based on experimental projects in Sweden and also on experiences abroad.[217] However, with the exception of a small number of projects which were allowed to continue, the recommendations were

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[215] *The Swedish Experience* p. 14. It is rare to come across any reference to 'drug use' in the official Swedish literature on drug policy: virtually all references are to 'drug abuse'. Any use of illegal drugs other than 'heavy drug abuse' is understood to be abuse. It is worth quoting the main policy recommendation of Norman Zinberg's work on drug-taking: that every possible effort – legally, medically, and socially – should be made to distinguish between: 'the two basic types of psychoactive drug consumption: that which is experimental, recreational, and circumstantial, and therefore has minimal social costs ['drug use']; and that which is dysfunctional, intensified, and compulsive, and therefore has high social costs ['drug misuse' or 'drug abuse']' (*op. cit.,* 203).

[216] *The Swedish Experience,* p.10.

[217] Not only were SES encouraged by the WHO and supported by the medical profession in many countries and their governments, there was also consistent circumstantial evidence of less HIV infection and no evidence of the spread of drug misuse. Gould notes the fact 'that Norway, the only other country to operate a *restrictive* line similar to Sweden's, distributed 1 million clean needles to IVDUs in 1991' (*op. cit.,* p.215 (n.17)).

rejected after considerable public debate. According to Gould, "The medical consensus in favour of SES was rejected by a much wider consensus of drug agency workers, militant pressure groups and the political establishment. It was felt that [SESs] would not only condone drug misuse but encourage it.'[218] According to the official policy statement:

> The Swedish Government rapidly decided that the restrictive line was to be maintained and at the same time the sights of drug control policy were raised. The Government and Riksdag laid down that, in view of the AIDS menace, the aim of drug policy should be to *reach all i.v. abusers with detoxification, sampling and treatment. In* other words, offensive drug abuser care was looked on as the most effective safeguard against the HIV threat.[219]

Thus, in the end, an abstinence-based approach again won the day. In seeking to explain 'why a country with a proud record on public health issues [chose] to reject the path of harm reduction adopted by the international medical community', Gould refers to the historical power of the temperance movement and also to the close correspondence of view on drug issues between the resrictive lobby and the political parties. He quotes Henrik Tham: 'The reaction against drugs has been so strong and so widespread in Sweden, because the campaign has been seen as a means to strengthen a threatened social identity.'[220] Through an analysis of prohibitionist stances during public drug policy debates, Tham identifies a number of interrelated themes which show a concern for 'traditional values', 'consensus', 'the concept of the *folk* [people]' and 'Sweden versus the rest of the

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[218] Gould, *op. cit.,* at p. 195.

[219] *The Swedish Experience* p. 11 (emphases in original).

[220] Tham, 'Drug control as a national project' (1992) 9 *Nordisk Alkoholtidskrift* quoted in Gould, *op. cit.,* at p.213.

world'.[221] 'What is portrayed', according to Gould, 'is a picture of a people united against outside forces in defence of the national values of orderliness and conscientiousness.'[222] The wider social structure and culture must be understood when the issue touches on a national obsession:

> Drugs like heroin, cannabis and cocaine are seen as a threat partly because they are foreign. They, like immigrants, come from abroad and have come to symbolise a weakening of the national identity. In common with alcohol and other drugs, they pollute the body. But perhaps as important is the contrast presented by drug-induced attitudes and behaviour to the attitudes and behaviour of ordinary Swedes. In a comprehensive analysis of a number of studies of national character, Daun has shown the degree to which Swedes see themselves and are seen by others as rational, self-controlled, well-organised, practical and betraying little emotion ... Almost by definition, the drug misuser represents the opposite of all of these qualities … The moral panic surrounding the drugs issue is the ironic means whereby a rational society seeks to protect itself.[223]

Further explanatory themes emerge in another recent study

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[231] Criticism of other drug policies is common in Sweden. Gould remarks how, during the SES debate, the Netherlands and the UK were considered to have capitulated in the 'war against drugs'. 'Sweden, it was claimed, was ... unique. It had created a comprehensive caring network of drug agencies; it had criminalised drug use; it was firm in its stand for a drug-free society' (*op. cit.,* at p.213).

[222] *Ibid.,* at p. 213.

[323] *Ibid.*, at p. 214 citing Daun, *Svensk mentalitet* (Stockholm, 1989).

Swedish drug policy was analysed by Tim Boekhout van Solinge as part of the 'national studies' series conducted by the Centre for Drug Research (CEDRO) at the University of Amsterdam. In *The Swedish Drug Control System: An in-depth review and analysis,*[224] he argues that the relatively low rate of drug use is the result more of cultural and social factors such as the homogenous character of society and the absence of a strong urban culture than the restrictive drug policy. van Solinge emphasises that, in line with other European countries and despite the restrictive line, drug use has increased in Sweden during the 1990s. The increases in the use of cannabis, heroin and Ecstasy have been parallelled with an increase in the number of drug addicts (mainly consisting of intravenous amphetamine users – he refers to estimates which suggest that their number has increased from 12,000 in 1979 to 17,000 in 1992). Overall, however, against a background of relatively low drug use but high public fears about the 'threat' posed to society, van Solinge concludes that drugs provide a convenient scapegoat in the context of an economic crisis which has resulted in a declining welfare state. As Sunesson points out, low youth unemployment during the 1980s certainly contributed to low use levels but that era has ended.

Generally, sensitivity to the dependence of drug use patterns on other aspects of social policy is found in Sweden as much as in the Netherlands. As stated in the *National Plan of Action (for prevention of alcohol related harm and drug abuse in Sweden)* (prepared by a Steering Group under the chairmanship of the NIPH and presented to the Swedish government in 1995):[225]

> [T]here is ... a limit to what alcohol and drug policy can achieve. No matter how well-constructed that policy may be, it will have little chance of succeeding if the main body of social policy allows large groups of people to be left outside.
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> Alcohol and drug policy expresses the

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[224] (Amsterdam, 1997).

[225] (Stockholm. 1995).

> determination of society to combat drugs and not to condone an increase in alcohol-related injuries. To be credible, that message from society must be based on measures which create social security for people. A restrictive policy on alcohol and drugs must proceed hand in hand with a policy vigorously counteracting unemployment, segregation and marginalisation.[226]

Another characteristic of Swedish drug policy is the role played by voluntary, civilian organisations. Many such groups are often present in the public spaces associated with drug-dealing and drug-taking. An account of one such group will NOW be given, before turning to the Ecstasy policies of the countries being discussed: The organisation known as *Farsor Morsor pa stan* ('Parents in the City') was founded in Stockholm in 1990 and has since spread to several other Swedish cities. The activities of this voluntary organisation include small groups of adults, identifiable by distinctive jackets, walking around the areas of Swedish cities that are known to be places where illegal drug dealing and prostitution are concentrated. An information leaflet of the Stockholm-based group describes itself as follows: 'Farsor and Morsor operates totally idealistically aiming to support young people by offering them adult contacts. Our ambition is to forestall violence, abuse, criminality and every kind of segregation ... We circulate among young people [in the] evenings and nights in the streets. We make ourselves available and we care. We try to act as good examples, set limits, interfere in fights or ensure that a young person affected by alcohol or drugs receives adequate medical treatment.' *Farsar and Morsor,* which has no enforcement powers whatsoever, operate as part of a network which includes social and police authorities and other

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[226] *Ibid.,* p.47. 'Proneness to drug-taking is rooted in social, cultural and psychological conditions, and also in individual persons' values and assessments of the risk entailed by purchasing and using drugs' *(The Swedish Experience).*

voluntary groups. In particular, co-ordination and discussion between these various bodies takes place around bank holidays and other occasions such as the end of the school and university terms. Members of the group are sometimes called as witnesses in legal actions against those selling drugs or those involved in street violence. There is no training as such, and full membership of the group is based on having 'walked' in the city on at least five occasions. Funding comes from various corporate sources and state subventions.

The existence of the offence of *drug use* in Sweden is perhaps the outstanding hallmark of that country's drug policy.[227] In Sweden, the law which makes the use of drugs a criminal offence was passed in 1988. Gould explains that 'it was felt the passing of such a law ... would have an important psychological, or symbolic effect' even though, at that time, the punishment was limited to a fine.[238] Later, in 1993, the consumption of drugs was made an imprisonable offence.

The practical operation of this law, far from being purely psychological or symbolic, involves an intensified police surveillance of behaviour, in particular looking for signs of illegal intoxication. Blood and urine samples are taken from suspects by police. One senior Swedish police official has explained the rationale underlying this law as follows:

We are disturbing them [the users], standing in the

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[227] *Continuity* and *Change* notes that the use of drugs in itself is also not a criminal offence in the Netherlands, Germany, Denmark, Spain, Greece, Portugal, or the United Kingdom (p. 6). In Ireland, with the exception of heroin, it is not a statutory offence to use any illegal drug (Misuse of Drugs Act 1977, s.16). For a discussion of the offence of use, see Murphy, 'Drugs, Drug Prohibition and Crime', *op. cit.,* pp. 8-9. The criminalisation of drug use, as will become clear below, plays a particularly important role with regard to Swedish Ecstasy policy.

[228] Gould, *op. cit.*, at p.215 (n.2).

> way of their activities, threatening them with compulsory treatment and making life difficult for them. The more difficult it is, the more the other way of living stands out as a better alternative, that is a drug free life.[239]

Naturally, a great deal of discussion of this law refers to the human rights tradition and questions whether such practice constitutes a violation of that tradition in Sweden. Apart from the basic intervention in private life, as Sunesson has pointed out: 'People have feet and drug scenes are mobile. It is the sickest and weakest who get left behind and harrassed.'[230] In Ireland, for example, the constitutional right to bodily integrity would immediately be invoked. In Sweden, however, such is the ferocity of the 'anti-drug' feeling, that country's constitutionalism accepts the practice of the 'use laws'. Lenke believes that the 1988 law 'did not accomplish anything. Nor was anything accomplished when the law was tightened in 1993'.[231] Similarly, Yates claims that Swedish draconian laws 'are not having any effect on drug availability or use'.[232] He refers to evidence showing that amphetamine is so common that it is cheaper than alcohol; that heroin is brought into the country in great amounts and sold cheaply by Eastern European gangs;[233] that 20% of young Swedes in major cities use drugs, mostly cannabis; and that crime, particularly violent crime, has increased as the drug

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[229] Quoted in Lenke and Olsson, 'Sweden: Zero Tolerance Wins the Argument?' in Dorn, Jepsen and Savona (eds.), *European Drug-Policies* and *Enforcement* (London, 1996) p.111.

[230] 'The chemically controlled maniac and other everyday myths', *Oberoende,* January-February, 1998 (trans. John Yates).

[231] *Op. cit.*

[233] *Op. cit.,* at p.90.

[233] See also, Sigfridsson and Tragardh, 'Heroin epidemic in "drug-free" Sweden', *Aftonbladet,* November 3, 1997.

laws have become more repressive.[234] The 'use laws', however, play an important role in relation to Swedish Ecstasy policy.

Partly as a consequence of its peripheral geographical location, and perhaps to some extent because of the repressiveness of its drug policy generally, Swedish society did not have to confront the emergence of patterns of widespread Ecstasy use until early in this decade, some years later than most other European countries. One of the major law enforcement measures taken in Sweden to curb and repress Ecstasy use is a branch of the police force known as the 'Rave Commission', which began its work in 1996. In addition to house searches and other traditional police powers, the Commission is described by Linton as 'The Only Culture Police in the Western World' because of its undercover operations at raves, which search for 'suspicious signs' amongst ravers.[235] The 'signs' relate to pupil-size, steadiness of fingers, dryness of mouth and jaw-grinding. Suspicion of use warrants a blood and/or urine analysis by the Commission. According to Linton:

> The operations of the Commission ... have nothing corresponding to them in the western world … The method – that the police, without the suspect having caused anyone else harm, are allowed to penetrate the skin of a person to check the condition of the individual's internal fluids and substances – is made possible by [the 'use laws']. No other comparable democratic countries are practising anything similar.

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[234] Yates concludes his analysis as follows: 'None of this prevents the fanatics of Sweden holding their country up as an example for the rest of Europe to follow. As Europe is the best hope the world has of instituting sane drug laws, the actions of Sweden represent a threat that is out of all proportion to their relatively small size' (*op. cit.,* at p.90).

[235] Linton, 'The Rave Commission – The Only Culture Police in the Western World', *Arbetaren,* March 9, 1998.

Echoing Lenke, Linton also comments: 'however, there is nothing that indicates that use of drugs has dropped'. Further, according to one social worker:

> It's boiling hot among the youth. Now it has gone too far. Before the Rave Commission existed youth used to talk about music, dance, girls, guys, clothes, and to some degree about drugs, but since the Rave Commission got started the only topic of conversation is cops and the Commission. The Commission is killing a culture that has very many positive traits which it would be in the interest of society to adopt instead of choking.[236]

Concluding observations

Given that the drug policies of the Netherlands and Sweden were chosen for their stark contrasts, much of what might be said by way of a comparative analysis between the two countries is already evident. At virtually every point (leaving aside the issue of drug legalisation, on which the Dutch ultimately are flexible), there are substantial divergences and differences. The place of Ireland in relation to these countries is also apparent: since the 1960s, Irish drug policy has remained largely in the mould of the deterrence perspective and in particular its moral-legal dimension. This ideology remains strong yet there is an increasing sensitivity to a broader range of factors in assessing appropriate responses. In many ways, this challenge to the hegemonic drug-policy ideology of the twentieth-century reflects the fact that the Netherlands, and not Sweden, appears to be winning, albeit only marginally, the drug propoganda war in the European Union. Its latest manifestation in Ireland – a harm

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[236] One Swedish Ecstasy user comments: '[The Rave Commision's] work has only one effect. Youth are feeling growing hatred for government authority. They are acting like fascists. People don't use less drugs, but now they take them at home.'

reduction campaign aimed at Ecstasy users, albeit for now only in one Task Force area – is of tremendous significance for Irish Ecstasy policy. It remains to be seen how contested the debate will be as to the success or otherwise of this campaign.

One of the central differences between the three countries surveyed in this chapter is the 'myth' in Sweden, to use Sunnesson's term, which gives drugs 'an almost magical power to enslave their victims'. As she points out, this myth justifies repressive policies but ignores set and setting:

> Drug use and abuse are more like alcohol use and abuse than the authorities dare to admit. In both cases it is a question of social activities that are learned and carried out in contexts where use is accepted and tolerated. Heavy abuse is destructive and devastating in both cases, but can be reversed when the social circumstances of the abuser changes. Of thousands and thousands of Vietnam veterans who came home as heroin abusers, only a tiny minority continued as abusers in the USA. It is not the drugs that are in control, it is rather social circumstances that determine abuse.

Although the phrase 'liberty with responsibility' was coined by the Swedes regarding the abandonment of the ration book system, it has at no point been applied to illicit drugs. The rhetoric employed by the Swedish authorities has come in for widespread criticism, with the use of language like 'narcofascists' by their opponents being a commonplace.

Henrik Tham believes that different sets of data can be interpreted so as to give rise to the result that one favours. His view is that the balance is against describing Swedish policy as 'successful'. This is because of the increased costs involved in the control of drugs. 'Such costs are connected to the disregard for law, increased use of limited law enforcement resources, increased use of compulsory treatment, more and longer prison

sentences and possibly increased mortality among drug abusers.'[237] In Gould's view, it is a perception of the consequences of legalisation that poses the real problem from the point of view of the Swedish mentality:

> In a climate where drug misuse had clearly come to be seen as such an enormous social threat, it was not easy to argue that the threat of HIV infection was an even greater one. Harm reduction in general and SES in particular were regarded as dangerous steps on the slippery path to the legalisation of drugs.[238]

The Swedish Experience, while adamant that 'Sweden is not a completely drug-free society, but the target has been achieved in that use of drugs in Sweden occurs on a limited scale by international standards', nonetheless recognises that in recent years, 'there have been growing reports of an upsurge of drug abuse' and 'the growth of international drug trafficking and the prospect of a Europe without frontiers – as well as tendencies towards a liberalisation of drug policy in other countries – are subjecting Swedish drug policy to increased pressure'.[239]

These 'tendencies towards liberalisation' have of course been pioneered in the EU by the Netherlands, whose drug policy is frequently referred to in the ongoing debates about Irish policy. Far too often, these references are of a vague and very general nature: Dutch policy is 'a disaster' or is 'working perfectly', the Dutch are said to be 'retreating' from their liberal position or 'on the verge' of complete legalisation. The reality, as this chapter has hopefully demonstrated, is somewhat more complex. In terms of drug-policy evaluation, *Continuity and Change* states:

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[237] Tham, 'The Swedish drug policy – a restrictive and successful model?' (1996) 13 *Nordisk Alkoholtidskrift.*

[238] Gould, p.197.

[239] *Op. cit.,* pp.31-33.

> No matter how much opinions on drugs policy may vary, there is a broad consensus on the ultimate criterion according to which the effectiveness of any national drugs policy should be measured. This is of course the number of hard drug addicts, especially the number of hard drug users under the age of 21, and changes in those numbers.[240]

As indicated in the overview of Dutch policy above, the number of heroin users in the Netherlands is well below the European average the number under the age of 21 is also relatively low, even among vulnerable groups, and has continued to fall in recent years.[241] These details speak for themselves. If more is needed, one can also note that, 'per head of population, there are between two and three times as many Irish opiate addicts as there are Dutch'.[242] In terms of restricting the potential problems associated with drug use generally, as Paul O'Mahony has observed, 'the best scientific evaluations of the Dutch approach indicate that it is a definite, if limited, success'.[243] As regards Ecstasy, Dutch policy is similarly successful. As concluded by the CVO report, the principles contained in *City Hall and 'House',* when adhered to, guarantee the safest possible form of Ecstasy use 'in the [Dutch] entertainment circuit'.

It should also of course be explicitly remarked that there is the view that the tolerance of Dutch drug policy does not go far enough. Richard Stevenson, for example, has noted that all non-prohibition options short of legalisation (such as Dutch-style 'decriminalisation'):

> represent easements of policy as it applies to users rather than dealers. Decriminalisation is only a

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[240] *Op. cit.,* p.9.

[241] *Ibid.,* p. 10.

[242] O'Mahony, *op. cit.,* p.82.

[243] O'Mahony, *op. cit.,* p.82.

> partial approach. It does not tackle the illegal trade which prospers from an increase in drug use and sponsors terrorism and political corruption. Legalisation deals directly with the fundamental problem which is to wrest control of drug markets from criminals.[244]

This perception of the 'fundamental problem' is of course open to question. We would suggest that drug-related harm could more properly be described in this way. At any rate, the two – criminal control of drug markets and drug-related harm – are by no means unrelated. Regulation and standardisation, particularly in the case of what the Dutch refer to as hard drugs, aid the cause of harm reduction. If the international opposition to the war on drugs continues to increase,[245] the current Dutch pilot project that provides heroin to addicts on medical grounds, and indeed the major findings of *Ecstasy in the Entertainment Circuit,* could well have a very prominent role in the introduction to the successor to *Continuity and Change.*

In terms of the Netherlands and Sweden taken together, the report of a 'fact-finding mission' by G Van der Giessen (Chair, Amsterdam City Social Welfare and Health. Care) and G van Brussel (Senior Medical Officer, Drugs Unit of the Amsterdam City Health Service) in February 1996 *(Sweden and the drugs problem seen through Dutch eyes),* observed that the Swedish leitmotif in dealing with psychotropic substances is the imperative of external control. In practice, this means state-enforced limitations on consumption of all such substances. These 'fact-finders' link this to the policy idea of

> the basic inability to consume any intoxicant with

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[244]Stevenson, *op. cit.,* p.51.

[245] For some recent developments, see Humphreys, 'Letter urges UN to reconsider futile drug war policies' *The Irish Times,* June 6, 1998 and Murphy. 'Trocaire calls for rethink on drugs', *The Sunday Tribune,* June 7, 1998.

> moderation. This social 'given' is reflected in the Swedish view of use/consumption of these substances. In turn this translates as policy oriented to external rather than internal checks and controls.

In terms of perceived or partial consequences, despite major similarities in the WHO yearbook of statistics for the two countries – average life expectancy, deaths from heart-related disorders, cancer, etc. are almost identical — there are major differences in relation to male suicides and alcohol-related deaths. Sweden has a higher suicide rate amongst both males and females, and a higher rate of death due to cirrhosis of the liver.

These differences, from the Dutch 'internal control' perspective, speak for the perceived superiority of their social and drug policies. As for Ireland, despite the fact that Irish people consume less alcohol than the European average and spend no more on alcohol than people in most other countries, there is a very definite national image, as in Sweden, of heavy drinking. It has been argued that the profound ambivalence of Irish people to alcohol – as revealed by the patterns and visibility of Irish alcohol consumption – results in the great prevalence of alcohol problems in Ireland.[246] John Waters has offered a view of problem drinking in Ireland that has at least shades of the 'Nordic tradition of drunkenness':

> If there were psychiatrists' couches for peoples and societies Ireland would long since have been diagnosed as an alcoholic nation. We like to fool ourselves by thinking of drink as a social lubricant, but its main function in Ireland is as an analgesic ... We use it to enter the joyous, creative and resourceful aspects of our personality, to escape the self-loathing which

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[246] See Morgan and Grube 'The Irish and alcohol: A classic case of ambivalence' (1994) 15 *The Irish Journal of Psychology,* 390.

results from centuries of abuse.[247]

Waters goes on to argue convincingly, in the context of a discussion on the popularity of Ecstasy among Irish young people and the resistance to strict drink-driving laws in Ireland, that to treat the former drug as a 'scourge' and alcohol – 'a more consistently lethal one – as a harmless, social lubricant is an act of criminal hypocrisy and denial'.[248] Ecstasy can also be lethal, of course; 'the question, however, is whether this potential property, which legal drugs also possess, is enough to merit the demonisation that so often takes place. From the evidence of this chapter, and indeed of this report, such demonisation is not warranted and is thankfully in retreat.

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[247] 'Why drugs campaign is doomed to failure', *The Irish Times,* August 1, 1995.

[248] *Ibid.*

CHAPTER FOUR

REPORTS ON INTERVIEWS WITH ECSTASY USERS

Introduction

The following report on Ecstasy users was conducted on the basis of 20 in-depth user interviews and 5 interviews with a category of respondents termed for project purposes 'cultural commentators'. The category 'cultural commentators' is comprised of people who have direct knowledge of aspects of the dance scene and associated patterns of drug use. It is comprised of respondents from community drugs projects, the field of journalism, and people working in a night club and a music shop. The interviews with drug users were conducted in 1997 and 1998 in Cork and Dublin. The sample chosen involved users between the ages of 17 and 27 with a deliberate bias to people in their twenties. It included a group interview with a number of Dublin teenagers. The sample included two respondents drawn from the sphere of drug treatment, in order to consider some of the dimensions of obviously problematic usage. The bias to people in their twenties was used to provide a longitudinal perspective on patterns of use.

Respondents were selected through a snowball sampling procedure. Interviews were difficult to arrange as targets were being asked to comment on an illegal activity, which naturally created a degree of nervousness. This may also have affected the quality of the interviews in ways difficult to detect, though we are confident that on the whole this was not a major factor. The interviews were conducted according to a pre-designed format that sought to place users in a broader life-historical context, and not to narrowly focus on drug use alone. The interviews were then coded across 10 basic categories – and associated sub-categories

– as a basis for the following report.

The interviews attempt to report on qualitative aspects of Ecstasy usage. They do not strive for representativity in the manner of a survey method. It was therefore felt that certain interesting issues could not be effectively pursued. One of these was the link between socio-economic status and problematic drug use. While it is widely attested that Ecstacy is a cross-class drug, there may be connections between class background and dependency problems (as is clear in the case of heroin). However, this would require a much wider sample than could be afforded by the resources in the current project. Another interesting issue that was not explicitly dealt with was geographical differences between experiences in Dublin, Cork, smaller cities, and towns. It was felt that the general issues first of all needed to be outlined in a study of this kind before exploring locational issues in detail. The current study is a prerequisite to that kind of study, clarifying what are the critical distinguishing variables to be examined. This report therefore is largely addressed to the Cork and Dublin experience, but its findings can without doubt find application in other contexts.

Usage Histories

In relation to **initiation,** Ecstasy consumption was, by a very large distance, a product of social interaction with peers. This social interaction would on the whole appear uncoerced. The model of peer pressure, in the sense of people being persuaded against their better judgement, does not appear to have much salience. There were some instances of individuals who did not intend to take Ecstasy being prevailed upon to do so, but these individuals were likely to have become Ecstasy users sooner or later as a consequence of lifestyle factors. For example, one woman was part of a drug-using sub-cultural scene in Amsterdam. Ecstasy initiation was often driven by the reports of others who claimed to have had astonishing experiences on the ‘new’ drug, hence arousing the curiosity of members of the sample. Other reasons given were, in a couple of cases, the high publicity that

attended a number of deaths from Ecstasy, which alerted people to the presence of the drug. Another factor appears to be its widespread usage. If everyone is doing it, why shouldn't I? This tendency was enhanced by the extensive commercialisation of the drug which gives it the appearance of safety. In general, however, reasons such as these are background factors. What appears as really decisive is the latent immersion in a culture of peers, the spontaneous acceptance at a given moment that this is the time to 'drop an E'. The other factors work as a kind of preconditioning, selecting which members of the population belong to the situations and networks that produce a positive response when confronted with the choice. This invariably happens in a social setting, normally but not exclusively a club. There are, of course, some exceptions.

The literature suggests that 16-29 is for heterosexuals the age spectrum in which Ecstasy is used. This appears to be borne out in the sample. Initiation began somewhere between 16 and early-20s, though normally in people's teens. Initial consumption tended to be low – most people preferred to confine themselves to half a tab and thereafter increase the dosage. The extent to which the dosage is increased can be related to gender factors, with women tending to use lower quantities of the drug, and also to individual factors. In many cases the first or second experience appears to be the most satisfying. The fact that Ecstasy is a drug dependent on a satisfying social atmosphere and that initial consumption tends to happen in group settings meant that a qualitatively new kind of collective experience suddenly opens up to the user. This experience was frequently referred to as being the best. Sometimes, the first time may not acquire this status; a variety of reasons including mood, quality of Ecstasy and the context may make the second or subsequent usage the most memorable.

In relation to **level** of consumption, the usage pattern would suggest that there is progressive increase in consumption in some cases, as users become more familiar with the drug. This appears to be motivated by a number of factors. Users feel they can handle the drug better with experience. They seek to return to

the original euphoric experience through increased consumption. This was referred to as 'chasing the first buzz'. They simply do not get a buzz out of lower consumption levels. Additionally, they wish to extend the length of the experience. However, it would be wrong to say that increased consumption intrinsically leads to some kind of dependence. In this regard, a number of categories appear to emerge from the sample. The first category are those who do not increase their consumption very much by comparison with others, always staying in the range 1/2 to 1 or even 2. These users will typically not belong to sub-cultures where drugs are very important – though they may consume quite a lot of drugs – and use Ecstasy on given, suitable occasions. A second category are those users whose consumption levels are high, both in the sense of regularity of consumption and quantity of tabs consumed (often 4 or 5). Yet this category, while they may experience uncontrolled usage which may bring problematic experience over the medium term (2 years), together with short-term problems in coming down, and occasional bad experiences, nonetheless demonstrate the capacity to severely reduce or eliminate Ecstasy usage over time. The third category are unable to do so and become problem users. In this case, Ecstasy is part of a problem in which other drugs also have a role. But Ecstasy is part of the addiction. While it is attested not to be physically addictive, it appears in these cases, in conjunction with other factors, to be psychologically addictive. Some users also draw a connection between usage levels and quality. One user has severely reduced his consumption, amongst other factors, because of worries about quality. This appears to be not uncommon and certainly plays a part in the assessment of risks.

A major issue emerging around Ecstasy consumption is the degree to which it is used with other drugs. From the evidence of the sample, **poly-drug use** would appear to be very common. Nearly everyone had commenced their drug-taking careers with cannabis in their mid- to late-teens. Ecstasy is often consumed with speed ('to increase the buzz') and hash is used to ease the trauma of coming down the perceived value of speed is that it prolongs the experience of Ecstasy, allowing people to go on

beyond the normal four-hour interval of Ecstasy. There is some evidence to suggest that cocaine is being used more widely as well, which may in part reflect concerns at the quality of Ecstasy available and the fact that cocaine is now less expensive than it was in the past. It is difficult to determine whether Ecstasy is causal of other drug usage; the fact that a majority of the sample had commenced on cannabis suggests broader orientations on the acceptability of 'soft' drug use than the category Ecstasy user. There appears to be a culture of experimentation which develops with drug usage and which – though our research did not examine this systematically – may be linked with certain personality types. This culture of experimentation takes many users into poly-soft-drug use. In this sense, the issue of Ecstasy becomes bound up with the issue of the effects of soft drugs more generally.

A major issue in the media and in policy networks is the extent to which certain soft drugs lead on to 'hard' drugs such as heroin or cocaine. Heroin is sometimes used to come down from Ecstasy. This is apparently more prevalent in Dublin where there is a general culture of heroin usage than elsewhere in the country. The interviews contained several references to so-called 'party packs' containing 2 E tabs, some hash and a wrap of heroin. One person thought they were a good idea as she liked to come down with heroin but another thought they were dangerous, Heroin seems to acquire the status of a liminal issue for the sample. While some could contemplate it, and a few used it regularly, most were opposed to it, even though in one or two cases they might have tried it or could imagine trying it. The fact that some had tried it and still spoke negatively about it suggests that it was unlikely that they would ever succumb to heroin addiction. It had the status of a once-off event in a previous period of higher drug usage. In one case, it was unclear whether the person had an addictive relationship to heroin, but heroin certainly played an important role in her drug consumption. Interestingly, a factor which she cited as being influential in enabling her to stop using heroin after a period of one year was returing from Amsterdam to her home city of Cork,

in which she knew she would not have access to heroin, either from suppliers or within her peer group.

It is probable that in Dublin, as distinct from elsewhere in the country, heroin is more connected with Ecstasy usage, and that this is particularly linked to contexts within the city in which heroin is already an established problem,[249] which is not the same as saying that Ecstasy usage is a 'gateway' to heroin. A number of the sample drew attention to a heroin-using context as being important to linking Ecstasy and heroin through such factors as prior history of heroin usage, easy availability of heroin, or examples of peers who use it. On the whole, however, the majority of the interviewees did not use heroin and did not contemplate using it, which is in keeping with trends of recreational drug use discovered in other contexts.

The relationship between alcohol and Ecstasy usage threw up some interesting findings. Approximately half the interviewees would use alcohol regularly with Ecstasy in spite of the general health consensus that this should not be done because of the danger of dehydration. There seemed to be some self-regulatory mechanisms built into the use of this combination such as not drinking excessively or staying with moderate Ecstasy consumption. A problem would appear to be that the circumstances of taking Ecstasy can often involve significant alcohol consumption at the beginning of the night, as very often taking Ecstasy is not the working out of a pre-planned activity. It depends on such factors as supply, mood, company. Another reaction for many people, though, is to find that Ecstasy and alcohol compete with one another. A number of interviewees gave up alcohol as a consequence of Ecstasy usage, though this would be an extreme reaction. Interestingly, some of the sample gave up or limited alcohol consumption for the period of time in which they were actively involved in the dance scene. As they moved away from this scene, they recommenced use of alcohol in recreational and leisure time. Certainly, however, reduced consumption of alcohol and, consequently, less alcohol-oriented

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[249] See O'Keefe (*op. cit.*) for discussion of this issue.

behaviour, is a product of relatively widespread Ecstasy usage. In general, direct experiential and indirect commentary does suggest that alcohol and Ecstasy usage are significantly used together.

The issue of 'coming down' off Ecstasy was generally regarded as problematic, though a few regarded it as unproblematic. It would seem clear that even moderate consumption of Ecstasy will lead to at least some unpleasant experience in the day or days after consumption. The degree of unpleasantness will depend on factors such as the extent of consumption, personality type and life situation at the given time. One person observed that he would never take Ecstasy if his mood was not good. The most common 'consequences were, psychologically, feelings of mild depression, increased irritability and even paranoia and, physically, increased tiredness. It is difficult to assess how genuinely problematic these experiences were for light to moderate users. Some users reported a kind of deeper 'ecology of emotions' in which swings between high and low were all part of the intensity of the experiences, that you couldn't have one without the other. However, it does seem clear that even in the light to moderate category some care needs to be taken not to take Ecstasy on a night where you have work the next day. One interviewee reported it would be simply impossible to work the day after consumption. A further reason why it is difficult to be sure about the actual depth of problematic experience in Ecstasy-related coming down is the more basic question of how much of it is actually Ecstasy-related. Some users were quick to highlight their view that speed is a more dangerous drug and the practice of taking speed with Ecstasy – or, indeed. Ecstasy with elements of speed in it – creates more intense problems than Ecstasy alone. More intensive pharmacological and psychological research on the experience of usage is needed to elucidate these phenomena.

A further widely reported aspect of the coming down experience is the use of other drugs to assist in the process. Two main candidates present themselves in the present sample: cannabis and heroin. Heroin has been dealt with above. Cannabis

is used extensively. There is a confident assumption that it mitigates the worst effects of coming down. In the case of the respondents currently receiving treatment for drug problems, there was evidence of use of tranquilizers, to ease the come down. Speaking of the phenomenon of polydrug use amongst problem users, it was commented that: 'It's not a case of one day they're doing E, one day they're doing hash. They'll use E's, hash, drink and tablets all in the one hour'.

In the case of the wider sample, since most of them had begun their illicit drug experience with cannabis it cannot be said that Ecstasy leads to cannabis use. More likely is the thesis that the boundaries between certain kinds of what are described as recreational drugs, LSD, Ecstasy, cannabis and speed, are porous and that users will move between them at will. Using a term from economics, the barriers to entry into usage of any additional one of the set if you have used any other one are very low. In this respect, cannabis is like an antidote to the Ecstasy/speed combination or Ecstasy usage alone.

Quite a few of the older interviewees have either given up Ecstasy usage altogether or reduced their consumption substantially. This raises the question of whether there is a cycle in Ecstasy usage. A distinct pattern of usage is to progress to high consumption for two to four years and then for either of two reasons to severely lower or terminate consumption. The first reason is the physical and psychological effects of prolonged high consumption leading to an intensification to the problems of coming down or, indeed, penetrating more widely into everyday experience as a sense of general dissatisfaction and irritation. This is exacerbated by the sense of risk that lower quality Ecstasy engenders. The second reason, which may or may not be related, is boredom. The Ecstasy experience has been indulged often enough, users do not get the same buzz from using the drug, they probably tire of the interaction patterns, they may have more demanding work or study lifes, all these lead to a sense of the inappropriateness of continuing Ecstasy usage. What is clear is that this seems to be an endogenous kind of learning; no cataclysic event from the outside or sudden

awareness that drugs are impossibly risky seems to influence it. It would seem, and this again needs further research, to have something to do with maturational patterns, not in the sense of superior wisdom but a certain loss of hedonistic impulse perhaps brought on by the acquisition of greater responsibilities. It is probably also something to do with the gradual breaking up of post-adolescent peer networks around the mid-twenties as a variety of factors (differentiation of lifestyles, emigration, family formation, etc.) begin to kick in.

Bad experiences are near universal to Ecstasy users. These can range from nausea, to immobility, muscle spasms, dehydration, and the psychological one of paranoia and, in one case, reports of hallucination. Bad experiences seem on the whole to be closely linked to the quality of the Ecstasy consumed. One user distinguishes between two kinds of Ecstasy, one called a 'smacky' and the other called a 'rushy' the former tends to produce a kind of immobilisation or at least inactivity out of which bad experiences may come. In this connection, hallucination is not regarded as a likely effect of Ecstasy. It is possible that other admixtures in Ecstasy may have caused this condition. Further to this, a number of people commented that speed is more physically and psychologically dangerous than Ecstasy. One user described it as 'a more psychotic drug' than Ecstasy. It also appears to be harder to control physically. One user thought deaths or bad experiences from Ecstasy could be attributed to the speed that was in it – or consumed with it. One commentator/interviewee observed that speed appears to be really taking off and joining Ecstasy as a mass consumption drug. At the very least, this would seem to necessitate the need for some caution and adequate harm reduction strategies.

Longer-term health effects known to users appear to be on a continuum with what has already been observed. That is to say, prolonged usage leads to certain kinds of problem that appear to transfer from effects of the drug in the narrow sense to conditions of everyday living. In a couple of cases, this led to serious problems which required some form of rehabilitation, though it would probably be true that Ecstasy alone did not cause

this condition. There appears to be some truth in the observation of one user that heavy and prolonged Ecstasy usage can exacerbate psychological and, if recent research is to be believed, certain genetic dispositions to physical breakdown. More generally, health problems appear to be manifested as an erosion of bodily tolerance. One user described it as getting out of your body too often. Another spoke of a general irritation. Given that most medical research is undecided on the implications of Ecstasy usage, and suggests that serious consequences, if any, are likely to be long-term, it was not surprising to discover that no major physical or mental malfunctions could be detected by users all still in their twenties. Some of the interviewees compared the effect to alcohol; something you do to excess early in life but get out of as a practice and a health risk at a certain time.

Risk, Quality and Education

The question of health is closely connected to the issue of risk assessment by Ecstasy users. The way in which risk was constructed was, except in a few cases, what might be described as concerned relativism. The interviewees in general saw themselves as partaking in valid recreational activities, legitimated by the large numbers who do the same, and compare these activities with other legal options such as smoking, drinking and driving cars, but were still wary about possible health effects. The types of argument that get put forward therefore are of the type: (a) great numbers do it with only a few well-publicised mishaps; (b) other activities are equally dangerous; and (c) the evidence of serious health effects is not strong enough to justify discontinuation. These assessments are embedded in an extensive repertoire of known cases – as almost everybody in a given peer network will be disposed to take Ecstasy – and therefore counter-acts any attempt to encourage people to say ‘no’ to drugs. One interviewee, who was not Irish, did have very clear safety rules based on a somewhat different assessment of risk. She confined herself to a small dosage and did not engage in poly-drug use. It is reasonable to suppose that

this is far from uncommon in the Irish scene but its representativity would require clearly focussed survey research.

The issue of long-term risk was not very clear. The interviewees were reasonably aware of the medical assessment, which is still somewhat anecdotal and vague. It suffers from many of the same problems that attend some of the judgements in this report, i.e. to what extent is Ecstasy itself causal of problems or is it at most only one element, and perhaps not a major one, in a wider set? The difficulties in making such assessments lie in the complexity of the context, given such factors as poly-drug use, changing personalities and personal situations, prevailing cultural attitudes and the scarcity of research into these issues. It is not therefore surprising that users did not have clear views on long-term effects. One user said he would discontinue the practice if evidence emerged of health risks. Others would observe clear warning signs in their own or friends' personalities that necessitated reduction or cessation. A number of interviewees, who had psychological problems related to Ecstasy, were convinced of the long-term dangers. But the most significant observation is probably that assessments of long-term risk, given the prevailing state of knowledge, are simply not taken seriously by young people awash in the excitement of Ecstasy usage or, at least they are only taken seriously if what is considered manifestly excessive consumption is the case.

What is taken very seriously is the issue of quality of E. A number of judgements on this issue clearly emerged in the sample. First, there is a strong feeling that the quality of E available in Ireland is poor and very much connected with the bad experiences that people report. Second, there is an impression, expecially amongst a number of the sample who have used E over a relatively longer period, that the quality has reduced. Third, the quality of Ecstasy available in Ireland is much inferior to that available in Holland, where testing regimes are in place in clubs. Fourth, there is an impression that it is what is mixed in with Ecstasy in the manufacturing process, rather than Ecstasy itself, that causes shorter- and longer-term problems. It is likely that there is some truth in each of these assertions. How

much will depend on other research. But quality is a major concern of the sample, though in only a couple of cases did it significantly reduce consumption. Many drew attention to the fact that poor quality is a product of the generally repressive and negative climate towards drug use. To mitigate the effects of poor quality, interviewees in general appeared more comfortable buying Ecstasy from a friend or someone they knew.

Issues of risk, quality and health are, of course, closely connected to knowledge about safe practices and effects of the drug. It was striking how little impact official information campaigns had made. The message of 'just say no' appeared oversimplified, a product of general moral opposition to drug-taking. The absence of serious drugs education in the schools was noted by a few interviewees. The futility of teachers or officials opposed to drugs seeking to persuade young people about drug use was noted by a few. Users do not like being presented as problems, as lacking in self-esteem, one commentator noted. The general sense of indifference to existing educational campaigns confirms the widespread impression of inter-generational barriers, of contrary ways of viewing the world, enjoyment, assessing risk, which cannot be bridged by prescriptive, negative educating. Sympathetic media, peer interaction, personal and friends' experience, all counted as more valid sources of information than official information.

All of this raises the question of alternatives. Recent policy initiatives that emphasise the desirability of some form of campaign guided by the principle of harm reduction would appear to be likely to fall on sympathetic ground. Users consistently advocated facts-based as opposed to morally prescriptive information; medical and testing facilities in clubs; peer-oriented forms of communication and education. The problems with this are well-known in the Irish context. The bind of accepting that Ecstasy use is prevalent in exchange for more effective leverage on user behaviour creates enormous problems for political, health and educational actors in a setting which sees drug use as morally deviant. In this context, there were some references to the perceived mistake of treating all drugs

alike, which hampered attempts at providing useful and respected information to guide recreational drug usage.

Expressive Descriptions of Users' Experiences

As a drug, Ecstasy is distinguished by the importance of social context. The importance of social atmosphere is widely attested and confirmed strongly by the sample. The vast majority of people were initiated either in clubs or other collective environments such as parties or pubs. Taking Ecstasy alone was unusual, but sometimes Ecstasy would be taken or continued after clubs in small-group settings.

The importance of social setting for what was deemed as positive Ecstasy experience appears to derive from the behaviour-inducing effects of the drug. In the sample, pretty near uniformly, Ecstasy consumption was associated with a turning outwards to the social, greater friendliness, relaxation, unthreatening touching by strangers or friends and social confidence. The quality of the experience did vary in relation to the quality of the setting (music, dance, atmosphere), the quality of the Ecstasy taken, and the degree of experiences (early experiences were more euphoric), but everyone reported strong positive associations between Ecstasy and the above socially-expressed emotions. There is always considerable interpretive risk in probing beneath the manifest level in personal and social psychological observations, but it would appear that Ecstasy usage was a distinctive type of loss of teenage inhibitions in a way analogous to the effects of alcohol, though quite different in the actual quality of experience.

The categories used in describing what might be called the 'high E experience' (i.e. the experiences associated with early use) varied, though the underlying experiences appeared remarkably consistent. One user described it as everyone appearing as brothers and sisters. A general feeling was that the Ecstasy experience involved a new connection between self and social, with enhanced friendliness and relaxation being the most common observation. A number of interviewees did highlight that

though Ecstasy was a social experience, the new relation to self associated with it, described by one as a kind of deeper awareness of the nature of one's existence, was pivotal. To conjecture a little on the basis of the interviewees, Ecstasy could be described in its effects for users as something of a 'romantic' drug, perceived to unlock inner experiences and making them amenable to collective sharing. A loss of shyness is observed associated with a weakening in the height of the experience of norm-guided roles, associated with family or post-adolescent sexual behaviour. All these changes appear to betoken a new freedom, an euphoric release of potentials for collective experience, a different kind of social blending. It would be analytically unwise to underestimate the power of these feelings, or in the case of the interviewees the positive memory of them years later, for in these characteristic feelings lies the seductive power of Ecstasy, the reason for its extraordinary appeal to young people. They are certainly in need of more social psychological work, including in-depth self-descriptions of users.

Also critical to the experience is the impact of dance and music. As is clear the previous chapters of this report, an immense rave culture exists that transcends the use of Ecstasy in the narrow sense. However, this rave culture grew with Ecstasy usage and the two are characterised by close affinity. The combination of the 'right' music and dance is important in providing a setting for the release of the socio-emotional desire to connect and the immense outpouring of physical energy. The sense from users who complained about early club closing is that there is a need for a transfiguring yet safe context in which they can release the new desire for movement, closeness, even in some cases, touching and massage. The right music and the right social setting, clubs for some and 'free parties' for others, provide this. Rave music has become highly differentiated and its different forms will appeal to different groups but in most contexts it appears to be an essential requisite. To dance is very important for some, but by no means perceived as a necessary accompaniment to Ecstasy use as music is. Some people preferred

to talk, listening to music, and sometimes the experience generated by taking Ecstasy would not conduce to physical movement. This appeared to be particularly related to bad quality Ecstasy.

Two interesting dimensions of Ecstasy usage was the impact on gender relations and aggression. As observed earlier. Ecstasy appears to promise a freedom from certain norms, albeit as some users pointed out only on a temporary basis, which encircle social interaction amongst young people. On the count of gender relations, while for younger users, Ecstasy, and rave culture generally, can be an occasion for the expression of sexual identity through dress etc, there is apparently across all categories and ages of user, something of a change in norms of sexual interaction under the immediate impact of Ecstasy. The sense of collective identification, enhanced by music and dance, appears to lead to a reduction of standard sexual role-playing associated with collective settings such as clubs or parties. Women and men, it is claimed, generally interact more freely with less of a goal-oriented style. This, of course, is by no means always the case. One woman described the experience of nuisance she felt from the close presence of males who were acting with a sense of intimacy towards her. There are also difficulties associated with collective settings in which some people are under the influence of Ecstasy and others under the influence of alcohol. The sexual behaviour associated with the latter is not consistent with that associated with the former, leading to problematic cross-overs. It was not manifestly stated by the users, but this must be a major factor in trying to get all of a relevant group under the influence of Ecstasy, which in turn might explain the extent to which Ecstasy infiltrates entire peer groups as part of a process of ‘normalisation’, a fact referred to by almost everyone.

There was a widespread conception that aggressive and volent behaviour was seriously reduced under the influence of Ecstasy. People experienced raves without a sense of manifest threat, which was reported as a major release from conventional social interaction in the same settings. The attractiveness of this

freedom has to be measured against a wider appreciation of the drink scene, which is characterised by insecurity and threat, brought on by the ever-present threat of aggression and violence. Drink-related violence appears to be a growing problem and as with other 'releases' associated with Ecstasy does much to explain its contrasting popularity. It should be noted that many interviewees reported on aggression and violence associated with dealing in drugs. The evidence here was sufficiently compelling to suggest that this is a significant factor in club violence.

Venues, Atmospheres and Costs

The experience of Ecstasy is, as already observed, conditioned powerfully by social setting. In this respect clubs, as the forum where most young people experience Ecstasy both for the first time and most commonly, play a pivotal part. The club scene in the perception of users has changed rapidly in Ireland over the last five or so years. In the beginning, certain specific venues in the major cities dominated. These were specialised haunts where the early drug-using innovation was concentrated. The degree to which Ecstasy has penetrated youth culture, attested by surveys, by descriptions of users, and by anecdotal evidence is both cause and consequences of changes in the club scene. It is a cause of change in that the almost spontaneous diffusion of Ecstasy led to clubs quickly catching on to the necessity of providing rave environments. It is a consequence in that the early commercial success of rave impacted powerfully on supply-side perceptions and led to a new packaging of rave as a commodity geared towards a mass audience. It is now possible to speak of a rave industry. In any case, there has been a huge expansion in the kinds of club in which Ecstasy is available, a restructuring of rave music to cater for mass and progressively younger taste, and a massive increase in the size of venues in Dublin as big new clubs are emerging.

These phenomena are interesting in themselves, but the interest of this report is on how this impacts on users experiences.The expansion of Ecstasy usage associated with its

commercialisation, set in the context of a powerfully negative attitude to drug taking at an institutional level, expressed in early closing hours and legislation focusing on sanctions on clubs and pubs that are found to have drug-dealing going on in their premises, is forcing Ecstasy usage to some extent outside of the club scene. This leads to a differentiation of sites for rave and Ecstasy usage which move beyond clubs to house parties and the free party scene in the countryside or isolated houses. The experience of the club scene itself is ambivalent in that while Ecstasy continues to be consumed, a multitude of young people leave the clubs under the influence of Ecstasy and move to other settings. In this process, something of the safety and comfort of clubs is lost and they become exposed to social controls in the form of the police. There are also reports of messy scenes outside clubs as people under the influence of drugs are disgorged. This led to calls by a large number of interviewees to significantly extend the opening hours of clubs, and to introduce suitable harm reduction and informational measures in clubs. This is clearly some distance from the existing policy consensus where, even if it does enter policy formulations at working group level as an unelaborated acceptance of the need for 'harm reduction' and is supported by the majority of professionals working the area, it will encounter serious implementation bottle-necks by the unreadiness of politicians and other actors to take on what will probably be a largely hostile public opinion.

Some of the interviewees were proponents of the free party scene which takes place at isolated locations in the countryside. This appears to be a manifestation of a more sub-cultural element in the rave scene, where anti-authoritarian and non-commercial orientations engage with hedonistic ones. These venues are generally equipped with adequate sound systems and can sometimes attract numbers into the thousands. In the report of the interviewees, violence appears to be non-existent at these venues, though there are no explicit arrangements made for stewarding. Some minimal provision is made for safety by marking off ditches. The main difference in terms of safety in relation

to adverse effects of the drug in the eyes of the participants is that it would take longer for ambulances to reach these venues. The kinds of people who attend them are on the whole different to the mainstream scene, comprising of new age travellers, bikers and other people with alternative orientations. They attract antagonistic attention from guards, though the extent of actual surveillance is hard to quantify. The sample would have had to have been much bigger to have dealt adequately with the different profiles and drug consumption patterns of those who attended the free party scene.

One major difference between the free party scene and mainstream Ecstasy usage is one of cost. The free party scene is as the name suggests free to enter and it is probable that internal supply networks would make Ecstasy more cheaply available. The cost of Ecstasy in mainstream venues has come down. Most of the respondents noted it currently cost between £10-12 pounds per tablet, a reduction of more than half from its entry cost of about £25 some years ago. Venue costs would amount to about £5-6 pounds so the cost of a night's entertainment could be significant, especially if multi-tablet usage was in question. On the whole, however, cost did not appear to be a significant barrier to Ecstasy usage. If a typical night consisted of a few drinks, one or two tablets, plus club entry costs, it probably compared reasonably well with the equivalent costs of a night out on alcohol. The absence of cost sensititivity probably indicates something of the by now well-attested cross-class nature of Ecstasy usage. One user highlighted this fact by drawing attention to the significant cost of Ecstasy for him, which acted as a deterrent to use in the period of high Ecstasy costs. He instead used LSD which was cheaper.

There was much criticism of Irish clubs in the sample. They were described as unhygienic, having aggressive bouncers, no facilities for 'chilling out' and playing the wrong music. They received unfavourable comparison with clubs in Scotland in contrast to which Cork clubs in particular were accused of producing an obsessive and overly self-conscious relationship between drugs and music. Irish clubs were also compared

unfavourably by a number of interviewees to clubs in Holland on the counts of hygiene, safety and atmosphere. It has to be noted, though, that while music, hygiene, and atmosphere lie in the control of clubs, factors such as drug safety cannot be in the current climate.

There appeared to be no significant problems with acquiring Ecstasy. The fact that there is Garda surveillance of drug-dealing in clubs was raised by one commentator, but in general there appeared to be no major problems for the users either in availability of ease of acquisition. Some users observed that buying Ecstasy from a stranger could be unpleasant and another referred to ethical problems in supporting the criminal underworld, even if indirectly.

Clubs are especially important to gay culture given the degree of wider intolerance that exists. One commentator noted that the age of those taking Ecstasy amongst gay people is higher than that for heterosexuals and extends well into the thirties in many cases. More generally, this observation appears to support the close identification between club going – -and the particular social atmosphere that attends to it – and consumption of Ecstasy. It may well be that more protracted Ecstasy consumption amongst some gay people owes something to other cultural attributes, but in all likelihood it owes something also to the basic variable of the existence of an older persons' club scene.

The commercialisation of rave has been driven by a huge consumption of rave products. Some of the sample did invest in rave clothes, posters and other items, but probably did so to a lesser extent than average. This is perhaps a product of the bias of the sample towards somewhat older people who could report on a longer experience. There is undoubtedly an affinity, which one user noted, between the commercialisation of rave and the perceived low risk in taking Ecstasy.

Values and Attitudes

It was difficult in the format of a single interview to tease out

basic value orientations. A discriminator for value orientations was assumed to be 'cultural investment in E culture'. This was a difficult variable to analyse as high commitment could be specific to Ecstasy usage or could encompass wider commitment to an alternative rave culture with Ecstasy consumption as an element. It would be safe to assume that though that consumption of Ecstasy for a significant period was accompanied by some kind of cultural commitment, and that associated with this cultural commitment was a somewhat counter-cultural value spectrum. In a sense, a minimally anti-authoritarian value spectrum could be anticipated. To continue consuming Ecstasy for a period of time in the Irish context requires a degree of rupture with existing, strongly entrenched norms and associated social control mechanisms. In that sense, protracted Ecstasy consumption is at least minimally subversive, leading to an anti-authoritarian value orientation. It is likely that this orientation could migrate in certain cases to other alternative value orientations such as higher enviromental consciousness, vegetarianism and so on. The research we have conducted did not have the resources to probe these issues in detail. But such associations would be unsurprising given the relatively long-run associations between drug usage and counter-cultural manifestations.

Another value that could be identified was a kind of 'bodily liberalism', which asserted that drug usage was a matter for individuals in relation to their own bodies. This is a huge latent value that to some extent must underpin all illegal drug usage. If a user knows a drug to be illegal and still consumes it, this serves as a basic example of bodily liberalism. One commentator interviewed notes that a strong consciousness of this value permeates young peoples cultures today and that any attempt to speak to them from an authoritative non-discursive standpoint is doomed to failure.

Another undoubted value concomitant of drug usage was an above-average commitment to hedonism. This again was a value that is difficult to define. It certainly includes a guilt-free attitude to self-indulgence, a capacity, even for a short time, to live outside of certain kinds of purpose-oriented norms (such

as those guiding attitudes to work, education, etc.) and a capacity to accept some risk in pursuit of pleasure. This was undoubtedly present in the sample but we were unable to probe the social origins of this orientation and how it might explain a proclivity to engage in drug consumption in the first place. Some commentators have observed that the decline of religious adherence is an important factor in orienting people to drug-taking and this, while normally expressed as a nostalgia and despair at the secularisation of the world, probably has some substance. With the loss of potency of religious norms that promoted conformism and controlled transitions from childhood to adulthood roles, hedonisistic orientations acquire more ground.

Another value orientation that received attention in the analysis was that of authenticity. This is an orientation that can be read in different ways and probably can be more easily classified as an attitude rather than a value. A consistent motif running through the interviewees was a certain scepticism about the authenticity of the rave experience. This can best be summed up as the view that it is or was good in itself, but not to take it too seriously as a long-term model of social relations. From the perspective offered by the passing of time, the rave experience in its purest sense of complete communality does not last. Insofar as participants in raves act as if it could, they engage in a behaviour that will inevitably prove false over time. It is tempting to read this as a functional rationalisation of experience, of an attitude that shows that most of the older interviewees are distancing themselves from the euphoric illusioning of E-accompanied rave: it's a way of getting out, getting distance, getting control and putting drug-related behaviour in the context of the rest of life, rather than the other way around.

CHAPTER FIVE

ANALYSIS OF SELECTED MEDIA TEXTS ON ECSTASY

Introduction

The Irish "public culture" on the drugs issue is not difficult to describe: Public consciousness of drug use is almost wholly negative and portrays soft-drugs in the same terms as hard drugs, that is, as associated with criminality, violence, despair, embedded personal problems and so on. This consciousness, which is far from wholly confined to the general public with no specific first-hand experience of drugs, but extends also to many politicians, health administrators, professionals and others, inhibits the possibility of de-polarisation of the drugs issue and the emergence of informed, and, in relation to youth culture, influential debate.

In the following pages, we proceed to an analysis of what might be called the deficit of deliberation on the soft drugs issue in Ireland. Enhanced and vital deliberation of the issue in the public domain could produce the kind of re-orientation in thinking that would produce a shift in consciousness and make possible necessary policy innovation. Three indicators of possible change are considered. These are, firstly, responses to survey results, which provide factual information on the extent and nature of soft drug use amongst young people. The second is the penetration into opinion pieces of new kinds of thinking on the Ecstacy and wider soft drugs problem. The third is the degree to which the wider context presses on public debate in Ireland which may indicate the need for re-orientation.

The coverage of news media reports does not purport to be exhaustive, merely representative of changing trends and contexts. Coverage of the soft drugs issue – apart from the more

sensational matter – tends to be rather scanty in Irish newspapers. In selecting articles to illustrate the above points, the sample size of articles for analysis collected over a 12-month period is approximately thirty – some are cases of marginal relevance. Due to their repetitiveness and often non-argumentative nature, there is little point in analysing each one. This is the basis for representative analysis. In the following sections, each of the above indicators of cultural change are analysed in turn.

Response to Facts

A key text in the first category was *The Examiner* lead article of Friday May 15th, 1998 'Government fail on education against drugs'. This was a response to a Union of Students of Ireland survey which demonstrated widespread usage of illegal drugs by young people. Perhaps the most telling figure was that 53% of students regarded drugs as part of their social lives. *The Examiner* editorial occurred in a context in which a Ministerial Task Force (see Chapter Three above) had previously supported, albeit highly tentatively, a shift to a harm reduction strategy in the case of soft drugs and in a context in which the USI had been calling for some time for a replacement of the 'just say no' approach with a harm reduction one *(The Irish Times,* April 22nd, 1998: 'USI leader urges new approach to drug warnings; Government told 'just say no' appraoch will not work with young people'). Notwithstanding, *The Examiner* – as is clear from the phrase 'education against drugs' – appears to be working within the 'just say no' frame of reference. Further examples include:

> [the survey] indicates the frightening degree [to which] our young people are dangerously inculcated into the drugs culture [and] peer pressure can be very difficult to resist and that, coupled with curiousity, can be an influencing factor as to whether or not a young person embards on a road which largely leads to grief [and] [our young people] are not adequately

educated on the dangers of drug use.

It may be observed that none of these formulations would have much resonance with the majority of the users interviewed as part of this report. However, *The Examiner's* intention is not simply to reiterate moral and responsible opposition to drug-taking. Since it does not advocate a clear way forward the message has to be inferred more indirectly. First, it is clear on the negative. The Government's education policy is not working. Second, it does not attempt to dispute or shy away from the implications of the survey results and warns parents not to be complacent. Third, in the very last sentence the nearest it comes to a positive suggestion is put forward: 'another approach must be taken in relation to educating young people about the dangers of using illegal drugs'. The latter is probably a coded message calling for facts-based information and harm reduction measures, at least to a minimal extent.

This editorial both demonstrates a probable willingness to consider new measures in line with policy innovations elsewhere but it does so in such a coded, negative way that it is hard to be sure on specifics. It indicates that having built a moral consensus on drug use as an absolute, undifferentiated wrong, having contributed to build up this pre-factual attitude in public consciousness, it is extremely difficult to tread on new ground, to find words which do not openly contradict the pre-established consensus and yet initiate needed change. As a way of building a new agenda, it is at most a slow and contradictory process.

Later, on June 6th 1998, under the heading 'Drug survey not all bad', a shorter piece again reported on the scale of drug usage: 'more than half of youths try drugs before they are 17 years of age' the 'not all bad' dimension derives from the fact that the 'majority of those interviewed were of the opinion that illegal drugs should not be decrminalised'. If the formulation is closely examined, it is 'illegal drugs' and not cannabis which is referred to, a formulation repeated in the article of the previous day (June 5th) reporting on the findings of the survey

entitled ‘More than half of youths try drugs before 17’ which observes that: ‘As for the current independent-led campaign sweeping Britain to de-criminalise the so-called soft drug of marijuana, the survey suggest that a similar campaign here would get short-shrift.’ All the reader is missing, is factually-informed views on the issue in question, the de-criminalisation of cannabis, the precise basis of the assertion. These formulations are highlighted to indicate that media reporting; even in relation to fact-based reporting, is highly circumscribed by the prevailing impression of the moral consensus. The problem is that if innovation is to proceed in a meaningful time-frame, as at least appears to be indicated by a general sensibility among the policy community of the need for re-orientation, this moral consensus has to be significantly adapted. *The Examiner,* a highly representative barometer of the opinions of middle Ireland, would appear to be reluctant to provide any kind of leadership towards facilitating that change.

New Opinion Pieces

A general example of a new kind of opinion piece, arising from shifting contextual moorings provided by the legalise cannabis campaign in England, by the less-developed but advancing movement in the same direction in Ireland, and by the inescapable fact of rampant soft drug use, is the piece by Brendan O’Connor in *The Sunday Independent* of April 12th 1998 entitled ‘Making a hash of war on drugs’. This piece argues against the ‘gateway’ argument that advances the proposition that drug initiation through cannabis leads inexorably to use of hard drugs such as heroin and cocaine. The full details of the argument need not detain us here. What is interesting is, first, that the piece appears at all, which suggests that the above contextual factors are beginning to influence opinion leadership and, second, that the point is made that cannabis use does not cause heroin use. In relation to the latter, the filters between one and the other are empirically quite weak. Even more germane is the author’s point that the symbolic consensus that they are highly connected leads

to a mix of policies, that makes them connected in practice. The non-differentiation of the drugs problem is reflected in the creation of criminal supply sub-cultures which any person seeking any kind of drug encounters, directly or indirectly, 'where they will be offered all kinds of other drugs too'.

Two other pieces, going back some time to November 19th 1996, appeared in *The Irish Times*, both under the authorship of Cormac O'Keeffe. The first piece is a sobering piece on the health implications of ecstacy called 'Legacy of a Love Buzz' and the second entitled 'Time to stop demonising?' provides evidence to support 'harm reduction' strategies, a point of view defended – implicitly – by such formulations as 'we need to know how to minimise the harm users are doing to themselves'. Dr. Des Corrigan is also quoted in the interview using the same relativising argument used by users in the interviews:

When I talk to teachers and parents about drugs I make the point that the drugs that are far more likely to kill their children – and themselves – are the two legal drugs [alcohol and tobacco].

Pieces such as these are important in that they largely adopt an explicit attitude in which the message is not so highly coded as to be difficult to recognise. The pervasiveness of rave and associated Ecstasy culture appears to require explicit treatment. In relation to attitude change, little could be more explicit – at least, to the eyes of young people – than the AIB ad for its mortgage service which contained a psychedelic image of a young man and woman attired in far-out wedding clothes under a house name sign saying 'Dun Raven'. In the context of such manifest images of the power and pervasiveness of rave culture, and their official acceptance by major financial institutions, it would appear time for a transfer of opinion leadership for changed policies from isolated commentators into 'official' voices.

Outside influences

We have already attested to the influence of the outside in terms of, on the one hand, cultural change in the form, for example, of the movement to legalise cannabis in Britain, and, on the other, institutional change expressed in changed policies and implementation regimes. These two dimensions come together in an *Examiner* report of January '15, 1998 which is entitled 'Mounting Opposition to EU soft drugs plan: All 15 Irish MEPs to vote against proposal'. This provides a useful summary of politicians views when set in a different cultural and institutional context. The rights and wrongs of the particular measure do not concern us directly here. What is interesting is the formulations provided by Irish MEPs. Mary Banotti of Fine Gael is reported as saying that:

> nothing convinced [me] ... that there was a case for legalising illegal drugs. Such a development would simply add hugely to the level of human misery caused by the trade in illegal drugs. It would be absurd and bordering on the criminal to allow the free sale of so-called soft drugs. There is nothing soft about these drugs. They are dangerous, damaging, and their use leads frequently to dependence on hard drugs and to early deaths of the addicts.

The paper further reports the view of the Fianna Fail MEP, Liam Hyland, who called for a massive rejection of the proposals, which he said were the most dangerous set of proposals ever to be presented to the Strasbourg Parliament.

The paper reports that all 15 Irish MEPs were to vote against the proposal, drafted by the Dutch Socialist MEP and former health minister, Hedy d'Ancona, who aimed to harmonise the widely divergent laws in the EU by decriminalising soft drugs and making hard drugs available on prescription. Two issues emerge here of particular interest to this report. The first is that the EU forms not only a relevant cultural context – as such,

developments in Western Europe were often ignored in the past – but a relevant institutional context, including a statutory and judicial framework. In this sense, the need for minimal European convergence on drugs policy acts as a spur towards institutional innovation in Ireland. The second is that if minimal institutional innovation is to happen here sufficient to provide a basis for certain policies generally thought desirable such as facts-based information and other; harm reduction measures, something of a rethink of the kind of views associated with Mary Banotti will have to prevail. One of the relevant issues, for example, may well become not the confident assertion that soft drug use leads to hard drug use, but encouragement of the attitude that one *need not* lead to the other.

The main point arising from this short media analysis is that clarity about, and explicit commitment to, policy innovations such as harm reduction is needed if these policies are really to gain ground. If the cultural ground is to be cleared for this amongst the general public, then opinion leadership is required by influential commentators, policy-makers and the editorial strategies of newspapers. Given that it is at some level a policy aspiration, it is time perhaps that debate followed on the implications.

CONCLUSION

The incidence of recreational use of drugs amongst young people has increased notably in recent years, in Ireland as well as in many other European societies. In terms of recent drug trends, a notable development is the emergence of a 'club culture' scene, intimately associated with an international 'dance culture,' in which use of the drug Ecstasy ('MDMA') and other drugs features prominently.

It is apparent from even a general analysis of Irish drug policies and recent media coverage of drugs issues in Ireland, that understandings of, and responses to, drugs issues in Ireland, at an institutional and a socio-cultural level, are undergoing pronounced change. Whilst this change has been facilitated, to some extent, by information emanating from the research community, it is important not to convey a sense of complacency about the current state of knowledge. Reporting on drugs issue in Ireland in 1996, the Health Research Board identified a number of key priorities and information needs for the future. Included in this comprehensive range of recommendations are some issues which have particular resonance for the social scientific research community. Information gaps at three specific levels of research were identified: first, national population surveys are needed to establish levels of drug use, and attitudes and perceptions towards drug use, in addition to regular surveys of young people, which are necessary to discover emergent trends of drug use; second, sociological and ethnographic studies of drug-using communities are highlighted as necessary to provide qualitative information about the social nature of drug use; and third, the need for extensive evaluation in the implementation of policy in all areas is highlighted as a prerequisite to increased effectiveness of policy-led interventions.

In the context of Ecstasy use in Ireland, this report has

operated on the second two levels of research mentioned by the Health Research Board: qualitative information has been derived from interviews with drug users, and policy evaluation has proceeded on the basis of comparative analysis – comparing policy and other responses, at both local and state levels, in a variety of other European countries.

One of the implications of the widespread popularity of dance culture is that new formulas and models of rave, and associated changes in patterns of drug use, all emerging in a given context, are likely to be taken up in other contexts. Substantial moves have been made towards recognising and identifying needs amongst the population of young people who use drugs in recreational contexts elsewhere. It has been noted, for example, that countries such as Britain, the Netherlands and Germany 'had forward-looking NGOs in touch with consumer trends, which could implement harm-reduction programmes found acceptable by local government, event organisers and drug users'. As a result of such initiatives, models are available, which serve as reference points in the development of strategies which are commensurate with levels of use and specific needs. These models are available from these other national contexts which have experienced an upsurge in levels of recreational drug use amongst young people, and which have responded in a progressive, open fashion. In terms of responding to new and changing needs of drug users, the evidence would suggest that regular monitoring of drug use trends amongst target groups, at a national level is required, in addition to European level analysis and cross comparisons between member states.[250] In domestic terms, the

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[250] Ongoing research which is of interest in this respect is 'The European model project' which is currently engaged in monitoring drug use in the club scenes in three different national contexts with the objective of producing prevention material which directly responds to both gender specific and contextually specific needs. Partners in this project are Lifeline, Manchester, Jellinek, Amsterdam and Buro fur Suchtpravention, Hamburg.

successes of the Dutch monitoring model are important to bear in mind as regards future policy directions.

It is evident from the results of the Irish user interviews included in this report that the societal and policy responses that users without serious, obvious problems would like to see on the basis of their experiences of drug-taking fit a definite pattern. They desire a less morally prescriptive environment, with recognition of their right to take certain substances that they – mostly – see as no more abusive than other highly legitimated substances. They would wish society to respond to their needs in a meaningful way through greater toleration, facts-based information, wider harm reduction measures, testing facilities in clubs and so forth. Yet, as is abundantly clear from this report, this has not been the dominant institutional response to widespread consumption of Ecstasy in Ireland. The wider institutional order has framed Ecstasy use and other soft drug use in a wider context of illegal substance abuse, portrays users as lacking in self-esteem, appeals to their sense of self-preservation, and genuinely portrays a strong moral anti-drugs line.

This polarisation has in recent times become somewhat less extreme. There is some evidence, minimal and uncertain but still real for that, of a re-orientation of institutional thinking, driven by the scale of Ecstacy use, the introduction of new kinds of arguments into public culture, a re-assessment of policy failure, and policy change elsewhere, which might go some way to meet users' perceptions of adequate responses. It might be possible, from that standpoint, to envisage a de-moralisation of the terms of the debate and to see new kinds of policy introduced to address an issue that everyone agrees is very much in need of addressing. The values and attitudes of users, for example, that tend to exclude heroin and other substance use will have to be encouraged. The shift from outright to qualified negativity towards soft drugs will therefore have to be countenanced. In addition, the campaign, launched by the Dun Laoighaire Drugs Task Force and the Eastern Health Board in July 1998, which aims to regulate clubs and provide factual information to users as well

as advice on how to reduce, rather than stop, the damage to themselves, is a major indication of how the demonisation of Ecstasy would appear to be in retreat.

Despite this initiative, however, there are presently few indications that on-site drug testing is anywhere on the Irish horizon. On the other hand, it seems even less likely 'that the Irish state would introduce anything approaching the draconian 'use laws' of Sweden, on the basis of Ireland's constitutional history, as well as the broader political and public culture. This report's overall analysis of the situations in the Netherlands and Sweden, the two countries at opposite ends of the drug-policy spectrum in the European Union, suggests that the EU 'propoganda war' is being won by the Dutch, but that the impact of this is extremely subtle.

The specific knowledge generated by the research referred to by the Research Board – the terms of which this report has endeavoured to fulfill, albeit only partially – is essential to enable the policy making process to function in a pro-active (rather than a reactive) manner, ensuring that drug-related problems can be dealt with effectively and immediately. It is hoped that this report has contributed something of value in this regard.

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