

**UNDERSTANDING CONTROLLED ILLICIT DRUG USE:  
A STUDY OF COCAINE USE IN SYDNEY, MELBOURNE  
AND CANBERRA**

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I certify this thesis is my own composition and  
that all sources have been acknowledged.

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## ABSTRACT

This thesis examines the issue of controlled illicit drug use with specific focus upon one drug, cocaine, and its use in present day Australia. In adopting the controlled drug use perspective, with its emphasis upon "drug, set and setting", the study attempts an understanding of the various factors which influence the drug using experience.

The first half of the thesis charts the history of cocaine use, the known pharmacological effects of the drug and the development of the theoretical perspective on control in the last twenty years.

Having established this framework, the second half is concerned with the empirical evidence from the study of cocaine users in Sydney, Melbourne and Canberra. In analysing both quantitative and qualitative data, the picture emerges of a group of users with a set of attitudes and beliefs which govern their use of cocaine and act towards control.

The conclusion reached is that cocaine use fits in very easily with everyday life and resembles many other modern "entertainments".

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# INTRODUCTION

The concept of controlled illicit drug use has been current for some twenty years now. Once inconceivable, the idea that drugs such as cocaine and heroin are able to be used over time without resultant dependency upon them, this is now seen as characterising the majority of users of any drug. While scientific and media circles concentrate upon "drug abuse" and the "drug problem", there has been little attention focussed on the people who are successful in maintaining control over their drug use. It is with these people, and the question of how they achieve this control in reference to one drug, cocaine, that this thesis is concerned.

What is meant by the term "controlled drug use"? In a general sense it is the exercise of moderation in the use of drugs so as to maintain culturally acceptable levels of use. "Acceptable levels" are those where no detriment is experienced to the health of the individual or to their ability to carry out everyday activities eg. work, family and social commitments. Maloff and Levison provide a useful definition in their discussion of general substance use:

broadly described, controls are the regulatory mechanisms that direct the behaviours of systems. In this sense, controls in substance use regulate (1) substance seeking behaviours (2) substance-using patterns, and (3) behavioural changes produced by taking substances (Maloff and Levison, 1980: 1).

There are three levels at which control has been approached analytically: the medical-pharmacological; the societal and; the social-psychological level. Traditionally, the emphasis has been with the first two approaches.

A medical-pharmacological position analyses the issue of control from the viewpoint of drug effects on human beings. Basically, drugs are seen as having the power to completely overwhelm people: self-control with illicit drug use is deemed a virtual impossibility. Illicit drug users are in fact "sick" individuals who require professional "help" in order to control their use of drugs. Essentially, that is a case of people having to be protected from the damage they can inflict upon themselves through "abusing" drugs.<sup>1</sup> As will be seen in chapters two and three of this thesis, these assumptions underly most of the thought and research done on illicit drug use to date.

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<sup>1</sup> Stephen Mugford has developed an argument about the broader pathology paradigm within drugs research. See Mugford, S. and Cohen, P. 1988 "Pathology, pleasure, profit and the state: towards an integrated theory of drug use".

At the societal level, 'control' is seen in terms of eradication. That is, illicit drug use is a problem to be controlled ie. eliminated, through legislation prohibiting use, preventing trafficking and supply of drugs and public education programmes to dissuade people from using drugs. Again, this position assumes that people are unable to exercise free will and choice with drug use. While large scale social control of this type has proven to be largely ineffectual, a tremendous amount of resources in western societies are channelled into "solving the drug problem" this way.

In contrast to the first two approaches, the social psychological perspective makes no judgements about whether drugs ought or ought not be used in the first place. The fact that human societies have always taken drugs of one kind or another, and will undoubtedly continue to do so, is taken as read. Instead, the emphasis is upon determining the complexity of factors which combine to produce a drug using experience and how self-control is exercised in most drug using situations. The principal factors are what Norman Zinberg, a leading researcher in this area, describes as "drug, set and setting". That is, a combination of the pharmacological effects of a given drug, the personality of the user and the environment in which use takes place. This approach is adopted as the theoretical framework for the present study.

Given this perspective, where should we start in the attempt to understand controlled illicit drug use? Theoretically, it is a matter of re-thinking the way illicit drug use has been conceptualised. Sociology has viewed illicit drug use as one of the "classic" examples of deviance, along with prostitution, delinquency and homosexuality. In the 'mainstream' view, illicit drug users are deviants because they break the law, mix in drug sub-cultures and flout mainstream societal norms and values. "Controlled illicit drug use" though, by its very nature, suggests an adherence to one of the basic tenets of society, that is, self-restraint in personal behaviour. There may in fact be a large degree of "normality", for want of a better term, about the way drugs are used and in the perceptions of users about their drug use. Given that controlled use represents the majority of users it brings into question whether a deviance framework provides enough scope for understanding the phenomena.

At a practical level, the issue of controlled use provides an important insight into the non-controlled users: the so-called abusers, addicts or dependents. In order to understand how and why certain users lose control it is necessary to ask the "all important question" (Zinberg, 1984:vii) of how and why many others are able to achieve and maintain control.

While cocaine was chosen as the drug on which to base the research, to a certain extent any drug would have sufficed. In fact part of the aim of this study is to redress two major lacks in the general drugs research area.

The first of these is the paucity of research which has subjects drawn from the community at large. The few studies which have focussed on specific use patterns of users have tended to generate samples from those who have come to the attention of official agencies, whether they be hospitals, re-habilitation centres or criminal justice institutions eg. the courts or prisons. These people generally represent the minority of users who are experiencing severe problems through their drug use.

The second area of neglect has been in terms of treating user's accounts of their usage patterns as legitimate. Following on from the belief that all drug users are abusers, or have some basic personality deficiency, it is thought that any of their views on drugs would simply be a "deluded mind" speaking and certainly not to be taken seriously. The fact that user accounts offer a wealth of information and insight has thus to date been over-looked.

There were a number of factors which influenced the decision to investigate cocaine use.

As far as investigating controlled use was concerned, cocaine seemed to be ideal because of its reputation as a "seductive", highly addictive drug which was basically irresistible to the user<sup>2</sup>.

Cocaine, used as an illicit drug for recreational purposes has come to the fore again in the last twenty years. This recent period has witnessed a tremendous increase in the number of people using cocaine, particularly in the United States where estimates indicate that twenty-five million Americans have had some experience with it. In Australia, no reliable estimates of numbers using the drug exist but increases in seizures of cocaine by police and customs have led authorities to conclude that a significant increase in use has occurred. Not surprisingly, speculation has arisen as to whether Australia can expect to face similar kinds of problems with the drug as are currently being experienced in the U.S.

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<sup>2</sup>The notion of "seduction" with cocaine use is popular amongst American psychiatrists. See Stone, Fromme and Kagan (1984).

The attention focussed on cocaine has revealed that there is very little factual information about the way the drug is used in this country. Any discussion of cocaine is based either on research carried out in the United States or on the popular stereotypes of cocaine users. The U.S. data provides a good starting point, but it is a mistake to assume that the Australian situation directly reflects what happens there, except for a five or ten year lag in events here. Reliance on stereotypes is bound to be misleading as they usually only refer to the more 'visible' of users. In the case of cocaine the stereotypical users being the 'fast lane' or yuppie (young upwardly mobile professionals) sets. It stands to reason that use must be across a wider social spectrum than this, a point which is borne out by the present study. The challenge for this research was thus to determine the "who, what, how, where, when" of cocaine use in Australia.

The thesis is set out in two parts. The first half provides a background and theoretical framework for understanding the empirical research, which is then detailed in the second half.

Chapter One traces the long history of cocaine, from the initial use by South American Indians of coca leaves in ritual and ceremony, to present day use of "crack", a cocaine derivative, in the United States.

The practice of chewing coca leaves was discovered by the Spanish through their conquest of the Incan Empire in the sixteenth century, though it was some three hundred years before any great interest was shown in it by European society. It took a process of purification, both chemical and cultural, before it was seen as having any use at all. There followed a period of intense scientific investigation with the substance isolated from coca leaves, known as cocaine. Sigmund Freud and William Halstead were two of the leading figures to be involved with the research which sought to understand the effects of cocaine. First heralded as a "wonder drug", cocaine soon fell out of favour as more and more adverse effects were noted. At the same time though cocaine was used as one of the main ingredients in patent medicines and supported a flourishing industry for some thirty or more years.

Economic and political interests have always played a major role in shaping the way cocaine has been used, and this is seen in no better way than around the turn of the century when restrictive laws were introduced limiting use of the drug to pure medicine. Since the imposition of illicit status cocaine has had various waves of popularity.

Australia's history with the drug really began in the 1920's when this country had one of the highest consumption rates per capita in the world. First prevalent amongst servicemen returning from the first world war, it became the drug of choice amongst prostitutes and underworld figures in Sydney and Melbourne. In the United States and Europe the drug remained popular amongst bohemian sets up until World War Two. It re-emerged in the late 1960's and this latest era has become the domain of drug enforcement agencies as concentrated, if rather unsuccessful, attempts have been made to "win the war" against cocaine and illicit drug use in general.

The last twenty years has witnessed a renewed scientific and medical interest in cocaine, the results of which are examined in Chapter Two "Methods, pharmacology and effects of cocaine use". Initially, the chapter focusses on ; the different methods of ingesting cocaine into the body; the effects of dosage levels and adulterants and; the pharmacological action of cocaine, namely as a local anesthetic and as a stimulant of the sympathetic nervous system.

Having established the basics, the subject of the adverse effects from cocaine is addressed. What emerges as the main issue is cocaine's potential as a dependency producing drug. The area of addiction and dependency has been described as a "conceptual minefield" and considerable space is devoted to analysing the definitions of these concepts and how cocaine fits with them. The fact is that notions of addiction and dependency have largely shaped the social research carried out on illicit drug use. This chapter is one which might not normally be expected in a sociological thesis but it is crucial to the study. In order to understand controlled drug use it is necessary to account for both the social determinants of use and the pharmacological effects of a drug.

The first half of the thesis culminates with Chapter Three "The development of the controlled drug use perspective", an analysis of the sociological based studies of illicit drug use.

The chapter begins by examining the growing dissatisfaction with the concept of society's "drug problem". This concept, with its inherent focus on addiction/dependency has prevented realistic appraisals of illicit drug use taking place. Today, the trend continues as official agencies concentrate upon dispelling the "myth" of safe or problem-free illicit drug use, in the process creating counter myths of their own.

The recognition that the majority of drug users are not dependents was the catalyst for a new conceptual approach, one which is analysed in the second half of the chapter. The controlled drug use perspective places great emphasis on the informal social controls of the using environment (the "setting") as determinant in how a particular drug is used. The final section outlines the major substantive studies which have used this approach as their basis. These studies were important for establishing that controlled use could be maintained over time and identifying the various self-control techniques employed by users.

The second half of the thesis is concerned with the empirical study of cocaine users in Sydney, Melbourne and Canberra.

Chapter Four outlines the methodology of the research. Studies of illicit drug users, drawn from a community base, have evolved their own common methodology. Subjects are usually located through snowball sampling techniques, personal background data is collected and intensive interviews dealing with their drug use patterns are carried out; this basic methodology was adopted here as well.

While the generation of a sample through snowballing can present difficulties cocaine users were contacted with relative ease in all three cities. The only difficulty was experienced in attempting to reach users from higher socio-economic strata. The main limitation of this methodology which concerned the researcher was the inability to verify the authenticity of respondents ie. were they in fact genuine cocaine users. It was thought that the extensive nature of the interview would find out any bogus subjects and as it turned out, no such cases appeared.

Chapter Five "Cocaine users: a social profile" analyses the data obtained through the self-administered questionnaire.

In demographic terms, the users in the study closely resemble those surveyed in U.S. studies. High in educational achievement (the vast majority having attended a tertiary institution at some time), their income levels are relatively low (the majority under twenty thousand dollars a year) and they represent a broad spectrum of occupational categories. A major difference noted was in the high number of women contacted here, the sample was split forty-one men to thirty-two women, whereas overseas the common ratio has been eighty per cent men to twenty per cent women.

The cocaine users appeared to be in basic good health and compared quite favourably with a general population sample. The only real problems were in the area of psychiatric morbidity yet these would certainly not be classified as severe.

Finally, this chapter examines a number of issues involved with social integration and social values. The picture emerges of a group with a liberal outlook who have few ties at an institutional level yet strong inter-personal relationships.

Chapter Six "Cocaine users:the maintenance of controlled drug use" deals with the actual drug use patterns, establishing, if you like, the "drug profile" of the respondents.

The first section traces the individuals drug using history. Most commenced illicit drug use in the mid teen years by using marijuana and with friends from established social networks. The pattern of using amongst friends continued with the use of cocaine. The other notable features are the relatively small amounts of the drug consumed and the fact that it is seldom taken in isolation: the "cocaine experience" invariably includes ingestion of at least one other drug such as alcohol or marijuana.

While most respondents pointed to the high price of cocaine as a limiting factor, it was obvious that there were underlying attitudes and beliefs which governed their use of the drug. These attitudes were also borne out on a range of issues, including the ill effects from cocaine use, the question of drug legalisation and government portrayals of cocaine. One of the most surprising features is that far from being a group who are enraptured with cocaine, the respondents were on the whole slightly skeptical about the usefulness of the drug.

Chapter Seven concludes the thesis, drawing out the implications for social policy as well the directions for future research.

# CHAPTER ONE

## THE HISTORY OF COCAINE

### 1.1 INTRODUCTION

The recent upsurge in the use of cocaine, particularly in the the United States which is purported to be in the midst of a "cocaine epidemic"<sup>1</sup>, has brought a tremendous amount of interest in the drug. While the subject of cocaine use appears in much mass media discussions to be a recent phenomenon, in reality it has a long history of use, of trafficking and as a substance subjected to scientific research.

This chapter charts the history of cocaine, from its origins amongst Indian tribes in South America to present day use in Australia. After discovery by the west of coca, the history became first centred in Europe and then later in the United States. The first scientific investigations of coca leaves and the subsequent purified substance known as cocaine took place in Europe. It was here as well that the practice of including cocaine in patent medicine was established. The patent medicine industry boomed in the United States and by the end of the nineteenth century, cocaine use and debate over the need for prohibition of the drug were focussed in this country. The United States led the way in anti-drug laws and by the 1920's many other nations had also enacted such legislation.

Australian use of cocaine only began during the great wave of illicit use in the 1920's. The drug was extremely popular up until the late 1930's but then almost completely disappeared from the public scene until it re-emerged again in the 1970's. The latest period of cocaine use has been witnessed by fear and speculation in government and media circles that Australia faces a severe social problem with cocaine, along the lines of the U.S., in the near future. What is neglected in these concerns is the fact that Australian drug use has never followed on automatically from overseas trends and that a good many factors would have to change before a "cocaine epidemic" can be expected here.

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<sup>1</sup>Richard Clayton's article "Snow blind or snowblinded", 1984, evaluates the whole question of whether a "cocaine epidemic" is taking place, and if so, what the implications are for policy.

## 1.2 EARLY USE AND DISCOVERY BY THE WEST OF COCA

It is impossible to determine the exact date when cocaine, or rather coca, was first used<sup>2</sup>. Archaeological evidence has placed the date at around 3,000 B.C.<sup>3</sup>. Siegel reports that bags containing coca leaves were found in burial graves of Peruvian Indians indicating their use in Shamanistic rituals. Martin describes this further when he states:

The Indian medicine man valued coca specifically for its narcotic effects; the mild mental excitation which follows the mastication of the leaves enabled him to enter more easily into a trance state in which he could communicate with the spiritual forces of nature (Martin, 1970:424) <sup>4</sup>.

Coca chewing was prevalent amongst the Yunga tribe of the Andes where coca was valued for its stimulating and hunger-deadening effects as well as an anesthetic for basic operations.

There are many myths associated with the origin of the coca plant and coca chewing. An Indian legend suggests that the god of thunder, lightning and snow, Khunu, was angered by the Yungu tribe burning the forests, with the fires supposedly blackening the god's palaces on top of the snow-capped mountains. As punishment, the Yungu tribe were forced to become nomads, where, "hungry and thirsty, the Indians discovered that by chewing coca leaves, they were given strength and did not feel the effects of the high altitude" (McLaughlin, 1973: 531).

The use of the coca plant really became prominent during the Inca empire. Use of coca by the Inca's was initially restricted, being reserved for religious rituals and as rewards for outstanding military service. Coca was thus the domain of nobles and those with political power. Incan myths about the origins of coca supported the special position it was held within the society. The most common myth describes how the god, Inti, instructed the moon mother, Mama Quilla, to plant coca in the humid valleys of the Andes and that only the descendents of the gods were allowed to consume it. This was how coca came to be known as the "divine plant". Basically, coca was seen as a gift from the gods in order:

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<sup>2</sup>As will be seen, there is a difference between chewing coca leaves and ingesting the cocaine synthesised from them.

<sup>3</sup>Siegel, R.K., 1982, and Van Dyke, C. and Byck, R., 1983, examine the archaeological evidence in some depth.

<sup>4</sup>Martin uses the term "narcotic" as an equivalent of "psychoactive". Narcotic actually means a drug which produces a state of stupor, insensibility and unconsciousness.

to mitigate the hunger and thirst of the Inca's so that they would be better able to endure earthly demands (Petersen, Jaffe et al, 1980: 231).

Another Incan myth relates how coca originated from a beautiful woman who, having been executed for adultery was cut in half and buried. From one part of her remains the coca plant grew, to be consumed only by men in her memory (Petersen, 1977 ). This could be seen as the first connection between cocaine and sexual behaviour. As will be seen later in this chapter, the link between cocaine and sexual excitation has been a major part of popular mythology surrounding the drug.

The Inca's were the first to control the growth of the coca plant. They established special coca plantations called "cocales" during the reign of the Topa Inca, which were owned by the state and allowed them to limit the usage of the plant. As Reinerman states:

rulers control over the production and distribution of coca was a symbol of their authority over the people, and, therefore, testimony to the centrality of coca in Indian society (Reinerman, 1979: 226).

While coca chewing was primarily for nobility and priests, it was on occasion given to soldiers during military campaigns, to those working on public projects or other favoured groups. These were special occasions and "a gift of coca was considered one of the highest ranks of imperial favour" (Martin, 1970:426)<sup>5</sup>. Coca played a very important role in many of the Incan rituals. It was used in the initiation of young nobles, as a present to the nobles of conquered tribes and as a special sacrifice at the temple of the sun in Cuzco (Martin, 1970).

An event of great significance in the history of coca was the end of the Incan Empire and the Spanish conquest in the sixteenth century. While the growth in use by Indians is often associated with the Spanish conquest of Cuzco in 1536, it appears that coca use had become more widespread before that point. Most commentators point out that the Incan Empire was crumbling before the arrival of the Spanish and that part of this breakdown was that "coca had lost much of its earlier significance and was no longer a symbol of exclusive political rank or social status" (Petersen, 1977: 39). Coca still maintained a deep religious significance (which continues to this day), although its use was now more common among the masses<sup>6</sup>.

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<sup>5</sup>See also Siegel, RK., 1982, for discussion of the use of coca leaves in most religious festivals.

<sup>6</sup>See Martin, T., 1970, p. 426, for further discussion.

The Spanish were initially opposed to the practice of coca chewing on religious grounds. Spanish missionaries considered it a pagan practice and as such, vulgar and debasing. Essentially, as coca held such a significant position in Indian culture, it was seen as a barrier to religious conversion. Reinerman identifies another important factor in that:

the conquistadores considered the bitter taste of coca unfit for European gentlemen - its effects the illusory product of a pact with the devil (Reinerman, 1979: 226).

The Spanish reacted by outlawing the chewing of coca leaves. The attitude of the Spanish changed when they observed that coca reduced the fatigue, hunger and thirst of the Indian workers. In fact, many workers would simply not labour unless they had a supply of coca leaves. Some actually committed suicide rather than suffer the hardship of work without coca (Nicholi, 1984). The Spanish abhorrence of coca chewing was set aside when a law was passed by Phillip II in 1569 which deemed the practice to be essential to the well-being of the Andean Indians. To appease the missionaries, Phillip II still encouraged them to end the idolatrous use of the plant. The Spanish began cultivation the coca plants themselves and gave coca to the workers as part of their wages. It seems that as soon as the economic imperative was seen in coca usage (ie. enabling the Inca workers to work long, hard hours in mines) then the notion of its "evilness" was somehow diminished. In other words, as there was a profit to be made the strong religious opposition was able to be overcome.

It is interesting that such an economic reading, useful though it is in the Spanish Imperial setting, does not explain why the Spanish, and European society in general, took some time before seeing coca as having any benefit for themselves. There were a number of favourable reports about its use and potential profitability reaching Europe at the time. The Spaniard Nicholas Monardes wrote of the coca leaf chewing practice in his essay "Joyfull Newes of the Newe founde worlde" published in 1596. He described the intoxicating nature of the tobacco and coca leaf mixture and the way in which great contentment was achieved when it was consumed (Petersen, 1977). Abraham Cowley, a British physician, wrote in glowing poetic terms about coca in 1662 in his *Book of Plants*. Cowley's verse describes the way in which sucking the juices of the leaves "staves off ....long hunger, and long labour can sustain". Petersen (1977:19) relates how a former Jesuit, Antonio Julian, believed that coca should have been given to the labouring classes of Spain in order to improve their health and productivity. He saw tremendous economic potential in coca, and he felt it should have been encouraged as the preferred stimulant drink in Spain. This would have reduced the

drain resulting from coffee and tea imports, and if it could be encouraged elsewhere in Europe, provide large export earnings. As it was, this did not eventuate.

The standard explanation for why Europeans did not take up coca asserts that it was the poorly preserved leaves that were available to Europeans and thus their lack of potency, which prevented its widespread adoption. While the pharmacological argument about loss of potency is important, it ignores the cultural opposition to the drug. As was seen earlier, it was conceived of as a pagan practice and involving pacts with the devil, therefore it would seem almost impossible to establish use amongst what was a deeply religious population. In other words here was a case where cultural and religious concerns were obviously pre-eminent over pure economic interests.

### **1.3 THE ERA OF SCIENTIFIC RESEARCH AND PATENT MEDICINE**

While reports extolling the virtues of coca continued to be brought back to Europe, it was not until the nineteenth century and the isolation of cocaine from the coca plant, that the drug really came to public attention. In the first instance, attention was only of a medical nature, as researchers investigated the properties of the substance.

The first scientific investigation of coca was of a botanical nature. The botanist Joseph de Jussieu, on an expedition to Peru in 1750, sent specimens back to his brother Antoine in Paris. These were analysed and preserved at the Museum of Natural History. The resultant study brought the classification *Erythroxyton coca* (Petersen, 1977: 20).

It was another hundred years before the active ingredient in coca, cocaine, was isolated. Friedrich Gaedcke, a German chemist, was the first to separate alkaloidal cocaine from the coca leaf. The small crystals he extracted from a distillate of dry residue of an aqueous coca mixture, he named erythroxyline. It is Albert Niemann of the University of Gottingen who is credited with the chemical characterisation and purification of the substance, which he named cocaine. Another researcher at the University of Gottingen, William Lossen, continued the study and in 1862 ascertained the chemical formula of cocaine.

It was in this period that the influential work of Paolo Mantegazza was published. Mantegazza, an Italian neurologist, made what Petersen says was "a significant contribution to the psychopharmacology of coca" (Petersen, 1977: 21).

Mantegazza wrote praising the virtues of coca, based on his own experiences using the plant. His descriptions were extremely lyrical and colourful. He wrote:

I flew about in the spaces of 77,348 worlds, one more splendid than another. I prefer a life of ten years with coca to one of a hundred thousand without it (Grinspoon and Bakalar, 1976: 19).

Mantegazza recommended coca as a remedy for such illnesses as digestive disorders, toothache, and neurasthenia. Mantegazza was aware of harmful effects from coca and noted that emaciation, digestive complaints and "moral depravity" would ensue if the drug was over-used. It was these words of warning which meant that Mantegazza was taken seriously by other physicians. As Grinspoon and Bakalar note:

If coca had in fact often produced the extravagant "psychedelic" effects described by Mantegazza physicians would have been reminded of opium dreams or alcoholic delirium and the drug would not have become nearly so popular (Grinspoon and Bakalar, 1976: 20).

In the period following the publication of Mantegazza's "On the Hygienic and Medicinal Virtues of Coca" there were two main developments: various popular medicine products were released which contained cocaine and scientific and medical research on cocaine flourished.

The first of the so-called "patent medicines" was Vin Mariani, a blend of coca extract and wine which was produced by the Corsican chemist Angelo Mariani and patented in 1863. It proved to be extremely popular and Mariani was able to cite The Prince of Wales, The Czar of Russia and Pope Leo XIII amongst those dignitaries who had benefitted from its use. Importantly, Vin Mariani was also endorsed by prominent physicians. Leonard Corning described it as "the remedy par excellence against worry" (Grinspoon and Bakalar, 1976:26), while De Fauvel of Paris prescribed Mariani preparations for various complaints, especially throat disorders. William Mortimer dedicated his "History of Coca" to Mariani, describing him as a "recognised exponent of the Divine Plant" (Ashley, 1975: 44). Mariani produced a range of products including an elixir, which contained a greater alcohol content than the wine, and pastilles or throat lozenges.

Mariani was the first to really exploit the potential of coca leaves. It is widely acknowledged that not only was he a chemist of notable ability but also an entrepreneur of great skill. He compiled an encyclopedia of those eminent persons who had endorsed Vin Mariani. Each listing had the person's biography, etched portrait and

testimonial to the Mariani products. This was an important part of his advertising which was not directed at the general public, but rather focussed on the celebrities of the day (this was perhaps a forerunner to modern advertising where celebrities, sportspersons etc. are paid vast sums of money to endorse products - Mariani was lucky in that he received the endorsements for free).

Mariani achieved great success in both Europe and America. While there are no firm records of the volume of the business, it is clear that Mariani became an extremely rich man as a result of the cocaine products (Ashley, 1975). The success of his products has been attributed to both the shrewd advertising and the fact that all the products contained generous portions of cocaine.

Mariani's success came at a time when the patent medicine industry was beginning to flourish. As Ashley points out:

There wasn't an affliction known to men for which some enterprising hustler didn't have a "cure" or relief" (Ashley, 1975: 46).

The general uplifting effects of cocaine meant that it was extremely popular and was prescribed as a cure for a whole range of disorders, from the common cold to opiate addiction and venereal disease.

Following Mariani's lead, there was a plethora of Americans who produced cocaine products. Metcalf's Coca Wine was almost an exact imitation of Vin Mariani. Described as a "pleasant tonic and invigorator", it claimed to be the cure for almost as many, if not more, disorders than the Mariani mixtures. The makers of Metcalf's Coca Wine also followed Mariani by claiming that public speakers, singers, actors found it to be a "valuable tonic to the vocal chords", while athletes, pedestrians and baseball players<sup>7</sup> used it to "impart energy to every movement, and prevent fatigue" (Ashley, 1975:47). Some other notable cocaine medicines were Dr. Tucker's Specific, Dr. Mitchell's Coca-Bola and Nyal's Compound Extract of Damianc (supposedly a cure for impotence).

Perhaps the most famous "imitation" of Mariani to emerge was the drink coca-cola. First produced by a Georgia pharmacist, John Styth Pemberton in 1886, it combined cocaine and caffeine in a syrup form. Pemberton had released the previous

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<sup>7</sup>There would probably be a number of professional baseball players in the United States today who would agree with these claims in relation to cocaine. There have been several scandals in recent years involving baseball players and prosecutions for cocaine use.

year what was thought to be a direct copy of Vin Mariani, entitled "French Wine Coca - Ideal Nerve and Tonic Stimulant", although it was generally considered inferior to Mariani's concoction. With coca-cola, Pemberton produced a "soft drink" which soon proved to be extremely popular. The name, of course, still survives today, although cocaine was removed from the drink in 1903 and replaced by flavouring from de-cocainized coca leaves. Pemberton initially conceived of the drink as a medicine, describing it as a "remarkable therapeutic agent" and a "sovereign remedy" (Ashley, 1975: 46). Coca-cola soon had its own imitations including such exotic titles as "Vari-Kola Compound Syrup", "Rococola", "Wiseola" and "Pilsbury's Coke Extract". By 1909 there were 69 imitations of coca-cola which still contained cocaine.

The patent medicine industry prospered for some twenty years from the 1880's on, but the growth in laws and regulations covering the sale and preparation of these products gradually brought an end to this "boom period" (the development of the restrictive laws are examined in sections 1.5 and 1.6).

At the same time as the patent medicine industry was discovering the wonders of cocaine, mainstream science was having its own "love affair" with the drug. The name Sigmund Freud is often associated with the first research on the effects of cocaine in humans, but Freud was not the first to conduct research in this area. Professor Schroff, a Viennese medical researcher, noted in 1862, the numbing effects of cocaine on the lips and tongue, as well as dilation of the pupils, when it was swallowed. Von Anrep at the Wurzburg Pharmacological Institute also noted similar effects, although his experiments were limited to animals. In 1868, Thomas Moreno y Maiz, Surgeon General of the Peruvian army, reported the numbing effects of cocaine on frogs and suggested use of cocaine as a local anesthetic. This suggestion was ignored by medical surgeons, perhaps because Maiz had used cocaine on himself and claimed that it had given him "some of the most blessed moments of my life" (Grinspoon and Bakalar, 1976: 20).

Theodor Aschenbrandt, a surgeon in the German army, conducted the first experiments on humans of any note. Aschenbrandt had become interested in the effects of cocaine while studying under Von Anrep at Wurzburg and was determined to carry on from where Von Anrep left off. As Petersen reports, the main obstacle to research was the lack of suitable subjects:

Strong and healthy people, exposed to the greatest exertion, hunger, thirst and the like, precluded this work (Petersen, 1979: 221).

His work with the Bavarian Artillery, however, did provide such subjects. In the autumn of 1883, while on maneuvers, Aschenbrandt had to deal with numerous cases of exhaustion and diarrhea. He obtained a supply of cocaine and found that upon ingestion soldiers were able to resume arduous duties and effective functioning. Healthy soldiers, given cocaine secretly in their water, exhibited more energy and greater ability to endure fatigue than did others (Ashley, 1975).

The other main scientific thrust at the time, in respect of cocaine, was in determining its usefulness as a cure for opiate addiction. Dr. W.H. Bentley, in 1878, reported in *The Therapeutic Gazette of Detroit* on his success in switching opium addicts and alcoholics to the use of cocaine. In 1880, a Dr. Palmer publishing in the *Louisville Medical News*, gave extensive accounts of the treatment of morphine addiction with cocaine (Ashley, 1975:21). By 1883 the U.S. Surgeon-General's Office listed over fifty scientific papers on the use of cocaine in addiction treatment.

#### 1.4 FREUD AND COCAINE

It was the work of both Aschenbrandt and Bentley which sparked Sigmund Freud's interest in cocaine. It is widely acknowledged that in early 1884, Freud was looking for some area of research in which he could make a "brilliant discovery that would bring his name to prominence in the competitive medical world of Vienna" (Thornton, 1986: 42). This would also allow him to marry his fiance Martha Bernays. Freud read Aschenbrandt's paper, as well as other reports on cocaine, in the *Detroit Therapeutic Gazette* and was determined to investigate cocaine further.

Freud ordered his first supply of cocaine in early 1884 from Merck of Darmstadt. As has been ironically noted, Freud experienced the "plight of most cocaine seekers" - he was unable to afford the high cost of the drug. Having obtained the cocaine on credit, Freud began his first experimentation. He started with himself, dissolving a twentieth of a gram in water and noting that it changed his bad mood into cheerfulness and a feeling of having dined well<sup>8</sup>. Freud next tested it on his colleague and close friend Ernest von Fleischl-Marxow, who was suffering from morphine addiction<sup>9</sup>. Fleischl was in the midst of a withdrawal attempt when Freud gave him

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<sup>8</sup>Freud apparently suffered from bouts of depression for most of his life and found cocaine to be a great relief to his despondent moods (Nicholi, 1984: 254).

<sup>9</sup>Fleischl's morphine addiction was the result of a surgical accident. "At the age of twenty five, while performing an autopsy, he had contracted an infection. Amputation of the right thumb saved him from death, but the continual growth of neuromas required repeated operations. His recourse to morphia for the pain eventually became an addiction" (Thornton, 1986: 33).

cocaine; he "clutched at the new drug 'like a drowning man'" (Ashley, 1975:25), and found that it did greatly relieve the withdrawal from morphine. Fleischl's positive reaction, coupled with his own experiences made Freud extremely enthusiastic; he even sent some to Martha to "make her strong and give her rosy cheeks" (Thornton, 1986: 43), and was recommending it strongly to both friends and colleagues.

Freud's initial research culminated in the publishing of his paper "Uber Coca" (For Coca). In what has been called a "song of praise to the magical substance", Freud presented the history of coca, a review of the scientific research up to that point, the findings of his own experiments and a recommendation of the therapeutic uses of cocaine. His recommendations were that cocaine be used as a stimulant; for digestive disorders of the stomach; in treating tuberculosis; for alcohol and morphine addiction; for alleviation of asthma; as an aphrodisiac; and as a local anesthetic. The only recommendation which has remained medically useful is that of cocaine as a local anesthetic. Thornton asserts that "Uber Coca" had many deficiencies as a scientific paper, with much of it being "vague and disorganised". Freud provided little concrete information about his experiments, especially on "the number of subjects treated, the dosages employed, and the duration of the treatment" (Thornton, 1986: 45).

The discovery of cocaine as a local anesthetic is not actually attributed to Freud but instead to a colleague, Karl Koller. Within three months of "Uber Coca"'s publication in July, 1884, Koller was reporting upon the successful use of cocaine as a local anesthetic in eye operations. Freud was thus robbed of the fame which he hoped his cocaine research would bring.

Koller came upon cocaine in the quest for an anesthetic which could be used for the extremely sensitive practice of eye surgery. As Petersen outlines:

such a substance was vital because in much of eye surgery the patient's co-operation is needed, precluding the use of general anesthesia. Moreover, the general anesthesia used at the time was known to induce post-operative nausea and vomiting, the strain of which could cause damage to the operated eye (Petersen, 1984: 24).

The idea of using cocaine apparently arose when Koller witnessed Freud relieve the intense eye pain of an intern by applying some directly to the eye. Koller subsequently experimented with animals and on himself, all of which proved successful and he published in September 1884. It was Koller's work which brought a sudden great interest in cocaine, an indicator being that the December 6th, 1884, issue of the British Medical Journal had seven articles on the subject (Grinspoon and Bakalar, 1976: 23).

While Koller enjoyed success, Freud continued to publish on cocaine. In January 1885, he published a paper which detailed the ability of cocaine to increase muscular strength for a period of approximately five hours. In August of the same year, he published a general review recommending cocaine as a treatment for "nervousness" and depression, while still claiming that there were no addictive tendencies in cocaine use. It soon emerged that this was far from the truth. The fact was that von Fleischl, who having successfully withdrawn from morphia, had developed a "far more formidable allegiance to cocaine" (Thornton, 1986: 49).

The condition of Fleischl caused Freud considerable personal anxiety and engendered a great deal of criticism from fellow physicians. By January 1885, Fleischl was using approximately one gram of cocaine intravenously a day. By June that year, Fleischl was taking what Freud described as "frightful" doses and was experiencing psychotic reactions, seeing "white snakes creeping over his skin" (in Ashley, 1975: 26). Fleischl's psychological and physical deterioration was alarming, but Freud still felt there was no inherent problem with cocaine.

The Fleischl case, along with a growing list of adverse reactions amongst other users, brought severe criticism of Freud and distrust of cocaine. By 1886 there were growing numbers of people who had taken the "cocaine cure" for morphine addiction yet were experiencing toxic effects and cocaine psychosis. A patient of Freud's had actually died from an overdose of cocaine he had prescribed, although Freud had written that there was no lethal dose in humans (Nicholi, 1984 ). Albert Erlenmeyer, the authority on drug addiction of the time, took Freud to task and accused of him of being responsible for the "third scourge of humanity" (the other two being alcohol and morphine) (Grinspoon and Bakalar, 1976: 30)<sup>10</sup>.

In 1887 Freud did respond to the what was now growing number of critics, although his arguments were far from convincing. He suggested that cocaine was not an inherently addicting substance and that toxic reactions could be avoided through non-subcutaneous use. These were ineffectual arguments against the growing dissatisfaction with cocaine, and by 1887 the European medical community was against any use of cocaine other than as a local anesthetic. Freud published his last paper on cocaine in 1887, "Craving For and Fear Of Cocaine" in which he conceded that cocaine dependence could occur although it was still a rare occurrence. Freud's reputation was at stake, however, and thus he ceased to publicly advocate cocaine's use. There

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<sup>10</sup>For greater detail on Erlenmeyer's criticisms, and his own findings on cocaine and morphine reactions, see Grinspoon and Bakalar (1976: 30-31).

certainly has been a great deal of speculation as to when he personally stopped using cocaine and how much effect the drug had upon his later work<sup>11</sup>.

While cocaine was falling out of favour in Europe, the American medical profession still maintained an active interest in the drug. The Americans did follow a similar path to the Europeans: initial absorption with the positive aspects of the drug followed by recognition and abhorrence of the negative consequences of use.

As in Europe, eminent physicians were involved in research on cocaine. Dr. William Hammond, a former Surgeon General of the United States, in his research on cocaine made conclusions which basically supported those made by Freud. Again, this was based largely on findings from self-experimentation. Hammond's work was actually cited by Freud in his 1887 paper. William Mortimer of New York published a "History of Coca" in 1901 which contained all the existing knowledge of coca and cocaine to that point. Mortimer was essentially an advocate of cocaine and he was the first to carry out a survey of fellow physicians attitudes towards cocaine. He surveyed five thousand physicians of whom 1206 responded; he tabulated the results and presented them as an appendix to his history.

The most significant American figure to be associated with cocaine was the so-called "father of modern surgery", Dr. William Halstead. Halstead is famous not only for the surgical practices he pioneered but also for the dependence on cocaine he developed. At approximately the same time that Koller was discovering cocaine's local anesthetic properties, Halstead was using the drug in a "nerve block" technique. This involved injecting cocaine into nerve centres to produce a regional anesthesia (Nicholi, 1984: 256). He completed one thousand successful operations using this method and published extensively in 1884. According to Ashley, at one point Halstead wasn't heard from for a year, due mainly to the fact that he, "like all conscientious researchers, had used himself as a guinea pig and had acquired a good-sized cocaine habit" (Ashley, 1975: 33). Halstead had several stays in hospital and a ocean voyage to the Windward Islands which supposedly cured him of the habit. The truth was that the treatments failed and Halstead subsequently began using morphine in the hope that this would "cure" the cocaine dependency. Inevitably, he became addicted to morphine. Recent evidence suggests that Halstead continued using cocaine right up until his death

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<sup>11</sup>E.M. Thornton's "The Freudian Fallacy" presents an argument that Freud was addicted to cocaine throughout the period when the theories of the unconscious mind and child sexuality were developed. An argument which was posited by the German psychoanalyst Jurgen von Scheidt (see Grinspoon and Bakalar (1976).

in 1922<sup>12</sup>. Halstead's case was the American equivalent of Fleischl in Europe and certainly drew attention to the possible negative consequences of cocaine use.

## 1.5 COCAINE'S "FALL FROM GRACE"

It was in America, around the turn of the century, that anti-cocaine sentiments took on definite shape. In a reaction which Petersen describes as "inevitable" to any so-called "wonder drug":

initial widespread acceptance was increasingly tempered by the recognition that cocaine had undesirable side effects and could pose a serious health hazard (Petersen, 1979 :28).

A movement began which sought to prohibit non-medical use and culminated in the passing of various federal laws, severely restricting use. There were a number of social, economic and political interests behind this movement and the leading "moral entrepreneurs", as Craig Reinerman (1979: 229) calls them, were members of the medical profession.

Initial anti-cocaine reactions came from the addiction specialists, who became disillusioned when it became obvious that cocaine provided no solution to morphine addiction. The physicians involved with treating opium and morphine addicts were the first to become suspicious of cocaine. They had seen morphine, the supposed "saviour of mankind" become a tremendous problem and they were extremely apprehensive when it seemed the same pattern was developing with cocaine (Ashley, 1975).

While physicians desired a restriction on the use of cocaine, achieving this was not straightforward. The fact was that medicine enjoyed little scientific authority and the

distinction between "legitimate" medical practice and the practice of selling medicines were not as clear as physicians would have liked (Reinerman, 1979: 229).

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<sup>12</sup>William Welch and William Osler, two physicians who were close to Halstead at the John Hopkins Hospital, have both noted Halstead's use of cocaine. Osler stated that until 1898, Halstead was using no less than three grains of cocaine per day, which he managed to reduce to one and a half grains per day for the next ten or so years. Osler believed the last ten years he went without cocaine while Welch asserts that Halstead would "disappear" for occasional binges up until his death (Grane and Frederick, 1984: 1746)

In fact just about anybody could obtain a medical degree and literacy was certainly not one of the essential requirements. Ashley, with a good degree of irony, summarises the situation well:

The typical doctor practicing in the last third of the nineteenth century was a badly educated incompetent who followed one medical fad after another and knew so little about drugs that he was unable to dispute intelligently the preposterous claims of the patent medicine men (Ashley, 1975: 62).

By the turn of the century, however, American medicine (through the American Medical Association and the American Pharmaceutical Association) was seeking more stringent professional standards for both training and practice.

It was no accident that the issue around which the professionalisation of medicine took place was cocaine. As Craig Reinerman points out, the increase in reports of ill effects were not enough in themselves to account for the "mobilisation of physicians around the issue, nor the shape of their efforts" (Reinerman, 1979: 229). The more deciding features were the concern with the direct threat from the patent medicine industry (which as we've seen, cocaine played a major role in ) and the supposed menace of "cocaine-crazed" negroes (see also Helmer, 1980).

There is no doubt that patent medicine was a major stumbling block for professional medicine. While the incredible range of potions and tonics, promising cures for every disease known, and some unknown, presented a tremendous image problem for doctors, it was perhaps in economic terms that patent medicines threatened most. For some doctors it was a case of patent medicines depriving them of potential patients, while for others, it was a case of patent medicines forming a large part of their profits. A measure of the integral role patent medicine played was seen in the various medical journals which carried advertisements for such medicines. The Journal of the American Medical Association continued to carry patent medicine advertisements until 1905<sup>13</sup><sup>14</sup>. The Pharmaceutical Association suffered most directly and continually voiced its opposition to patent medicine and the millions of dollars in trade it denied the pharmacists.

If the reaction against cocaine was inevitable, or at least highly predictable, so was its association with a racial group. While opium went hand in hand with the

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<sup>13</sup>Robert Ashley details the argument concerning the economic interests of the burgeoning medical profession. See Ashley, (1975: 62-65).

<sup>14</sup>Thomas Szasz is also concerned with the so-called "medical imperialism" in relation to notions of addiction and dependency. See Szasz (1974) Chapter 3.

Chinese, cocaine came to be associated with the southern blacks in the United States. Indeed, this has been seen as part of a wider social process:

Yet the movements for Prohibition and Drug controls were both nativistic and moralistic, and shared a rhetoric: alcohol and drugs were both associated with groups perceived to threaten the social order (Reinarman, 1979: 236).

The medical profession played its part in generating the myth of the dangers posed through blacks using cocaine. In 1900, The Journal of the American Medical Association published reports of blacks becoming addicted to "a new form of vice" in "cocaine sniffing" (Musto, 1973: 21). In 1902, The Philadelphia Medical Journal made the unsubstantiated claim that cocaine was the drug of choice amongst black convicts (Musto, 1973). The American Pharmacological Association also became concerned about "negro cocainists" at this time. A Committee on the Acquirement of the Drug Habit reported in 1902 and 1903. While displaying "reasonable concern about the over prescription of psycho active drugs", the Committee also exhibited "straightforward racial prejudice" (Grinspoon and Bakalar, 1976: 39). It made such statements as "Indiana reports that a good many negroes and a few white women are addicted to cocaine", "the negroes, the lower and criminal classes, are naturally most readily influenced" (Grinspoon and Bakalar, 1976: 39). Reports were even spreading overseas: the British Medical Journal, 1902, published a paper "The Cocaine Habit Among Negroes" which detailed the use of cocaine on southern plantations.

Mass media portrayals of cocaine use amongst blacks were even more sensational than the medical journal accounts. The New York Daily Tribune, in 1903, published an article by a Colonel J.W. Watson of Georgia who claimed that:

many of the horrible crimes committed in the southern states by the coloured people can be traced directly to the cocaine habit (Watson in Schatzmann, 1975: 8).

While providing no evidence for this assertion, Watson felt the situation was serious enough to warrant stringent laws prohibiting the use of cocaine by blacks. The New York Times published quite extensively on the cocaine issue. A 1908 piece, "The growing menace of cocaine", described how cocaine was easily available to negroes in the form of patent medicines, which "Jew peddlers" were only too willing to dispense. Other articles from the same period referred to "mass murders by crazed (black) cocaine takers", "negro cocaine fiends" and the ever present threat of rape to white women by cocaine using black men (Schatzmann, 1975), the latter point once again raising the supposed connection between cocaine and sexual excitation.

There was no concrete evidence to support the claims being made about blacks and cocaine<sup>15</sup>. While it is true that blacks did use cocaine, mainly in the form of patent medicines, they used no more, in fact probably less, than the white population. To a certain extent it was the whites who were responsible for the use of cocaine amongst southern blacks. It was common practice on plantations for cocaine to be distributed amongst blacks, a means by which servility and productivity could be ensured. As well, most states prohibited blacks from drinking alcohol thus providing no other alternative than cocaine.

As far as "superhuman" efforts and "heinous" crimes were concerned, these were just "fearmongering fantasies" and nothing more (Ashley, 1975: 68). Ashley likens the episode to the McCarthy era in the 1950's, suggesting that:

Cocaine was a convenient explanation of "crime waves", a way of explaining white fears of blacks without having to face why they were really feared (Ashley, 1975: 69).

David Musto writes in a similar vein:

These fantasies characterised white fear, not the reality of cocaine's effects, and gave one more reason for the repression of blacks (Musto, 1983: 6).

Craig Reinerman suggests that white fears at the time were based on economic concerns. In 1907 and 1908, unemployment in the south increased dramatically which meant that whites and blacks were competing for dwindling jobs. These events coincided with the height of the concern over black cocaine use. An "economic conflict was transformed into racial conflict, and racial conflict, in turn, was expressed (in part) as conflict over drug use" (Reinerman, 1976: 235).

Whatever the reasons for white fears were, the point to be made is that the properties of the drug became quite secondary to the economic and social concerns associated with it. Certainly the fearmongering campaign was extremely important in providing a suitable climate for the anti-drug legislation which followed.

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<sup>15</sup>John Helmer's article "Blacks and cocaine" (in Keller et al, 1983: pp.14-29) looks in detail at the evidence which negates the concept of the "black cocaine fiend", and at usage patterns amongst blacks at the turn of the century.

## 1.6 THE AGE OF ANTI-DRUG LAWS

Attempts at regulating cocaine use began as early as 1887. Oregon was the first state to pass a restrictive law and many states soon followed suit<sup>16</sup>. These state laws, which required that cocaine be obtained only through a doctor's prescription, were ineffectual. Cocaine was still legally available in the form of patent medicines and could be obtained by mail order from states which did not have drug regulations. Musto reports how New York State reformers, who had passed restrictive laws in 1893, were frustrated by the fact that bordering New Jersey had extremely lax narcotic laws, which negated their earnest attempts at control (Musto, 1983).

The first federal attempt at control came with the Pure Food and Drug Act of 1906. This required that all medicines containing cocaine ( and opium) must list such contents on the label and also prohibited inter-state shipment of these food and drink products. As well, this Act made the first restrictions on the importation of coca leaves. Again, this was a law which proved to be ineffectual. Many patent medicine manufacturers simply ignored the regulations, and as the fines were small and imprisonment unlikely, there was no real reason for adhering to the law.

The Harrison Narcotics Act of 1914 proved to be the turning point as far as controlling cocaine use was concerned<sup>17</sup>. It was the first legislation to have a marked impact on drug use and remained the basis of anti-drug laws for some fifty years.

The Act took the major step of banning the use of cocaine in proprietary medicines. Cocaine was hence only available from physicians for "legitimate medical use" (Grinspoon and Bakalar, 1976: 41). As well, anyone involved in the handling, distribution or sale of narcotics (opium, coca or their derivatives) was required to be registered with the Bureau of Internal Review and was subject to special taxation. The "teeth" of the Act lay in the penalties for violation which were fines up to \$2,000 and prison sentences of up to five years.

The Harrison Act was amended on several occasions over the next fifty years. In 1922, the penalties were increased to a \$5,000 fine and maximum ten years

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<sup>16</sup>By 1914, just before the enactment of the Harrison Act, some forty-six states had their own legislation to restrict distribution and use of cocaine.

<sup>17</sup>Craig Reinerman, (1979: 232-236), analyses the political and economic context of the Harrison Act, with particular focus on the "moral entrepreneurs" who played a major role in the passing of legislation.

imprisonment, while cocaine became officially classified as a narcotic<sup>18</sup>. Amendments in 1951 and 1956 increased the penalties further, providing for mandatory prison sentences.

To say that the Harrison Act was generally effective is to say that cocaine virtually disappeared from the public scene as a result. Cocaine went from being a part of everyday life for many Americans to what Ashley terms an "especially dangerous drug". As far as achieving the goal of eliminating non-medical cocaine use was concerned, the Act was a failure. It seems certain that illicit use of cocaine was widespread for at least ten to fifteen years after the passing of the act, although because of its illegal status, the exact numbers of users will never be known. Information from this period is unreliable, being based primarily on newspaper reports, which it must be said, tended to be rather sensational in nature<sup>19</sup>.

The English did not begin to regulate cocaine use until 1916. In Britain, attention had been focussed primarily on the opium trade, and calls to end it had been growing since the turn of the century. It was in 1916 that it became obvious to authorities that Britain was a major source of smuggled drugs, particularly cocaine, throughout the world (Parssinen, 1983: 130). A scandal involving the selling of cocaine to Canadian troops hastened the government to extend the Defence of the Realm Act 40B, in July of 1916, which restricted the drug to prescription through a dispensing chemist. The end of the war and expiration of the Defence of the Realm Act brought re-newed interest in controlling the use of opium and cocaine. It was another two years before the Dangerous Drugs Act was passed in 1920; this strictly limited the import/export and dispensing of heroin, cocaine etc. As in the United States the main effect of the act was not to eliminate use but simply drive it underground. Parssinen suggests that cocaine was by far the most popular street drug in Britain during the 1920's (Parssinen, 1983: 133).

## 1.7 COCAINE USE IN THE INTER-WAR YEARS

One thing the Harrison Act achieved in the United States was to narrow the social class of those who used cocaine. The act made cocaine more difficult to obtain, which increased the price considerably and in turn meant that only the more affluent

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<sup>18</sup>As various writers point out, the classification of cocaine as a narcotic is quite incorrect. See Grinspoon and Bakalar (1976:44), and Petersen R.C., (1977:27).

<sup>19</sup>Richard Ashley, (1975: 83-85) sketches the approach taken by the newspapers of the time, with their focus on "cocaine fiends" and in reporting notable arrests made by narcotics agents.

could afford it. As Ashley outlines, the poor white and blacks were in no position to afford either the new black market prices (in the 1920's the price was around thirty dollars per ounce, a trebling of the 1910 price of ten dollars per ounce) or the expense of paying a doctor for a prescription (Ashley, 1975). The rich, on the other hand, were only slightly hindered by the drug laws because of their ability to consult doctors and when buying on the black market, buy in quantity. The high price of cocaine and its growing exclusivity gave birth to the idea of cocaine as a symbol of success and sophistication - "cocaine became a plaything of the more adventurous and less respectable among the wealthy" (Grinspoon and Bakalar, 1976: 48).

A process taking place at the same time was the association of cocaine with the "fringe" or "bohemian" elements of society. Jazz musicians, actors, actresses and members of the "cultural avant garde" (Petersen, 1977:31) became identified as the principal using group of the 1920's. Musicians were implicated by the fact that many songs contained references to cocaine. The best known of these was Cole Porter's "I get a kick out of you" which in its original version contained the lines:

I get no kick from cocaine  
I'm sure that if  
I took even one sniff  
It would bore me terrifically too  
(in Petersen, 1977: 31).

Porter's 1933 song "You're getting to be a habit" also contained numerous drug references. Cocaine or "joy powder" as it was known, was very much part of the Hollywood scene of the 1920's. While attempts were made to keep secret the use of drugs by the "stars", various scandals did emerge. The actress Mabel Normand had a two thousand dollar a month expenditure on "cokey"; Tallulah Bankhead often bought little pouches of "snow" to parties; and Barbara LaMarr, who died of a heroin overdose in 1926, aged 26, was also a consumer of large quantities of cocaine (Starks, 1982).

Cocaine also featured in some of the Hollywood films of the era. "For His Son" (1912), directed by D.W. Griffith told the story of a man developing a new soft drink "dopokoke", for that "tired feeling", in order to afford his son's wedding. The son finds the drink no longer satisfies and resorts to taking extra pinches from a cocaine bottle. His life descends into addiction and ruin and the film ends with the death of the son and the message: "the awful result of criminal selfishness" (Starks, 1982: 41). Comical treatments of cocaine were the norm. A 1916 film "The Mystery of the Leaping Fish" had a detective called "Coke Ennyday" and contained many scenes which satirised the methods of taking cocaine. There were also films with a more serious bent, which either explicitly or implicitly carried the message warning of the

dangers of drug abuse. Films such as "The Pace That Kills" (1928) and "Cocaine Fiends" (1939) were the most notable in this variety and had similar plots in depicting character's whose lives were ruined through cocaine abuse. It has been suggested that these films were actually carefully constructed parodies, which while taken seriously by the general public, were intended as comedy for those "in the know". "Cocaine Fiends" was the last film for some thirty years which dealt with cocaine in any depth. It wasn't until the re-emergence of cocaine in the late 1960's and early 1970's that films focussed on the subject.

As far as America was concerned, cocaine was "out of sight out of mind" after 1930. While again, there is no concrete evidence about usage levels, it is generally agreed that cocaine use became insignificant. Grinspoon and Bakalar summarise the reasons why cocaine disappeared:

New restrictions on importation, manufacture, and distribution were introduced; substitutes were found for many of the surgical and prescription uses of cocaine; amphetamines appeared on the market in 1932 and provided a stimulant that was cheaper, more accessible and longer lasting, if less attractive to connoisseurs; the Depression made luxuries like cocaine less available (Grinspoon and Bakalar, 1976: 47).

Outside of the United States, cocaine was finding new popularity in the 1920's and '30's. While it had never completely disappeared from the European scene in the early part of the century, it was during, and after World War 1 that use became significant again. It has been suggested that cocaine use was common to both sides during the war. There is little evidence of such occurrences, outside of anecdotal accounts, yet McCoy asserts that historians have generally ignored drug abuse amongst soldiers. In relation to Allied drug use, he states:

Subjected to constant artillery bombardment and gruelling battlefield conditions, soldiers sought relief and an incompetent Imperial dispensary provided it - in the form of heroin, morphine and most commonly, cocaine (McCoy, 1980: 82).

The soldiers returning home after the war did not lose their predilection for cocaine and thus exported new demands for the drug all around the world: cocaine even became popular in such places as India and Egypt (Ashley, 1975).

The history of cocaine in Australia began in this period after World War I, and as the drug had already acquired its illicit status, there are few factual details of the way

the drug was used. Most of what has been written of that time is based on newspaper reports and the limited official statistics available<sup>20</sup>.

It appears certain that ANZAC's returning to Australia from the war were responsible for an increased demand for cocaine. Most of the illicit cocaine came directly from licit pharmacy stores (McCoy, 1980; Haydock-Wilson, 1986). In some cases, police in the guise of ex-servicemen were able to obtain cocaine without prescription from certain chemist shops by simply walking in and asking for it (McCoy 1980). During the 1920's cocaine also became associated with the underworld, or what would now be called "organised crime". As Haydock-Wilson notes:

In Sydney and Melbourne in particular it did not take criminal elements long to realise the large profits which lay in the traffic (Haydock-Wilson, 1985: 78).

In England and on the continent, cocaine use gradually became confined to the rich and the bohemian sets. The practice was apparently rife amongst the English upper classes and German authorities were extremely concerned about its prominence in Berlin's fashionable west-end (Ashley, 1975: 98). Germany was supposedly the world's largest user of cocaine in this period. This may have been true for total quantity of cocaine consumed, but in terms of kilograms per million of population, Australia was largest with 14.67 kilograms in 1929 (Haydock-Wilson, 1985: 77). Europe soon followed the United States, and by 1933, cocaine use was no longer common, and it had certainly disappeared from public view.

## 1.8 THE LATEST ERA OF COCAINE USE

It is not surprising, given the developments of the 1960's, that cocaine became popular again in the 1970's. First, widespread use of psychedelics and marijuana pre-disposed a whole generation to drug use. The taking of drugs for pleasurable or recreational purposes became commonplace practice. Along this line, Reinerman suggests that cocaine became an obvious alternative for:

young people who had learned to enjoy drug use, but found themselves struggling to survive in the Seventies after sliding through the stoned Sixties (Reinerman, 1977: 239).

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<sup>20</sup>See Alfred McCoy's "Drug Traffic: Narcotics and Organised Crime in Australia" (1980) for the most extensive account of this era.

A second important point was that the availability of amphetamines became severely restricted: as cocaine had similar effects it became the natural substitute. A third factor was societal change at the level of morals and values. Established institutions and attitudes were all challenged and the influence of the so-called "counter-culture" was immense. Associated with this was the way "attitudes and practices of avant garde and fringe groups were taken over by a large section of the public" (Grinspoon and Bakalar, 1976: 49): cocaine use became one such practice. Finally, the use of cocaine by high status individuals, particularly those in the entertainment industry, all helped give the drug "high social visibility" (Grinspoon and Bakalar, 1976: 49) <sup>21</sup>.

There is considerable evidence of the growth in cocaine use in the United States during the 1970's and 1980's. While all estimations of supply and consumption have their inherent weaknesses, they give a fairly good picture of the trends in use.

On the supply side, the U.S. Customs seizures of cocaine give one indicator of the dramatic increases in the trafficking of the drug. In 1960, 11 pounds of cocaine were seized; in 1970 227 pounds; in 1972, 619 pounds and in 1980 the figure was a massive 6,500 pounds (Grabowski and Dworkin, 1985: 1067). The estimated range of cocaine imported annually into the U.S. is between 30 and 60 tons.

On the consumption side, several on-going surveys have been established by the National Institute on Drug Abuse (NIDA) in order to estimate levels of drug use. The High School Senior Survey began in 1975. At that time, 5.6% of respondents reported cocaine use; in 1981 this figure rose to 12.4%; it fell again in 1982 to 11.5%; in 1985, the year of the latest survey, an all-time high was recorded of 17% (Grabowski and Dworkin, 1985: 1068). The National Household Survey, first conducted in 1974, also produces statistics indicating large increases in cocaine use. The lifetime prevalence of individuals (the number of people trying cocaine at least once) has increased five-fold in ten years. In 1974, 5.3 million had used cocaine; in 1976, 6.4 million; in 1977, 9.8 million; in 1979, 15.1 million; and in 1982, 21.5 million (Adams et al, 1987: 50). The number of people using cocaine at the time of surveying (or within one month) increased from 1.6 million in 1977 to 4.2 million in 1982 (Adams et al, 1987: 50).

Recently, there has been an emphasis upon collecting information on the adverse health consequences of drug abuse. The DAWN Survey (Drug Abuse Warning

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<sup>21</sup>Richard Ashley, (1975: 119-127), gauges the re-emergence of cocaine by the media attention on the drug. He examines the portrayal of cocaine in the late 1960's movies such as "Easyrider" and "Superfly".

Network) collates such information from hospitals and medical examiners. Its figure concerning hospital emergency room "mentions" of cocaine (ie. people seeking help at a hospital with some problem associated with cocaine use), also depicts massive increases. In 1978 there were 2,038 mentions, while in 1983, the figure rose to 6,180. In the first quarter of 1985 there were just under 2,500 mentions (Grabowski and Dworkin, 1985: 1070). Another indicator of the health problems is data from the National Cocaine Hotline, "800-COCAINE", a telephone counselling service for those experiencing problems with cocaine. In its first two years the hotline received 1.2 million calls; these calls came from all geographic regions and a wide social spectrum. The typical caller (taken from a random sample of callers) was "white, middle-class male, 25-35 years old, with no prior history of drug addiction or psychiatric illness" (Washton and Gold, 1987: 33).

Cocaine re-emerged in Australia during the 1970's. The only real agreement reached about the latest wave of cocaine popularity is the lack of reliable indicators of usage levels. There is a reliance upon seizure rates and cocaine-related arrest rates as sources of information on the drug's use. Using seizures as a basis suggests quite a significant increase in use between the mid 1970's and mid 1980's: in 1974 there were just 46 grams seized whilst in 1984 the figure had risen to 13 100 grams. Using arrest rates suggests quite a different picture: cocaine accounted for only 0.3% of all drug offences in N.S.W. during 1982 (Reilly, 1986: 7).

The various governmental inquiries into drug use during the late 1970's pointed to the lack of a reliable data base on the consumption of drugs<sup>22</sup>. The Williams Commission, set up to investigate the drugs question throughout Australia, stated that:

The Commission did not receive sufficient information to enable it to accurately estimate the extent of the illegal use of drugs in the Australian community. The evidence presented was often localized, of doubtful quality or simply represented educated opinions (Williams Commission, 1980: A287).

In a stronger vein, the report from the Senate Standing Committee on Social Welfare: "Drug problems in Australia-an intoxicated society?" declared:

The current debate is distinguished by extreme views, masked hysteria, misinformation and lack of perspective (SSCSW, 1977: 15).

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<sup>22</sup>The other major inquiry not mentioned here was "The South Australian Royal Commission Into the Non-Medical Use of Drugs" (1978).

This report contained some enlightened views on drug use. In discussing the drug debate it was stated:

Drug use arises within a society of which we all are a part. All people use drugs and blanket moral protestations of their evil are largely hypocritical. It is society itself that creates the conditions which lead to licit and illicit taking of drugs to excess, for drug use is derived from the basic mores of our society. The use of drugs is not just a problem of deviance.

While cocaine has enjoyed increased popularity in recent years, there are still few people experiencing problems with their use. Drug Treatment agencies and hospitals reported cocaine as being responsible for around one per cent of all drug related problems in 1984 (Reilly, 1986: 7). While there is obviously not a significant health problem in Australia with cocaine, the alarm bells have been sounding. Some commentators look at the U.S. situation and imagine that Australia will follow suit in the near future<sup>23</sup>. There is a definite demand for the drug in Australia, and it is believed that if the limited supply of cocaine were to increase with a significant price drop, than many more personal and social problems are likely to ensue (Haydock-Wilson, 1985; Reilly, 1986).

An important point to bear in mind is that Australian drug trends do not always follow those from overseas, the drug PCP being such an example:

Just because a pattern of drug use occurs in the USA, and even elsewhere, it does not have to occur also in Australia. PCP (angel dust) has been a major problem in the USA. It has not been a problem here because of effective law enforcement activity, a (more or less) voluntary agreement with the media that PCP should be given no space, and perhaps lack of demand (Cocaine Overview, 1985: 3).

Recently, there have been suggestions that far from being on the increase, cocaine use is actually on the decline. Federal police believe the boom period may be over, yet as Jarratt notes, this might just be a function of drug awareness campaigns and a police crack down, which have:

sent dealers and importers further underground than they have been in recent years. There is probably more cocaine in Australia than ever before (this despite recent multi-million dollar seizures) and yet its presence is less visible than at any other time in the 1980s (Jarratt, 1987: 48).

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<sup>23</sup>See Pierce and Levy's article "The looming cocaine problem in Australia" in Medical Journal of Australia, vol. 144, p.562.

The latest era of cocaine use has many echoes of the past about it, however, there have been some quite unique developments. The most significant of these has been the growth in the practice of "freebasing" cocaine. This is where the cocaine hydrochloride (that which is snorted) is converted through chemical process into an anhydrous freebase, which is burnt, and the fumes inhaled or smoked. Freebasing came to public light in 1978, when the comedian Richard Pryor nearly incinerated himself while converting cocaine to freebase, using ether. Freebasing reached a new level with the appearance of "crack" on the U.S. drug scene in 1985. This supposedly instantly addicting form of freebase was so-named because of the crackling noise the rock-like crystals made when burnt. Crack brought freebasing to a much wider circle of users than had previously indulged in freebasing, due mainly to its cheapness (a small vial of crack sells for twenty dollars on the street), convenience and "instant rush" characteristics (NIDA Notes, 1986: 4). Crack has actually been conceived of as the "junk food analog" of cocaine (Inciardi, 1986:1). While not a feature unique to this era, "bingeing"(where large amounts of cocaine are consumed in relatively short time periods), has become a more common practice. Binges are characterised by:

runs in three to ten-day cycles, involving 6 to 36 hours of cocaine use, one or two days of crash, one or two days of recovery, one or two days of not using cocaine, and then repeating the cycle (NIDA Notes, 1986: 4).

## 1.9 CONCLUSION

In analysing the history of cocaine, the interesting feature is the way many of the past issues and beliefs surrounding the drug are still relevant today. For example, the present conception of cocaine as an "evil" drug with incredible powers over the individual bears a remarkable likeness to the views of the Europeans who first encountered coca use amongst the Incans. Similarly, the movement to have cocaine use prohibited, which began one hundred years ago, has a parallel with the moves by some groups today to have stricter legislation in force against all illicit drug users and sellers.

Perhaps the most constant theme has been that scientific and public discussion of cocaine takes place with little being known about the way cocaine is actually used by the majority of users. There has been a great deal of scientific research on the drug in recent times, which will be examined in Chapter Two, yet few substantive studies of usage patterns have been conducted.

## **CHAPTER TWO**

### **METHODS, PHARMACOLOGY AND EFFECTS OF COCAINE USE**

#### **2.1 INTRODUCTION**

The concern of this chapter is the effect that cocaine has upon the human body. The subject will only be touched on here, but of course there is a tremendous amount of medical and pharmacological research being conducted.

A major reason for examining the pharmacology of cocaine is to help understand what might be termed the "biological reductionist model" of drug use. This is where a drug effect, or drug experience, is seen as nothing more than a function of the physiological effects of the particular drug. Such a position has been at the root of the majority of research and thought on drug use to date. There is of course a sociological equivalent to this, where the way a drug is experienced is attributed totally to the social environment in which use takes place. The aim with this study is to establish a position somewhere between the two extremes. While the leaning is obviously with the social determinants of cocaine use, the pharmacological properties of the drug must always be kept in mind.

The chapter consists of two basic parts. The first part deals with the determinants of effect, and what are the specific effects from cocaine. The second part concerns the adverse effects that can be experienced: of particular relevance is the issue of what constitutes addiction and dependency and to what extent cocaine is a dependency producing drug.

To begin, those factors which influence the physiological and behavioural effects upon the body will be examined.

## 2.2 DETERMINANTS OF EFFECT

### (A) Methods of use.

There are four methods through which cocaine can be ingested into the body:

- (i) intranasal;
- (ii) intravenous;
- (iii) oral;
- (iv) Smoking.

#### (i) Intranasal.

The most common route of administration of cocaine is intranasal or "snorting" as it is better known. A "line" of cocaine hydrochloride is inhaled into the nose where it is absorbed into the bloodstream through mucous membranes. The term "line" is derived from the arrangement of cocaine into 1/2 cm by 5 cm columns on a mirror or piece of glass which is then inhaled usually through a straw or rolled-up dollar bill. Absorption through nasal mucosa is an extremely effective method; studies have shown cocaine to be present in the blood within three minutes<sup>1</sup>. The psychological effects of the drug are obviously quite subjective, but generally:

the user experiences 20-40 minutes of stimulation and sometimes euphoria. Typically the individual becomes talkative, and feels energetic and self-confident. The effects of a single dose diminish after 20-40 minutes, generally with no discernable after effects (Wesson and Smith, 1977:141)

Van Dyke and Byck, in studies on surgical patients and healthy volunteers, found that while peak concentrations of cocaine in the plasma were reached fifteen to sixty minutes after administration, cocaine persisted in the plasma for a total of four to six hours. Cocaine was also detectable on the nasal mucosa as long as three hours after administration (Van Dyke and Byck, 1983).

#### (ii) Intravenous.

Intravenous use is much less common than snorting and produces a completely different effect. Within ten to twenty seconds of injection, users experience a rush of euphoria, often described as being of "orgasmic" intensity (undoubtedly another facet of the sexual attraction or sexual mythology surrounding the drug). This rush wears off extremely quickly, within a matter of minutes, although the sensation of being "high" will last for thirty to forty minutes. Cocaine is also injected in combination with other

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<sup>1</sup>See, for example, Byck et al (1977) "Cocaine: blood concentration and physiological effect after intranasal application in man".

drugs. The "speedball", the euphemistic term for the combination of cocaine and heroin, is the most common mixture and users report that the heroin decreases the "tense, irritable, overactive symptoms" (Cohen, 1984:3) that can occur when cocaine is injected by itself. As well, the presence of heroin can make the often dramatic "come-down" from cocaine less severe.

(iii) Oral.

Taking cocaine orally is a rare practice in western society today. It was long believed that the cocaine was made inactive by this method: the cocaine undergoing breakdown in the stomach and liver (Cohen, 1984: Jones, 1984). Recent evidence has shown this to be false. Studies of South American native coca leaf chewers found that cocaine plasma concentrations were of similar levels to that achieved through intranasal administration of cocaine hydrochloride (Jeri, 1984).

It was originally thought that the practice of chewing coca leaves, which contain only 0.6% cocaine, did not produce a cocaine "high" but that any effects were due to the alkaline material ("tocra") which was chewed along with the leaves. Paly and associates have demonstrated that cocaine is absorbed both through oral mucosa membranes and lower gastrointestinal tract mucosa. The "tocra" actually acts to improve the absorption of cocaine by the mucosal membranes. Paly found that under experimental conditions, coca leaf chewers had similar cocaine plasma concentration levels to that achieved through intranasal administration (Paly et al, 1980). Similar findings were produced by Dyke et al who administered cocaine hydrochloride to four male subjects. The main difference between oral and intranasal routes was that with the former, cocaine was not detected in the plasma for thirty minutes. After that point, the same pharmacological and psychological effects were noted as for intranasal use (Dyke et al, 1983).

In the past, of course, oral administration was extremely popular with the use of patent medicines such as Vin Mariani and Coca-cola. Today, knowledge of the effectiveness of oral administration is limited to scientific circles: it remains an uncommon practice amongst users.

(iv) Smoking.

Smoking cocaine consists of the inhalation of vapours from burning alkaloidal cocaine. "Freebasing" or "basing" as it is commonly known, receives its name from the chemical process through which the cocaine alkaloid is "freed" from the hydrochloric

salt yielding cocaine as the "freed" or "freebase" (Siegel, 1982). Lee explains this process in more detail:

when an alkali like ammonium hydrochloride is added to a water solution of cocaine hydrochloride, the cocaine (base) is freed from the HCL molecule. It may then be separated from the water by filtration or extraction with a solvent like petroleum ether (Lee, 1981: 52).

The chemical conversion is necessary because the cocaine hydrochloride volatilizes at 195°C, with some resultant decomposition of the salt, whereas the alkaloidal cocaine volatilizes at only 98°C.

Freebasing is similar to intravenous use because of the quick onset of effects. The smoke is inhaled into the lungs, travels to the left side of the heart and then directly to the brain - the effects are felt within five to ten seconds. The initial rush lasts only a few minutes but is extremely intense. Described by Michael Aldrich as a:

feeling of warmth and excitement that starts in your chest, works up through your spine, clear up out the top of your head and while you're holding your breath, it feels as if the cosmos is spinning (Aldrich in Lee, 1981: 58).

The smoking of coca paste, as practiced in several South American and Caribbean countries, is similar to freebasing<sup>2</sup>. Coca paste consists of between forty to ninety per cent cocaine sulphate, as well as associated coca alkaloids, varying quantities of benzoic acid, methanol and kerosene (Siegel, 1982). The paste is usually combined with tobacco, sometimes marijuana as well, and is smoked in cigarette form. The effects produced are very similar to freebasing. The difference between the two is that freebase is a much more concentrated and "purer" form of cocaine. That is not to say the freebase is completely pure; it still contains many of the adulterants which are used in the making of cocaine hydrochloride.

Freebasing has reached peak popularity in the United States in the last ten years. First reported in 1974, it grew out of the practice of smoking cocaine hydrochloride. Mixing cocaine with marijuana or other "herbal smoking mixtures" into cigarettes (imitating the practice of coca paste smoking) was found to produce psychoactive effects. Gottlieb reports that the effects were not as intoxicating as with snorting but that the aphrodisiacal properties were far more pronounced (Gottlieb, 1976: 50). Siegel suggests that freebase was stumbled upon by accident by some "furtive southern

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<sup>2</sup>Jeri et al (1980) have reported on the use of coca paste in Peru and other South American countries in the late 1970's which was supposed to have reached near epidemic proportions.

California alchemist in 1974" (Siegel, 1982: 431). Since then the practice has spread widely and a whole "freebase paraphenalia" industry has developed.

As will be discussed in Section 2.4, the abuse of freebase has raised considerable concern both amongst devotees and medical authorities. The "Cocaine Consumer's Handbook" was moved to state:

The author feels a moral responsibility to especially discourage the use of freebase cocaine. While the old saying "anything in moderation" still holds true, the use of freebase tends to encourage anything but moderation (Lee, 1981: 60).

(B) Dosage.

Dosage level is one of the main determinants of the effect of cocaine in humans. While dosage cannot be taken as the only "clear indicator of the effect to be produced" (Byck and Van Dyck, 1977: 99), there is a definite relationship between increases in dosage and the intensity and time duration of effect.

The normal single dose consumed by users is between 20mg and 30mg, with the range being between zero and 200mg. The single lethal dose has been estimated at 1.2 grams although severe toxic effects have been experienced with as little as 20 milligrams (Estroff and Gold, 1986:62).

There have been numerous experimental studies investigating the effects of varying dosage levels<sup>3</sup>. Not surprisingly, most find that as dose increases, effects are more pronounced. Fischmann and Schuster's 1976 study found that heart rate, blood pressure and respiratory rate all increased as the dose ranged from 4 to 32 mg; major effects being reported after doses of 16mg and more. Studies by Post et al found that intravenous doses of 2.5 to 25 mg produced marked increases in the physiological measures of heart, respiratory etc. as well as noticeable mood changes (Post et al, 1974). There is a problem of making comparisons between the studies: most use different methodologies as well as taking subjects from widely varying populations.

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<sup>3</sup> Some of the more notable studies include Resnick et al (1977) and Post et al (1978).

(C) Adulterants.

The presence of adulterants in cocaine adds another dimension to the pharmacological effects of the drug. In a strict sense, any effects from adulterated cocaine are not "cocaine reactions" (which perhaps explains why clinical and laboratory studies ignore the issue and restrict themselves to using pure cocaine samples), but in daily use, the majority of cocaine users' experiences are with adulterated cocaine and thus it is this range of effects that must be understood.

Black market or street cocaine is re-knowned for being highly adulterated. The Pharm Chem laboratories of California conduct analyses of samples of illicit drugs volunteered by users. Their results do not claim to be representative of all street drugs but they do provide some knowledge of their actual contents. Cocaine is the most frequently submitted drug for analysis. Ninety-five per cent of samples submitted as cocaine did in fact contain cocaine: total substitution of other drugs for cocaine is obviously rare. An average of between seventy and eighty per cent of all samples were adulterated. The actual content of cocaine per sample ranged from ten per cent to eighty-five per cent - the mean being around fifty per cent (Grabowski and Dworkin, 1985).

The range of adulterants is quite large. Any white powder can be, and is, employed to do the job of stretching the cocaine further. The common ones are:  
lidocaine - a local anesthetic similar to cocaine yet with no euphoric effects;  
lactose and sucrose - sugars;  
mannitol - a mild baby laxative, especially common in the United States;  
inositol - a B vitamin;  
caffeine;  
amphetamine, "speed".

The minimum effect of having adulterants in cocaine is that the actual dosage level is greatly reduced ie. a person taking 20mg of street cocaine intranasally will actually only be consuming ten or less milligrams of cocaine. The maximum effects can be toxic reactions against the adulterants. Particularly common is irritation of the nasal membranes when substances are present which are not absorbable by the mucous membranes. Less common is infection brought about by cutting agents containing particles and bacteria.

## 2.3 COCAINE'S PHARMACOLOGICAL ACTION IN HUMANS

Cocaine has two principal actions upon the body:

- (i) anesthetic properties at the point of application ie. when applied to the mucous membranes or topically to the eye, local anesthesia is experienced.
- (ii) stimulation of the sympathetic nervous system by interfering in the communication between nerve cells (Grinspoon and Bakalar, 1976: 76).

### (i) Anesthetic properties.

Cocaine is the only "therapeutically-useful" (Kegley et al, 1977: 608), naturally occurring local anesthetic. While the general systemic action of cocaine is understood, it is not known exactly how it operates at the nerve site.

At the systemic level, cocaine and all local anesthetics, act on nerve cell membranes to prevent the conduction of nerve impulses or the electrical impulses which travel along a nerve cell. This is done by altering the membrane of the nerve cell. To understand how this occurs it is necessary to know how a nerve cell works under normal conditions. It is an extremely complex process but Van Dyke and Byck offer one of the more succinct explanations:

When the cell is in its resting state, there is an electric potential difference of from 60 to 70 millivolts between the inside of the axon (the impulse-conducting filament that emerges from the body of the cell) and the fluid surrounding the axon. The axoplasm inside the axon is electrically negative with respect to the fluid outside the cell membrane. When the cell is stimulated, the signal called the action potential travels down the axon as a wave of electrical depolarization. A slight depolarization of the axon membrane usually causes a large transient increase in the permeability of the membrane to positively charged sodium ions outside the cell. As the ions pass through channels in the membrane into the axoplasm, the potential difference between the axoplasm and the surrounding fluid is reduced. The movement of charge is a self-limiting process, and soon after the action potential is initiated potassium, calcium and other positively charged ions leak out of the axon and restore the electrochemical equilibrium of the cell (Van Dyke and Byck, 1982: 110-111).

Cocaine, it is thought, acts to block the movement of sodium ions through the axon membrane. As a result "the depolarization of the axon is prevented and the nerve impulse is blocked" (Van Dyke and Byck, 1982: 112). Cocaine ceases to have its

anesthetic effect as its molecules are gradually broken down and diffused into the bloodstream.

(ii) Cocaine and the sympathetic nervous system.

In basic terms, cocaine's stimulation of the sympathetic nervous system occurs because the drug interferes with the chemical signals that pass from cell to cell.

Grinspoon and Bakalar describe the normal communication that takes place between cells:

At the synapse, the electrical impulse generated in a nerve cell causes the release of a transmitter substance that diffuses across a short space to a receptor site on the adjoining cell and generates another electrical impulse: in this way signals are broadcast through a nerve network (Grinspoon and Bakalar, 1976: 76).

The transmitter substances, or neurotransmitters as they are known, which do not stimulate the next nerve cell are either broken down by enzymes, diffuse into adjoining tissue or are taken back-up by the releasing cell. Cocaine's presence in the synaptic cleft inhibits the re-uptake of neurotransmitters and thus mimics the effects of the release of more neurotransmitters (drugs with this action are called sympathomimetic). The neurotransmitters remain at the cleft for a longer period than usual and continue to stimulate the receptors of the adjoining cell. It is also believed that cocaine stimulates the release of more neurotransmitters into the synaptic cleft.

Cocaine acts on three neurotransmitters in the Central Nervous System (CNS); norepinephrine, dopamine and serotonin.

It is believed that cocaine, in mimicking the natural physiological stress response, stimulates the energy producing mechanisms to prepare the CNS and skeletal muscles for "fight or flight", ie. cocaine produces the chemistry of emotional excitement, tension and anxiety while the brain believes that everything is fine (Van dyke and Byck, 1982; Siegel, 1984). The blocking of the re-uptake of norepinephrine is thought to be responsible for this. Scientists once believed that cocaine's action on norepinephrine explained all of the drug's stimulating effects but recent experiments have shown that dopamine and serotonin are equally important.

Dopamine has been found to play a critical role in what human's experience as euphoria<sup>4</sup>. Roy Wise and Michael Bozarth have experimented with drugs to selectively block norepinephrine and dopamine systems in the brain. Their findings were that:

some anti-psychotic drugs - which block the dopamine system but do nothing to the norepinephrine system - effectively block the rewarding effects of cocaine (Wise and Bozarth, 1981: 467).

As with norepinephrine, cocaine blocks the re-uptake of dopamine and thus produces the feeling of euphoria. Wise suggests that the dopamine blocking process provides a powerful reward which is what makes cocaine a "habit-forming" drug (in Hammer and Hazelton, 1985: 24). The question of cocaine's "addictive" qualities will be dealt with in Section 2.5.

Unlike the dopamine and norepinephrine systems, cocaine has the effect of depleting supplies of serotonin. Serotonin is known as the "sleep transmitter" and it is the depletion of this, in combination with the release and blockade of re-uptake of norepinephrine and dopamine, which is thought to explain the decreased desire for sleep when cocaine is administered (Gold et al, 1986: 40).

## 2.4 ADVERSE EFFECTS OF COCAINE USE

The Peruvian marching powder. Yes, the Colombian dancing dust. We're talking about cocaine. Mmm, what a wonderful drug ..... anything that makes you paranoid and impotent, yeah, give me more of that!

Comedian Robin Williams

Cocaine's reputation as a "safe recreational drug" has been under attack in recent years. More and more evidence is being produced which demonstrates the negative effects from its use, or "abuse", as it is commonly termed. While it is still true that occasional use of cocaine by the intranasal route rarely causes any serious problems, long term use and continual use over short periods of time, can produce major dysfunctions. This applies particularly to those using cocaine intravenously and freebasing.

To begin, we shall examine the various adverse effects which result from the different routes of administration.

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<sup>4</sup>For a review of the research on dopamine see Robert Byck and Craig Van Dyke's article "What are the effects of cocaine in man" in Cocaine:1977 NIDA Research Monograph 13.

(i) Intranasal.

With intranasal use, it is the site of administration where negative effects are usually experienced. Long term continuous use produces intense vasoconstriction of the mucous membranes in the nose, and rhinorrhea when the cocaine ceases to be present. Another result of the vasoconstriction can be perforation of the nasal septum, although this is an extremely rare occurrence (Estroff and Gold, 1986: Grabowski and Dworkin, 1985). The most common effects are swollen or ulcerated noses with the symptoms of "runniness" or bleeding (Grinspoon and Bakalar, 1976: Cohen, 1984: Young, 1987:). General physiological adverse effects, which usually follow long periods of use, are of the following order:

nervousness, irritability and restlessness from over stimulation, sometimes extending to mild paranoia; physical exhaustion and mental confusion from insomnia; undesired weight loss; fatigue or lassitude in coming down (Grinspoon and Bakalar, 1976: 130).

(ii) Intravenous.

The problems associated with intravenous cocaine use are, for the most part, those associated with any intravenous (I.V.) drug use. The use of unsterile needles can result in serious infections. Skin disorders, abscesses and cellulitis, are the most common but pneumonia and bacterial endocarditis can ensue from the unsterile drug being carried through the bloodstream. The practice of sharing needles between various users is extremely dangerous: hepatitis and Acquired Immuno Deficiency Syndrome (AIDS) are two possible outcomes.

Animal experiments have also pointed to the dangers inherent in intravenous use. Johanson and associates conducted experiments where monkeys were given unlimited access to intravenous cocaine. The monkeys developed hyperactivity, tactile hallucinations, ataxia, severe weight loss and convulsions until they injected themselves to death within periods of five days (Johanson et al, 1976). Other animal studies have produced similar results<sup>5</sup>. The conclusion from these studies is that intravenous cocaine use provides one of the most powerful drug reinforcers.

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<sup>5</sup>See, for example, Post and Rose (1976), and Stripling and Ellinwood (1976) as well as Woods' review article on the subject "Behavioural effects of cocaine in animals" in Cocaine:1977.

Except in rare circumstances, humans do not gorge themselves on cocaine until they kill themselves, but consumption of large quantities of the drug over relatively short periods of time does take place. So-called "bingeing" can last from a matter of hours to a number of days. The "binge" will usually end when either supplies are exhausted or the participants themselves are exhausted. Bingeing is something which is common to all methods of cocaine use.

Another range of problems with intravenous use can occur when cocaine is injected in combination with other drugs. The "speedball" as it is known can produce fatal results. With the typical speedball (cocaine and heroin), when the effect of the cocaine is wearing off the continual action of the heroin causes a dramatic shift in physiological function which can lead to respiratory depression and death (Grabowski and Dworkin, 1985; McConnell, 1982). The American actor John Belushi was the most notable person to die in such fashion.

(iii) Freebase.

The adverse physiological effects from freebase are very much an unknown. The practice has only been current for ten years and thus little research has taken place investigating the chronic effects.

Not surprisingly, freebase is known to have a toxic effect upon the lungs. Weiss' study of ten chronic cocaine freebase smokers has shown they suffer a marked reduction in the carbon monoxide diffusing capacity of their lungs (Weiss et al, 1987). Lee hypothesises that as freebase tends to re-crystallize in the bowl and stem of the pipe which is used, then it is fair to assume that the same kind of process take place in the lungs (Lee, 1981).

A non-physiological danger, but a very real one all the same, is the possibility of explosion during preparation and use of freebase. The use of ether in the chemical process of converting cocaine hydrochloride to base means that ether fumes can accumulate: a small spark and the fumes can be ignited. The American comedian Richard Pryor did exactly this.

What is seen as the greatest danger of freebase is its tendency to produce compulsive use patterns. As Lee describes it, the " most prevalent danger of freebase consumption is its tendency to totally captivate its user" (Lee, 1981, 60). Another writer describes freebase this way:

You get to the point where freebase is the only thing in your life. You live, die, everything for freebase and in that comes chronic use, lack of sleep, hallucinations, paranoia (Incaba, 1981:60),

Dr. Sidney Cohen suggests freebase cocaine is unlike any other drug or human activity in the way it compels the user to "persist repetitively in its acquisition" (McConnell, 1982: 6).

Freebase experiments with animals, although limited, also indicate the drug's supposed "compulsive" nature. Siegel's 1979 study showed that while monkeys were able to titrate their own doses they used upwards of an ounce of freebase cocaine everyday for periods of twenty days at a time (Siegel, 1979).

So far we have discussed the negative effects of cocaine use arising from the individual routes of administration. We shall now examine the more general adverse consequences of use.

#### Psychological problems.

The psychological disorders which follow chronic cocaine use are extremely varied - the specific symptoms are dependent on the individual user.

Most cocaine induced psychotic episodes are of limited duration and disappear as levels of the drug drop from the body. For some time it was believed that cocaine did not produce long lasting psychosis. It is now known that it can produce major psychiatric symptoms such as depression and schizophrenia, which persist long after the drug has disappeared from the system (Estroff and Gold, 1986: Carabajal, 1980). Cocaine can also exacerbate pre-existing psychiatric disorders.

Psychological problems have been conceptualised as progressing through four successive stages (Estroff and Gold, 1986). The first stage, cocaine euphoria, encompasses all the stimulant effects of cocaine or what may be regarded as "normal" responses to the drug eg. hyperactivity, hypersexuality and insomnia. Cocaine dysphoria or "cocaine depression" is the next stage and the symptoms of this include anxiety, melancholy, apathy, sexual indifference and compulsion to use more cocaine (Young, 1987: Siegel, 1982: Estroff and Gold, 1986).

The third stage signals the beginning of serious psychotic episodes. The chronic user in this phase will continue to suffer most of the symptoms of stage two, but in addition, can experience hallucinations. The most common cocaine hallucinations are of a tactile nature where the user feels animals or insects moving in the skin. First documented by Magnan and Saury in 1889, they have since been known as "Magnan's sign" or "cocaine bugs" (Siegel, 1978: 309). Such tactile hallucinations are sometimes followed by visual, auditory and olfactory ones<sup>6</sup>. Siegel's recent research on cocaine hallucinations has identified the phenomena of "snow lights" or "snow spots". These are found to precede tactile hallucinations and consist of users' experiencing the "sensation of object movement in the periphery of the visual field" (Siegel, 1978: 310) - something akin to the twinkling of sunlight reflected from snow crystals. The important point about hallucinations in stage three are that the user is consciously aware that such occurrences are a figment of their imagination.

The final stage, "cocaine psychosis", occurs when the user believes the hallucinations to be real. Siegel cites the example of a patient who presented him with ten vials of "cocaine bugs". The vials were found to contain dry skin tissue which the patient had scratched off (Siegel in McConnell, 1982). In this fourth stage, extreme paranoia, aggressiveness and suicidal tendencies are also symptoms which can be experienced. At this level there is very little to distinguish cocaine psychosis from "classic" psychotic disorders<sup>7</sup>.

### Sexual problems.

The idea that cocaine use can cause sexual dysfunctions has been current for some time. Around the turn of the century, it was part of a "scare tactics" approach adopted by authorities to dissuade people from using the drug. Reports were published which stated that cocaine's initial stimulation of the sex drive soon brought about impotence in males and sterility in females (Siegel, 1982). A study of cocaine users in the 1920's found that only twenty to thirty per cent of users became sexually excited with cocaine but that continued stimulation did result in impotence and frigidity (Siegel, 1982: 72).

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<sup>6</sup>Siegel examines these effects in his article "Cocaine hallucinations" *Am. J. Psychiatry*, 135 (3) pp.309-314, 1982.

<sup>7</sup>Thomas Young (1987) looks at the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association - the DSM III scale details the effects of cocaine.

Today, there are conflicting views on the seriousness of cocaine associated sexual problems. It is still true that the occasional user, employing any route of administration, is more likely to experience sexual excitation than any sexual dysfunction. Cocaine can increase libido, prolong sexual intercourse and produce more intense orgasms for both sexes (Grinspoon and Bakalar, 1976; Ashley, 1975; Spotts and Shontz, 1980) When problems occur, which as we've said comes with heavy use patterns, the results are quite the opposite: loss of interest in sex; erectile and ejaculatory problems in males; and inability to achieve orgasm in females<sup>8</sup>. There is debate as to whether such problems continue when chronic use ceases. David Smith of the Haight-Ashbury Clinic, suggests that:

most find when they stop using the drug they don't return to the level of sexual functioning which pre-dated their involvement with cocaine (Smith in McConnell, 1982: 9).

Siegel, on the basis of his own clinical studies concludes that chronic cocaine users experiencing sexual problems almost entirely return to "normal" sexual behaviour after dis-continuing cocaine use (Siegel, 1982).

### Sudden Death.

Sudden death from using cocaine can occur regardless of the route of administration or the dosage level. Deaths have been recorded when as little as 20mg was ingested intranasally. The symptoms and signs that such a reaction are imminent include dysphoria, hyperthermia, tachycardia, mydriasis, stupor and seizures (Weitli and Wright, 1979; Mittleman and Weitli, 1984). Anyone with a history of heart disorders is especially at risk. As Cohen explains:

The increased demand of the heart for oxygen following cocaine-taking causes coronary insufficiency. The increased heart rate, blood pressure and general excitation is too much for an already embarrassed coronary circulation (Cohen, 1984: 8).

People who are perfectly healthy can also suffer sudden fatal cocaine reactions. The death of the American athlete Len Bias is a case in point. Bias took cocaine for the first time, suffered a brain seizure which interrupted the electrical activity monitoring the heartbeat and a fatal heart seizure followed (Hill, 1986). Sudden death from cocaine use is an extremely rare occurrence yet Dr. Arnold Washton, a cocaine abuse expert in

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<sup>8</sup>Gottlieb (1976, p. 47) makes an interesting, if somewhat cynical point that "while cocaine may briefly result in heightened interest and even performance, it requires delicate timing which is not the strong point of individuals who turn to stimulant drugs".

the United States, has suggested that taking cocaine is analogous to playing a game of Russian roulette (in Hill, 1986). Another form of fatal cocaine intoxication has occurred where excited delirium has preceded a collapse. Weitli and Fishbain outline the situation:

Symptoms began with the acute onset of an intense paranoia, followed by bizarre and violent behaviour necessitating forcible restraint. The symptoms were frequently accompanied by unexpected strength and hyperthermia. Fatal respiratory collapse occurred suddenly and without warning, generally within a few minutes to an hour after the victim was restrained (Weitli and Fishbain, 1985: 873).

Perhaps the tales of blacks displaying incredible strength and resistance to bullets, from earlier this century, were not entirely mythology!

Death from cocaine can occur without any warning to the victim. As was discussed in Section 2.3, taking cocaine puts the body into the chemical state of fear - the "fight or flight" syndrome - while the brain is still experiencing a sense of well-being. Therefore, someone experiencing a cardiac or respiratory problem may have no awareness of such symptoms.

## 2.5 COCAINE AND ADDICTION

From the review of the harmful effects of cocaine use, what emerges as the crucial issue is whether cocaine is an addictive or dependency producing drug. Assertions have been made that using cocaine (particularly freebase) is the most compulsive of human activities and that it is a drug which is craved far more than any other drug. What basis there is in such claims will now be examined. Any such analysis must begin by looking at the definitions of the terms "addiction" and "dependency".

### Definitions of addiction and dependency.

When terms such as addiction and dependency are used the question arises as to what is precisely meant by these expressions. There is no short and precise answer to this question. While there are definitions, and they shall be examined briefly, they are by no means foolproof and are certainly the subject of a great deal of debate. As Robert Apsler points out, existing measures of drug use are characterised by a lack of standardization, an absence of clear definitions of basic concepts and the presence of

serious practical obstacles to accurate measurement (Apsler, 1984). A similar view is that a:

monstrous tangle of social, psychological and pharmacological issues surrounds the concepts of drug addiction, habituation and dependence (Grinspoon and Bakalar, 1976: 176).

There have been serious attempts at developing standard definitions in the drugs area. The World Health Organisation's Expert Committee on Addiction Producing Drugs came up with what was thought to be the standard definitions of both physiological addiction and psychological habituation. Young has summarised the definitions in tabular form (see Table 2.1).

These definitions were extremely problematic. According to Norman Zinberg, a major flaw was the confusion in the terms used. He points out that is very difficult to separate desire and compulsion from physical and psychic dependence. He poses the questions:

How can either physical or psychic dependence exist without a desire or compulsion? And conversely, is not the reason for a desire or compulsion the existence of psychic or physical dependence (Zinberg, 1984: 30).

Another result of the definitions were that addiction and habituation were open to misinterpretation. Young outlines how addiction was equated with any use of drugs outside of legal medical practice. Addiction had become:

an emotive term based more on the implicit demand that something should be done to stop a drug's use than on any empirical description of how a drug taker relates to a specific drug (Young, 1971: 43).

**Table 2.1 1957 WHO Definitions of Addiction and Habituation**

	<u>Addiction</u>	<u>Habituation</u>
1. Attitude to drug	Compulsion to continue use	Desire to continue use
2. Tolerance	Tendency to increase dose	No such tendency
3. Psychic dependence	Present	Present
4. Physical dependence	Generally present	Absent - no withdrawal symptoms

(Young, 1971:42)

Young also took issue with the way certain drugs did not fit this dichotomy between addiction and habituation. He uses the example of amphetamines, which produce tolerance but not physical dependence and therefore one must ask whether they be called habituating or addictive. Young was also critical of the way social factors surrounding drug use were ignored in the WHO definitions. He argues that:

distinctions between habituation and addiction are fallacious in that they assume that the same drug in different social settings will have essentially similar effects (Young, 1971: 44).

The definitions of habituation and addiction had so many weaknesses and problems in application that they were soon rejected as general descriptions of chronic drug use. A medical definition of addiction still persisted, and does to this day. It can be summarised as follows:

drug addiction is a condition induced in higher mammals by chronic administration of certain central nervous system depressants like opiates, alcohol and barbituates; a gradual adaptation of the nervous system produces a latent hyperexcitability that becomes manifest when the drug is withdrawn and includes physiological symptoms that are interpreted as a physical need for the drug (Grinspoon and Bakalar, 1976: 178).

The Expert Committee responded to the problems with "addiction" by coming up with one, more widely encompassing definition, termed dependency. This was:

a state of psychic dependence or physical dependence, or both, on a drug, arising in a person following administration of that drug on a periodic or continued basis... all of these drugs have one effect in common: they are capable of creating, in certain individuals, a particular state of mind that is termed "psychic dependence". In this situation, there is a feeling of satisfaction and psychic drive that requires periodic or continuous administration of the drug to produce pleasure or to avoid discomfort (Goode, 1972 :22).

This definition still made the tenuous distinction between psychic and physical dependence. Apsler draws attention to the circular reasoning with the dependency definition. It was developed in order to describe a particular form of drug use, however, when the question is asked 'why are they using drugs all the time?', a common answer is because they are dependent - drug dependence has become a cause and is used as an explanation of the pattern of drug use it was supposed to be defining (Apsler , 1984: 36).

Another criticism levelled at the dependency definition was its lack of reference to the relationship between drug use and social factors of drug use. Erich Goode feels the term confuses more than it clarifies, due mainly to its focus on the drug itself rather than the individual using it. For Goode, it is simply illogical to attempt to explain something variable (some users using drugs more heavily while others use more infrequently) in terms of a constant (the drug), (Goode, 1972). Further, it was thought that "dependence" carries the idea of enslavement to a drug: that "some chemical compounds have a mysterious power over the will that only coercive authority can cope with: it is a denial of personal freedom and moral autonomy" (Grinspoon and Bakalar, 1976:187).

The adoption of the term dependence was still seen as a step in the right direction. It made current the idea that there were varying degrees of dependence on substances and not just two contrasting conditions (addiction and habituation) with their emphasis upon the notion of "disease". Another positive aspect was seen in the vagueness of the term. It was felt this would allow dependence to remain free of the connotations which had come to be associated with addiction. It was basically a much less "morally loaded" term than addiction had been. The vagueness of dependence was also seen as a drawback in that it could be applied to things such as love of food or love of sex. As Grinspoon and Bakalar point out:

To like and want a drug, and to feel some disappointment when it is not available is no different from liking and wanting and being unhappy in the absence of anything else (Grinspoon and Bakalar, 1976: 186)

### Cocaine and the definitions of addiction and dependence

The question is how cocaine is classified according to the various standard definitions discussed above.

According to the medical definition of addiction, cocaine is a physically non-addicting substance. It does not produce a "clearly definable withdrawal syndrome as with opiates or barbituates" (Gold et al, 1986:49) or a pattern of tolerance. In fact, the medical definition specifies drugs which are central nervous system depressants thus immediately discounting cocaine as addictive.

The World Health Organisation's definition of a "drug dependence of the cocaine type" embodies the idea of cocaine as a psychically rather than physically dependent drug. The four characteristics of the cocaine dependence were set down as:

- (1) An overpowering desire or need to continue taking the drug and to obtain it by any means;
- (2) absence of tolerance to the effects of the drug during continued administration; in the more frequent periodic use, the drug may be taken at short intervals, resulting in the build-up of an intense toxic reaction;
- (3) a psychic dependence on the effects of the drug related to a subjective and individual appreciation of these effects; and
- (4) absence of physical dependence and hence absence of an abstinence syndrome on abrupt withdrawal; withdrawal is attended by a psychic disturbance manifested by craving for the drug. (Young, 1974: 23).

What is now being disputed is whether there is an absence of tolerance and withdrawal symptoms from cocaine.

Looking first at the issue of tolerance, this is defined as an "adaptation of the nervous system to the effects of a given amount of a drug which makes it necessary to keep taking more of the drug to get the same effects" (Grinspoon and Bakalar, 1976: 180). The reverse of tolerance is sensitization where the same dosage level, after a period of continued use, produces different and more accentuated effects.

The idea that cocaine produces a decrease in tolerance and an increase in sensitization, comes from a large body of animal experimental studies. These studies demonstrated that rats display increased hyperactivity, stereotyped movements and convulsive behaviours after daily injections of the same dose. The increased sensitization persisted for as long as seven weeks after discontinuation of injection. The dosage levels varied between 7-40 mg/kg of body weight (Post and Rose, 1976; Stripling and Ellinwood, 1977; Ellinwood and Kilbey, 1980; Stripling and Hendricks, 1981).

There are studies which have produced exactly opposite results to those above. Matsuzaki's experiments with monkeys found that tolerance developed to the convulsive, respiratory and cardiac effects of high daily intravenous doses of cocaine (Matsuzaki, 1976). Experimentation with lower doses of cocaine have also produced tolerance in relation to schedule controlled behaviour (Branch and Dearing, 1982; Thompson, 1977).

What then is the conclusion to be reached from this conflicting evidence? Grabowski and Dworkin suggest we can conclude nothing more than:

the development of tolerance and sensitization to the behavioural and physiological effects of cocaine appears to be a function of the dose, behaviour and species investigated (Grabowski and Dworkin, 1985: 1081).

Reese Jones builds upon this basic position. He asserts that tolerance must involve a variety of adaptive mechanisms and changes, and that "decreases in some cocaine effects with repeated doses are not necessarily inconsistent with concomitant increased variety in other effects" (Jones, 1984: 46). Jones believes the notion of "pharmacological kindling", as advanced by Post and Kopanda, provides a good explanation for this phenomena. Post and Kopanda hypothesised that convulsions which occur after continued electrical stimulation of certain regions of the brain, at levels which initially fail to produce seizures, may be analogous to the tolerance and sensitization effects of cocaine. That is, the progressive increases in irritability, restlessness, hypervigilance, paranoid and suspicious behaviour with prolonged high-dose cocaine use in humans may be the correlate of the kindling phenomenon observed in animal experiments (Jones, 1984). What Jones concludes is that:

in such a state, concurrent increasing and decreasing sensitivity to a drug, certainly does not fit the simplistic model of what tolerance to a drug should represent. On the other hand, if one conceives of tolerance as involving a number of mechanisms... then what is commonly observed clinically fits (Jones, 1984: 47).

Many of the "drug abuse experts" are now of the view that a true cocaine withdrawal does exist<sup>9</sup>. There is no comparison with the severe withdrawals experienced with opiates, barbituates and alcohol but the depression, paranoia, fatigue, craving, agitation, sweating and chills, insomnia, eating disorders and muscular pain which follow periods of heavy use are all considered to constitute a genuine withdrawal. The point that is stressed about these withdrawal symptoms is the way they act as negative reinforcement. For a long time it was assumed that the only reason why people continued using cocaine was for the euphoria or "intense high" that is experienced. Now, the desire to avoid the dysphoria associated with the withdrawal symptoms is seen as an equally important factor. Cohen summarises the process:

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<sup>9</sup>Mark Gold and Arnold Washton are the most prominent advocates of this position. This is due mainly to their work with the 800-COCAINE national "hotline" in the United States (see Gold and Washton, 1984).

cocaine users find themselves impelled to return to cocaine because of the positive reinforcement (reward) of the intense euphoria, the negative reinforcement (punishment) of the intense dysphoria experienced after discontinuing its use, which is relieved by using more cocaine (Cohen, 1984: 9).

There are those who remain unconvinced by such arguments. Grabowski and Dworkin suggest that the so-called "cocaine withdrawal symptoms" may be nothing more than "rebound like" phenomena, which are commonly observed with extended use of amphetamines (Grabowski and Dworkin, 1985). The "rebound" is where a period of intense euphoria is followed by a period of equally intense dysphoria, however, the "crash" is not considered to constitute a physiological abstinence syndrome. Perhaps the final point on this issue belongs to Edward Gottheil who states:

one can debate about the extent to which physiological dependency occurs, but the issue is really of little consequence since the overwhelming problem is the degree of psychological dependency and craving deriving from the extremely strong reinforcing power of this drug (Gottheil, 1987: 26).

## 2.6 CONCLUSION

It is obvious that no definitive statements can be made about what constitutes dependency and what type of dependency cocaine is supposed to produce. In Chapter Three we shall see the question "why dependency" is equally perplexing. There has been a pre-occupation within the drug research area on the whole issue of dependency. Theoretical arguments about the dependent state predominate with an according emphasis in substantive studies upon investigating the characteristics of "addicts" or "dependents".

While there is nothing wrong with attempts at understanding dependency (there can be no denying that dependency problems do exist) it is the manner in which researchers, particularly medical and pharmacological ones, draw conclusions about all illicit drug use from studying abuse characteristics which is of concern. The simple fact is that the vast majority of users of any drug are not dependents or do not experience any significant problems through their use of the drug. This is largely overlooked and has meant that a vital perspective on dependence has been lost. That is, in attempting to understand abusers of a drug it is essential to know what the non-abusers are like. Recently there have been attempts at understanding this second half of the equation as it were. The following chapter examines how the concept of "controlled drug use" has been developed.

# CHAPTER THREE

## THE DEVELOPMENT OF THE CONTROLLED DRUG USE PERSPECTIVE

### 3.1 INTRODUCTION

The drugs themselves fall into two main groups - the "white stuff" as it is known (any powdered drug such as heroin, cocaine and morphine) and the "weeds" (marijuana and hashish). Many addicts .... start their journey into darkness by smoking marijuana ("reefers" or "charge").

The smoke is inhaled deeply, generally by a group of addicts at a time and often from one communal cigarette passed from hand to hand round the circle. Normal inhibitions disappear and a combination of marijuana and the cheapest red wine or rough cider is often accompanied by debauchery and a general lowering of standards. It is when hemp and hashish fail to give satisfaction - as inevitably happens - that the addict moves on to the point of no return - the "white stuff".  
(Agnew, 1964: 14-15).

The greatest hazard in the use of cocaine is addiction, which may develop after a very short time.

Addiction is commonest in unstable and psychotic persons and is particularly deleterious because the addicts prefer company and try to induce their friends to share their pleasures. Cocaine addicts ..... are dangerous and commonly carry weapons which they are likely to use.

Mental deterioration takes place, and most addicts end up as pitifully reduced, grumbling and irritating inmates in mental institutions.

(Encyclopedia Britannica, 1968: 994).

These two comments contain some fairly extraordinary claims in relation to cocaine and marijuana use. We now know that marijuana use does not lead "inevitably" to the use of the "white stuff" whilst the idea that "cocaine addicts" carry weapons, which they are likely to use, is just preposterous. Given our present level of understanding of drug use, one would think such views would no longer be current. The fact is that some equally extreme statements are being made today although they tend to be disguised in the form of "scientific facts". Such statements usually do contain an element of truth (for example, most users of heroin and cocaine, the "white stuff", have used marijuana first) but they are often only applicable to a small number of users.

The purpose of this chapter is to show how a more realistic approach to drug use has been developed, one which is the basis of the present study. It is an approach

which while being aware of the physical properties of drugs, and their potential for harm to users, stresses the social factors of drug use which act in a way to maintain use at a controlled level. In analysing this theme, the chapter is divided into three sections.

First, the chapter examines how concerns with the "drug problem" have dominated research and thought on drug use. The concept of a "drug problem" has entailed investigations of dependency/addiction issues yet the "drug problem" refers to all illicit drug use, so in this way references are made about all drug use from studying the properties of dependent users. Linked to this is an exclusion of evidence which might negate such a position through the dispelling of the "myths of safe drug use" and the warning of the great dangers inherent in any use of illicit drugs. As will be shown, it was dissatisfaction with this outlook led first to critique of the addiction perspective and then to an alternative position with its focus on controlled drug use.

The concern of the second part of this chapter is the controlled drug use perspective. What began with Becker's classic study of marijuana use was extended in the 1970's with the work of such people as Norman Zinberg, Robert Apsler and Ronald Siegel. It is now widely accepted that the majority of users of any drug do not constitute dependent or "problem" users.

The final section of this chapter examines the major empirical studies undertaken on controlled cocaine use. These provide a background and point of comparison for the Australian study to be detailed in chapter four.

### **3.2 THE DRUG PROBLEM**

In Chapter One it was seen how the "cocaine menace" was constructed in the early part of this century. The idea of cocaine's "evil nature" was based upon a series of supposed "scientific facts", half-truths and blatant falsehoods. Cocaine was viewed as a highly addictive drug with the potential to totally destroy any person who meddled with it. By the time restricting regulations were introduced cocaine was seen as nothing less than a plague, which if let go, would wreak havoc on the entire population.

When cocaine was re-discovered in the late 1960's and 1970's, the old myths surrounding its use were re-discovered as well. This was not surprising, given that condemnatory attitudes toward illicit drug use had not changed in the intervening years and there had been no research to suggest cocaine was anything other than an evil,

debasement habit. Cocaine, along with marijuana, heroin and LSD became one of the main constituents of the "drug problem" in western society.

With the modern era of illicit drug use came a tremendous desire to understand the "drug problem" in order to facilitate its elimination. While politicians and policy makers maintained such lofty goals, social theorists were more concerned with understanding why the "drug problem" concept existed at all. It was quite obvious that a huge disjunction existed between official portrayals of the "drug problem" and the reality of drug usage. One of the glaring incongruities was the focus upon illicit drugs while licit drugs, such as alcohol and tobacco, posed far greater health, social and economic problems for the community. The realisation was therefore that:

Drug use has become mystified. It is something quite different from other behaviour. Drugs are seen to exercise a strange power over people. Everyone is in danger of being taken over. Drug users have become a class apart: a threat to society (Drew, 1986: 265).

An author who has provided one of the more scathing critiques of the "drug problem" myth is Thomas Szasz. His basic argument is that the drug problem consists of nothing more than the:

passionate promotion and panicky prohibition of various substances; the habitual use and the dreaded avoidance of certain drugs; and most generally, the regulation by language, law, custom, religion.... of certain kinds of ceremonial and sumptuary behaviours (Szasz, 1974: i).

The "dangerous drugs", addicts, pushers etc. are for Szasz, the scapegoats of our modern, secular, therapeutically imbued societies, comparable with the witches, Jews and madmen from previous times.

Szasz goes as far as to suggest the problem is a mere construction of language - "the verbal shaping of the "problem" itself constitutes much or even all of the ensuing problem" (Szasz, 1974: 11). He believes that we have literally talked ourselves into having a drug problem:

We declared first this and then that drug "bad" and "dangerous"; gave them nasty names like "dope" and "narcotic"; and passed laws prohibiting their use. The result: our present problems of drug abuse and drug addiction (Szasz, 1974: 11).

What is termed "addiction mongering" consists of three inter-twined mechanisms. First, the classification as "dangerous narcotics" of certain substances which are neither particularly dangerous and certainly not narcotic eg. marijuana and

amphetamines. Second, the prohibition of these substances and persecution of those associated with their use as bad criminals (pushers) and as mad patients (addicts and dope fiends). Finally, the persistent claim that use is increasing at an alarming rate.

While the concept of drug addiction as a disease has been widely held, Szasz considers it more of a "despised kind of deviance" with the 'addict' constituting a stigmatized identity rather than a bona fide patient. As with the "drug problem" itself, Szasz believes "drug addiction" is a result of semantics, having no basis in social reality. He acknowledges that habituation may occur and that certain drugs can have harmful effects but that:

the difference between someone "using a drug" and his being "addicted" to it is not a matter of fact, but a matter of our moral attitude and political strategy toward him (Szasz, 1974:54)

As illustration of this point, Szasz cites the examples of tobacco and gin, part of "common parlance" and certainly not considered drugs, while marijuana and valium are most definitely harmful drugs. In reality, all four substances are drugs and with equal potential to cause harm.

Arguments like those of Szasz are not entirely new. It has been an obvious incongruity since the beginning of the "drug problem" myth how much stress was laid upon illicit drugs while those licit drugs such as tobacco and alcohol were almost completely ignored. Mugford, writing on the evolution of drug policies in Australia, makes this point as well. He notes how discussions of the consequences of alcohol and tobacco use have taken place<sup>1</sup> yet these tend to become "submerged by the waves of rhetoric about more 'newsworthy' topics (Mugford, 1986: 155)<sup>2</sup>.

Dissatisfaction with the "addiction as disease" concept has been voiced by many authors in the drugs area<sup>3</sup>. Saleeby suggests that the disease model provided a more humane view of addicts, as opposed to the "heavy-handed moralizing and harsh social treatment" previously lathered upon them, but that little scientific evidence has been produced to support its foundation claim that addicts are sick (Saleeby, 1985). Les Drew believes that the:

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<sup>1</sup>Mugford notes the recent Australian government efforts, such as the anti-smoking and drink-driving campaigns. Despite this, there still remains the glaring hypocrisy of alcohol and tobacco companies' sponsorship of major sporting events.

<sup>2</sup>See Berke Breathed's cartoon (Appendix 4) for an incisive and amusing view on the whole issue of hypocrisy within the drugs field.

<sup>3</sup>See for example Moss and Nicholson, 1983; Peele, 1986; and Watts, 1981.

moral viewpoint has never been totally surrendered, even though lip service may have been given to the need to see people as sick rather than sinners (Drew, 1986: 265).

He also points out how no evidence exists to suggest there is a lack of choice in the use of drugs, another of the basic tenets of the disease model. Drew's major quarrel with this model is the way it treats humans as "little different from laboratory animals". He proceeds to advocate a "way of life" model, which analyses the interaction of drug, person and environment and stresses that people with drug dependence problems have "predicaments" rather than a disease or illness<sup>4</sup>. The "drug, person, environment" is the basis of the controlled drug use perspective, which will be analysed in section 3.3.

Finally, one of the more recent critiques has come from Krinavek (1987). She takes issue with the three major assumptions of the disease model: predisposition, loss of control over use and progression. While all three are very doubtful concepts, predisposition is the shakiest: "it has been impossible to demonstrate a consistent physical or psychological factor that would distinguish the addict from the non-addict" (Krinavek, 1987:35). Krinavek's conclusion is that:

The disease model, therefore, can neither demonstrate a clear etiology for addiction nor can it predict its causes and symptoms with any accuracy (Krinavek, 1987:35).

Criticism of the disease model of addiction has fostered a re-appraisal of the notion of addiction and dependency. Addiction originally described a wide range of experiences, something which is lost in its present exclusive association with drug use<sup>5</sup>. Addiction and dependency have become almost "dirty words" according to Jeff Moss - "if you've got it get rid of it" is the prevailing attitude (Moss, 1982: 5). Now, there is emphasis being placed upon once again widening the scope of dependency. The realisation is that there is a vast number of dependencies which satisfy human needs. As Saleeby states:

the nature of human nature is that we can and do become addicted to anything: diet cola, money, sex ..... it is not particularly the substance, object or experience that is addicting. Rather, it is our need for symbolic resonance (Saleeby, 1986: 19).

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<sup>4</sup>Drew's "way of life" model is one of the social-psychological explanations of drug dependence which are becoming increasingly popular amongst theorists. Saleeby's article "A social psychological perspective on addiction: themes and disharmonies" (1986) provides an excellent review of this approach.

<sup>5</sup>Moss has what he calls his "addiction iceberg". The visible tip of the iceberg consists of mind altering drugs we normally associate with addiction. Just below the surface are non-drug experiences which are increasingly being considered addictive eg. television watching, working (thus the term "workaholic"). The bulk of the iceberg is formed by interpersonal relationships which Moss claims have all the hallmarks of addiction eg. parents/children and expert/client relationships (Moss, 1982:5).

Stanton Peele also holds a similar position, believing that addiction is not located in substances but with the person and their "search for a given experience" (Peele, 1986: 23).

Szasz locates the blame for these misapprehensions about drug use squarely with the medical profession. He believes:

the single most important issue in coming to grips with the problem of drug use and drug avoidance is, in my opinion, the medical perspective on moral conduct (Szasz, 1974: 4).

Szasz's assumption is that an innate human desire for scapegoatism is now expressed through "pharmacomythology" and what he terms the "characteristic rituals of ceremonial chemistry" (Szasz, 1974: 20). The basis of this pharmacomythology is that whatever promotes health eg. "good food", "good drugs" must be cultivated whilst anything which promotes illness, especially "dangerous drugs" must be eliminated or discouraged. In essence, "medical values have replaced religious rituals, medical rituals have taken the place of religious values" (Szasz, 1974: 21). Watts is another proponent of this viewpoint. He sees the "territorial interests of the medical profession (Watts, 1981:455) as determinant. Krinavek concurs when she states:

Another assumption about disease is that they are primarily medical matters and this profession is responsible for their management (Krinavek, 1987: 37).

Undoubtedly, Szasz succeeds in locating the principal weaknesses with the "drug problem" concept. Whether his argument concerning the root of the problem ie. a medical profession attempting to govern moral conduct, is correct is another matter. His approach is rather one dimensional in its scope. He ignores the possibility of other moral and political groups, such as pharmaceutical, tobacco and alcohol interests having any influence upon the process of defining what are socially acceptable drugs.

So far the notion of the "drug problem" has been discussed at a theoretical level. What shall be examined now are the empirical or practical outcomes of a pre-occupation with the "drug problem".

The desire to understand the drug problem, so that it could be eradicated, fostered research which focussed primarily on addicts/dependents. Extending Szasz's argument of semantics, it was a case of the word "problem" engendering attention upon

the "problem "users ie. the addicts or dependents. The fact that they only constitute a small proportion of all drug users was simply, or conveniently, overlooked.

From a purely practical viewpoint, dependents were, and continue to be, studied because of their relatively easy accessibility to researchers. It is quite a straightforward process contacting potential subjects if they had come to the attention of either the criminal justice system or hospitals and rehabilitation programmes. These institutions also collect data on such people, which in turn has been analysed by drug researchers (see, for example, the DAWN statistics from the United States).

The supposed link between drug dependence and crime has received a tremendous amount of attention. Popular belief has it that drug addicts commit a wide range of crimes both to support, and because of, their drug habit. As Wardlaw points out:

the view is firmly entrenched that a major proportion of crime is directly linked to the use of illicit drugs. This belief is a foundation for a number of our law enforcement and drug control policies (Wardlaw, 1976: 1).

The assumption behind the notion of a drug habit having to be supported is that drugs themselves produce uncontrollable needs in people: needs that people will do anything to satisfy including stealing, murdering etc.. There is no recognition that a variety of social factors are involved in producing crime committing drug users. Recent evidence indicates that criminal behaviour often precedes drug using and thus other causal factors are involved aside from the drug. The important point as far as the general mystifying process is concerned, is that the drug dependency-crime link helps to perpetuate the idea of high social cost to the community as a result of illicit drugs.

Scientific researchers investigating "drug abuse" often claim to be de-bunking the myths associated with psychoactive drug use, yet they usually do little more than to propagate different myths which stress the hazards of non-medical drug use. As the present study deals with cocaine the discussion will be limited to research done on "cocaine abuse", yet it certainly applies to research on any other illicit drug.

The main myth which comes under attack is that cocaine is a "safe drug", a "relatively innocuous non-addicting substance" (Cohen, 1984: 5). William Pollin, the Director of the American National Institute on Drug Abuse, talks of the "great danger of cocaine" and how it is "powerfully addictive and extremely dangerous" (Pollin, 1985: 98). Pollin bases his claims primarily on the many pharmacological studies done with

cocaine. Another medical doctor, Sidney Cohen, writes in a similar vein in his 1984 article, "Recent developments in the abuse of cocaine". While Cohen does acknowledge that "80 per cent of the people who have tried cocaine never become compulsive users" (Cohen, 1984: 9), he focuses upon the growing numbers of people who cannot control their use of the drug. In his discussion of the "Lethal and non-lethal reactions to cocaine", Cohen includes "body-packing" (the way people will carry rubber sheaths filled with cocaine in their body as a means of smuggling) and the use of un-sterile needles amongst the harmful reactions. Obviously such practices are dangerous but they can hardly be attributed to the drug itself as a causal factor.

There is no intention here to suggest no detrimental effects can ensue from the use of cocaine, rather it is the manner in which researchers, particularly medical and pharmacological, draw conclusions about all illicit drug use from studying abuse characteristics which is of concern. "Abuse" itself is a highly emotive term (which as we've seen does not accurately describe the majority of users) and carries with it a moral condemnation of illicit drug use. Erich Goode, writing in 1972, referred to the "innumerable biases, some hidden, many not so hidden" (Goode, 1972: 9) in the drugs literature. Goode is critical of the:

medical men who inform the public about the dangerous practice of drug "abuse". Morality and ideology are labelled "science" if two conditions hold: (1) the propounder of a given viewpoint has scientific credentials in the public eye, and (2) the view presented is in line with dominant opinion (Goode, 1972: 9).

What Goode speaks of still goes on today, and the issues are being further clouded and mystified.

In the Australian context, the current "Drug Offensive" is producing its share of mis-information and sensational claims about drug abuse. The pamphlet released purporting to explain the "facts" about cocaine is a good case in point. The pamphlet is full of morally-loaded statements which portray cocaine as some form of evil substance. It devotes considerable space to "Overdose and toxic reactions", discussing the many different ways "sudden death" from cocaine can occur. The fact that sudden death, or any death as a result of cocaine use, would occur under the worst circumstances in around half a per cent of users is not mentioned. In a section under the title "Immediate Effects" it is stated:

One of the most common clinical symptoms is an anxiety reaction or panic attack which can give the user the feeling that she or he is having a heart attack, losing control or going to die.

It is concluded that

Such fears are sometimes fully justified (NCADA, 1987: 3).

Throughout this discussion the critique of the biological or chemical reductionist position (that is, 'Drug A' produces 'Effect B', with 'Effect B' often being dependency) has been prominent. The emphasis has been upon the need to understand the social factors involved with drug use behaviour. In doing this, there is a need to avoid going to the other extreme by assuming a sociological reductionist position (that is, 'Drug A' produces a effect which is entirely the result of the social environment) with the resultant belief that there are no problems to be explained. Undoubtedly, there are such problems, and as Saleeby notes, ignoring the biology of addiction:

runs the risk of making inane or trivial what for thousands of individuals and families has been tragic (Saleeby, 1985: 28).

Similarly, Mugford in his discussion of the possibility of liberalizing present drug laws, warns against those

who react to exaggerated claims of the dangers of certain drugs (eg. marijuana) with equally exaggerated counter claims (Mugford, 1986: 155).

For those who assert the lack of dangers do not have to "pick up the pieces after the introduction of rash policies" (Mugford, 1986:155).

In the last ten to fifteen years there has been research which has been more realistic in its approach. The social factors involved with drug use have been shown to be equally, if not more important than the basic pharmacological properties of the drugs. As well, there have been attempts to understand the phenomena of controlled drug use.

### **3.3 THE CONTROLLED DRUG USE PERSPECTIVE**

The pioneering sociological work on drug use was Howard Becker's study of marijuana use. Becker's approach came from a desire to understand how a deviant act, marijuana use, was able to be undertaken despite the societal pressures against its use. In doing this he highlighted features of the user group which were obviously extremely important in determining the way the drug was used.

The research began with an analysis of the process of "becoming a marijuana user". Through interviews with fifty marijuana users he details the way people learn first, the technique of smoking marijuana, then how to perceive the effects and finally to enjoy the effects. In this process, the role of the experienced user is seen as vital to a person becoming a "successful" marijuana user.

In the second part of the study, Becker examines how the various formal and informal social controls gradually become less effective and allow a person to maintain their use of marijuana. His focus is upon control through limiting of supply and access to the drug; control through the need to maintain secrecy about the act; and control through definition of the act as immoral. With all three of these, Becker refers to the way the user group and setting all provide what he terms "rationalisations and justifications" for the maintenance of views and activities against the dominant societal ones. While there is no discussion of the way users maintain controlled use through various "rules" of use, his description of the "inside view" of users gave some indication of what was later recognised as a basic factor in controlled use. Of course Becker's concentration upon the deviance inherent in marijuana use ignored the possibility that users might maintain some fairly "mainstream" notions in terms of the way they actually use the drug.

Becker was skeptical of the view that all drug users are addicts. He did not support the "conventional stereotype" of the marijuana user as someone who had become "a slave to the drug" and whose "moral barricades" had been broken down (Becker, 1963:73). Becker still carried the notion of the "extraordinary" nature, if you like, to doing drugs. For him, the whole furtive aspect of illicit drug taking is seen as the underlying motivation or concern of the activity. Thus, there is his concentration upon the need to maintain secrecy and deal with disapproval from non-users. The highlighting of the way external standards or expectations impact upon the marijuana user ignores the possibility that these external standards of control may also come from the using group, not only society at large.

What emerged as a fundamental, if rather obvious, issue was the fact drugs are not taken in an isolated context by the user. As was stated earlier, the long running assumption was that drugs are taken by people and certain effects result. It was acknowledged that the user's personality may have a bearing on the equation, but this only led to the quest for discovering the "addictive personality"<sup>6</sup>. There was no

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<sup>6</sup> Saleeby (1985) points out that despite the focus upon determining the "addictive personality", not one piece of evidence exists to implicate a psychological factor or trait as producing those prone to addiction.

perception that the effects of a drug could be greatly influenced by the environment in which it was taken. Of course users themselves have known such an idea for a long time. Amongst marijuana users it is well known that the best "stoned" occasions take place when one feels extremely comfortable with all the people the drug is taken with. It is only relatively recently that drugs research has taken account of this factor and studied it in any way<sup>7</sup>.

The concepts of set and setting are now common terms in the drugs area. It was Norman Zinberg who developed these concepts in an effort to "understand what impels someone to use an illicit drug and how that drug affects the user" (Zinberg, 1984: 5). Zinberg actually identified three factors which were determinant to drug use. The first is the drug itself, that is, the pharmacological properties of the substance and their action on the body. The set is described as the "attitude of the person at the time of use, including his personality structure" (Zinberg, 1984:5). Finally, the setting is the physical and social setting within which the use occurs. It is the social setting, Zinberg contends, which has not been investigated to any degree and it is:

the social setting, through the development of sanctions and rituals, that brings the use of illicit drugs under control (Zinberg, 1984:5).

Social sanctions are values and rules of conduct whilst social rituals are the patterns of behaviour. These two together can be seen as informal social controls. These social controls apply to the use of all drugs, operating in a variety of social settings. Zinberg gives the examples of drinking beer at football games and marijuana use at rock concerts.

Zinberg is quick to point out that the existence of these informal controls does not guarantee that they will be effective. In fact, he believes the inherent conflict between the law (formal controls) and the social group's approval of use (informal controls) makes "controlled use of illicit drugs more complex and more difficult to achieve than the controlled use of licit drugs" (Zinberg, 1984: 7). He acknowledges that the application of social controls does not always lead to moderate use.

The notion of there being two basic alternatives in illicit drug taking: total abstinence or unchecked excess (ie. addiction) is criticised strongly by Zinberg. While

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<sup>7</sup>This raises the interesting point of whether drugs researchers should use the drugs they are investigating, in order to gain an appreciation for such factors as user environment. In the early 1970's, the personal use of illicit drugs by researchers such as Timothy Leary and Andrew Weil was much publicised. More recently, as drugs research has become more legitimate and perhaps in the name of "value-free, objective science", researchers have tended to remain non-users, or at least do not make their personal use publicly known.

this has been the dominant attitude taken toward illicit drugs, it does not permit an understanding of controlled use. As well, it ignores the fact that:

even the most severely affected alcoholics and addicts, exhibit some control in that they actually use less of the intoxicating substance than they could (Zinberg, 1984: 7).

Zinberg links this to a societal emphasis upon moderate drug use and acceptable behaviour. The result of this "cultural insistence on extreme decorum" is that drug and set are seen as over determinant in drug abuse. That is "social standards are broken because of the power of the drug or some personality disorder of the user" (Zinberg, 1984: 8), thus overlooking setting variables such as one's time of life, status and geographical location.

From his own research, Zinberg identifies four overlapping ways in which rituals and sanctions function:

1. Sanctions define moderate use and condemn compulsive use, eg., for opiate users "don't use every day".
2. Sanctions limit use to the settings that are conducive to a positive or "safe" drug experience, eg. for psychedelics "use in a good place at a good time with good people". Two associated rituals are selecting rural settings and avoiding driving while "tripping".
3. Sanctions identify potentially untoward drug effects. Rituals embody precautions to be taken before and during use.
4. Sanctions and rituals operate to compartmentalize drug use and support the user's non-drug related obligations and relationships, eg. only using drugs in the evening or at weekends to avoid interfering with work performance. It is not examined how these controlling rituals and sanctions are acquired by users but Zinberg asserts that the using peer group is very important to this process.

Zinberg's work was very important from the view of establishing controlled use as the characteristic drug use style and also as a legitimate area for study.

Maloff et al developed the idea of informal social controls further with their concept of "cultural recipes" of use. Cultural recipes are basically "formulae describing what substances can be used in what amounts to achieve desired results" (Maloff et al, 1980: 7). For Maloff et al, the role of the significant "other" is extremely important in determining which recipes will be learned by who and for what purposes. As they explain:

People learn to use substances by learning these 'recipes' and developing a taste for the effects they make possible, all this through the association with others who teach them what,

when, why, how, where and with whom to use (Maloff et al, 1980: 7).

Maloff et al are obviously referring to all substances yet in a related paper, Maloff and Levison, make clear the reference to drug use when discussing social learning and group norms which provide guidelines for how to behave "under the influence" (Maloff and Levison, 1980: 2).

Robert Apsler is another researcher who takes up the issue of control. As was discussed earlier, Apsler takes issue with the lack of adequate measures of drug use within psycho-social research, the lack of standardization and the absence of clear definitions of basic concepts such as drug abuse and loss of control.

Apsler reviews the role that the concept of control, and more specifically, loss of control has had in alcohol and drug research. He points out that loss of control scales have not been uni-dimensional, in that:

some items in the loss of control scale involve violation of an external standard (sometimes getting drunk at inappropriate times) while others deal with violation of internal standards (drinking "after I promised myself not to") (Apsler, 1986: 39).

It is these internal-external standards which Apsler incorporates into a new measure, called "control style". Accordingly, there are two different ways of controlling drug use. There are those people who tailor their frequency and quantity by those around them (external standards) contrasted with those who use an internal personal guide such as feeling high, mellow etc. (internal standards). Apsler suggests that the two types of individuals may well differ in the amounts of drug they use, but their different styles of controlling use are probably directly related to whether they experience drug problems.

A study was conducted to investigate control styles using randomly selected subjects from Boston in 1976. It was found that respondents control the use of different substances in different ways, but that:

with few exceptions, individuals who employ internal control styles score more negatively on the dependent measures, regardless of substance, than those relying on external control styles (Apsler, 1986:42).

Apsler concurs with Zinberg in stressing that social regulatory mechanisms result in controlled use whilst the absence of these mechanisms tends to result in compulsive use.

The conclusion reached by Apsler is that studying drug use requires more than just knowing the frequency and quantity of use, rather a sensible study will "utilize both traditional measures and a measure of control style" (Apsler, 1986: 47).

### **3.4 RESEARCH INTO CONTROLLED DRUG USE**

In the last ten years there have been a number of substantive studies of controlled cocaine use. Using the theoretical approach detailed above, the research has sought to understand what characterises the "average" or "typical" cocaine user: basically, establishing what is the reality of cocaine use today. Primarily the research has been conducted in the United States, where in recent years cocaine has become the major illicit drug used.

Part of the new outlook has involved the development of a typology of five broad patterns of drug use. The five categories being experimental, social-recreational, circumstantial-situational, intensive and compulsive. It provides a clear alternative to the "abstinence versus addiction" view of drug use.

Experimental use, as the term suggests, is a single or short-term use which is motivated usually by curiosity or peer group pressure.

Social-recreational users are characterised by intermittent or infrequent use, usually restricted to social situations. Obviously such a category encompasses a wide spectrum of users. With cocaine, it could range from a person consuming one to two grams every two to three months to the same amount per week. "Bingeing" is a common recreational pattern. This is where a large amount of a drug may be consumed over the period of a few days, or a weekend, and then it may not be used again for weeks or months.

Circumstantial-situational is where a drug is only used in certain situations and usually for a specific purpose. An example is stimulant use to increase short term performance, common amongst students and long-distance drivers. Cocaine, used for sexual stimulation (as perceived by users) is another good example. Circumstantial-situational can almost be thought of as a sub-category of social-recreational use.

Intensive use, as David Reilly points out, is not a clear cut category. It is thought of as "an increase in the frequency and amount used, but the duration is

limited" (Reilly, 1986: 8). It is thus placed as an intermediate category between social-recreational and compulsive users. Just where it fits between these two groups is unclear.

The final category is compulsive use, synonymous with addiction or dependence. As was seen earlier, these terms are highly controversial and subject to a great deal of debate as to their exact meaning. Compulsive use, however, implies:

frequent high dose use to the extent that the compulsive user's life becomes involved with the acquisition and use of the drug to the detriment of other activities (Reilly, 1986: 8).

This classification of patterns of drug use has some basic anomalies. First, the boundaries between the five categories are, to say the least, hazy. This is especially the case between social-recreational and the intensive and compulsive categories. When do you cease to classify a user as social-recreational and instead classify them as intensive or compulsive? There are no clear guidelines for doing so. This leads into a second criticism, which is the underlying assumption of progression in this model. That is, that a user is likely to graduate from one category to the next until compulsion is reached. This is obviously a false assumption and is along the same lines of thinking as the idea that marijuana use will inevitably lead to the use of so-called "harder" drugs. Despite its weaknesses, this classification does at least acknowledge the existence of controlled users through the social-recreational and circumstantial-situational categories.

The main problem encountered in quantitative research on cocaine use, and all illicit drug use for that matter, is representativeness of samples. The "hidden" nature of the activity, brought about through its illegality, makes the task of drawing a representative sample of users almost impossible. Estimations of total user populations can at best be only "ball-park" figures. As a result, the research projects have not even attempted representative samples for the most part but have opted instead for "select" users or those obtained through snowballing methods<sup>8</sup>. Constructing a picture of the "typical" cocaine user is therefore quite difficult but these studies do provide some insight into user practices and user beliefs about the drug.

Perhaps the foremost study of social-recreational cocaine use is Ronald Siegel's longitudinal project with ninety-nine Californian users over a ten year period from 1974 to 1983. Only fifty of the subjects were available for the follow-up in 1983.

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<sup>8</sup>The snowball sampling method will be discussed in greater depth in chapter four.

There are several important findings from Siegel's research. First, only eight per cent of users went on to intensified use and ten per cent to compulsive use. Of the rest, fifty per cent remained social-recreational users and thirty-two per cent became circumstantial-situational users. This finding provided empirical evidence against the notion that abuse or compulsive use was an inevitable outcome from using illicit drugs ie. it goes against the progression model of drug use. A second major factor was in relation to user's negative effects from cocaine. Siegel found that while long-term positive effects consistently overshadowed negative effects, users were able to cope by themselves with any negative experiences. As Siegel points out:

most users initiated self-control strategies in order to treat their own negative effects and crisis reactions. The most common strategy was to titrate or restrict the amount of cocaine used in a given period of time (Siegel, 1984:104).

Other methods of control employed by subjects were buying or carrying limited amounts of cocaine at one time and also periodic abstinence from cocaine for periods ranging from a few days to a few months. Siegel's study indicates that long-term use of cocaine does not fit the "escalating dependency model" by more frequent pattern of use. In conclusion, Siegel states that:

social users are capable of controlling use with no escalation to more individual-oriented patterns (Siegel, 1984: 108).

Another finding from the study was the association between cocaine use and previous use of other drugs. Siegel found that all subjects had previously used alcohol and marijuana, whilst twenty-seven per cent had experiences with amphetamines, twenty per cent with barbituates and ten per cent with hallucinogens other than cannabis. This certainly supports the notion of marijuana as a "gateway" drug.

One of the limiting factors to Siegel's study was the fact that approximately seventy-five per cent of the subjects were university students at the beginning of the project. It is feasible that this group may have had more awareness and information about drugs than a general population sample of cocaine users. As with any student sample, there are innumerable biases which could be present.

Waldorf et al conducted a study of thirty-two cocaine users over a six month period in 1976. Their data was collected through intensive interviews and observation of the subjects in their use settings. Like Siegel's study, it was found that users experienced few negative effects from their use of cocaine. Those who did were likely to have such complaints as nasal irritations and what they believed to be tolerance

effects. Cocaine was generally used in combination with other drugs, the most common being alcohol and marijuana. For this group of users, cocaine was not considered a major activity of their lives and certainly none considered themselves addicted to the drug. There was an awareness of the psychological dependence cocaine produced but it was still not enough to cause great concern for the users (in Smart, 1984).

Spotts and Shontz's 1980 study attempted to gauge a wide spectrum of users through their representative case method. They selected a small number of users (nine) who each supposedly represented a different "lifestyle" or "life adjustment pattern" (Spotts and Shontz, 1980: 7). The researchers gave a detailed account of each subject's personal history including their family background, employment history, relationships etc. as well as a full drug use history. Emphasis was placed upon investigating how their drug use fitted into their everyday life. Spotts and Shontz concentrated upon intravenous users in order to "confirm or refute the myths or realities surrounding the use of cocaine in its potentially most hazardous form" (Smart, 1986:49). Again, the picture emerged of users who experienced few 'problems' with their use and who while being aware of the potential dangers inherent in cocaine use, particularly in relation to tolerance, felt that they were not themselves experiencing them or if so, only in mild forms. Those with higher levels of use did report such adverse reactions as paranoia, hallucinations, tension and anxiety. One of the respondents claimed to have used three grams of cocaine intravenously per day for two years.

Grinspoon and Bakalar (1976), in their extensive review "Cocaine: a drug and its social evolution" present quotes from interviews they conducted with seventeen users. While they do not provide any statistics on those interviewed they do provide information on a range of issues including obtaining supplies, adverse effects and the general "drug culture". Their findings were that even those who used only intranasally experienced problems such as insomnia, irritability and anxiety. Severe toxic reactions were, however, extremely rare in this group.

Phillips and Wynne have reported anecdotal information from interviews with approximately one hundred cocaine users. They found users who believed that cocaine did not have any serious harmful effects; that it enhanced creative and physical performance and had strong aphrodisiacal properties (Phillips and Wynne, 1980).

One of the more extensive studies was conducted in Toronto, Canada, by the Alcoholism and Drug Addiction Research Foundation. One hundred and eleven cocaine users were contacted through a snowball sampling method, beginning with the

researchers own personal acquaintances. A public advertising campaign in the Toronto area was also used to contact just over half the subjects. There were no demographic differences between the two contact groups. The results indicated users with fairly well self-controlled use patterns.

The basic use patterns consisted of intranasal users, with quite infrequent usage: approximately fifty per cent used less than ten times per year. The average age of first use was twenty-two years while most had used other illicit drugs before cocaine, primarily cannabis. One third of users reported daily use of both cannabis and alcohol. Cocaine was easily accessed with most purchasing from people they considered friends rather than just dealers. The actual time and place of use confirmed the "social-recreational" nature of cocaine use. Cocaine was typically used at a friends place or the respondents own home. Twelve per cent stated they would use it wherever they could acquire it, while only six per cent said they were most likely to use it in the workplace. Use overwhelmingly took place at night and forty-eight per cent indicated that it was mainly consumed for "socialisation" reasons ie. partying, while twenty-three per cent stated it was mainly for leisure or relaxation.

In respect of the negative effects of cocaine, the Toronto study found that, not surprisingly, level of cocaine use was an indicator or predictor of those experiencing problems. Essentially, those in the "moderate" and "heavy" using groups were more likely to report such effects as nausea, paranoia, mental exhaustion, sores or bleeding in the nose than those in the "light" using group. "Light" use was defined as use of cocaine no more than two times in the past year while "heavy" use was defined as either "use of four or more lines at least ten times during the past year or use of one to four lines at least forty times during that period" (Smart, 1984: 7). "Moderate" users were those who fell in between the "light" and "heavy" categories. There was an equal split between those who experienced no problems, or only those of a minor nature, and those who experienced at least one of the more 'serious' problems.

A final factor was respondent's evaluation of the overall impact of cocaine upon their life. Sixty-six per cent said it had little, if any, effect; twenty three per cent stated it had a positive impact while ten per cent suggested it was entirely negative. The conclusion reached at the end of the study was that:

cocaine use from the user's point of view, like many other social-recreational drugs, appears to have both functional and dysfunctional aspects associated with it. Use is functional in the sense that users derive both desired results: growth in self-awareness, ability to easily socialize with others, for instance.

At the same time, however, the dysfunctional aspects are apparent; some pay the price of consequences serious enough to develop into medical complications (Smart, 1984: 23).

The most recent study of cocaine users was conducted in Amsterdam in 1987. The aim of this study was to locate subjects from "non-deviant subcultures". The criteria for inclusion in the sample were that respondents had not been convicted for a felony or been in a drug rehabilitation program for two years previous to the study. As well as this, respondents had to have had a minimum life experience of twenty five instances of cocaine use. Despite these rather strict criteria, one hundred and sixty users were located through a randomized snowball procedure.

The average age of respondents was thirty years. The average age at first cocaine use was twenty two years whilst the average number of years using cocaine was six years. One of the interesting aspects of the study was the analysis of the "dynamics of use" over time. It was found that thirty-four per cent of the sample never exceeded a low level of use. When ex-users who never exceeded a low level were included the figure rose to forty eight per cent. As well, of the twenty per cent who reached a high level of use, only two per cent maintained this level of use over time (Cohen, 1987).

The Amsterdam study also examined the various control mechanisms employed by users. The adherence to snorting as a route of administration is seen as an important controlling factor. Sixty per cent of respondents thought free-basing or injecting cocaine was an unhealthy or "junky" type of behaviour. Respondents also indicated that maintaining cocaine use in social settings was another desired activity ie. only using cocaine with friends or in party situations. A large majority (84%) also experienced periods of abstinence from use. Of these, fifty-five per cent said the reason for abstinence was a lack of availability or financial constraints; twenty-five per cent reported reasons due to negative experiences with the drug. Another factor which Cohen, the chief researcher, believes plays a part in control is knowing other users who are using cocaine in what is considered a "risky" manner - the sample mentioned an average of eight others who they believed were so-called "risky" users (Cohen, 1987).

### 3.5 CONCLUSION

This chapter has covered a great deal of ground in the drugs area. In one sense, it has been impossible to do justice to the wealth of ideas, questions and debates which are current in the field. What has been attempted is to chart the development of a

sociological explanation for controlled drug use, beginning with the critiques of the official and medical views on "drug abuse", which gave recognition to the environmental factors of drug use and in turn spawned a theoretical basis for understanding drug use. The controlled drug use perspective may not provide all the answers to the question of how people are able to control their use of drugs like cocaine, but it does present guidelines for research into what constitutes the major drug using group. It is an approach which forms the basis of the empirical study to be described in the following chapters.

# CHAPTER FOUR

## METHODOLOGY

### 4.1 INTRODUCTION

This chapter outlines the methodology employed in the study of cocaine users in Sydney, Melbourne and Canberra.

The basic aim was to gather a range of information on cocaine users in order to understand how the drug is used in Australia. This was done through a personal background questionnaire and an intensive interview dealing with illicit drug use patterns. Subject selection criteria was not particularly strict: both past and present users were included.

The desire to draw a sample from a wide community base entailed the use of a snowball sampling technique. Researchers, relying on their own personal and professional networks, were able to access the bulk of users. Difficulties were encountered when it was attempted to access users from the higher socio-economic spheres, the so-called "glitterati". Despite repeated efforts by the Melbourne interviewer, this group remained elusive.

Norman Zinberg summarises the fundamental methodological issues of this type of research when he poses the questions:

How can controlled users be recruited? What kinds of information about controlled users are critical? What instruments or approaches should be used to collect data? Can it reasonably be expected that the data will be reliable and valid? (Zinberg, 1984: 46).

It was felt that all these issues were addressed quite satisfactorily by the research methodology.

### 4.2 AIMS OF THE STUDY

This study was exploratory in its approach. The primary goal, as stated earlier, was to gather information which would inform upon the "how, what, when, where, with whom" questions of cocaine use in Australia. There being no previous substantive research on the "typical" cocaine user meant this was the first to attempt to fill an

obvious void in knowledge. By "typical", it is meant users who had not presented for treatment or had been arrested for a cocaine offence<sup>1</sup>. The aim was to access these typical users and determine the distinctive characteristics of their use of cocaine.

The study actually arose, and was able to attract funding, because of a wave of government and media concern about cocaine in late 1985. Reports of the "cocaine epidemic" and rise in popularity of "crack" from the United States, brought speculation about whether Australia was likely to face similar problems with cocaine. While being skeptical that Australia was about to suffer a "cocaine epidemic", this study determined upon finding out what typical cocaine users were like and whether they're usage patterns reflected the concern being expressed in officialdom.

With the exploratory nature of the study in mind, there was an obvious need for a comparative outlook in shaping the research. The objective was to produce data which would facilitate comparisons with other drug using populations studied, as well as so-called "normal" samples from the general population. Towards this end, the questionnaire made use of certain measures and attitude scales used in other studies. For example, the GHQ scale, a standard in Australian social-psychiatric studies was included while various questions from the 1985 Reark drug study and National Social Science Survey were also used. The interview questions were framed in such a general way so as to allow comparison with studies of varying focus.

The other major aim of the research was to determine how users controlled their use of cocaine. Following on from the discussion in Chapter Three, the emphasis was upon determining the relative importance of 'set' and 'setting' variables in this process. The 'set' variables were examined through personality measures and various attitudinal questions such as awareness of the negative effects of cocaine. 'Setting' was investigated through accounts of the different situations in which cocaine was used and the factors which users believed restricted their use of cocaine.

### 4.3 RESEARCH INSTRUMENTS

Data was collected through two means: a self-completed questionnaire<sup>2</sup> and an open-ended in depth interview<sup>3</sup>. The questionnaire combined a series of questions

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<sup>1</sup>Estimates from the United States place the figure on these "typical" users as high as ninety to ninety-five per cent of all cocaine users. It is reasonable that the same, if not higher percentages would apply in Australia.

<sup>2</sup>See Appendix One.

<sup>3</sup>See Appendix Two which shows the standard questions all interviewers asked.

routinely employed in positivistic research. These included socio-demographic characteristics (age, sex, religion, education, income etc.), personality variables, social and support networks, personal relationships, well being and health and a series of attitude measures. The interview consisted of five main sections: general patterns and history of illicit drug use; supply and price; views on cocaine and the law; pros and cons of cocaine use and; cocaine and social contacts. Interviews were not restricted to these set questions and valuable information was often gathered by the general discussion which was promoted by the interviewers.

At an early stage, the decision had to be made whether to pay subjects or not. Given the amount of time required to complete both the questionnaire and the interview (approximately three hours as it turned out) a fee-for-service arrangement seemed appropriate. After consultation with research colleagues, a fee of fifty dollars was settled upon.

The payment of subjects generally worked as an advantage to the study. In some cases the fee was a definite incentive for people to become subjects of the research. It is known from the Canberra sample that a number of respondents would not have taken part if it had been on a voluntary basis. In some cases arranging a convenient time for interview was difficult, and if there had been no payment involved, they might not have made the necessary efforts. Another advantage in payment was that respondents seemed to feel obligated to produce another person to be interviewed. While in no way was it a condition of being a subject, it still transpired that subjects felt part of the fifty dollar fee was to provide another link in the referral chain. On the negative side there was always the possibility of attracting people posing as cocaine users in order to collect the money. Luckily, no such cases were encountered. What did arise as a rather unexpected problem was the \$50 being considered too little, almost an insult, by certain respondents. This occurred with a number of the higher socio-economic individuals who declined to be interviewed. This issue is discussed in more depth in Section 4.5.

The interviews themselves took place in a number of settings. The majority of Sydney and Melbourne interviews were conducted either at the subjects' or the researchers' place of residence. A few took place at the subject's workplace. In Canberra, the interviews were conducted entirely at university offices. While the researcher was flexible about the location, all interviewees seemed happier with the university site. There were a couple of factors at work here. First, many were a little suspicious or wary of the research before being interviewed, despite reassurances about

strict confidentiality being maintained. There were often fears held that this research was an elaborate hoax set up by the police in order to collect information about cocaine users and dealers. Second, in a number of cases, respondents had group house members or de facto partners who were ignorant or disapproved of their cocaine use thus immediately ruling out their homes as possible sites for interview.

#### **4.4 CRITERIA FOR SUBJECT SELECTION**

In keeping with the exploratory nature of the study, the conditions for subject selection were not at all strict. Present or past users were accepted although non-users were restricted to having used within the last eighteen months. There were no restrictions placed on such variables as age, sex, income etc. as has been the case with some of the previous research (see Cohen, 1987; Zinberg, 1984).

A liberal attitude was adopted towards the level of cocaine used by subjects. People were included even if they appeared to border on experimental use or the compulsive and intensive categories. With the latter, it was felt they might be a source of valuable information on some of the more serious adverse effects and whether they were able to deal successfully with any such problems. A point that also needs to be made is that drug use levels do not remain static. Most users have fluctuations in the amount they use and it would seem futile to eliminate subjects because they have not always remained within the bounds of the social-recreational category. Obviously if numbers of intensive and compulsive users had become high then a re-think would have been required.

#### **4.5 LOCATION OF THE SAMPLE: THE SNOWBALL TECHNIQUE**

In studying illicit drug use in the community, it is almost impossible to obtain a representative sample of any kind. Biernacki and Waldorf (1981) describe a method whereby a representative sample from the entire population is drawn and then screened to locate drug users. While such a method is obviously prohibitive in the financial sense (to obtain, say one hundred drug users, would require a population sample in the thousands) it also relies upon respondents openly admitting in a survey to illegal behaviour; a highly unlikely occurrence.

This study made no attempt to obtain a representative sample, relying instead on snowball method to generate the sample. A public advertising campaign was an obvious

alternative, but the time and cost involved in screening potential subjects was deemed too be great for the numbers we wished to obtain in each city. The proceeding discussion will focus on the Canberra interviews as these were the ones the author personally conducted. Much of what is said though is equally applicable to the other cities.

The Canberra subjects were located both through fortuitous circumstances<sup>4</sup> and people considered to be knowledgeable contacts.

In the first case, it was a matter of making enquiries among one's own social network. The author did not personally know any cocaine users prior to commencing the research but determined upon a policy of mentioning the study on cocaine use to whoever possible, in an effort to generate contacts. This turned out to be quite a successful approach.

Initially, it was a matter of a subject volunteering herself upon finding out that the research on social-recreational cocaine use was being conducted. A conversation with a group of friends, discussing the topic of the Masters thesis, brought a friend's girlfriend stating that she would be able to "help" with the research. Later, she revealed the she was a cocaine user herself and was willing to be interviewed. She was the first interview conducted in Canberra and began a chain which yielded seven interviews.

The above example demonstrates a factor common to the whole study. Starting points were often made through the most unlikely sources or what may be termed "weak ties" (Granovetter, 1975). That is, the connection between the researcher and the intermediary was not a particularly strong one nor was the intermediary necessarily associated with drug use themselves. None the less, they had a friend or a "friend of a friend" who might be able to help. One such case was where Stephen Mugford asked some "respectable middle class" friends from a rather conservative area in Sydney whether they knew any cocaine users. Expecting a laughing response

it transpired that they knew a young doctor, the son of a friend, who smoked a lot of cannabis, and who they thought just might be a cocaine user. Three phone calls later I was talking to a pharmacist, a friend of the doctor ..... and the latter was perfectly willing to be interviewed (Mugford, 1987: 14).

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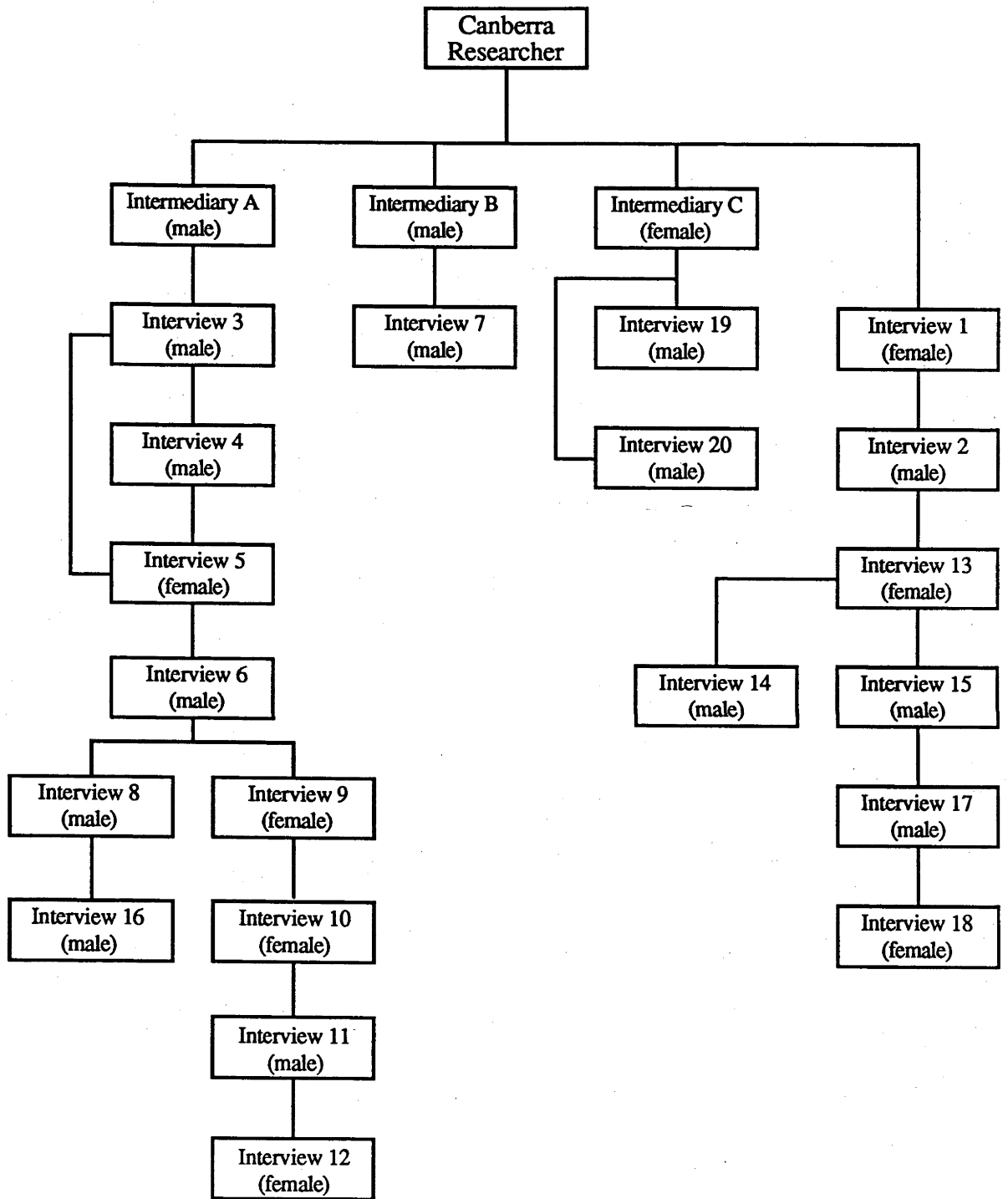
<sup>4</sup> Biernacki and Waldorf (1981) discuss the fortuitous starting of referral chains and suggest it is "not entirely a process of chance but results from an increasing sensitivity and attentiveness to information related to the study's focus" (Biernacki and Waldorf, 1981: 141). In our study, the broadcasting amongst the researcher's personal networks was an example of this.

While the "weak ties" approach was successful, respondents were also found through people known to have some connection with illicit drug use. A fellow Canberra researcher contacted was able to provide what turned out to be an extremely useful starting point. The person was his own son (another of the surprising elements to the research!) who while not a particularly regular user of cocaine himself, was still able to put us in touch with people who were. Similarly, a friend who was known to be a user of marijuana and amphetamines was asked if they could provide any contacts; it took a period of five months but they were eventually able to locate two subjects for the study.

Biernacki and Waldorf (1981) suggest one of the major problems in a snowball or chain referral sampling method is the actual location of respondents. In this study, this was achieved with relative ease. In fact, it would seem to be a fair conclusion that most people are only one or two steps (contact wise that is) from a cocaine user. Forty interviews were conducted in Sydney, ten in Melbourne, over a period of six to eight months. Twenty interviews were conducted in Canberra, over roughly the same time period, using four distinct referral chains. The path of the interviews is displayed in Figure 4.1.

There were several notable features to the development of referral chains. When more than one 'next contact' was proffered by an interviewee it tended to guarantee the continuation of a particular chain. For example, "Interview 6" provided two other subjects. One of these, "Interview 8", took some time before he could advance another person (as witnessed by it being "Interview 16") and after that the chain finished. In contrast, "Interview 9", the second referral by "Interview 6", led to three more interviews in quick succession. This trend was also witnessed in the chain beginning with "Interview 1". "Interview 13" provided two contacts, one of which, "Interview 14", was unable to produce another interviewee while "Interview 15" produced two more interviews. Another feature of this chain was the time it took to unfold. After two initial interviews the chain appeared to "dry up". "Interview 1" said he knew a few people who he was sure would be willing to participate, but, after several 'reminder' telephone calls to him nothing developed. After a three month period though he contacted the researcher and produced "Interview 13", which in turn led to four more respondents

Figure 4.1 Canberra Interview Referral Chain Networks



The use of intermediaries to generate subjects worked well. "Intermediary A" began the longest referral chain in Canberra and while "Intermediary C" only produced two respondents, these were people who were confident of being able to continue the chain. Their potential referrals were not pursued as the quota of twenty interviews had been reached.

The main sampling problems arose in terms of obtaining respondents from the so-called "fast lane" or "glitterati" sets.

Popular belief has it that cocaine use is extremely common amongst the glitterati. Tales abound of "cocaine parties" where the drug is freely available and is used quite openly; instead of bowls of peanuts on the coffee tables there are bowls of cocaine. The natural progression of our referral chains in Sydney and Canberra did not locate these users and focussed efforts by the Melbourne researcher also proved unsuccessful<sup>5</sup>. One Melbourne respondent reported having attended a party where approximately one hundred and sixty guests were using cocaine. Other respondents mentioned vague knowledge of such parties but no substantial evidence was able to be produced. There were others who spoke in terms of parties where cocaine was abundant but when questioned further, it turned out that there was usually a room set aside for cocaine use and only for those "in the know". It would seem that cocaine use amongst the glitterati is not pure mythology yet just what their use patterns are, and whether they differ that much from the users contacted in this study, still remains to be determined.

There are several explanations for why the "high flyers" were not able to be contacted. To begin, many of these people would be prominent public figures and thus would be extremely circumspect about who they revealed their cocaine use to. In a basic sense, they have a lot more to lose if they are found out than some of the respondents from lower socio-economic positions. The question of the confidentiality of the study would thus be of primary concern. A second factor was that the researcher did not mix personally in the glitterati circles. He suggests that a researcher with strong contacts in the "fast lane" professions and occupations might have had more success in locating respondents. At the least, it would require a researcher with available time and money to frequent locales which would perhaps facilitate entry into this circle. Finally, the fifty dollar interview fee proved to be a stumbling block. It was taken as more of an insult and offering no money was thought to be a more appropriate tactic. For the kind of information we were seeking, this figure was seen as grossly inadequate. Some

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<sup>5</sup> See Appendix 3 which describes in detail the problems encountered by the Melbourne researcher.

potential respondents actually thought it was insulting and were put off for this reason. Offering no money was thought to be a more appropriate tactic for the higher socio-economic sphere. Even so, no interviews were obtained by trying this approach, so obviously the money question was not the primary reason for the problems encountered.

#### **4.6 THE AUTHENTICITY OF RESPONDENTS AND THEIR RESPONSES**

The question of whether subjects were bona fide cocaine users was a major concern with the snowball sampling method. The concern was double given that payment of subjects was also involved.

Various methods have been employed by previous studies for detecting false subjects. Zinberg (1984), in his study of controlled users, relied on screening questions in order to identify respondents who fitted his strict selection criteria<sup>6</sup>. As candidates did not know the selection criteria it was almost impossible for them to deceive the researchers about their eligibility without being found out. Smart et al (1986) in their Canadian study, did not pay respondents thus there was little incentive for deception. Still, a method of checking the consistency of responses was applied through asking the subject about their lifetime cocaine use at two separate points in the interview. Biernacki and Waldorf employed a similar method in their study of ex-heroin addicts, also noting if respondents became unusually agitated or acted suspiciously during the interview, as a sign of continuing addiction. They also recommend a process of verification of respondent accounts through third parties. The snowball sample, by definition, entails subjects knowing other subjects and as other people's experiences often came up in conversation, it was possible to corroborate information in this way (Biernacki and Waldorf, 1981).

In our study of social-recreational cocaine use, no strict verification method was employed. Selection criteria were fairly loose thus a demanding screening test seemed inappropriate. The basic premise was that the interview questions would find out any non-cocaine users. Answers to questions on use levels, obtaining supplies and prices would have been difficult to make up on the spot. While there was the possibility of referrals being primed by those already interviewed, the interview was sufficiently long to make this a difficult task as well.

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<sup>6</sup>See Zinberg, N. 1984, pp. 52-56 for details of his selection criteria.

With the Canberra interviews no cases were encountered where it was felt the subject was "making the whole thing up". There was only one case where a respondent reported different base levels of use at different points in the interview: there was little question that he was a cocaine user but he was perhaps enlarging his actual usage level. Corroboration was also obtained through different subjects, in some cases from different referral chains, describing the same events. For example, a drugs bust, not reported in the media was mentioned by several respondents while a certain house where supplies were obtained was mentioned on various occasions. As stated earlier, this study was fortunate in that no bogus subjects participated in order to collect the fifty dollar fee. Of course in the final sense, it was necessary to rely very much upon the honesty of subjects to give truthful replies to our questions.

## CHAPTER FIVE

### COCAINE USERS: A SOCIAL PROFILE

#### 5.1 INTRODUCTION

The aim of this chapter is to establish a basic profile of the cocaine users in the study. While it is known this group has a defining characteristic in their use of cocaine, the interest is in what other characteristics, if any, set the group apart from the wider society. To answer this, a number of questions from the National Social Science Survey (NSSS 1985) were included, thus allowing direct comparisons to be made with a general population sample. As the age structure of the cocaine users was between eighteen and thirty-nine, the NSSS data was restricted to that age range as well. Further, to control for the fact that the cocaine sample was un-married and non-religious, two sub-sets from the NSSS were used: what shall be called NSSS "Non-affiliated" (225 respondents who were un-married, non-religious and between 18-39 years old) and NSSS "Affiliated" (218 respondents who were married, religiously affiliated and between 18-39 years old). As will be seen, there were some pronounced differences between these groups.

In terms of socio-demographic characteristics, the Australian cocaine users are remarkably similar to those contacted in overseas studies. While high in educational achievement, their income levels are relatively low and they represent a broad spectrum of occupational categories.

In analysing the basic health status of the cocaine users, the results are fairly positive. While there are certain problem areas, particularly in relation to psychiatric morbidity, they could not be classified as severe.

On a range of variables grouped under the heading "social integration", the results are somewhat conflicting. While the cocaine users are not highly integrated at the institutional level ie. they are un-married, neither politically nor religiously aligned, belong to no voluntary organisations etc. they are well integrated at the inter-personal level ie. strong kin and friendship ties, high satisfaction with aspects of life etc. The conclusion reached is that while not of the "mainstream", this is a group who are basically well-adjusted, happy and satisfied with their lives.

Finally, the attitudes on present day social issues completes the picture of a group with a fairly liberal outlook and "alternative" approach to life.

## 5.2 SOCIO-DEMOGRAPHIC PROFILE

The first notable feature of our sample was the high ratio of women to men; thirty-two females (44%) to forty-one males (56%). In Sydney the split by gender was exactly half and half(20:20). This was particularly interesting given there was no intent on behalf of the researchers to contact equal numbers of men and women. In other studies where there was no set policy on the sex of the sample, the numbers of men have usually far outweighed the number of women, something in the order of 75-85% men (see for example, Smart, 1986; Cohen, 1987).

The age range was eighteen to forty-nine years, with a mean of 27.6 and a median of 26. The concentration of respondents fell in the age bracket 20-35 years old, with only four subjects over the age of 35. This result is also in line with previous research, where the indications were that illicit drug use tends to be the domain of the young. In Chapter Six, it will be seen how this "time of life" variable plays an important role in the control of drug use. Of course the age distribution may only be a reflection of the age structure of the researchers themselves. Since the start points were all personal contacts, and since friendship networks have a tendency to age homophily, these results could be an artifact of the method. The fact that there was a range of thirty-one years would suggest this was not the case. If there is an error here, it would probably be in the direction of underestimating the teenage use, but if one recalls that cocaine is expensive (around \$200 a gram at the time of the study) this is rather less likely to be a problem.

The education levels were all well above average. Only twelve respondents (16%) had not attended a tertiary institution of any kind. Of the sixty-one who did, thirty-five obtained a degree, diploma or trade qualification. Only six had trade certificates (electrical and hairdressing being four of these) while the majority of degrees and diplomas were in the Arts area. These included ten Bachelor of Arts and three Diplomas of Art and Art Education. There were only four degrees in the sciences which included one Master of Science.

The high levels of education were not borne out in the incomes of the sample. For the 1985-86 tax year, our base for the questionnaire, approximately 70% reported

pre-tax incomes of under \$20,000 a year, with half of these under \$10,000. Only five respondents reported incomes over \$30,000 a year (see Table 5.1). This provides a clear illustration of the inability of the study to locate users from the so-called "glitterati" set. Again, this result is consistent with the U.S. studies, where incomes of over \$25,000 are also uncommon. The low incomes are put in some perspective when one examines the type of work being carried out by the respondents. Only thirty-six (49%) were working full-time for pay. Of the remainder, twenty-three (31.5%) were employed part-time, eight (11%) were engaged in full-time study and six (8%) were unemployed.

**Table 5.1 Pre-Tax Personal Income**

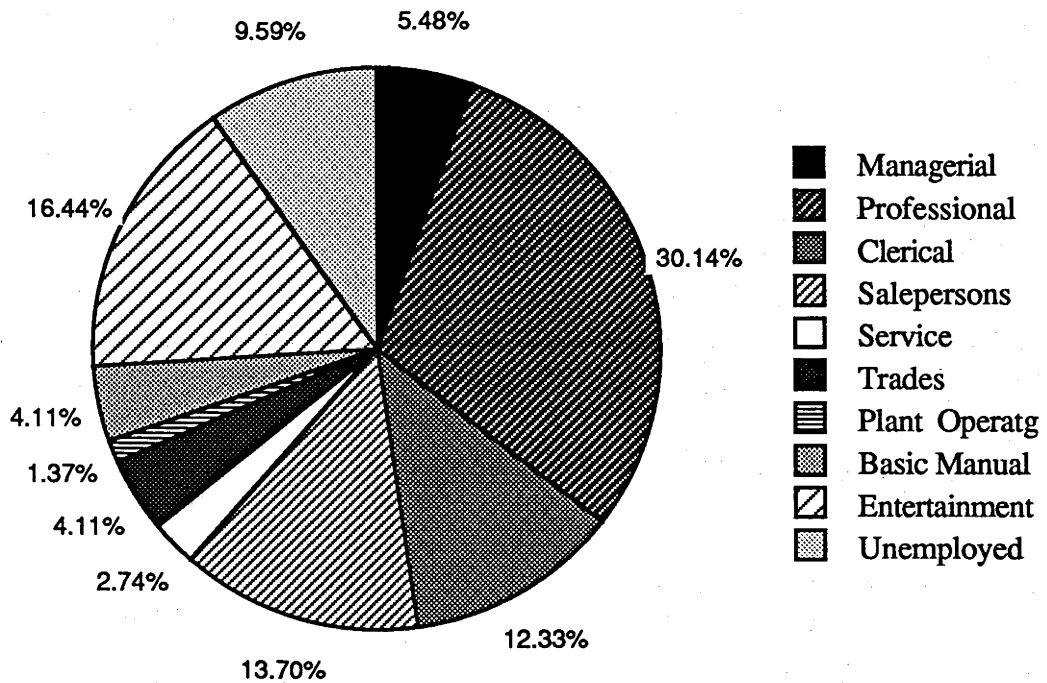
<u>INCOME BRACKET</u>	<u>FREQUENCY</u>	<u>PERCENT</u>	<u>CUMULATIVE %</u>
0 - 4999	14	19.4	19.4
5000 - 9999	12	16.7	36.1
10000 - 14999	11	15.3	51.4
15000 - 19999	15	20.8	72.2
20000 - 24999	10	13.9	86.1
25000 - 29999	05	6.9	93.1
30000 - 34999	03	4.2	97.2
35000 - 39999	00	0.0	97.2
40000 - 44999	00	0.0	97.2
45000 - upward	02	2.8	100.0

While subjects did not rate a high income as particularly important, they were still dissatisfied with their present income level. Asked directly about their satisfaction with the amount of money they earn, 36% expressed some degree of dissatisfaction. This actually constituted one of the major reasons for dissatisfaction with work, rating second only to concerns over job security (see Table 5.2). When asked the slightly more theoretical question of how important is a job that provides a high income, only 15% ranked this as a very important factor. In fact, this ranked as the least significant factor with an "interesting job", "using skills and abilities" and "a feeling of accomplishment" considered the most important.

There was a wide range of occupations amongst respondents. Using a ten category classification (see Figure 5.1), the majority were located in semi-professional and professional areas. Industries that were well represented included the

film/music/entertainment/media cluster (12 people, 16%), sales persons (10 people, 14%) and a number from areas such as law, education and health (22 people, 30%).

**Figure 5.1 General Job Categories**



The levels of job satisfaction were extremely high. Using five point scales, where one and two express dis-satisfaction, three neutrality, and four and five degrees of satisfaction, the highest percentage of dis-satisfaction was only 42% for concerns over job security (see Table 5.2). The results square well with the general income levels as well as the job categories, and the concern over security can be understood when it is remembered that a number of people are engaged in non-tenured work areas such as the film and entertainment industry. This last factor is also witnessed by looking at the employer categories. A quarter of respondents are actually self-employed. Just over forty per cent are employed by private companies, where security is obviously better than self-employment but not as good as the public sector (the remaining 34% of employed respondents working for either the state or federal governments).

**Table 5.2 Work Dis-Satisfaction**

<u>WORK FACTOR</u>	<u>PERCENTAGE DIS-SATISFIED</u>
Importance of work	17
Chance to use skills etc.	25
Security and predictability of future	42
People met at work	11
Income	36
Pride in work	11
Degree of say in decisions at work	27
OVERALL SATISFACTION	15

### **5.3 PERSONAL HEALTH**

One of the issues neglected in the sociological research on cocaine, or certainly not reported to any great extent, is the basic health of respondents. While the specific adverse effects of cocaine use are usually examined in detail, not so the general health status of the users. This is an important issue, however, when one considers that most of the arguments condemning cocaine use are based on the assumption that users are, or are likely to become, unhealthy. The presumption seems to be that a user has an unhealthy mind to use cocaine in the first place and will become unhealthy physically as a consequence of use.

The cocaine users contacted in this study reported generally satisfactory levels of both physical health and mental well-being. While there were certain problem areas, particularly in relation to psychiatric morbidity, there was nothing to suggest that this group was enjoying overall poor health. Some error is likely in the measurements of these variables because respondents were asked to recall illnesses and ailments from up to five years previous. Of course, short of a comprehensive examination by a medical practitioner these measurements can only provide a basic sketch of health.

The first measures were of various symptoms that can occur from drug use, although obviously not identified as such in the questionnaire. Respondents were asked how often over the last six months they had suffered from fifteen different complaints eg. "rapid or missing heart beats", "dizziness and fainting", "body aches and pains" and were given the choice of three occurrence rates: often, sometimes and never. The 'often' category representing those with a significant problem. There was no symptom

which more than ten per cent of respondents reported experiencing often. The highest was 9.6% for "body aches and pain" and "severe fatigue/exhaustion". No single person reported more than three symptoms which they experienced often. The modal category was "never" for all symptoms except indigestion, headaches/migraines and diarrhoea which are quite common complaints.

The question of whether a doctor had diagnosed and treated a complaint in the previous five years produces a less positive picture. The results, summarised in Table 5.3, indicate much higher percentages who had experienced these problems than was the case for the previous drug symptoms questions. The highest figure was just under one in four (18 people, 24.7%) for those experiencing lung or breathing problems. This result is put in some perspective when it is realised that of the eighteen, only four were non-smokers. In fact, this is quite a heavy smoking group on the whole. Seventy-five per cent smoke; two-thirds do so on a daily basis; and 60% smoke more than fifteen cigarettes a day. The three problems associated with some form of mental disorder - insomnia, anxiety state and depression - were the next highest occurring with 19.2%, 21.9% and 16.4% respectively. Individually these figures are not particularly high, but taken together they seem indicative of some level of minor psychiatric morbidity, something which is borne out by the GHQ measurement. Another figure which is interesting is the percentage of people with gall bladder, liver or pancreas problems. Unfortunately, it was not possible to ascertain the seriousness of these problems and whether they resulted directly from drug use (for example, hepatitis from the practice of sharing needles with intravenous drug use).

**Table 5.3 Conditions Treated By Doctor In Previous Five Years**

<u>COMPLAINT</u>	<u>PERCENTAGE</u>
High blood pressure	6.8
Heart disease	1.4
Kidney or bladder trouble	13.7
Lung or breathing problems	24.7
Blood clot	2.7
Gall bladder, liver or pancreas	13.7
Insomnia	19.2
Stomach problems/ulcer	13.7
Anxiety state	21.9
Depression	16.4
Bowel disorders	5.5

The twenty eight item General Health Questionnaire (GHQ) was used as a more comprehensive measure of mental health. It was developed by psychiatrists as a tool for detecting people with diagnosable psychiatric disorders and is "focussed on the hinterland between psychological sickness and health" (Goldberg and Hillier, 1979: 139). The questions are concerned with two types of phenomena: inability to carry out ones normal "healthy" functions and the appearance of new symptoms of a distressing nature (Goldberg and Hillier, 1979). GHQ scores were calculated using the "GHQ scoring method": 0 for a 'normal' answer and 1 for an 'abnormal' one. The distinction is then made between a low score (0 - 4) and a high score (5 - 28). From Table 5.4 it can be seen that a majority of the respondents (64%) were in the low score category. For purposes of comparison, included in Table 5.4 are data from Goldberg and Hillier's study of 200 patients. From this it appears the cocaine users most closely approximate the sub-clinical category, although the cocaine users have a slightly higher percentage in the top of the high scores group. The definition of sub-clinical being those people who are not readily diagnosable in psychiatric terms, but who are suffering from some form of mental disturbance. Whether there are in fact a significant number of the cocaine users with disorders is impossible to determine here, but as a group, they would appear to fall in that "psychological hinterland" which Goldberg and Hillier describe. They are obviously not enjoying perfect or "normal" health but the disorders they are experiencing, are for the most part, not severe.

**Table 5.4 GHQ Scores For Cocaine Users And Goldberg And Hillier's Patient Sample**

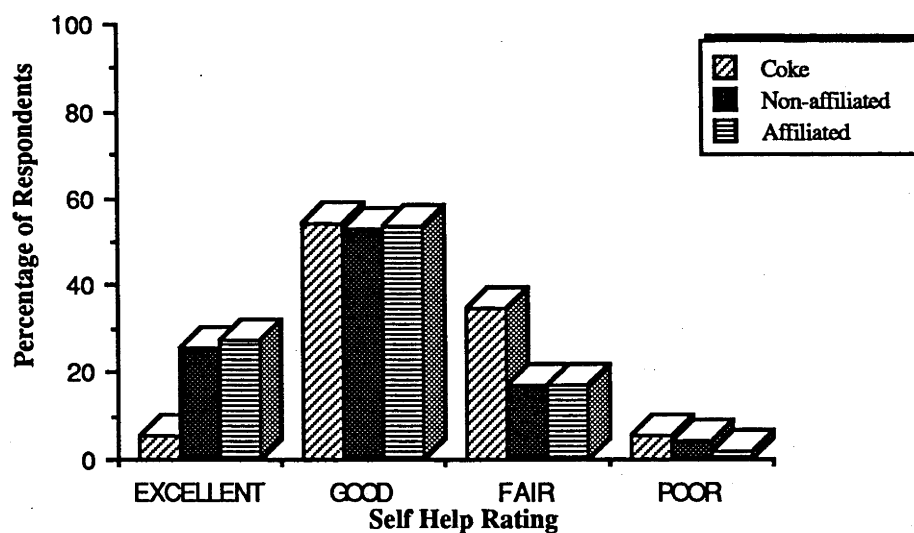
<u>GHQ SCORE</u>	<u>COCAINE SAMPLE</u>	-----CLINICAL STATUS-----				
		<u>NORMAL</u>	<u>SUB CLINICAL</u>	<u>MILD CASE</u>	<u>MOD.</u>	<u>SEVERE</u>
	N=72*	N=50	N=57	N=64	N=23	N=6
	%	%	%	%	%	%
<b>High scores</b>						
12-28	12	0	9	33	61	100
6-11	18	10	21	53	35	0
5	6	6	7	6	0	0
<b>Low scores</b>						
0-4	64	84	63	8	4	0

\* One missing case

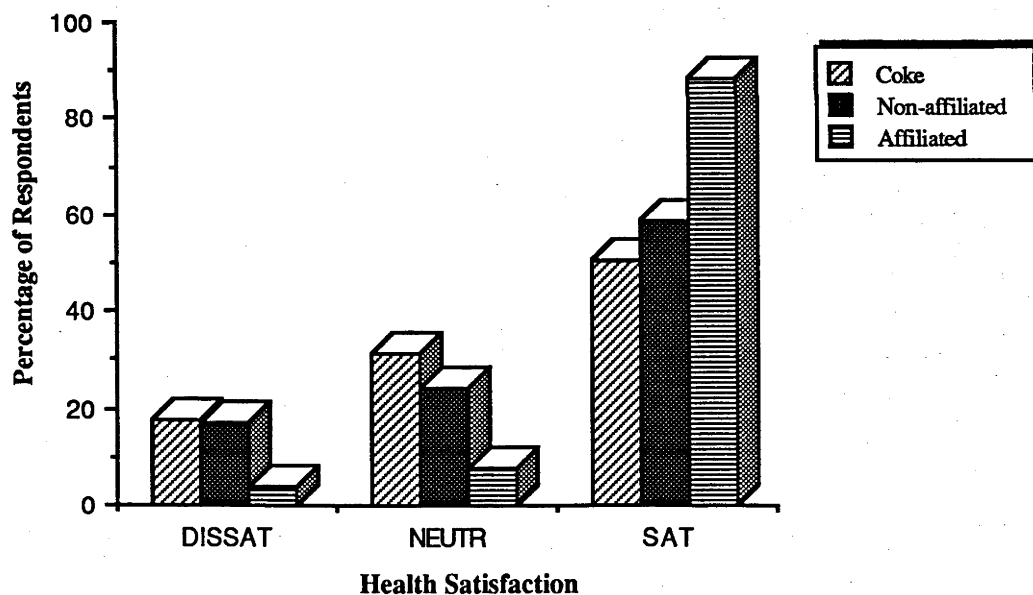
There is only a slight relationship between high levels of cocaine use and high GHQ scores. Sixty per cent of those with GHQ scores above five used cocaine in the range from daily to weekly, when at their peak use period (chi square = 0.1763). Similarly, 63% of those with high GHQ scores used cocaine within two to three weeks prior to interviewing. There was also a small distinction between those who identified themselves as present users and those who were past users of the drug. Just over one-third of present users had high GHQ scores while only one-fifth of past users had such scores. A final interesting factor is the relationship between heroin use and the GHQ score. While use of heroin per se is not correlated with high GHQ scores, seven of the eight identified as regular heroin users had scores in the 6-19 range.

The picture of respondent's health documented so far correlates fairly closely with their own estimations of it. When asked how they would rate their own health, in comparison with people of the same age and sex, only four cocaine users (5.5%) believed themselves to be in excellent health. The majority, thirty-nine respondents (53.4%) placed themselves in good health, while twenty-five (34.2%) said fair and five (6.8%) thought poor health. When these figures are compared with those from the National Social Science Survey (NSSS), a few differences are noted (see Figure 5.2 and Figure 5.3). In the "NSSS Affiliated" sample (married, religious, 18-39 year olds), 27% rated themselves in excellent health while only 17% thought they were in fair health. The figure for good health was 53.9%, almost identical to the cocaine users. As far as the "NSSS Non-affiliated" sample is concerned, they are basically the same as "NSSS Affiliated": 25.3% in excellent health; 52.9% in good health; 17.4% in fair health; and 4.4% in poor health. Again, the image of the cocaine users is of a group with health just below what might be expected in a general population equivalent.

**Figure 5.2 Self Rated Health**



**Figure 5.3 Satisfaction With Health And Physical Condition**



The final health issue to be examined concerns use of medicines, alcohol and tobacco. The use patterns of common medicines are summarised in Table 5.5. Overall the results are fairly positive. Four of the six medicines - sedatives, tranquilisers, pep pills and cough medicine - are used by between ten and twenty per cent of all respondents. Only one or two of these use at a rate which could be considered

dangerous, that is, more than ten days per month. Thirty-three (48%) report using vitamins on a regular basis but there can only be a small potential for harm from such usage. The highest frequency was for pain relievers with forty-nine (67%) using drugs such as panadol, aspirin and cold tablets. In this case, the vast majority use pain relievers on no more than five days per month.

**Table 5.5 Use Of Common Medicines**

<u>MEDICINE</u>	<u>NONE</u>	<u>1-2 DAYS</u>	<u>3-5 DAYS</u>	<u>6-9 DAYS</u>	<u>ABOVE 10 DAYS</u>	<u>PER CENT PRESCRIBED</u>
	NO.	NO.	NO.	NO.	NO.	%
PAIN RELIEF	24	23	20	2	4	4
VITAMINS	38	4	11	4	16	2
SEDATIVES	61	4	4	0	4	33
PEP PILLS	59	9	3	1	1	7
TRANQUILZRS	63	4	2	2	2	40
COUGH MIX.	62	6	2	2	1	18

While the results tend to suggest a fair degree of moderation being practiced, in strict medical terms, this is far from being true. Given that most of the medicines have not been prescribed by a doctor (excluding vitamins and pain relievers which do not require a prescription), would put these usages squarely in the "abuse" category. The highest figure for use under prescription was only 40% of those using tranquilisers. When it is remembered that this is a group of illicit drug takers it is not surprising that they are prepared to use common, legal drugs without medical prescription.

Perhaps one of the greatest health risks appears in the use of alcohol and tobacco by the cocaine sample. From Table 5.6 it is obvious that they are heavy users of both substances; 49% smoking every day and 37% drinking alcohol on twenty or more days a month. Of the smokers, 40% are "pack-a-day" smokers - either twenty or twenty-five cigarettes, the two standard size of cigarette packs. A further 15% smoke more than twenty-five cigarettes a day.

Only three people claim to be non-drinkers. On consumption levels, alcohol appears to be used less heavily than tobacco. Sixty per cent of drinkers have less than three to four drinks on any given drinking occasion. Twenty-eight per cent of drinkers

have between five and eight drinks while eleven per cent have above nine drinks per occasion.

**Table 5.6 Tobacco And Alcohol Consumption**

FREQUENCY OF USE	SMOKERS		DRINKERS	
	NO.	%	NO.	%
NONE	18	24.7	3	4.1
1-2 DAYS	4	5.5	4	5.5
3-5 DAYS	2	2.7	6	8.2
6-9 DAYS	4	5.5	12	16.4
10-19 DAYS	4	5.5	21	28.8
20 OR MORE	5	6.8	15	20.5
EVERY DAY	36	49.3	12	16.4

#### 5.4 SOCIAL INTEGRATION

This section deals with a range of factors grouped under the heading social integration.

First, while 45% are in de facto relationships, not one is currently in a legal marriage. Given the extraordinarily high number of married persons in the population at large, in the age range of our sample (18-49) this is quite a striking result. The present household arrangements for the sample are summarised in Table 5.7.

A similar result emerges when we examine the area of religious affiliation. Whatever the average person means when they fill out the 'religion' box on forms like the questionnaire here, the majority do make some identification. This was not the case with the cocaine users. Only five identify in any way with an organised religion. The same was true for membership of voluntary organisations: only eight respondents were involved with some community based group.

**Table 5.7 Present Household Family Arrangements**

<b><u>ARRANGEMENT</u></b>	<b><u>FREQUENCY</u></b>	<b><u>PERCENT</u></b>
WITH DE FACTO	14	19.2
WITH DE FACTO + CHILDREN	6	8.2
PARTNER (SAME SEX)	2	2.7
WITH PARENT(S)	6	8.2
ALONE NEVER MARRIED	11	15.1
ALONE FORMERLY MARRIED	2	2.7
WITH CHILDREN	1	1.4
GROUP HOUSE	16	21.9
GROUP HOUSE + PARTNER	11	15.1
UNIVERSITY RESIDENCE	1	1.4
NO FIXED ADDRESS	3	4.1

When we turn to political affiliation the pattern continues. Forty-one (56%) do not support a political party, and of those thirty-two that do, nine support minor or fringe parties (NDP, Communist, etc.). Of the remaining twenty-three, seventeen support the Labor Party and six support the Liberal Party.

All these results point to an appearance of low levels of social integration. While this may be true in the institutional sense, there are other indicators which suggest high levels of social integration at the more inter-personal level.

To begin, the evidence on family relationships points to a picture of "normality", and one quite unlike either that of the broken-homes-leads-to-delinquency chain, or the dependent-drug-users-are-over-attached-to-their-family, a view that is sometimes favoured by other schools of thought. On the broken homes issue, the picture is quite clear. Sixty-four (88%) of respondents were living with both their parents when aged fourteen (a generally useful measure); seven were with one of their parents; and two were with foster parents. On the other hand, apart from six of the younger respondents who are still students, this is not a group living at home in adulthood (see Table 5.7). Relations with kin were good, without evidence of their being 'suffocating'. Looking at Table 5.8, it can be seen how the majority regard their present relationships with kin as above average. The relationships with fathers are slightly less good, but still around the average mark.

**Table 5.8 Relationships With Kin**

<u>QUALITY OF RELATIONSHIP</u>	<u>FATHER*</u>	<u>MOTHER*</u>	<u>SIBLINGS**</u>
	%	%	%
EXCEPTIONALLY GOOD	8	21	30
VERY CLOSE	29	41	33
AVERAGE	32	29	20
NOT CLOSE	20	3	6
VERY POOR	12	6	11
	*N=66	*N=70	*N=70

A similar pattern emerges on other indicators of social integration at the interpersonal level. The respondents were asked how many people, apart from a 'partner' (where relevant), that they felt really close to. The format used was derived from a study of the aged in Sydney (see Kendig, 1986), and data from that survey indicate that a response of two or more such close contacts could be considered a reasonable level of contact. This applied to 89% of the cocaine users, and 66% were able to identify five or more. A rough measure of the density of the networks was gauged from how many of the people in the friendship networks know each other. 18% report that all the friends know each other; 47% most know each other; 23% most know a few others; and 10% most know no others.

Those involved in de facto relationships seemed, for the most part, to be enjoying positive, stable situations. Subjects were asked about a range of matters which can cause disagreements in relationships (the Spanier Dyadic Adjustment Scale). The majority of these presented no significant difficulties between partners. The two exceptions were "handling finances" and "recreation matters" where over sixty per cent of respondents had occasional to frequent disagreements with their partners. The other issue to stand out as a problem was in relation to sex. 26% stated that they had occasional to frequent disagreements about sex while 39% suggested that being too tired for sex was another problem. Related to this was 36% who had complaints about their partners failure to show love at certain times. While the relationships were obviously not perfect, there was the belief in the majority that their relationships would continue. 85% thought things were generally going well while more than ninety per cent thought their relationship had a more than fair chance of success in the future.

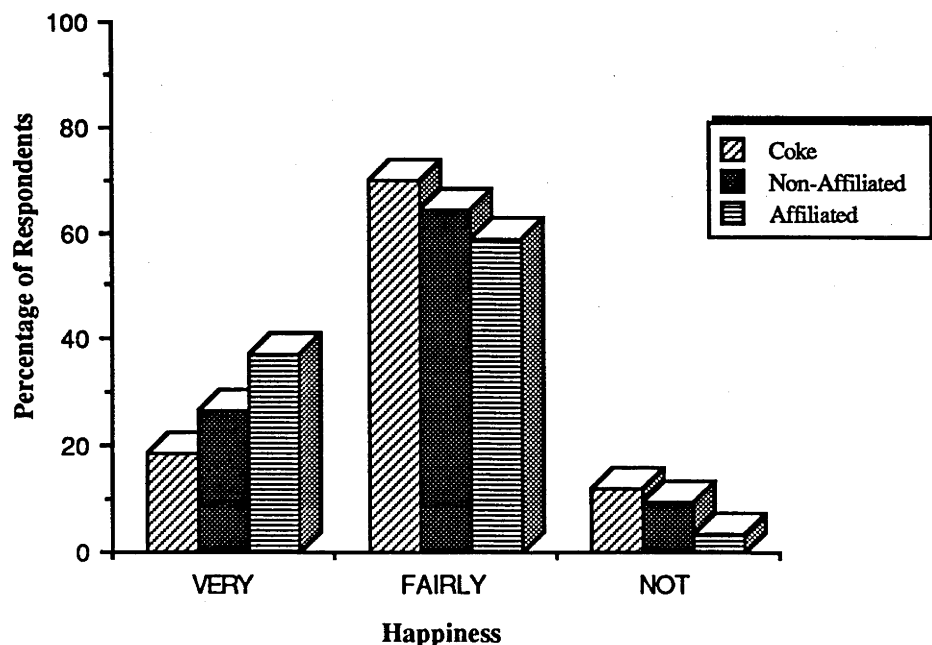
Since, following the kind of logic first espoused by Durkheim, one might consider both excessive integration and a shortage of integration to be a problem, the results here indicate a strongly positive picture. Almost all the respondents have

adequate levels of significant others, and the pattern of connections between them appears optimal.

The relatively high level of inter-personal integration exhibited by our respondents might then lead one to suppose that they would, in general be a fairly well-adjusted and happy group. The results from Section 5.3 on personal health certainly tend to indicate this as well. Examining some of the measures of personal happiness and satisfaction provides a fairly positive picture as well. Comparisons with the results from the survey of the general population also confirm the sense of "normality" about the cocaine users.

On a three point rating of happiness, the cocaine users rate themselves only slightly less happy than the NSSS samples. In fact, as Figure 5.4 demonstrates, the major difference is with the NSSS "Affiliated" sample. Thirty-seven per cent of these people rate themselves 'very happy' as opposed to only nineteen per cent of the cocaine users. On a series of questions about levels of satisfaction with various aspects of their lives, the majority were, with the exception of two areas, 'satisfied'. The satisfaction levels in relation to health, fitness and income fit closely the earlier patterns for the same variables. The levels of satisfaction were, however, lower than was the case with the NSSS samples, particularly the NSSS "Affiliated" group (see Table 5.9).

**Figure 5.4 Self Rated Happiness Levels**



Some of the differences can be explained when we remember the NSSS "Affiliated" sample is a religiously aligned group. So, for example, the fact that 77% of "NSSS "Affiliated" were satisfied with the purpose and meaning in their life compared to 63% and 55% for the "NSSS "Non-affiliated and cocaine samples respectively is not a surprising result. One that is rather Striking is that 90% of the "NSSS "Affiliated" group report satisfaction with their sex life, as compared with only 67% of cocaine users and 61% of "NSSS "Non-affiliated".

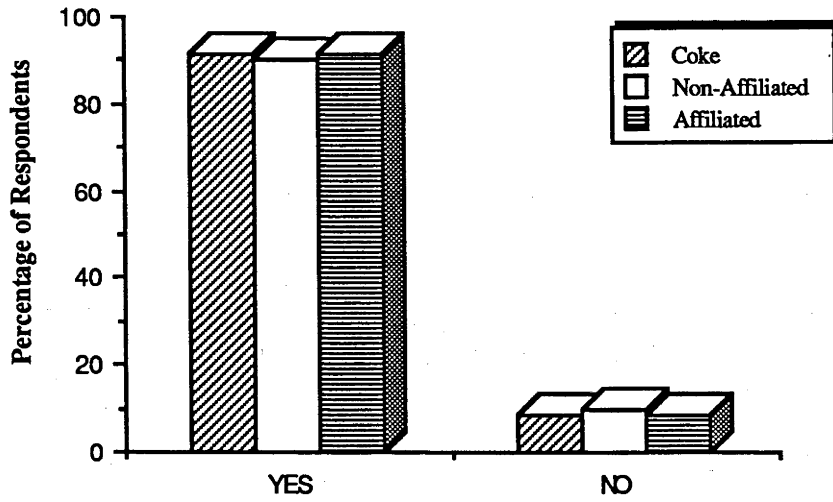
**Table 5.9 Satisfaction With Aspects Of Life**

<u>TYPE OF LIFE SATISFACTION</u>	<u>COKE USERS</u>	<u>NSSS AFFILIATED</u>	<u>NSSS NON-AFFIL</u>
SPARE TIME ACTIVITIES	63	64	65
FRIENDS	80	75	79
DAY TO DAY LIFE	68	67	60
THE FUN YOU ARE HAVING	59	70	68
DIVERSITY OF LIFE	53	62	61
MEANING IN LIFE	55	77	63
SELF	55	78	75
SEX LIFE	67	90	61
HEALTH	51	89	81
FITNESS	33	62	61
HOME AND FAMILY LIFE	64	89	74
INCOME	29	62	42
STANDARD OF LIFE	59	82	67
LIFE AS A WHOLE	69	90	83

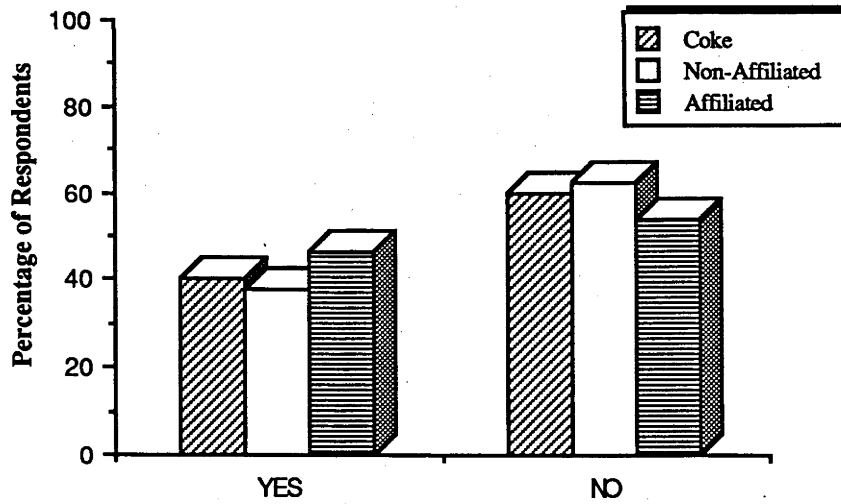
On a cluster of four questions, dealing with how things usually work out in the respondent's life, the cocaine users are almost directly comparable with the general population samples. As Figure 5.5 shows, the only major difference occurs with the question of whether one usually carries out the plans they make. A majority of the cocaine sample (60%) suggested that things come up and plans are changed, as opposed to only 42% of the NSSS "Affiliated" and 44% of NSSS "Non-affiliated".

Figure 5.5 Life Situation Questions

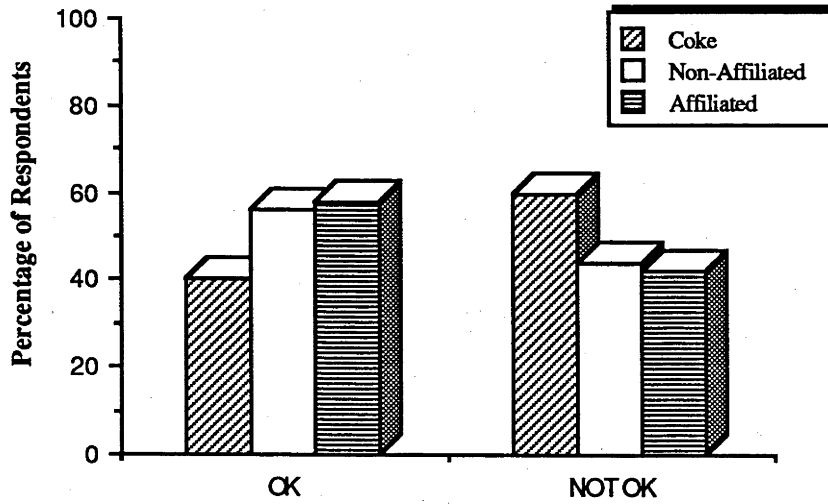
(a) Ability to Run One's Own Life



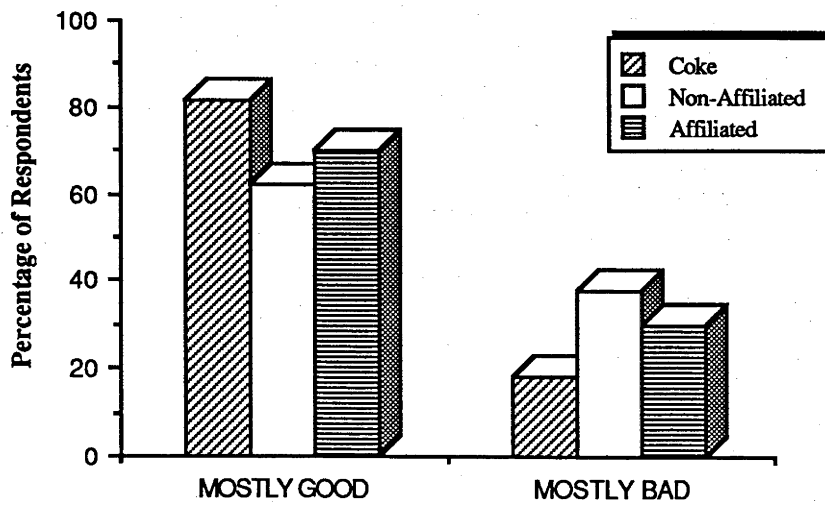
(b) Does Life Usually Work Out For You?



**(c) Whether Plans Work Out Okay**



**(d) Whether Good or Bad Luck Experienced**



Given that cocaine is a drug which is supposed to make one more talkative, sociable etc., one might expect that users are people who are not particularly confident or at ease in social situations. To examine this idea the measures of "affiliative tendency" and "sensitivity to rejection" were employed. These consist of a series of statements (eighteen for affiliative tendency and twenty for sensitivity to rejection) which respondents are asked whether they agree or disagree with.

For affiliative tendency an answer in the direction of affiliation is given a score of one (for example, with the statement "having friends is very important to me", an answer in the affirmative scores one) and therefore a maximum score of eighteen is possible. The cocaine users scored highly on this measure. The scores ranged between five and sixteen with a median of twelve. Eighty per cent of the sample scoring above ten. The results for sensitivity to rejection were equally positive. With this measure, a low score was the optimum ie. the lower the score the less sensitive to rejection. Statements were along the lines "I sometimes take criticisms too hard" and "I tend to associate less with people who are critical". Here, the range was between zero and thirteen with a median of seven.

These results indicate a group who are basically sociable and not particularly sensitive to rejection. This again provides support for the argument that the cocaine users are a group of well adjusted, reasonably happy and socially capable individuals, rather than being socially inept, dissatisfied people with major character flaws.

## 5.5 SOCIAL ISSUES

This section explores the attitudes of the cocaine users on a range of social issues. What emerges is a group with a fairly liberal, progressive outlook. This is in keeping with the fact that they do not belong to the institutional "mainstream" and while not supporting political parties to any extent, their leaning is to the left and the Labor Party. In contrast, the NSSS samples are largely conservative, particularly on the more controversial issues such as aboriginals, drug laws etc.

The first series of questions to be examined deal with various options open to the government and whether respondents favour or oppose them. The largest distinctions between the cocaine users and the NSSS samples occur with what might be called "law and order" issues. Only 11% of the cocaine group are in favour of the death penalty for murderers while 52% of the NSSS "Affiliated" and 43% of the NSSS

"Non-affiliated" are in favour. Similarly, on the question of stiffer sentences for law breakers, 77% and 60% of the NSSS samples ('Affiliated' and 'Non-affiliated' respectively) are in favour, while only 14% of the cocaine users hold such a view. On the question of whether marijuana should be legalized, not surprisingly, 94.5% of the cocaine sample are in favour. In contrast, only 28% of NSSS "Affiliated" are in favour while the NSSS "Non-affiliated" are much less conservative with 47% supporting legalising marijuana. On a number of other issues the differences between samples are still evident, although not as pronounced. For example, on the question of whether divorce should be made more difficult to obtain, 19% of the cocaine group are in favour as opposed to just 23% of NSSS "Non-affiliated" and 37% of NSSS "Affiliated". One notable exception to the trend is in relation to the idea of re-distributing wealth in favour of ordinary working people. While one might have expected the more conservative NSSS samples to oppose this suggestion, in actual fact, 55% of NSSS "Affiliated" and 60% of NSSS "Non-affiliated" were in favour. 66% of cocaine users were also in favour of this.

The next set of questions dealt with the amount of money being spent on various problems in Australia. Respondents were asked to indicate whether too much money, too little or the right amount was being spent on them. Again, there is a fundamental left-right split between the cocaine users and the general population samples.

The most striking result concerned the money spent on the military, armaments and defence. 85% of cocaine users believed too much was being spent, while 51% (NSSS "Affiliated") and 41% (NSSS "Non-affiliated") of the general population samples thought too little was being spent in this area. On three other issues (improving the conditions of aboriginals; helping the unemployed; and foreign aid) far greater percentages of the cocaine users than the NSSS samples believe too little is being spent. Their views converge on some of the less controversial points. Low percentages (less than fifteen per cent) across the board believe that too much is being spent in the areas of education, the roads, social services, science and technology and the environment.

The most interesting result is in relation to whether too much is spent on dealing with drug addiction. Twenty per cent of the cocaine sample believe too much is spent while only 4% and 3% of the NSSS "Affiliated" and NSSS "Non-affiliated" samples respectively hold such a view. This result can perhaps be explained by the fact that at the time of interviewing, the National Campaign Against Drug Abuse (NCADA) was in

full swing and many of the interviewees expressed dissatisfaction with it. Basically, they felt their own experiences and knowledge of the drug scene bore no relation to the information that was being propagated in the campaign and thus they saw it as a complete waste of time and money.

The attitudes toward drug use are fairly much what one would expect from an illicit drug using group. While basically cynical of any official view they are also well versed in the realities of drug use.

The above point is seen particularly with a series of statements which the respondents were asked to rate as either true or false. The essence of several of the statements were that licit drugs were the cause of more problems than illicit drugs eg. "alcohol causes more deaths in Australia each year than heroin, marijuana and all other illegal drugs put together". In each case (four in total), the majority believed such notions to be true. On the question of whether regular marijuana use eventually leads to use of cocaine, heroin or some other hard drug, 71% believed this to be false. They were even more dubious about the suggestion that "too much marijuana can lead to very severe illness or even death": 86% indicating false. An interesting result was that while 95% disagreed with the idea "you shouldn't take drugs for pleasure", only 42% agreed that "people should try things like drugs that affect the way you feel" (47% said this was false). In other words, while the cocaine users were quite happy with their own use of drugs they didn't feel it was something that everyone should do. This view was also expressed in the interviews, except in a slightly different guise, where the respondents believed they were capable of controlling their own use of cocaine but were doubtful about other's ability to do so.

The other drug attitudes covered in the questionnaire concerned whether respondents thought various drug taking behaviours were increasing or decreasing and their estimations of what proportions of Australians, their own age, were engaged in these activities. The increasing-decreasing data is presented in Table 5.10. The belief is that generally, most drug use is on the increase. The notable exception being tobacco use, which 58.9% believe is decreasing. The largest "don't know" categories reflect on the drugs where little information is actually known ie. sniffing glue, petrol etc., tranquilisers and barbituates. When we examine the estimations of the numbers using the drugs, we find that the cocaine users tend to over-estimate. For example, 52% say that a half to most of Australians their age

**Table 5.10 Whether Certain Drug Taking Behaviours Are Increasing Or Decreasing**

<u>DRUG</u>	<u>INCREASING</u>	<u>DECREASING</u>	<u>NO CHANGE</u>	<u>UNKNOWN</u>
	%	%	%	%
Marijuana	56.2	4.1	34.2	5.5
Tobacco	12.3	58.9	24.7	4.1
Barbituates	28.8	9.6	31.5	30.1
Cocaine	78.1	1.4	15.1	5.5
Excessive Alcohol	54.8	8.2	32.9	4.1
Excessive Tranqzr.	37.0	5.5	26.0	31.5
Sniffing Glue etc.	32.9	12.3	15.1	39.7
Amphetamines	42.5	8.2	20.5	28.8
Heroin	65.8	2.7	17.8	13.7
Hallucinogens	11.0	35.6	31.5	21.9

smoke marijuana. The interesting figure is for heroin use where the majority think less than one in fifty are users, remembering that 65.8% felt this to be an activity on the increase. Again, this demonstrates that users are cynical of the official views which suggest that there is some form of epidemic with heroin use.

## 5.6 CONCLUSION

This chapter has provided a comprehensive background on the respondents in the study and evidence to reject some of the popular beliefs about cocaine users in general.

One of the main indications is that cocaine use is spread across a wider cross-section of the community than has been believed in the past. Cocaine is obviously not restricted to the "glitterati" or "fast lane" sets as witnessed by the low income levels, high educational achievement and wide range of occupations represented in the sample.

The conception that all drug users are implicitly sick or unhealthy individuals can also be laid to rest. The generally high levels of physical and mental well-being and inter-personal integration indicate a group who are on the whole stable, well-adjusted people experiencing few severe "life problems". Comparison with the general population samples on a number of issues also produces a picture of "normality" about the cocaine users.

Finally, while the respondents maintain fairly liberal views on social issues they are by no means a radically alternative group. They may not belong to the mainstream but in some senses they are fairly conservative. This actually emerges more in the following chapter where attitudes about control and the question of drug legalisation are explored in more depth.

## CHAPTER SIX

# COCAINE USERS: THE MAINTENANCE OF CONTROLLED USE

### 6.1 INTRODUCTION

This chapter is concerned with the actual drug use patterns of the individuals in the study. The purpose is to establish how controlled use of cocaine is maintained by those individuals and how the results relate to the previous research conducted in this area. Throughout this thesis the emphasis has been upon understanding the multifarious factors which impinge upon the drug using experience and this is continued with the examination of the empirical results from the study.

The analysis begins with the more quantifiable features of the subject's drug use. That is, identifying the individual's drug use history; their introduction to use of cocaine; the level of cocaine use maintained; other illicit drugs consumed; and the social situations within which cocaine is taken. This type of data constitutes what might be thought of as the "drug profile" of the respondents - the drug equivalent to the social profile established in chapter five. While it is hard to talk in terms of a "typical" use pattern, the picture that emerges from the study is of a person using a quarter to half a gram of cocaine on the weekend, in a social situation (party, nightclub, etc.) with friends and usually with another drug such as alcohol or marijuana.

The second half of the chapter is devoted to "set" type questions. The focus is upon respondent's own beliefs in relation to their use of cocaine. By examining a range of issues including the limits placed on cocaine use, the negative reactions or ill effects, attitudes toward drug laws and government portrayals of illicit drug use, it is possible to gauge the beliefs which underly the respondent's use of cocaine.

### 6.2 USE OF COCAINE AND OTHER DRUGS

The majority of respondents began illicit drug use in their mid-teen years and with the use of marijuana. The age at which illicit drug use commenced ranged between twelve and twenty-five with a mean of 16.1 years. As Figure 6.1 demonstrates, the vast majority were using drugs from a fairly young age, with 75% doing so before the age of eighteen. With the exception of eight cases, all began by using marijuana or some other cannabis derivative. Of the eight exceptions, five began with LSD, although

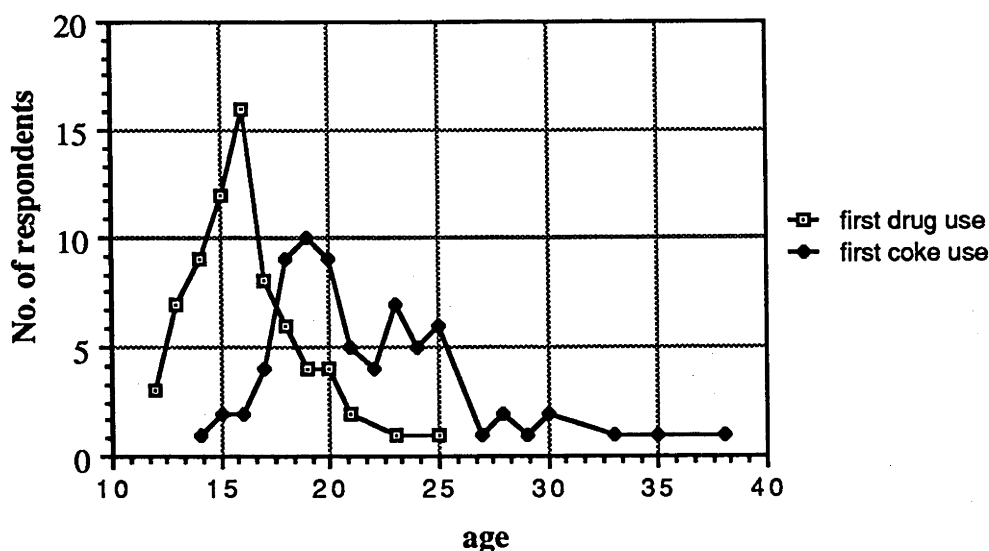
it must be noted that these were mostly 'one-off's' which were followed by more regular use of marijuana, two began with heroin and one with cocaine. Figure 6.1 also demonstrates the lag between first drug use and first use of cocaine. Generally, cocaine use began around five years later, the average age of commencement being 21.6 years. The age at initial use ranged between fourteen and thirty-eight although 87% had begun by the age of twenty-five. These results tend to confirm the notion of marijuana as a "gateway" drug. That is to say, the majority of those using drugs such as cocaine, heroin, amphetamines began with marijuana use. As Mugford points out:

It is the widespread availability and public acceptance of marijuana, plus its illicit status, means that it is likely to be the point at which people are prepared to "cross over" to illicit use (Mugford, 1987: 19).

This is not to imply that all marijuana users will necessarily end up using these drugs. It is not surprising, however, that someone who has used marijuana, and enjoyed its effects, will be more likely to engage in use of other illicit drugs, than someone who has not tried marijuana at all.

Of course licit drugs may also provide a gateway to illicit drug use. Without prompting from interviewers, twenty-two respondents (30%) mentioned alcohol and nineteen respondents (26%) mentioned tobacco as drugs they had used prior to cocaine. Remembering as well that nearly seventy per cent smoked tobacco regularly and sixty-five per cent drink on more than ten days a month, there does appear to be a strong link between licit and illicit drug use. The other point worth noting is that users themselves often classified tobacco and alcohol in the same category as illicit drugs like marijuana and cocaine.

**Figure 6.1 Age First Drug Use And Age First Cocaine Use**



**Table 6.1 Different Drugs Used And Consumption Levels**

DRUG	NONE	UNSPEC.	EXP.	OCCASNL	REGULAR
	%	%	%	%	%
MARIJUANA	0.0	41.1	8.2	9.6	41.1
SPEED	13.7	57.5	5.5	16.4	6.8
HEROIN	52.1	21.8	9.6	5.5	11.0
LSD	30.1	46.6	12.3	9.6	1.4
MUSHROOMS	64.4	28.8	5.5	1.4	0.0

Cocaine was one of a number of illicit drugs used by the group. Table 6.1 displays the drugs used and the consumption levels. From this it can be seen that marijuana was by far the most popular drug, with every respondent having used at some stage and 41% classified as regular users. Amphetamine or "speed" was the next popular with approximately 86% having tried the drug. Of these, a large majority used at an "unspecified" level. In a number of cases the use of speed was directly related to the availability of cocaine. While cocaine was usually preferred, if it was not available then speed may have been sought as an alternative. Another factor which may tend to raise the actual level of amphetamine consumed is the adulteration of cocaine with this drug. Amphetamine is one of the common adulterants and one of the complaints voiced by our respondents in relation to the quality of cocaine was that it seemed to be

"speedy". Nearly half the sample (48%) had some experience with heroin but only 11% identified themselves as regular users. Again, this provides evidence to refute the notion of "one taste of heroin and you're an addict", a popular misconception about the drug. The psychedelic drugs (LSD, magic mushrooms etc.) were basically drugs which many had experimented with but few used regularly. Seventy per cent had tried LSD but only one person reported regular use. A frequent occurrence was that respondents had initially enjoyed use of these drugs but that one or two "bad trips" had been enough to dissuade them from using again.

First experiences with cocaine usually occurred through chance circumstances and with friends from immediate social networks. Only five people suggested it was a deliberate policy on their part to seek out cocaine. One respondent described the situation during the following exchange:

Interviewer: How did you first come to try cocaine?

Respondent: I heard so much about it that I was actually dying to try it.

Interviewer: How did the opportunity to try it come about?

Respondent: I was going to a party and I thought it would be the perfect occasion, so I asked a friend to get me some.

For the majority though it was simply a case that while either visiting friends or in a party situation, they had been offered some cocaine and decided to try it. Most were knowledgeable about the drug prior to use and were aware of what effects could be expected from cocaine.

In previous research it was found that first-time experiences were associated with a great deal of apprehension on behalf of the novice and the presence of an experienced user or "significant other" to act as guide through the initial stages of use (see Becker, 1953 and Grinspoon and Bakalar, 1984). Becker, for example, found that with initial marijuana use there was a process of "learning to be stoned" in which the experienced user played a crucial role. With the present study there appeared to be little fear involved with first use of cocaine and the role of the experienced user did not assume immense importance. In describing their first occasions for use the respondents had little hesitation when the opportunity to try cocaine arose. Everyone described some "significant other", invariably a close friend or sibling, but their role was usually involved little more than providing the cocaine. A typical first experience was outlined by a Melbourne respondent:

It was a friend of mines' brother who was a regular user. We went around to his place and were just around there when he had a snort, then his brother, who was my friend, had a snort. It was more or less just like "do you want a cup of tea?" and it was passed around and I said "I'll have a go". So I tried it and it was great.

Similarly, a Sydney respondent described how a visit to a distant relative became the occasion for her first use of cocaine:

I knew about cocaine. I would have been about twenty and I went to visit my aunt, aunt by marriage. I remember dropping in on her one night just to see how she was going and she said "do you want to try this?", because she used to use a lot of it and I knew she used a lot. I mean I didn't go there thinking "oh, here I can get to try some cocaine" but as soon as she said do you want to try it, I said "yeah!".

The lack of apprehension in the novices can be attributed to a number of factors. First, all had used illicit drugs prior to cocaine and thus any doubts or fears would necessarily have been allayed at an earlier stage. Second, cocaine enjoyed a reputation amongst users as a safe, fun, "partying" type drug (these perceptions sometimes changed as users became more acquainted with the drug). In other words, there was no reason to fear the consequences of use. Finally, the general air of mystery surrounding illicit drug use seems to have been dispersed; there was a very matter of fact attitude toward the use of cocaine. As one respondent noted, "there wasn't a lot of fuss made about it. It was like if you want some, go for it, if you don't, fine - no worries".

Use of cocaine did not appear to affect the social networks of respondents to any extent. The respondents were asked whether once they began using cocaine, they found themselves associating more with other cocaine users and less with non-using friends or whether they felt they were frequenting any "coke scenes" (if such exist!) as well. Overwhelmingly, the responses were in the negative. For many, it was a case that they used so little of the drug that a change in social milieu was simply impossible. As this Sydney man stated:

No, I have a very infrequent use of cocaine and it's virtually only in party situations and people always offer it to me. I never go out and buy it.

For others, cocaine was only used in the "normal course of social events": cocaine was seen merely as an addition to their social circle rather than changing it in any way. This result is hardly surprising, given that most initial experiences with cocaine occurred with close friends or siblings. There was another group of users who while having a

heavier usage pattern still found no dramatic shifts in the people they mixed with; they may have felt they met more people as a result of using cocaine but their basic friendship networks remained unchanged. A typical reply in this category was:

Not so much because most of the people I was mixing with were also using cocaine or were starting to use cocaine a lot more. It just seemed to be something that everybody around you was doing and a lot more often.

There were seven respondents who felt there had been a change in their social networks after commencing use of cocaine. The circumstances were quite distinct in each case. For a Melbourne man, starting use of cocaine at high school, narrowed his friendship network dramatically. As he explains:

Like the bunch of kids at school who were snorting it were different. It wasn't like everyone in the school was doing it at that age. So we sort of had our own group that was different to the rest.

A Canberra respondent found that his frequenting of nightclubs increased his use of cocaine and was mixing with a group of people who were also regular users of the drug. Still, amongst the seven users there was a refutation of the notion that they were in the midsts of "coke scenes". As a Sydney woman described in this exchange:

Respondent: I suppose it brought me closer to the particular group of people that were also involved in using it, yeah.

Interviewer: Would you say you were frequenting a coke scene or anything like that?

Respondent: Not really a coke scene at all. I mean it was more a group of friends, who had a reasonable amount of money on them at the time, that used the drug before they went out somewhere. But the places they went out to were not the sort of places that a lot of people there were using cocaine, if you know what I mean.

Initial experiences with illicit drugs were far more likely to affect social networks than was the case with cocaine. Generally, first experiences with drugs occurred during secondary education, a time when social networks were still being established and when the distinctions between drug users (primarily marijuana smokers) and non-users were most clear. Many respondents identified this as a factor although only twenty-four believed it had left to a definite shift in the people they mixed with. As one respondent put it "I got on much better with people who smoked than people who didn't". For another it was a situation where friends from outside her school became more important because of their drug use:

Respondent: Yes, it changed from a catholic up-bringing with a lot of catholic friends to having my circle of friends who went to state school.

Interviewer: Because they were the people who smoked as well?

Respondent: Yes, that's right.

Still, for the majority it was a case that either drug use came to their existing friendship networks or they maintained close ties with both users and non-users. This was seen with a Melbourne man who stated:

I think because I was more heavily into marijuana than anything else at that stage and that did mean a slight change in the circle of friends, but I still had my old friends: close friends who I kept in close contact with.

The levels of cocaine being consumed varied quite widely within the sample. At the time of interview, 72% classified themselves as current users of cocaine. With the exception of seven cases, all had used cocaine within one year prior to interview. The majority (64%) had used within a period of two to three months before interview. As far as peak use levels were concerned, the respondents again represented a wide spectrum of use (see Table 6.2)). Just under 40% were in the heaviest use categories, namely daily and weekly use. A further 35% used between one to three times every month and 22% approximately three or four times a year.

**Table 6.2 Levels Of Cocaine Use At Peak Use**

<u>USAGE LEVEL</u>	<u>FREQUENCY</u>	<u>PERCENTAGE</u>
DAILY	14	19.2
WEEKLY	15	20.5
EVERY 2 - 3 WEEKS	14	19.2
MONTHLY	12	16.4
EVERY 2 - 3 MONTHS	13	17.8
EVERY SIX MONTHS	2	2.7
LESS THAN SIX MONTHLY	3	4.1

An important feature about the use of cocaine was that it was seldom used in isolation: cocaine was almost invariably accompanied by use of at least one other drug. Sixty-eight respondents (93%) identified this as the normal pattern of use. Alcohol and marijuana were by far the most popular drugs in this context. Seventy-five per cent used alcohol at the same time as cocaine while just under fifty per cent used marijuana. Cocaine was usually taken before going to parties, nightclubs, pubs etc., situations where alcohol, and to a lesser extent marijuana, use was almost inevitable. A Canberra subject, however, found that cocaine acted as a good counter-measure to the effects of alcohol:

One night I was at this nightclub, chatting up this young lady, but I was very drunk, really, really drunk, and I was ready to nod off, so I actually had some coke on me, and I wasn't into using a lot then, so I just went off to the toilets and had a line, and cocaine drives like a wedge of clear thinking right through the booze and it sort of pushes the haze and slurriness and unco-ordination aside. Whereas I was sort of stumbling and sort of falling into the toilet, on the way back I could walk a dead straight line.

Heroin and speed were also used in combination with cocaine: seven respondents (10%) using the former and nine respondents (12%) the latter. With heroin, it was the case of using both drugs at the same time; the so-called "speedball" combination. While this was described as a very pleasurable experience it was not a common occurrence.

For those fifty-three presently using cocaine, twenty-nine said their use was steady, twenty thought it was on the decrease and only four believed it was increasing. Fluctuation in basic use levels, which was common for all respondents, was most likely in the direction of less use. The reason for this being that difficulty was often

experienced in obtaining cocaine. Forty people (55%) suggested that they were not always able to arrange supplies when they desired it. This was particularly the case in Canberra where all supplies originated in Sydney, and this extra link often proved to be unreliable. Difficulty in obtaining supplies, in all cities, was compounded by the small number of sources from whom cocaine was obtained. Of the fifty-six who had purchased cocaine at some time, fifty had under three sources of supply. These sources were often just friends who were known prior to use of cocaine. An important point to note here was that non-availability of the drug was not conceived as a problem by the respondents. If cocaine was unavailable then the majority would simply go without. A minority might use another drug as an alternative, such as speed, but it was never a situation of desperately chasing down sources to obtain cocaine.

The basic usage patterns we've discussed so far were reflected in the quantities of cocaine bought and amounts of money spent on it. As Table 6.3 shows, the modal quantity bought at one time was one gram, with just under half (26 respondents, 46.5%) of those who purchased cocaine buying this amount. Only six would buy more than one gram while the rest purchased varying amounts up to one gram. The price range was between one hundred dollars and three hundred dollars, although the standard price was two hundred dollars a gram. Those who purchased cocaine for under two hundred dollars a gram were either receiving reductions for buying in "bulk" or were people whose peak use was some years ago when the drug was cheaper. Those who paid more than two hundred dollars believed they were paying more for a higher quality, uncut cocaine.

The amount of money spent on cocaine in an "average week", at the time of peak use, varied enormously. Sixteen people used it so infrequently that an average weekly amount was meaningless to them. Of the forty remaining, twenty spent under fifty dollars a week, fourteen spent between fifty and two hundred dollars and six spent between three hundred and fifty dollars and seven hundred dollars.

**Table 6.3 Quantity Of Cocaine Bought At One Time**

<u>AMOUNT BOUGHT</u>	<u>FREQUENCY</u>	<u>PERCENTAGE</u>
1 - 2 LINES WORTH	3	5.3
QUARTER OF A GRAM	10	18.0
HALF A GRAM	11	19.5
ONE GRAM	26	46.5
MORE THAN ONE GRAM	6	10.7

Another feature of the supply of cocaine was the lack of a clear cut separation between buyers and sellers. Twenty-one respondents (29%) had sold cocaine at some time. The typical situation was where they bought a quantity larger than their immediate wants, and then sold the remaining portions, usually in non-profit transactions with friends. Those who sold at this level emphasised the small-scale nature of the exercise. As this Sydney respondent stated:

I don't go around selling at pubs or anything like that. Its friends who just say "have you got any?" and its a case of "I haven't got much, how much do you want?" and they'll lay the price on you and you say "oh yeah, I've got that much so its all right". It is certainly not a money-making thing.

Others may raise the price slightly but only to cover the cost they incurred while purchasing it themselves. Another reason for selling was to reduce the amount they spent on personal use. As this Melbourne man explains:

On most occasions I would do that (sell) because that lessens the burden considerably. And you know, I think people want it, and its reciprocal. Sometimes I will buy the gram and then divide it up and I'll probably get half a lid for myself and totally recover the cost or else I'll keep one and a half caps for myself and it won't cost much.

There was one respondent who was involved at a higher level through financing the purchasing of cocaine in Sydney which was subsequently brought to Canberra. He was in no way involved in the distribution of the drug once it was in Canberra and only kept relatively small amounts, two to three grams for himself. The sums put forward were anything up to five thousand dollars per purchase (he was one of three "financial backers" as it were) and his return was usually double the initial amount. His involvement lasted for around one year and as far as he knew one member of the syndicate was still involved.

A practice more common than selling cocaine was the "splitting" of deals. Eighty nine per cent of respondents had at one time or another, shared the purchase of a unit (usually a gram) for shared use with friends. For many, unless they were given cocaine for free, this was the only way they could afford to purchase the drug. Typically, three or four friends would get together before a planned social occasion, each contribute between thirty and fifty dollars or whatever amount they could afford, and then one person would go off to buy the cocaine. Again, this pattern fits in with the notion of cocaine use inter-twining closely with friendship networks.

**Table 6.4 Degree Of Concern About Being Caught With Cocaine**

<u>DEGREE OF CONCERN</u>	<u>FREQUENCY</u>	<u>PERCENTAGE</u>
A VERY LARGE CONCERN	7	9.6
A CONCERN	23	31.5
NOT VERY CONCERNED	29	38.4
NO CONCERN	15	20.6

Cocaine's status as an illegal drug did not significantly effect the way cocaine was used. The respondents were asked how concerned they were over the possibility of being apprehended by the police whilst in possession of cocaine. Their replies were coded on a four point scale ranging from 'no concern' to 'very concerned'. As Table 6.4 demonstrates, the majority of respondents (forty-three people, 59%) fell in the two non-concerned categories. They attributed their lack of concern to the infrequent occasions when cocaine was actually in their possession and the small amounts consumed at any one time. For many, the fear of being caught never arose as an issue. In fact, a few respondents felt they were probably to blase about taking cocaine; at times they needed to remind themselves that it was an illegal activity. If a situation came about where apprehension was imminent, most were confident they would be able to conceal or dispose of the drug. For those who were more concerned, seven people (9.5%) "very concerned" and twenty-three (31.5%) "concerned", the greatest fear surrounded the purchase of cocaine, especially when buying from recognised dealers. As one person stated:

I suppose the only time I've ever worried about anything is that you'll just be collecting the package and the police raid you and you're with the dealer. I always think to myself "I hope if I'm going to get busted its not now, wait until I get in the car or get

home" because if you get caught with a gram or two then its difficult to get done bad but if you're in the dealer's house you're sort of in deep shit!.

As far as taking precautions to avoid detection, most employed simple common-sense procedures. Basically, it was a case that you make as little fuss as possible when taking the drug in public places. As this Sydney respondent commented:

You don't sort of tell everybody that you're taking a snort. You just go off quietly to a toilet, somewhere secluded. You try not to make too much noise about it. You keep it to you and your friends that are using it with you.

Another example was when arranging deals, people would try to avoid using the telephone, in case of buggings. If the telephone had to be used then cocaine would never be mentioned directly, code terms being used instead.

**Table 6.5 Concerns If Caught With Cocaine**

POSSIBLE OUTCOMES	A CONCERN		NOT A CONCERN	
	NO.	%	NO.	%
LARGE FINES	53	72.6	20	27.4
FAMILY TROUBLE	37	50.7	36	49.6
LOSS OF JOB	18	24.7	55	75.3
LOSS OF FACE	5	6.8	68	93.

Table 6.5 displays the concerns respondents would have if they were to be apprehended. The two major concerns were an inability to afford large fines and any family repercussions. The possibility of losing one's job was next and only five respondents believed it would cause loss of face. In fact, more typical was the view that it would be a sign of having "arrived" if you were to be caught with cocaine. Thirteen respondents had been arrested for drug offences at some time in the past. The majority of these were for possession of cannabis. Three people had served jail sentences for heroin offences. A further eleven people suggested they had had close brushes with the police; situations where friends, flat-mates had been apprehended or dealers had been arrested ten minutes before they had arrived to purchase drugs.

The respondents were predominantly inhalers or "snorters" of cocaine. Every respondent had employed this method of ingestion at some stage, and for the great majority, this was the principal method used. Twenty-three (31%) had injected cocaine but only twelve did so on a regular basis. An interesting sidelight was that fear of diseases such as AIDS, hepatitis etc. were not high amongst the concerns of the

intravenous users nor was it given as a reason why non-injectors had not tried this method. In fact, most non-injectors suggested it was a basic aversion to needles which had prevented them from using intravenously. As far as freebase cocaine is concerned, only seven subjects had experienced this and none on a regular basis. One respondent did report having tried crack but this occurred while on a visit to the United States.

So far in this chapter the discussion has touched on many issues involved with the "setting" factors of cocaine use. It has been established how cocaine use, from initial experiences to peak use, fits in very closely with pre-existing friendship networks. The following section examines in more depth the specific situations in which cocaine is used.

By far the most common situation for using cocaine was at parties. As Table 6.6 demonstrates, ninety-five per cent of respondents had used in this context at some time and for the vast majority, this was the typical situation. The cocaine itself was not always consumed at the party: very often it was a case of a group of friends getting together at one person's house, taking the cocaine and then going on to a party. For those who did consume at the party, it was usually done in a very discreet manner ie. going to a bedroom or bathroom. Of course one of the popular beliefs is the idea of the "coke party", where the drug is used quite openly. Not one of the respondents, however, described such events at parties they'd attended. While it may be the case that the majority of people at a particular party would be "coked", it was never the experience that it would actually be consumed publicly.

**Table 6.6 Typical Locations For Cocaine Consumption**

LOCATION	YES		NO	
	NO.	%	NO.	%
PARTIES	70	95.9	3	4.1
NIGHTCLUBS, PUBS	33	45.2	40	54.8
AT HOME ALONE	12	16.4	61	83.6
AT WORK	15	20.5	58	79.5
STUDYING, ETC.	7	9.6	66	90.4

There was general agreement that cocaine was an ideal "party drug". Most people felt they benefitted from being more sociable, able to talk to people for long periods and to people they might not normally mix with. As this Melbourne respondent said:

Yeah, at a party you just want to talk to people, you want to meet people and you want to do things. Like people you know sometimes at parties, you just get bored standing around drinking. And if you have a line everyone wants to get into having fun.

Similarly, another respondent summed up the benefits:

Oh, just a feeling of well-being. I'm out for a good night and that will make it better. And I'll feel more at ease, happier talking to people. I'll feel more alive.

Use of cocaine at nightclubs or pubs closely resembled the party situation. The emphasis upon discreet use is greater but the effects and benefits are very similar.

Fifteen subjects (20.5%) had used cocaine in a working environment. The majority of these were involved in the entertainment industry, primarily rock music and film making. They were able to confirm the popular notions about cocaine use being fairly prevalent in these areas. The long hours of work (eighteen to twenty hour days are not uncommon) mean that drug use becomes almost a necessity. Cocaine is used in this context for its physiological effect as a stimulant rather than as a source of pleasure. A Sydney man described a typical day for a road crew ("roadies") working on a rock tour:

They might wrap the show somewhere, pull it all down, pack it away on a truck, they might get back to their hotel at three or four o'clock in the morning, have two hours sleep, be up at six A.M., drive two hundred miles, set the whole thing up again. Nobody can survive in that way without some sort of thing... they tend to use it just to keep going rather than something just to party with.

Respondents outside the entertainment industry would combine work with cocaine on only rare occasions. Two people said that while working as a waiter/waitress they had used the drug to enable them to cope with long shifts, however, it was basically 'one-off' occurrences. The view held by these, and the majority of respondents was that it would be a waste to use cocaine while working; they saw it only as a drug for partying purposes.

The social aspect of the drug was also the reason why few people took cocaine at home by themselves. Twelve people had done this but only in an experimental sense, to "see what it was like". The conclusion reached was that it was a complete waste of the drug. Another of the less common situations for use was while studying. Only seven people had tried this and while it had been seen as effective there was still a feeling of waste. As one respondent stated "an expensive way of having No-Doze" (No-Doze being a caffeine based stimulant sold in chemist shops). The advantage of cocaine was the feeling of clear-headedness it produced:

You can have a line or whatever, and just quite easily sit up all night and do your essay and not feel depressed or anything about it.

### **6.3 LIMITS ON COCAINE USE**

The concern of this section is the beliefs held by respondents about the exercise of control over their use of cocaine.

As a starting point, respondents were asked to identify what they felt limited the amounts of cocaine they used. The responses fell into three main categories. First was a mention of some type of financial constraint; fifty-seven respondents (78%) referred to the high price of cocaine and/or the lack of disposable income to afford higher levels of use. A desire to maintain health rated second, with forty-one people (56%) stating some concern over the effects of cocaine on general health or a fear of addiction/dependency. The third group of responses came under the heading of "lack of available time". Nineteen respondents (26%) mentioned they only had, or wished to devote, a limited amount of time to cocaine use - there were other more important commitments in their life such as family and work.

**Table 6.7 Limits To Cocaine Use And Order In Which Mentioned**

<u>LIMITING FACTORS</u>	<u>FREQUENCY</u>	<u>PERCENTAGE</u>
A. FINANCIAL CONSTRAINTS - 1 'OTHER' FACTORS - 2	30	41.0
B. 'OTHER' FACTORS - 1	14	19.2
C. FINANCIAL CONSTRAINTS	10	13.7
D. 'OTHER' FACTORS	19	26.1

Another issue involved with this question was the number of different limiting factors mentioned and the order in which this was done (see Table 6.7). Only ten respondents gave financial constraints as their sole limiting factor whilst nineteen gave "other factors (health concerns and available time grouped together) as limitations. For those who gave a multiple response, thirty people mentioned financial constraints followed by one or more of the "other" factors, compared to fourteen who identified them in reverse order to this.

From the preceding results it could be concluded that as respondents obviously attach a good deal of importance to the financial aspect, they are in reality exercising little control over their use. That is, if there were to be a significant drop in the price of cocaine they would use more of the drug and therefore a proportion would experience some form of dependency problems. When the financial aspect is examined in more detail a slightly different picture emerges.

Under the heading 'financial constraints' were actually three sub-sets of answers.

First, and the minority of responses, were those who pointed to the two hundred dollar a gram price of cocaine as prohibitive and gave no qualifications to this. Second, and the majority of cases, were people who mentioned the high price of cocaine but suggested they did not wish to commit any more money than they were presently doing to cocaine use. This is an important distinction because it contains the notion of a disposable income to be spent on illicit drug use and thus the activity has been consciously allotted a limited role in the person's life. Some of the comments from

this category were of the nature "it's the amount I can afford. I mean I might have a thousand dollars but I wouldn't want to spend it" or "I mean I can't afford to dish out hundreds of dollars each week ... plus I don't know if I want to really" while another woman said "I've got money in the bank but I wouldn't want to be spending it that way... it's a choice". The third sub-set of answers noted the price and the difficulty in obtaining supplies. Again, this distinction is indicative of an underlying attitude where cocaine is simply not important enough for the user to chase around establishing dealer links.

The issue of price was pursued when the interviewers put the hypothetical question of what effect a lower purchase price would have upon personal usage. Only six respondents said they would definitely use more cocaine under such circumstances and gave no indication of what higher level of use they would maintain. One Sydney respondent was aware that there was a potential danger in such a situation:

Interviewer: If it was cheaper you would use more?

Respondent: Yes, I would actually.

Interviewer: At what sort of level?

Respondent: I'm glad that I can't really - I'm glad that I can't afford it. It's a bit scary of how much I would use it. I would like to be able to control it but I'm not sure.

There were twelve respondents who thought their usage might increase but still at a controlled level or only for a short period of time. Comments in this group were of the order "I would use a little more but I'd still be careful", "if it was available and at an everyday kind of price then I would probably use it once every couple of weeks". There was one particularly apt comment from a man who said given unlimited funds to spend on cocaine, he would "just get disillusioned with it quicker!".

The issue of financial constraints as a means of controlling illicit drug use is obviously fairly intricate. What this analysis has attempted to show is that while users may point to the high price of cocaine as a limiting factor, the majority of them have some notion of moderation or control embedded in this outlook. It is a matter for conjecture as to what increases in usage levels would result from a dramatic reduction in the price of the drug, but it is certainly not the case, as some policy analysts would suggest, that a drop in price automatically produces an increase in usage levels.

Turning now to what was earlier termed the "other" factors of control, it is useful to re-introduce Robert Apsler's notion of control style. One of the reasons for making the distinction between financial constraints and "other" factors is that it fits with Apsler's internal standard-external standard dichotomy. Remembering Apsler's

conception was based on examining specific instances of use, so an external standard was something like "if others are having a couple of joints, an individual will have a couple of joints also" whilst an internal standard was along the lines of "those who do not stop using a substance until they feel guilty about using too much" (Apsler, 1982: 40). In using it here, the concept is extended to the more general level of personal outlooks, the level at which the questioning was aimed. Thus, financial constraints can be seen as external standard, being a direct influence from the using environment whilst the "other" factors are essentially internal guides for control.

The category 'health concerns' contains quite a wide range of responses. First, were those people who mentioned specific health problems such as the strain on the heart or nasal disorders. As one person stated "I am aware of trying to limit the things that I think are stresses on the body and that includes alcohol and tobacco". Others voiced a desire to maintain healthy lifestyles or active attempts to "clean themselves up". As this Sydney woman stated:

Yes, my belief in life now which I never had before... I try to live a clean life now.

Another Sydney respondent expressed the same sentiment: "I don't lead the same kind of lifestyle. I'm getting older, getting straighter and hopefully healthier!". The fear of becoming dependent on cocaine was another of the general health concerns and as will be discussed in Section 6.4, addiction/dependency was seen by the majority as the greatest ill effect to be had from using cocaine. For some the concern over dependency was described in terms of having to have a self-imposed limit or will power. This was expressed in several ways: "I think just the idea of moderation in most things is essential", "my own will power to an extent", "well everyone gives themselves a level. Everyone sets that otherwise they'd be jumping on it all the time". One respondent was aware of the possibility of dependency and feared that it could easily happen to himself:

Sometimes I view my own use of marijuana as excessive and theres always the possibility that I would be as weak-willed with cocaine and find myself using it excessively.

Finally, a user's comment which reflects the views of a number of respondents:

I like to use when I want to use it. I would hate to rely on a drug to get me through everyday life.

There were two types of responses within those grouped under the heading "available time". The first type was where a personal commitment was given as the limitation upon use. These obligations consisted of family (two respondents with children) and work responsibilities. One Melbourne man had a girlfriend who did not

use cocaine and while she was not particularly disapproving of his use, he still tended to only use in social situations where she was not present. These responses can be seen as the embodiment of Zinberg's notion of the compartmentalization of drug use from everyday activities. The second type of response was where no specific priority was mentioned, but the subjects simply did not wish, through lack of interest or desire, to devote time to cocaine use. The following from a Sydney respondent explained the situation:

To some extent I'm getting a little bored with it too.... I spend more time at home, got other things to do, don't go out nearly as much and its not the sort of drug to sit in front of the T.V. and take.

Other typical replies were "I think my lack of desire more than anything: my lack of interest in it as a useful drug" and "I don't think I would just want to spend all the time on cocaine".

The following two sections deal with a range of drug issues which in some way reflect upon controlled drug use. The beliefs held by the subjects are all generally supportive of their maintenance of controlled cocaine use.

#### **6.4 ILL EFFECTS FROM COCAINE USE**

Drug users have often been portrayed as being naive in terms of knowing the harmful effects from drug use. They only find out when it is "too late" and they are dependent on a substance. Far from this, the cocaine users in this study maintained a high degree of awareness about the negative effects that could result from their use of cocaine. In some cases, respondents attributed rather more danger to cocaine use than most people would be at risk of experiencing.

The potential for addiction was seen as the major harmful effect by sixty-four per cent of respondents. Some saw it as a possibility inherent with all drug use: "if you start getting carried with any drug you are going to make a mess of yourself rather quickly", "I mean everything is dangerous done in excess". Others were unsure of specific addictive effects but knew of their existence, as in this comment from a Canberra subject: "I've never really come across any cocaine addicts as such but I can see that it would be a very damaging drug". The majority made a distinction between a psychological addiction, which cocaine engendered, as opposed to a physical addiction which something like heroin produces. This was usually stated in general terms like

"some sort of psychological dependence" or "I think its probably more psychological than it is physical", while others went into some detail about the "mental side of it". Basically cocaine was thought to have particular effects on the personality of someone who is addicted, causing severe depression and rapid changes in mood. A Melbourne woman spoke of the behaviour of an ex-boyfriend as an example:

He turned into a dreadful psychotic, schizophrenic type person, not the sort of person you would want to meet on a dark night. He would get to any lengths to get that drug even though he is not physically addicted.

The feeling of some was that cocaine, and all "uppers", were more damaging than heroin because of the psychological effects. A Sydney respondent stressed this point when he said "if you take it long enough and can afford to then you're going to kill yourself, I'm sure". Many people qualified their statements about addiction by saying that they felt it was more likely to occur in those who were either free-basing or injecting the drug.

Thirteen respondents mentioned the state of mind cocaine produced, though not necessarily as a result of being dependent, as a negative effect. Some saw this just in terms of producing an arrogance or self-assuredness:

I think because of that cockiness and over-confidence that people tend to get with cocaine that you become extremely arrogant and not a particularly fun type of person to be with.

Others saw the self-deception as dangerous and a cause of many problems. This statement summarised the situation well:

A real side effect of cocaine is that delusion, that delusion that you're having a good time, delusions of grandeur and also the delusion that you are making really informed "on the ball" decisions.

Five respondents pointed to negative physical reactions such as the increased heart rate and nasal irritations and eight respondents believed there were no adverse effects at all in using cocaine. Comments were from these people were along the lines that "I don't see it as addictive" and that there "were no bad effects except for the price".

At a more practical level, sixty-four per cent said the purity (or lack of it) of street cocaine was a cause for concern because of the unknown additives. It was acknowledged by all that cocaine was always cut, usually with speed or sugars, but it

was the fear of having something like Ajax in it which was the basis for concern. Those with no concern felt that way because they invariably received or bought their cocaine from trusted sources.

At this point a skeptical reader of this might suggest that simply knowing about the ill effects of a drug counts for nothing: many users simply delude themselves by thinking such harmful effects would never happen to them. Of course there is an element of truth in such an argument because some people who are dependent on substances refuse to admit it and maintain they are just recreational users. What must be remembered is that the users in the present study have almost without exception maintained controlled use for some time and thus for this group, awareness of adverse effects is more likely to act as a reinforcer for their usage levels.

As far as user's personal negative reactions are concerned, few experienced such effects. For the majority, negative reactions were limited to the period immediately following an incident of use - the so-called "come-down". The symptoms were invariably of a minor nature, likened to "hang-over" type effects, and consisted of mild depression, lethargy, irritability and general feelings of being "run down".

Eleven respondents referred to at some stage feeling as though they were "getting in too deep" with cocaine. All reported dealing with these reactions without resorting to professional treatment. A Sydney woman described the effects following a period of sustained use:

Respondent: Yeah, my nostrils and my skin, and you don't get enough sleep, you don't want to eat, you're not hungry.

Interviewer: What effect did that have overall?"

Respondent: Well, I lost quite a bit of weight during that time and my nose hurt a lot!

A Canberra woman spoke of the "psychotic moods" she experienced although "nobody believes they're doing it". Most talked in general terms about their ability to cope with the perception that one might become dependent on cocaine. One respondent said that it had "got out of hand - it was threatening my family and work; I had to cut down". A woman from Melbourne felt as though she was becoming addicted so she just stopped using it for around a year. She subsequently resumed use and has had no further problems. A number of people described some sort of self survival instinct, as this man stated:

I've been using a variety of drugs for long enough to know I can stop at the point where I think that I might be going overboard.

Another spoke of a kind of "powerbroker" within himself:

I've got this thing which has probably kept me alive until this point, sort of a powerbroker, something goes click and you say that's it, time to stop .... and I don't like the effects of addiction to anything.

While the vast majority of subjects in this study did not report any severe adverse effects, they were able to point to others who they believed used too much cocaine. Fifty-five respondents (75%) knew of at least one person who was in such a position and sixty-seven per cent of these knew two or more (see Table 6.8 for the distributions). There was a range of behaviours which made respondents aware of another's 'problem' use. Obviously physical factors were what many respondents based their judgements on, as the following statement exemplifies: "I wouldn't say actually addicted. I'd just say totally run down .... this friend of mine, every time I see him he's looking worse and worse". The financial aspect was what made many suspect friends of using excessively: "he was getting financially involved to the point where he was submerged in that thing. I told him and I warned him, be careful, and not long afterwards he stopped". The mental problems were identified as a predominant factor, especially by those who were well acquainted with a problem user. The following two quotes are illustrative of this point:

Well to me, they become paranoid, they become superficial, they lose their depth of feeling. They generally become people that I don't want to have much to do with. Because you can't separate the person from the drug. They become anxious .... and so they are people you can't trust. You never know where you're at with them.

They go crazy, they just lose touch, they go crazy, .... they lose weight, they get really strung out, .... they start thinking and they get of course the main symptom which is paranoia ..... and then weird stuff, you know, lies. I don't mean just financial ones but just weird lying and weird behaviour and then sort of physical and mental collapse. And I've seen that happen three or four times. Classic in the extreme!

**Table 6.8 Number Of People Known Who Use Too Much Cocaine**

<u>NUMBER KNOWN</u>	<u>FREQUENCY</u>	<u>PERCENTAGE</u>
ONE PERSON	18	32.7
TWO PEOPLE	10	18.2
THREE-FIVE PEOPLE	5	9.1
"A FEW"	22	40.0

The fact that users were aware of the adverse effects of cocaine use did not mean they agreed with the government's view of cocaine as a dangerous drug which is highly addictive. A slight majority of respondents (51%) expressed some degree of doubt over this portrayal. It was seen as a gross exaggeration and certainly not applicable to the majority of people using cocaine. One respondent was particularly adamant when he stated "they are way off beam about it, they're almost hysterical about it .... I just don't think they know very much about it" while another rather skeptical view was that "I reckon they're (the government) are probably pissed off because they can't tax it".

There was also the opinion that it was mis-placed emphasis to focus on the drugs themselves as dangerous; this comment from a Canberra respondent: "I don't think that in any of the illicit drugs there is anything particularly inherent in the drugs themselves that cause many of its effects". Others went so far as to suggest the real danger was in the government propagating mis-information, as this respondent pointed out:

Quite frankly I think that the way they've portrayed it is more dangerous than anything. I think half the attraction of illicit drugs is simply the fact that they are illicit.

**Table 6.9 Attitudes To Government Portrayal Of Cocaine As A Dangerous Drug**

<u>ATTITUDE</u>	<u>FREQUENCY</u>	<u>PERCENTAGE</u>
STRONGLY AGREE	8	11.0
AGREE	18	24.5
NEITHER	10	13.5
DISAGREE	29	40.0
STRONGLY DISAGREE	8	11.0

There was a strong feeling that other drugs, especially licit ones such as alcohol and tobacco, were equally as harmful as cocaine. The Australian government's National Campaign Against Drug Abuse came in for a tremendous amount of criticism. It was generally deemed to be a failure, the media advertisements being extremely biased in their depictions, and it was felt the money could have been much better spent in other areas. Finally, a number of people remarked on the disjuncture between the official views and their own using experiences:

Interviewer: Do you agree with the government's line on cocaine as extremely dangerous and highly addictive?

Respondent: No, except that I have I suppose swallowed the official line to the extent that when I began using I had this feeling like I'd be this frenzied idiot for the rest of my life, just craving cocaine, which obviously hasn't happened.

There was a significant proportion of respondents, thirty-five per cent, who were in agreement with the government's position. These were people who felt the addictiveness of cocaine was every bit as bad as the government made out. In fact, a few doubted whether it was possible to have occasional or recreational use at all. A Sydney respondent claimed that:

I guess I don't know anybody who I'd say would be an occasional user. People who use it tend to get into it with a bit of vengeance .... they've either stayed heavy users or they've dropped away from it.

Another in a similar vein:

I think that its not too bad if you're going to have a little dabble once every three or four months at a party but I don't know a lot of people who can do that.

A number of the subjects felt cocaine was the drug with the most potential for harm, as this woman noted "I'd be far more worried about a friend that got into cocaine heavily than a friend who got into heroin heavily". The ten respondents who were undecided felt unable to make a judgement either because of limited experience or limited knowledge of the drug.

## 6.5 GENERAL DRUG ISSUES AND FUTURE USE

In this final section we shall examine matters which might seem somewhat peripheral to controlled drug use yet still give an indication of user attitudes in that direction.

The question of legalising drugs such as marijuana, heroin and cocaine is one that enters most debates about illicit drug use. Popular belief has it that all drug users would have the drugs legalized, and on open sale, in order to facilitate "hassle free" use for themselves. This was not the case for the illicit drug users in this study. As Table 6.10 demonstrates, approximately one third of respondents would have neither cocaine or heroin legally available to the public. While the majority were in favour of de-criminalisation, there was still a sense of precaution in the favouring of registered addict or prescription schemes. Open sale was seen by very few as a viable alternative.

**Table 6.10 Attitudes Toward The Legalisation Of Cocaine And Heroin**

ATTITUDE	COCAINE		HEROIN	
	NO.	%	NO.	%
REMAIN ILLEGAL	24	32.9	21	28.8
OPEN SALE	12	16.4	5	6.8
PRESCRIPTION ONLY	10	13.7	12	16.4
REGISTERED 'ADDICTS'	5	6.8	19	26.0
LEGAL - UNSPECIFIED	18	24.7	14	19.2
UNSURE	4	5.5	2	2.8

Those who were against legalization of cocaine and heroin saw it as a case of "playing with fire". Many were of the opinion that while they themselves were able to control their use of these drugs they were not confident that other people would be as successful in this regard. One respondent thought that with cocaine "its just a dangerous thing .... too dangerous to make legal". Another was particularly against a situation of open sale:

If you could just walk in and buy it all the time I think a lot of people would start getting problems with it. I think it does help some kinds of psychological addiction if you rarely have enough.

A Melbourne man, in referring to heroin, went so far as to suggest "I think it should be heavier (the penalties) .... I think it's shocking stuff".

The arguments in favour of de-criminalization centred on the thesis that illegality itself created most of the problems associated with drug use. "My thoughts on all drugs, if they were part of our culture, part of our general lifestyle, they wouldn't have such ridiculous stigmas attached to them", "there's a real thrill attached to using anything illegal. Like it would break down some of the glamour and mystique if it were legal". One person saw the whole situation as a gross abuse of consumer rights:

When you make something illegal it means there is no marketing control. It means the people get sold bad quality stuff. So they, I mean they're consumers who are being really ripped off in a big way.

It was also pointed out the blatant hypocrisy existing in the law where drugs with proven harms, namely alcohol and tobacco, were still available yet drugs with perhaps less severe long term effects were illegal. As this Canberran succinctly put it: "These things, your little death sticks (cigarettes) are legal. It's crazy!"

The ranking of heroin as a more dangerous drug than cocaine was seen in that only five people thought heroin should be on open sale as compared to twelve for cocaine, and thirty-one believed heroin should be available either through prescription or to registered addicts, compared to only fifteen for cocaine. There was a significant proportion of respondents undecided about how these drugs should be available if they were to be de-criminalized. While the present situation with illegality was obviously not working, they were wary of open sale, felt prescription was too open to abuse and registered addict schemes had proven to be failures overseas.

Another argument concerned the crime and corruption which arises through cocaine and heroin's illegal status. This man made the claim that:

It stinks what its doing to people, really I'd say that nearly every single crime that's committed in Canberra is heroin related, drug related.

On the subject of corruption, sixty-seven respondents (92%) believed corruption in drug trafficking exists. Twenty-five of these said they knew for sure of corruption

taking place, either through first hand experiences or stories told to them from "reliable sources". Most of the incidents involved police and they were identified as the major agents of corruption by eighty per cent of all respondents. For many the situation was simple; take away the illegality and take away the crime and corruption.

One of the more interesting results concerned whether respondents had introduced anyone else to using cocaine. Just over a half said they had done so and the number of people introduced to it were usually no more than one or two. Everyone who had introduced another person to cocaine stressed that it was in no way a matter of "pushing" the drug; no one was ever forced to use the drug. The idea of peer group pressure was also refuted. It was simply a case of offering someone cocaine and if they refused, then fine - "more for everyone else to use!". Generally there were no qualms expressed about it, although this Sydney woman was an exception:

As a general rule I don't like doing that sort of thing, but if someone asks me to show them something, I will. If someone is curious enough about it, they'll ask you.

Those who had never introduced another person to cocaine said it was not as a result of a conscious decision on their part: the opportunity to do so had never arisen.

The final issue concerns whether the subjects see themselves using cocaine five years from now. Sixty (82%) responded in the affirmative. When asked at what levels they saw themselves using, twenty-three (38.3%) said at present levels, thirty-one (51%) at decreased levels and only six (10%) said they anticipated higher levels of use. Obviously this is all conjecture but given that many of our subjects will be earning higher incomes in five years and thus would technically have more money to spend on cocaine, it is interesting that they still see their use as being stable or decreasing. Thus although users point to finances as a limiting factor in their cocaine use, it does appear that concerns over health, available time etc. are equally important.

Many users also had a general conception that drug use was the domain of the young. The view is that drug use tapers off with age as one takes on more responsibilities and basically "settles down". These statements exemplify the point well: "I want to do all these bad things to to my body when I'm young and then when I'm older turn into a health nut", "I think generally as people get older they are much more judicious in what drugs they take and the frequency and situation in which they take those drugs" and "I don't think I'd ever get back into it again. I think as you grow older you start to want a bit more stability. I've had the buzz, I've been there".

Another aspect to this was that cocaine held little fascination or interest any more for many of the subjects. It was a matter of "I can take it or I can leave it" or as this man concluded:

Cocaine, I don't feel strongly about it either way and if I weren't to have any more cocaine I don't feel I would particularly miss it, or you know, be unhappy.

## 6.6 CONCLUSION

It is apparent from the results that despite respondent's general views that a financial concern is the main limiting factor, there are personal attitudes and beliefs which act to control their use of cocaine. In some it was described as a basic 'survival instinct' while for others it was seen as only a small, relatively insignificant part of their lives. It is seen as enjoyable thing to do but not to the extent that it assumes prominence over other parts of their lives. Even within the financial constraints were certain notions of disposable income and limited sources which acted towards control.

In this sense the findings return the emphasis to "set" variables ie. characteristics of the user personality. This may have been a result of bias in questions which tended to focus on the individual level, but there were many questions which gave respondents the opportunity to describe their social setting for drug use. It does appear as if users bring certain beliefs to their drug use which enables them to maintain control over that drug use.

# CHAPTER SEVEN

## RESEARCH CONCLUSIONS

### 7.1 INTRODUCTION

What are the conclusions to be reached at the end of this research?

To begin with, some comment can be made upon what cocaine use in Australia looks like, both in terms of demographic characteristics of the users and in the way cocaine is consumed by them. What emerges as a fundamental issue is the way cocaine users do not resemble the traditional stereotypes of; (1) all illicit drug users as "sick" individuals, both in a physical and psychiatric sense, who require medical help to enable them overcome their "abuse" of drugs, and; (2) cocaine users as members of the "glitterati" or "fast lane" sets. The overall picture is of an activity which fits in very closely with everyday life as a "normal" leisure pursuit.

In relation to the basic aim of the thesis, understanding how people are able to achieve and maintain controlled use of cocaine, the results point to two important processes at work. In terms of "set" variables, there are basic attitudes and beliefs held by the users on a range of issues, both directly and indirectly related to their use, which all act towards control. In terms of drug "setting", the important feature is the way cocaine use becomes a part of established friendship networks, rather than friendship networks being based around cocaine use, or illicit drug use in general.

In analysing these basic conclusions, the chapter is divided into three sections.

The first section draws out the comparisons between the present study and previous empirical research overseas. While there are a number of similarities in the findings, a major difference lies in the more skeptical views Australian cocaine users hold toward the drug than their overseas counterparts.

The second section examines how the research provides further evidence to negate the "drug abuse" conceptions surrounding illicit drug use. Part of this involves laying to rest the belief that drug use, by definition, implies some social or personal deficiency in the individual.

In the final part, the policy implications and directions for future research are examined. There is evidence to support both a continuation of present policy, in terms of restriction and prevention of supply, and the development of a new approach centred on de-criminalisation. As far as future research is concerned, there is obviously still a great need to chart the basic usage patterns of illicit drug users.

## **7.2 COMPARISONS WITH OVERSEAS RESEARCH**

It is possible to draw many parallels between the usage patterns of Australian cocaine users and those documented in overseas research.

The major link with Ronald Siegel's study of Californian users (Siegel, 1984) was on the issue of the negative consequences of use. As with Siegel's group, the Australian sample experienced very few adverse effects from using cocaine, and those who did were able to deal successfully with them without resorting to professional treatment. In both samples, users employed such practices as restricting the amount of cocaine used at a time or, more commonly, simply refraining from use for a period of time.

Where the present study differed from Siegel's was that the respondents here had a generally more negative outlook on cocaine. As one of the respondents so aptly put it, "you have to think hard about the good points" of cocaine. What does emerge is that as users become acquainted with cocaine, far from becoming enchanted with the drug, they tend to become more disenchanted with it and emphasise the negative aspects to its use.

This was also seen in the way Australian respondents possessed an awareness of the "medical facts" surrounding cocaine use. As well as knowing basic negative effects, comments were frequently made about addiction (differences between physical and psychological addiction) and dependency. Some respondents said they actually read up on the drug before becoming involved with it. So while users often upheld the so-called "myths of cocaine" they were also very aware of the "truths". The Spotts and Shontz study of nine "representative" cases (Spotts and Shontz, 1980) also located a high degree of awareness in their subjects of the potential dangers in cocaine use.

The social setting for cocaine use found here, namely in social situations with friends, was closely approximated in both The Toronto and Amsterdam studies. In

Toronto higher numbers used the drug in the workplace and twenty-three per cent used the drugs as a means to relax (Smart et al, 1984). In contrast, no Australians suggested that cocaine was a drug to relax with: this was seen as a complete waste of the drug. One of the interesting features from Amsterdam was that users identified adherence to inhalation as an important facet of their self-control (Cohen, 1987). While inhalation was the principal route of administration in Australia, it did not appear to figure in conscious attitudes toward control.

In terms of control style, the cocaine users here appeared to rely heavily on internal standards of control. While Apsler suggested that such users were more likely to experience problems with their drug use, this does not appear to be the case with our sample. Now it is not possible to generalize from the limited sample but as stated above, it does appear as if such internal standards, or set variables as Zinberg terms them, are of great importance in controlled drug use.

### **7.3 REJECTION OF THE "DRUG USER AS PATHOLOGICAL" PERSPECTIVE**

The basis of this research was that traditional views on the "drug problem" and "drug abuse" had prevented understanding of the reality of drug use. Awareness of this process of mystification was what guided the development of the controlled drug use perspective and the subsequent emphasis upon the factors of "drug, set and setting".

While there can be no denying that the majority of users of any drug are not addicts/dependents and do not experience problems with their use (ie. reporting for medical attention of one kind or another), the view of "drug user as deviant or sick person" could still hold true if it were possible to demonstrate some social or personality deficiency in illicit drug users. Perhaps some moral conservatives would suggest the simple fact that someone uses an illicit drug is enough to identify them as "sick" or "deviant", but as was pointed out in Chapter One, social, economic and political interests were behind the construction of cocaine as an "evil" drug, rather than any inherent properties in the drug itself (a process equally applicable to almost any drug), which rather undermines this moralist position.

The conclusion from the research was that no such social or personal deficiencies were evident in the cocaine users. On a range of health, personality and social measures, the cocaine users emerged as a group of healthy, well adjusted, happy and socially capable people. They also compared favourably with the general

population samples taken from the National Social Science Survey. The notable differences were in terms of age structure, marital status, religious affiliation, politics and social outlook: hardly variables from which an argument about personality deficiency could be constructed.

The issue of control also fits the pattern. Again, an argument about pathology could be made if it were possible to demonstrate that the cocaine users had a tenuous hold on controlled drug use. The evidence though was of fairly stable use patterns maintained over time, with personal belief systems that guided and restricted their use of cocaine. Illicit drug use was, on the whole, seen as a minor, enjoyable part of the individual's life and unlikely to become a predominant factor in it.

Given the general picture of "normality" which surrounds cocaine use, one might be tempted to conclude that there is really nothing to explain, or a problem worth investigating here: illicit cocaine use is simply a part of day-to-day life and much like many other "entertainments". We might just as well study people's predilection for watching video movies, and how they control this, as study recreational illicit drug use. At one level this is correct, and Stephen Mugford has developed a perspective where a number of leisure activities can be understood through analysing the "growth of modernity, the development of hedonism and the performing self, the commodification of time and leisure and the growth of entertainment" (Mugford, 1988: 31). The point to be stressed though is that cocaine does have the potential for serious adverse effects if used to excess, and thus understanding how its use is controlled is of far more importance than understanding something like how people stop themselves from watching five videos a night.

#### **7.4 POLICY IMPLICATIONS AND DIRECTIONS FOR FUTURE RESEARCH**

The fact that user's point to financial concerns does have some interesting implications from a policy viewpoint. While attempts at preventing drugs from entering the country are often seen as futile, it would appear that the fact that cocaine is not abundant in Australia, and therefore the price remains high (cocaine in the U.S. is approximately \$100), and acts as a controlling factor for the user, means that pursuing import restriction of the drug is perhaps a means of preventing Australia having the chance to develop problems along the lines of the U.S. While this may be practical in the short term, it is probably inadvisable in the long term. The reason being that if

organised crime were to concentrate upon the importation of cocaine, then, as has been witnessed with heroin, there is little chance of preventing large quantities of the drug from entering the country.

The former approach is very much one of "closing your eyes and hoping the problem will go away". A far more positive approach, and one supported by the present study, is to look at de-criminalization. What our research shows, in respect of this, is that having cocaine more freely available would not necessarily produce higher levels of use. Realistically, upon de-criminalizing the drug there would probably be a sharp increase in the number of users, but once the 'novelty' factor had lapsed, one could expect levels at not much higher than present, because to a great extent people who wish to use cocaine at present, do so - the drug's illegal status does not stop people from acquiring and using it.

As far as de-criminalization resulting in more people experiencing problems with cocaine, again, the evidence with present users does not support this. The cocaine users in the study were generally satisfied with their levels of use and when questioned about what levels they would maintain if cocaine were more easily obtained, few saw it having a tremendous impact. Remembering as well that respondents held very definite views about health concerns and keeping cocaine as a minor part of their social lives (the "compartmentalization" of drug use), then the assumption that legalisation automatically produces a "cocaine epidemic" seems unfounded.

The other major policy implication from the study was in terms of drug education programmes. The cocaine users felt that the present National Campaign Against Drug Abuse was out of touch with their reality of drug use and that it was a waste of time and money. The problem seems to lie in treating illicit drug users as "naughty children, playing with fire", which is how the Campaign was generally perceived. Programmes aimed at users would do better to present realistic appraisals of drug use than concentrating on the dire warnings about the great dangers of addiction.

From this discussion it follows that future research must be aimed at building the knowledge base on illicit drug use, in order that intelligent, well-informed policy decisions can be made. It is a damning comment that the major Australian governmental inquiries into drug use were unable to make any reasoned analysis of the extent of illicit drug use because of a simple lack of information on the subject. While efforts are being made, as witnessed by the present study, there is still a large number of un-knowns to be examined. For example, a longitudinal project charting illicit drug use over a period

of years, along the lines of Siegel's research in California, would be of immense value here. In general terms, a great deal of re-thinking must take place before the mystifications and mis-information surrounding drug use can be allayed: understanding controlled drug use is central to that process.

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APPENDIX ONE

Please do not put your name or address on this questionnaire. All material is collected anonymously and treated in strictest confidence.

THE SOCIAL USE OF COCAINE  
A RESEARCH PROJECT

PART I : BACKGROUND QUESTIONNAIRE

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## GENERAL ARRANGEMENTS

Participants in this research project will be asked to undertake two tasks. Part I involves the completion of this questionnaire, and Part II is an interview. Interviewers will arrange to collect Part I before, or at the commencement of, Part II.

On completion of both parts of their participation, interviewees will receive the sum of \$50 as a recognition of the time taken to help with the project and their provision of valuable data.

### The aims of the research

The aim of this project is to describe the social context within which cocaine is used. Many people are interested in the significance of this particular drug, but ignorance about it is vast, and useful information scanty. Dubious 'facts' are circulated, often of little more value than "take away the number you first thought of", and then hashed and re-hashed. Information that surfaces through medical or legal sources (which may be highly untypical of most users/usage) is extrapolated wildly and often irresponsibly.

In the present project we hope to redress the balance by providing reliable and objective data collected from a much wider range of people who have, at some point in time, used cocaine. The project has two parts, a questionnaire, and an interview. The purpose of the questionnaire is to collect "background" information about our respondents. This centres on routine questions (mostly unrelated to drug use) that we gather on all sorts of projects. The interview, which will be done after the questionnaire is completed, will cover the more focussed questions about cocaine itself.

### The Questionnaire

The following questionnaire is divided into several sections. Please work through at your leisure filling out the answers. Many of these questions concern matters of fact which we ask you to report on to the best of your recollection. No one is perfect and everyone makes some mistakes, so don't worry if you can't always be absolutely sure about your answer. If in doubt put your best guess - this will be much more use than leaving the response blank.

Other questions concern some ideas or opinions you may have. Remember that for these questions there is no "right" or "proper" answer. We want to know what you think, not what the common belief is. Your opinion (rather than public opinion) is what we seek, and this is why we do a survey of people who have access to information different from what "everybody knows".

### About the answers

1. Please answer as many questions as you can. No questions are obligatory, of course, but the more you can complete the better picture we can get.
2. Where you can answer, either
  - a. Circle the number of the response that best relates to you; or
  - b. Place a number or a few words in the space provided.
3. ALL RESPONSES AND ALL DETAILS REMAIN ABSOLUTELY CONFIDENTIAL AND ANONYMOUS.

Thank you for your co-operation.

OFFICE USE  
ONLY

Start Card I  
I.D.

1-3

SECTION I  
HEALTH AND WELLBEING

1. In the past six months have you suffered from the following? (circle a number)

	<u>Often</u>	<u>Sometimes</u>	<u>Never</u>
i) Rapid or missing heart beats	1	2	3
ii) Excessive sweating	1	2	3
iii) Indigestion	1	2	3
iv) Nausea and/or vomiting	1	2	3
v) Diarrhoea	1	2	3
vi) Constipation	1	2	3
vii) Headaches or migraine	1	2	3
viii) Body aches and pains	1	2	3
ix) Dizziness and fainting	1	2	3
x) Severe fatigue/exhaustion	1	2	3
xi) Shaking/trembling	1	2	3
xii) Cramps	1	2	3
xiii) Stomach pains	1	2	3
xiv) Dermatitis	1	2	3
xv) (Women only) Menstrual pain	1	2	3

4

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18

2. Has your doctor diagnosed and treated you for any of the following conditions in the last 5 years?

	<u>Yes</u>	<u>No</u>
i) High Blood Pressure	1	2
ii) Heart disease	1	2
iii) Kidney or bladder trouble	1	2
iv) Lung or breathing problems	1	2
v) Blood clot	1	2
vi) Gall bladder, liver or pancreas problems	1	2
vii) Insomnia	1	2
viii) Stomach problems/ulcer	1	2
ix) Anxiety state	1	2
x) Depression	1	2
xi) Bowel disorders (e.g. Ulcerative Colitis etc.)	1	2

19

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28

29

The next section looks at general items of health over the past few weeks.  
(Please circle the answer you feel most nearly correct.)

HAVE YOU RECENTLY:

Been feeling perfectly well and in good health?	Better than usual	Same as usual	Worse than usual	Much worse than usual	<input type="checkbox"/> 30
Lost much sleep over worry?	Not at all	No more than usual	Rather more than usual	Much more than usual	<input type="checkbox"/> 31
Been feeling nervous and strung-up all the time?	Not at all	No more than usual	Rather more than usual	Much more than usual	<input type="checkbox"/> 32
Been getting scared or panicky for no good reason?	Not at all	No more than usual	Rather more than usual	Much more than usual	<input type="checkbox"/> 33
Found everything getting on top of you?	Not at all	No more than usual	Rather more than usual	Much more than usual	<input type="checkbox"/> 34
Found at times you couldn't do anything because your nerves were too bad?	Not at all	No more than usual	Rather more than usual	Much more than usual	<input type="checkbox"/> 35
Found yourself wishing you were dead and away from it all?	Not at all	No more than usual	Rather more than usual	Much more than usual	<input type="checkbox"/> 36
Found that the idea of taking your own life kept coming into your mind?	Not at all	No more than usual	Rather more than usual	Much more than usual	<input type="checkbox"/> 37
Been feeling in need of a good tonic?	Not at all	No more than usual	Rather more than usual	Much more than usual	<input type="checkbox"/> 38
Been feeling run down and out of sorts?	Not at all	No more than usual	Rather more than usual	Much more than usual	<input type="checkbox"/> 39
Felt that you are ill?	Not at all	No more than usual	Rather more than usual	Much more than usual	<input type="checkbox"/> 40
Been able to enjoy your normal day-to-day activities?	Not at all	No more than usual	Rather more than usual	Much more than usual	<input type="checkbox"/> 41
Been thinking of yourself as a worthless person?	Not at all	No more than usual	Rather more than usual	Much more than usual	<input type="checkbox"/> 42
Felt that life is entirely hopeless?	Not at all	No more than usual	Rather more than usual	Much more than usual	<input type="checkbox"/> 43
Felt that life isn't worth living?	Not at all	No more than usual	Rather more than usual	Much more than usual	<input type="checkbox"/> 44
Thought of the possibility that you might do away with yourself?	Definitely not	I don't think so	Has crossed my mind	Definitely have	<input type="checkbox"/> 45
Been getting any pains in your head?	Not at all	No more than usual	Rather more than usual	Much more than usual	<input type="checkbox"/> 46
Been getting a feeling of tightness or pressure in your head?	Not at all	No more than usual	Rather more than usual	Much more than usual	<input type="checkbox"/> 47

Been having hot or cold spells?	Not at all	No more than usual	Rather more than usual	Much more than usual	<input type="checkbox"/> 48
Been managing to keep yourself busy and occupied?	More so than usual	Same as usual	Rather less than usual	Much less than usual	<input type="checkbox"/> 49
Been taking longer over the things you do?	Quicker than usual	Same as usual	Longer than usual	Much longer than usual	<input type="checkbox"/> 50
Felt on the whole you were doing things well?	Better than usual	About the same	Less well than usual	Much less well	<input type="checkbox"/> 51
Been satisfied with the way you've carried out your tasks?	More satisfied	About same as usual	Less satisfied than usual	Much less satisfied	<input type="checkbox"/> 52
Felt that you are playing a useful part in things?	More so than usual	Same as usual	Less useful than usual	Much less useful	<input type="checkbox"/> 53
Felt capable of making decisions about things?	More so than usual	Same as usual	Less so than usual	Much less capable	<input type="checkbox"/> 54
Had difficulty in staying asleep once you are off?	Not at all	No more than usual	Rather more than usual	Much more than usual	<input type="checkbox"/> 55
Felt constantly under strain?	Not at all	No more than usual	Rather more than usual	Much more than usual	<input type="checkbox"/> 56
Been getting edgy and bad-tempered?	Not at all	No more than usual	Rather more than usual	Much more than usual	<input type="checkbox"/> 57

4. Considering yourself in comparison with other people of the same age and sex as yourself, how would you rate your health? (Circle the appropriate number.)

Excellent	(Well above average)	1	
Good	(About or a little above average)	2	
Fair	(A little below average)	3	
Poor	(Definitely below average)	4	<input type="checkbox"/> 58

5. Now a few questions about how you feel things usually work out for you. (Circle the appropriate number.)

a. Have you usually felt pretty sure your life would work out the way you want it to, or have there been times when you haven't been very sure about it?

Usually pretty sure . . . . .	1
Sometimes not very sure . . . . .	2

 59

b. Do you feel you are the kind of person who gets his or her share of bad luck, or do you feel that you have mostly good luck?

Mostly <u>good</u> luck . . . . .	1
Mostly <u>bad</u> luck . . . . .	2

 60

c. When you make plans, do you usually carry things out as expected, or do things come up and make you have to change your plans?

Usually carry out things as expected . . . 1  
 Things come up and change plans . . . . 2

61

d. Some people feel they can run their lives pretty much the way they want to. Others feel that the problems of life are too big for them. Which one are you most like?

Can run own life . . . . . 1  
 Problems of life are too big . . . . . 2

62

e. Taking all things together, how would you say things are these days, would you say you're ...

Very happy . . . . . 1  
 Fairly happy . . . . . 2  
 Not too happy . . . . . 3

63

For each area of life listed here, write in the number that shows how much satisfaction you get from that area.

Dissatisfied					Satisfied	Not Applicable
1	2	3	4	5	6	

HOW MUCH SATISFACTION?  
Please circle a number

- a. How satisfied or dissatisfied are you with your spare time activities, the things you do in your non-working time? 1 2 3 4 5 6  64
- b. Your friends and friendships 1 2 3 4 5 6  65
- c. How interesting your day-to-day life is? 1 2 3 4 5 6  66
- d. How much fun you are having? 1 2 3 4 5 6  67
- e. The variety and diversity of your life? 1 2 3 4 5 6  68
- f. Your sense of purpose and meaning in life? 1 2 3 4 5 6  69
- g. Yourself -- what you are accomplishing and how you handle problems? 1 2 3 4 5 6  70
- h. Your children? 1 2 3 4 5 6  71
- i. Your marriage? 1 2 3 4 5 6  72
- j. Your sex life? 1 2 3 4 5 6  73
- k. Your health and physical condition 1 2 3 4 5 6  74
- l. Your physical fitness and the exercise you get? 1 2 3 4 5 6  75
- m. Your income and financial situation? 1 2 3 4 5 6  76
- n. Your housework -- the work you do around the house? 1 2 3 4 5 6  77
- o. Your home life, your family life? 1 2 3 4 5 6  78
- p. Your standard of living -- the things you have, like a car, appliances, and so on 1 2 3 4 5 6  79
- q. All things considered, how satisfied or dissatisfied are you with your life as a whole 1 2 3 4 5 6  80

SECTION 2

WORK

7. ... Last week what were you doing? (Circle one code only)

- Working full-time for pay . . . . . 1
- Working part-time for pay . . . . . 2
- With a job but not at work because of temporary  
illness, vacation, or strike . . . . . 3
- Unemployed, laid-off, looking for work . . . . . 4
- Retired . . . . . 5
- In school . . . . . 6
- Keeping house . . . . . 7

Other (Specify) \_\_\_\_\_

4

8. Now we have some questions about the work you are doing now, your occupation now.

If you are not working for pay now, please describe your last regular job

If you have never worked for as long as 1 year, please write "NA"

a. How many hours do you usually work in the average week?

WRITE NUMBER OF HOURS . . . . . \_\_\_\_\_  
hours

5-6

b. Was there more work available on your job so you could have worked longer hours for more pay, if you had wanted to?

- Yes . . . . . 1
- No . . . . . 2

7

c. Would you have liked to work more for extra pay, if you could have? (Not at penalty or overtime rates, but at your regular rate of pay.) How many more hours per week?

- No, no more . . . . . 98
- Yes: please write in how many  
more hours per week . . . . . \_\_\_\_\_  
hours

8-9

d. Would you have preferred to work less even if you earned less money? (How many hours less?)

- No, not less . . . . . 98
- Yes, prefer to work fewer hours  
(Please write in how many  
hours fewer). . . . . \_\_\_\_\_  
hours

10-11

e. What kind of work do you do? (What is your occupation called?)

DESCRIBE FULLY, USING 2 WORDS OR MORE (Do not use initials or abbreviations)

WHERE POSSIBLE, INCLUDE AWARD OR GOVERNMENT DESIGNATION

Occupation: \_\_\_\_\_

12

13

14

f. Do you work for a private company or what?

- Employee of a private company or business,  
working for wages or salary . . . . . 1
- Australian/Commonwealth/Federal Government employee . . . . . 2
- State Government employee . . . . . 3
- Local Government employee . . . . . 4
- Working without pay on a family business or farm . . . . . 5
- Self-employed; in partnership; conducting own business . . . . . 6
- Other (SPECIFY) \_\_\_\_\_

 15

g. Do you have a supervisor on your job to whom you are directly responsible?

- No . . . . . 1
- Yes . . . . . 2

 16

h. If so, does that person have a supervisor on the job to whom s/he is directly responsible?

- No . . . . . 1
- Yes . . . . . 2

 17

i. In your job, do you supervise anyone who is directly responsible to you?

- No . . . . . 1
- Yes . . . . . 2

 18

j. Do any of those persons supervise anyone else?

- No . . . . . 1
- Yes . . . . . 2

 19

Now some more questions about your work.

If you are a housewife, please answer about the work you do around the house.

If you are a student, please answer about your schooling.

The more satisfied you are, the higher the number you will give.

Dissatisfied					Satisfied
1	2	3	4	5	

- |   | Dissatisfied |   |   |   |   | Satisfied                   |
|---|--------------|---|---|---|---|-----------------------------|
| a. First, how satisfied or dissatisfied are you with the <u>importance</u> of your work and the feeling of accomplishment it gives you? | 1            | 2 | 3 | 4 | 5 | <input type="checkbox"/> 20 |
| b. The chance you get to use your skills and abilities?   | 1            | 2 | 3 | 4 | 5 | <input type="checkbox"/> 21 |
| c. How <u>interesting</u> your work is, and the enjoyment you get from it? (How satisfied or dissatisfied are you with that?)           | 1            | 2 | 3 | 4 | 5 | <input type="checkbox"/> 22 |
| d. The <u>security</u> and <u>predictability</u> of your future? (How satisfied or dissatisfied?)                                       | 1            | 2 | 3 | 4 | 5 | <input type="checkbox"/> 23 |

- e. The people you meet at work?  
(Housewives: the people you meet during the week) 1 2 3 4 5  24
- f. The amount of money that you earn from your work 1 2 3 4 5  25
- g. The amount of pride you can take in your work? 1 2 3 4 5  26
- h. The amount of say you have in decisions at work? 1 2 3 4 5  27
- i. All in all, how satisfied are you with the work you do? 1 2 3 4 5  28

10. Do you belong to a trade union?

- No . . . . . 1
- Yes . . . . . 2  29

11. Different people may look for different things in their work. How important are each of the following things for you?

- 1 The most important single thing
- 2 Extremely important
- 3 Very important indeed
- 4 Fairly important
- 5 Not important
- 6 Irrelevant, neither good nor bad
- 7 Undesirable, a bad thing

- |   | <u>IMPORTANCE</u> |   |   |        |   |   |             |                             |
|---|-------------------|---|---|--------|---|---|-------------|-----------------------------|
|   | The most          |   |   | Fairly |   |   | A bad thing |                             |
| a. A job that provides a high income how important is that?                             | 1                 | 2 | 3 | 4      | 5 | 6 | 7           | <input type="checkbox"/> 30 |
| b. A job that offers a reasonably secure, predictable future?                           | 1                 | 2 | 3 | 4      | 5 | 6 | 7           | <input type="checkbox"/> 31 |
| c. A job which is interesting to do?  | 1                 | 2 | 3 | 4      | 5 | 6 | 7           | <input type="checkbox"/> 32 |
| d. Work which is important and gives a feeling of accomplishment?                       | 1                 | 2 | 3 | 4      | 5 | 6 | 7           | <input type="checkbox"/> 33 |
| e. A job which gives you a chance to make friends?                                      | 1                 | 2 | 3 | 4      | 5 | 6 | 7           | <input type="checkbox"/> 34 |
| f. A job which uses your skills and abilities - lets you do the things you can do best? | 1                 | 2 | 3 | 4      | 5 | 6 | 7           | <input type="checkbox"/> 35 |

SECTION 3

SOCIAL ISSUES

Here are some views on social and political issues that people think are important in Australia today. Please show whether you agree or disagree with each view by circling the word that comes closest to your own opinion.

Yes!!	--	if you strongly agree
Yes	--	if you agree
??	--	if you neither agree nor disagree
No	--	if you disagree
No!!	--	if you strongly disagree

Please circle a whole word

- |    |  |       |     |    |    |      |                          |    |
|----|--|-------|-----|----|----|------|--------------------------|----|
| a. | Big business in this country has too much power  | Yes!! | Yes | ?? | No | No!! | <input type="checkbox"/> | 36 |
| b. | Employees should be given equal representation with shareholders on the boards of large companies                                      | Yes!! | Yes | ?? | No | No!! | <input type="checkbox"/> | 37 |
| c. | Stronger government control should be exercised over the activities of multi-national companies  | Yes!! | Yes | ?? | No | No!! | <input type="checkbox"/> | 38 |
| d. | Rich people should be taxed more heavily than they are now   | Yes!! | Yes | ?? | No | No!! | <input type="checkbox"/> | 39 |
| e. | If a migrant and someone born in Australia both apply for a job, the Australian should be given preferential treatment                 | Yes!! | Yes | ?? | No | No!! | <input type="checkbox"/> | 40 |
| f. | Stronger measures should be taken to protect the environment against pollution   | Yes!! | Yes | ?? | No | No!! | <input type="checkbox"/> | 41 |
| g. | Our industries need stronger protection against imports from abroad  | Yes!! | Yes | ?? | No | No!! | <input type="checkbox"/> | 42 |
| h. | Australia should mine uranium and sell it on the world market  | Yes!! | Yes | ?? | No | No!! | <input type="checkbox"/> | 43 |
| i. | Australia's uranium should stay in the ground  | Yes!! | Yes | ?? | No | No!! | <input type="checkbox"/> | 44 |
| j. | Government funds for education should go to State (government) schools only  | Yes!! | Yes | ?? | No | No!! | <input type="checkbox"/> | 45 |
| k. | When the Commonwealth provides revenue to the States, it should give greater assistance to <u>poor States</u> than to <u>rich</u> ones | Yes!! | Yes | ?? | No | No!! | <input type="checkbox"/> | 46 |
| l. | Generally speaking, those we elect to Parliament in Canberra lose touch with the people pretty quickly                                 | Yes!! | Yes | ?? | No | No!! | <input type="checkbox"/> | 47 |
| m. | Public servants don't care much about what people like me think  | Yes!! | Yes | ?? | No | No!! | <input type="checkbox"/> | 48 |
| n. | Thinking about all the different kinds of government in the world today, communism must be one of the very worst kinds                 | Yes!! | Yes | ?? | No | No!! | <input type="checkbox"/> | 49 |
| o. | Too many migrants have been let into this country  | Yes!! | Yes | ?? | No | No!! | <input type="checkbox"/> | 50 |
| p. | Only English speaking migrants should be allowed into Australia  | Yes!! | Yes | ?? | No | No!! | <input type="checkbox"/> | 51 |
| q. | Migrants should be encouraged to keep their ethnic identities in Australia   | Yes!! | Yes | ?? | No | No!! | <input type="checkbox"/> | 52 |

13. Here are some things the government might do. Some people are in favour of them and others opposed. How do you feel?

Please show how you feel by circling a number after each question.

- |                                 |
|---------------------------------|
| 1 Strongly in favour            |
| 2 In favour                     |
| 3 Neither in favour nor against |
| 4 Opposed                       |
| 5 Strongly opposed              |

Please circle a number

- |   |   |   |   |   |   |                          |    |
|---|---|---|---|---|---|--------------------------|----|
| a. First, giving stiffer sentences to people who break the law. (Are you in favour or opposed?)                         | 1 | 2 | 3 | 4 | 5 | <input type="checkbox"/> | 53 |
| b. The death penalty for persons convicted of murder  | 1 | 2 | 3 | 4 | 5 | <input type="checkbox"/> | 54 |
| c. Legalizing the use of marijuana (Are you in favour or opposed?)  | 1 | 2 | 3 | 4 | 5 | <input type="checkbox"/> | 55 |
| d. Making divorce more difficult to obtain  | 1 | 2 | 3 | 4 | 5 | <input type="checkbox"/> | 56 |
| e. A free health service provided by the government   | 1 | 2 | 3 | 4 | 5 | <input type="checkbox"/> | 57 |
| f. Stricter laws protecting the public against fraudulent selling and misleading advertising                            | 1 | 2 | 3 | 4 | 5 | <input type="checkbox"/> | 58 |
| g. Abolishing compulsory voting, so that people don't have to vote in federal and state elections if they don't want to | 1 | 2 | 3 | 4 | 5 | <input type="checkbox"/> | 59 |
| h. Increasing opportunities for women in business and industry  | 1 | 2 | 3 | 4 | 5 | <input type="checkbox"/> | 60 |
| i. Re-distributing income and wealth in favour of ordinary working people   | 1 | 2 | 3 | 4 | 5 | <input type="checkbox"/> | 61 |
| j. Cuts in tax rates for everybody  | 1 | 2 | 3 | 4 | 5 | <input type="checkbox"/> | 62 |
| k. Government ownership of big industries such as steel   | 1 | 2 | 3 | 4 | 5 | <input type="checkbox"/> | 63 |

14. We are faced with many problems in this country, none of which can be solved easily or inexpensively. We would like to know if you think we're spending too much money, too little money, or about the right amount on them.

Please show what you think by circling a number after each question.

- |                          |
|--------------------------|
| 1 Far too much           |
| 2 Too much               |
| 3 About the right amount |
| 4 Too little             |
| 5 Far too little         |

SPENDING

Please circle a number

- |   |   |   |   |   |   |                          |    |
|---|---|---|---|---|---|--------------------------|----|
| a. First, improving roads and highways -- are we spending too much or too little? | 1 | 2 | 3 | 4 | 5 | <input type="checkbox"/> | 64 |
| b. How about foreign aid?   | 1 | 2 | 3 | 4 | 5 | <input type="checkbox"/> | 65 |
| c. The military, armaments and defence?   | 1 | 2 | 3 | 4 | 5 | <input type="checkbox"/> | 66 |

d. Improving the nation's education system -- are we spending too much or too little on that?	1	2	3	4	5	<input type="checkbox"/>	67
e. Improving and protecting the environment?	1	2	3	4	5	<input type="checkbox"/>	68
f. Scientific research and new technology?	1	2	3	4	5	<input type="checkbox"/>	69
g. Pensions and other social services?	1	2	3	4	5	<input type="checkbox"/>	70
h. Improving the conditions of Aborigines?	1	2	3	4	5	<input type="checkbox"/>	71
i. Providing assistance for the unemployed?	1	2	3	4	5	<input type="checkbox"/>	72
j. Improving and protecting the nation's health	1	2	3	4	5	<input type="checkbox"/>	73
k. Dealing with drug addiction	1	2	3	4	5	<input type="checkbox"/>	74

SECTION 4  
PERSONAL RELATIONSHIPS

Cols 75-80  
Blank  
End Card 2  
Card 3  
I.D. \_\_\_\_\_  
1-3

15. Which of the following best describes your present household/family arrangements?  
Do you live: (Circle one)

- With your spouse (only) . . . . . 1
- With your de facto spouse (only) . . . . . 2
- With your spouse and child(ren) . . . . . 3
- With your de facto spouse and child(ren) . . . . . 4
- With a partner of the same sex . . . . . 5
- In the parental home . . . . . 6
- Alone, never married . . . . . 7
- Alone, formerly married . . . . . 8
- Living with children, formerly married . . . . . 9
- Living in a group house, no partner . . . . . 10
- Other (please specify) \_\_\_\_\_ 11

4  
 5

→ In any of these cases, please skip to the next section (Question 23 on page 15)

16. How often would you say the following events occur between you and your partner?  
(Circle a number)

	<u>Never</u>	<u>Less than once a month</u>	<u>Once or twice a month</u>	<u>Once or twice a week</u>	<u>Once a day</u>	<u>More often</u>	
a. Have a stimulating exchange of ideas	1	2	3	4	5	6	<input type="checkbox"/> 6
b. Laugh together	1	2	3	4	5	6	<input type="checkbox"/> 7
c. Calmly discuss something	1	2	3	4	5	6	<input type="checkbox"/> 8
d. Work together on a project	1	2	3	4	5	6	<input type="checkbox"/> 9

Most persons have disagreements in their relationships. Please indicate below the approximate extent of agreement or disagreement between you and your partner for each item on the following list. (Circle a number)

	<u>Always agree</u>	<u>Almost always agree</u>	<u>Occasionally disagree</u>	<u>Fre- quently disagree</u>	<u>Almost always disagree</u>	<u>Always disagree</u>	
a. Handling family finances	1	2	3	4	5	6	<input type="checkbox"/> 10
b. Matters of recreation	1	2	3	4	5	6	<input type="checkbox"/> 11
c. Religious matters	1	2	3	4	5	6	<input type="checkbox"/> 12
d. Demonstration of affection	1	2	3	4	5	6	<input type="checkbox"/> 13
e. Friends	1	2	3	4	5	6	<input type="checkbox"/> 14
f. Sex relations	1	2	3	4	5	6	<input type="checkbox"/> 15
g. Conventionality (correct or proper behaviour)	1	2	3	4	5	6	<input type="checkbox"/> 16
h. Philosophy of life	1	2	3	4	5	6	<input type="checkbox"/> 17
i. Ways of dealing with parents or "in-laws"	1	2	3	4	5	6	<input type="checkbox"/> 18
j. Aims, goals, and things believed important	1	2	3	4	5	6	<input type="checkbox"/> 19
k. Amount of time spent together	1	2	3	4	5	6	<input type="checkbox"/> 20
l. Making major decisions	1	2	3	4	5	6	<input type="checkbox"/> 21
m. Household tasks	1	2	3	4	5	6	<input type="checkbox"/> 22
n. Leisure time interests and activities	1	2	3	4	5	6	<input type="checkbox"/> 23
o. Career decisions	1	2	3	4	5	6	<input type="checkbox"/> 24

These are some things about which couples sometimes agree and sometimes disagree. Indicate if either item below caused differences of opinions or were problems in your relationship during the past few weeks. (Circle a number)

	<u>Yes</u>	<u>No</u>	
a. Being too tired for sex	1	2	<input type="checkbox"/> 25
b. Not showing love	1	2	<input type="checkbox"/> 26

19. a. Do you and your partner engage in outside interests together? (Circle a number)

<u>All of them</u>	<u>Most of them</u>	<u>Some of them</u>	<u>Very few of them</u>	<u>Never</u>	
1	2	3	4	5	<input type="checkbox"/> 27

b. Do you kiss your partner? (Circle a number)

<u>Every day</u>	<u>Almost Every day</u>	<u>Occasionally</u>	<u>Rarely</u>	<u>Never</u>	
1	2	3	4	5	<input type="checkbox"/> 28

20. Here are some things that sometimes happen in relationships. How often do they happen in yours? (Circle a number)

	<u>All the time</u>	<u>Most of the time</u>	<u>More often than not</u>	<u>Occasionally</u>	<u>Rarely</u>	<u>Never</u>	
a. How often do you discuss or have you considered divorce, separation, or terminating your relationship?	1	2	3	4	5	6	<input type="checkbox"/> 29
b. How often do you or your partner leave the house after a fight?	1	2	3	4	5	6	<input type="checkbox"/> 30
c. In general, how often do you think that things between you and your partner are going well?	1	2	3	4	5	6	<input type="checkbox"/> 31
d. Do you confide in your partner?	1	2	3	4	5	6	<input type="checkbox"/> 32
e. Do you ever regret that you married (or lived together)?	1	2	3	4	5	6	<input type="checkbox"/> 33
f. How often do you and your partner quarrel?	1	2	3	4	5	6	<input type="checkbox"/> 34
g. How often do you and your partner 'get on each other's nerves'?	1	2	3	4	5	6	<input type="checkbox"/> 35

21. The dots on the following line represent different degrees of happiness in your relationship. The middle point, 'happy', represents the degree of happiness of most relationships. Please circle the number which best describes the degree of happiness, all things considered, of your relationship.

<u>Extremely Unhappy</u>	<u>Fairly Unhappy</u>	<u>A little Unhappy</u>	<u>Happy</u>	<u>Very Happy</u>	<u>Extremely Happy</u>	<u>Perfect</u>	
0	1	2	3	4	5	6	<input type="checkbox"/> 36

Which of the following statements best describes how you feel about the future of your relationship? (Circle a number)

- a. I want desperately for my relationship to succeed, and would go to almost any length to see that it does. 1
- b. I want very much for my relationship to succeed, and will do all I can to see that it does. 2
- c. I want very much for my relationship to succeed, and will do my fair share to see that it does. 3  37
- d. It would be nice if my relationship succeeded, but I can't do much more than I am doing now to help it succeed. 4
- e. It would be nice if it succeeded, but I refuse to do any more than I am doing now to help it succeed. 5
- f. My relationship can never succeed, and there is no more that I can do to keep the relationship going. 6

SECTION 5

FAMILY BACKGROUND

23. Think back to age 14. When you were 14, which of the following best describes your home situation? (Circle a number).

- Living with both parents (and siblings if relevant) . . . . . 1
- Living with mother only ( " " " " ) . . . . . 2
- Living with father only ( " " " " ) . . . . . 3
- Living with other relatives but not with either parent ( " " " " ) . . . . . 4
- Living in foster care . . . . . 5
- Living in orphanage (or equivalent) . . . . . 6
- Other (please specify) \_\_\_\_\_ 7

38

24. (a) Is your father alive today? (Circle a number).

- Yes . . . . . 1
- No . . . . . 2
- Skip to Question 25

39

(b) Which of these best describes your current relationship with him?

- We are very close indeed, it is an exceptionally good relationship . . . . . 1
- We are very close, a bit more than average . . . . . 2
- It is an average sort of relationship . . . . . 3
- We aren't close, less than average . . . . . 4
- Our relationship is very poor indeed, much more negative than most . . . . . 5

40

(c) How long a journey would it be (using the mode of transport available to you) if you wanted to visit him? (Circle a number).

- No time at all - live in same house . . . . . 1
- Less than 5 minutes . . . . . 2
- 5 - 14 minutes . . . . . 3
- 15 - 39 " . . . . . 4
- 30 - 59 " . . . . . 5
- 1 - 2 hours . . . . . 6
- 2 - 4 " . . . . . 7
- 4 - 8 " . . . . . 8
- More than 8 hours . . . . . 9

41

(d) And how often do you see him, on average? (Circle a number).

- Daily . . . . . 1
- Several times a week . . . . . 2
- About once a week . . . . . 3
- About once a fortnight . . . . . 4
- About once a month . . . . . 5
- About five - nine times a year . . . . . 6
- About twice - four times a year . . . . . 7
- Only on special occasions (Xmas, weddings, funerals etc.) . . . . . 8
- Rarely or never . . . . . 9

42

(a) Is your mother alive today? (Circle a number).

- Yes . . . . . 1
- No . . . . . 2
- Skip to Question 26

43

(b) Which of these best describes your current relationship with her?

- We are very close indeed, it is an exceptionally good relationship . . . . . 1
- We are very close, a bit more than average . . . . . 2
- It is an average sort of relationship . . . . . 3
- We aren't close, less than average . . . . . 4
- Our relationship is very poor indeed, much more negative than most . . . . . 5

44

(c) How long a journey would it be (using the mode of transport available to you) if you wanted to visit her? (Circle a number).

- No time at all - live in same house . . . . . 1
- Less than 5 minutes . . . . . 2
- 5 - 14 minutes . . . . . 3
- 15 - 39 " . . . . . 4
- 30 - 59 " . . . . . 5
- 1 - 2 hours . . . . . 6
- 2 - 4 " . . . . . 7
- 4 - 8 " . . . . . 8
- More than 8 hours . . . . . 9

45

25. (d) And how often do you see her, on average? (Circle a number).

- Daily . . . . . 1
- Several times a week . . . . . 2
- About once a week . . . . . 3
- About once a fortnight . . . . . 4
- About once a month . . . . . 5
- About five - nine times a year . . . . . 6
- About twice - four times a year . . . . . 7
- Only on special occasions (Xmas, weddings, funerals etc.) . . 8
- Rarely or never . . . . . 9

46

26. If your mother and father are both alive, are they currently married and living together? (Circle a number).

- Not applicable . . . . . 1
- Yes . . . . . 2
- No, separated/divorced . . . . . 3
- No, one (or both) in nursing home or equivalent . . . . . 4
- No, were never married . . . . . 5

47

27. (a) How many currently living brothers and sisters do you have? (Circle a number).

- None . . . . . 0
  - One . . . . . 1
  - Two . . . . . 2
  - Three . . . . . 3
  - Four . . . . . 4
  - Five . . . . . 5
  - Six or more. . . . . 6
- Skip to Question 28

48

(b) How would you describe your relations with your brothers and sisters in general?

- Very close, see them often . . . . . 1
- Very close, although not able to see them often . . . . . 2
- Reasonably close . . . . . 3
- About average . . . . . 4
- Not very close . . . . . 5
- Quite distant, don't see too much of them . . . . . 6
- Definitely negative, don't see them unless I have to . . . . . 7

49

SECTION 6

FRIENDSHIP AND SOCIAL SUPPORT

Apart from your partner (if you have one) and your parent(s), if they are alive, but including everyone else (colleagues, neighbours, relatives, etc.), how many people do you know who you feel really close to, who are really important in your life? (Circle a number).

- None . . . . . 0
  - One . . . . . 1
  - Two . . . . . 2
  - Three . . . . . 3
  - Four . . . . . 4
  - Five . . . . . 5
  - Six . . . . . 6
  - Seven . . . . . 7
  - Eight . . . . . 8
  - Nine or more . . . 9
- Skip to Question 30

50

Now, think of all the people you counted for the last question, plus your partner/parents (if relevant). To what extent does each person know everyone else?

- Everybody knows everybody . . . . . 1
- Most people know most of the others . . . . . 2
- Most people know a few of the others . . . . . 3
- Most people know none (or few) of the others . . . . . 4
- Hardly anyone knows anyone else . . . . . 5

51

Thinking about all the people you feel close to, including partner/parents if relevant:

(a) How many of them know you really well as a person and accept you as you are?

52

\_\_\_\_\_  
(write in number)

53

(b) How many of them are people in whom you can confide your most intimate feelings and so on?

54

\_\_\_\_\_  
(write in number)

55

(c) How many of them make you feel needed and appreciated?

56

\_\_\_\_\_  
(write in number)

57

(d) How many of them are people with whom you enjoy common activities, hobbies, outings and such like?

58

\_\_\_\_\_  
(write in number)

59

31. (a) How many years have you personally lived here in this town (in this area)?

60  
 61

(write number of years)

(b) Is there any area right around here - that is, within a kilometre or two - where you would be afraid to walk at night?

Yes . . . . . 1  
No . . . . . 2

62

END CARD 3  
COLS 63-80  
BLANK  
CARD 4  
I.D. No. \_\_\_\_\_  
1-3

32. (a) How many people are there living around here from whom you can easily ask small favours - people you know well enough to borrow tools or things for cooking?

Please write number . . . \_\_\_\_\_  
None . . . . . 00

4  
 5

(b) How many people are there around here to whom you can turn in times of difficulty - someone you could trust, and whom you could expect real help from in times of trouble (apart from those at home)?

Please write number . . . \_\_\_\_\_  
None . . . . . 00

6  
 7

(c) Thinking now about this area, more widely... How many friends do you have in this area whom you could visit any time, without waiting for an invitation? You could arrive without being expected and still be sure you would be welcome - how many?

Please write number . . . \_\_\_\_\_  
None . . . . . 00

8  
 9

(d) When you are happy, are there any particular people who you feel sure will also feel happy, simply because you are happy?

Please write number . . . \_\_\_\_\_  
None . . . . . 00

10  
 11

33. (a) When you were growing up, would you say that your father was strict with you?

Very . . . . . 1  
Somewhat . . . . . 2  
Not very . . . . . 3  
Not at all . . . . . 4

12

(b) And how about your mother - how strict was she?

Very . . . . . 1  
Somewhat . . . . . 2  
Not very . . . . . 3  
Not at all . . . . . 4

13

(c) When you were growing up, was your father warm and loving with you or not?

- Very . . . . . 1
- Somewhat . . . . . 2
- Not very . . . . . 3
- Not at all . . . . . 4

14

(d) And how about your mother?

- Very . . . . . 1
- Somewhat . . . . . 2
- Not very . . . . . 3
- Not at all . . . . . 4

15

(e) How free did you feel to talk things over with your father when you were growing up?

- Completely free . . . . . 1
- Largely but not completely free . . 2
- Moderately free . . . . . 3
- Not particularly free . . . . . 4
- Not at all free . . . . . 5

16

(f) What about your mother? (How free did you feel to talk things over with her?)

- Completely free . . . . . 1
- Largely but not completely free . . 2
- Moderately free . . . . . 3
- Not particularly free . . . . . 4
- Not at all free . . . . . 5

17

SECTION 7

MEDICINE USE

4. (a) Have you taken pain relievers in the last four weeks? (E.g. Panadol, Aspirin, Bex, Disprin, Veganin, Codral.)

- No . . . . . 1
- Yes, on 1-2 days . . . . . 2
- Yes, on 3-5 days . . . . . 3
- Yes, on 6-9 days . . . . . 4
- Yes, on 10-19 days . . . . . 5
- Yes, on 20 or more days . . . . . 6
- Yes, every day . . . . . 7

18

(b) If Yes:

Were these medicines prescribed for you by a doctor?

- Yes . . . . . 1
- No . . . . . 2

19

35. (a) Have you taken vitamin supplements in the last four weeks? (E.g. Myadec, Pentavite, Supradyn, Pluravit.)

- No . . . . . 1
- Yes, on 1-2 days . . . . . 2
- Yes, on 3-5 days . . . . . 3
- Yes, on 6-9 days . . . . . 4
- Yes, on 10-19 days . . . . . 5
- Yes, on 20 or more days . . . . . 6
- Yes, on every day . . . . . 7

20

(b) If Yes:

Were these medicines prescribed for you by a doctor?

- Yes . . . . . 1
- No . . . . . 2

21

36. (a) Have you used sedatives in the last four weeks? (E.g. Amylbarb, Nembutal, Mandrax, Mogadon.)

- No . . . . . 1
- Yes, on 1-2 days . . . . . 2
- Yes, on 3-5 days . . . . . 3
- Yes, on 6-9 days . . . . . 4
- Yes, on 10-19 days . . . . . 5
- Yes, on 20 or more days . . . . . 6
- Yes, every day . . . . . 7

22

(b) If Yes:

Were these medicines prescribed for you by a doctor?

- Yes . . . . . 1
- No . . . . . 2

23

(a) Have you used tranquillisers in the last four weeks? (E.g. Valium, Largactil, Serapax, Librium.)

- No . . . . . 1
- Yes, on 1-2 days . . . . . 2
- Yes, on 3-5 days . . . . . 3
- Yes, on 6-9 days . . . . . 4
- Yes, on 10-19 days . . . . . 5
- Yes, on 20 or more days . . . . . 6
- Yes, every day . . . . . 7

24

(b) If Yes:

Were these medicines prescribed for you by a doctor?

- Yes . . . . . 1
- No . . . . . 2

25

(a) Have you used any pep pills in the last four weeks? (E.g. Dexadrine, Ritalin.)

- No . . . . . 1
- Yes, on 1-2 days . . . . . 2
- Yes, on 3-5 days . . . . . 3
- Yes, on 6-9 days . . . . . 4
- Yes, on 10-19 days . . . . . 5
- Yes, on 20 or more days . . . . . 6
- Yes, every day . . . . . 7

26

(b) If Yes:

Were these medicines prescribed for you by a doctor?

- Yes . . . . . 1
- No . . . . . 2

27

(a) Have you taken any cough medicines in the last four weeks?

- No . . . . . 1
- Yes, on 1-2 days . . . . . 2
- Yes, on 3-5 days . . . . . 3
- Yes, on 6-9 days . . . . . 4
- Yes, on 10-19 days . . . . . 5
- Yes, on 20 or more days . . . . . 6
- Yes, every day . . . . . 7

28

39. (b) If Yes:

Were these medicines prescribed for you by a doctor?

Yes . . . . . 1  
No . . . . . 2

29

SECTION 8

LEISURE ACTIVITIES

On average, about how many hours a day do you personally watch T.V.?  
(Circle a number).

- Never watch TV at all . . . . . 1
  - Less than 1 hour . . . . . 2
  - About 1-2 hours . . . . . 3
  - About 2-3 hours . . . . . 4
  - About 4-5 hours . . . . . 5
  - About 5-6 hours . . . . . 6
  - More than 6 hours . . . . . 7
- Skip to Question 42

30

When you watch TV, which station do you mainly watch? (Circle a number).

- Mostly ABC . . . . . 1
- ABC and commercial channels about equally . . . . . 2
- Mostly commercial TV . . . . . 3

31

(a) Have you smoked tobacco in the last four weeks?

- No . . . . . 1
- Yes, on 1-2 days . . . . . 2
- Yes, on 3-5 days . . . . . 3
- Yes, on 6-9 days . . . . . 4
- Yes, on 10-19 days . . . . . 5
- Yes, on 20 or more days . . . . . 6
- Yes, on every day . . . . . 7

32

(b) If you smoke tobacco, how many of each of the following do you smoke on an average day? Please indicate number.

- Cigarettes \_\_\_\_\_
- Cigars \_\_\_\_\_
- Pipefuls of tobacco \_\_\_\_\_

33

34

(a) Have you drunk alcohol in the last four weeks?

- No . . . . . 1
- Yes, on 1-2 days . . . . . 2
- Yes, on 3-5 days . . . . . 3
- Yes, on 6-9 days . . . . . 4
- Yes, on 10-19 days . . . . . 5
- Yes, on 20 or more days . . . . . 6
- Yes, every day . . . . . 7

35

43. (b) On a day when you drink alcohol, how many drinks would you usually have? ('1 drink' would be a 10oz glass of beer, a glass of table wine, a single measure of spirits, and so on.)

- Never drink alcohol . . . . . 1
- 1 or 2 . . . . . 2
- 3 or 4 . . . . . 3
- 5-8 . . . . . 4
- 9-12 . . . . . 5
- Over 12 . . . . . 6

36

44. Do you belong to any voluntary organizations (e.g. Church group, trade union, political party, civic or charitable group etc.) that you attend at least once a month? How many do you belong to?

- No . . . . . 01
- Yes (write in number) \_\_\_\_\_

37

45. Apart from voluntary organizations, how often in an average month, would you go out for some social-cum-leisure activity?

Type of Activity	Frequency in Average Month
(a) Visit hotel, club, or similar for a social drink . . . . .	_____ (write in a number)
(b) Go to restaurant for a meal . . . . .	_____ (write in a number)
(c) Have dinner or barbecue etc. with relatives . . . . .	_____ (write in a number)
(d) Have dinner or barbecue etc. with friends . . . . .	_____ (write in a number)
(e) Go to a movie, play or concert etc. . . . .	_____ (write in a number)

38  39  
 40  41  
 42  43  
 44  45  
 46  47

46. People often have different views about friendship and social activities. Below are some statements on which we would like your views. Please circle a number for each statement to show whether you agree or disagree with it. The number 1 after each statement is for "agree", the number 2 is for "disagree".

	<u>AGREE</u>	<u>DISAGREE</u>
(1) When I meet someone new, I don't make much effort to be liked . . . . .	1	2
(2) I'd sometimes rather be with strangers than with people I know . . . . .	1	2
(3) If I don't enjoy a party, I don't mind being the first one to leave . . . . .	1	2
(4) When I'm not feeling well, I would rather be with others than alone . . . . .	1	2
(5) I would be very hurt if a close friend contradicted me in public . . . . .	1	2
(6) I would rather be considered intelligent than sociable . . . . .	1	2

48  
 49  
 50  
 51  
 52  
 53

AGREE

DISAGREE

- (7) When a group is talking about something important,  
I like to say what I feel. . . . . 1 2  54
- (8) Having friends is very important to me . . . . . 1 2  55
- (9) I don't usually mix with people who are critical . . . . . 1 2  56
- (10) I often visit people without being invited . . . . . 1 2  57
- (11) I enjoy a good movie more than a big party . . . . . 1 2  58
- (12) I don't mind going somewhere even if I know that  
some of the people there don't like me . . . . . 1 2  59
- (13) I like to make as many friends as I can . . . . . 1 2  60
- (14) When two of my friends are arguing I don't mind  
taking sides to support the one I agree with . . . . . 1 2  61
- (15) If I ask someone to go somewhere with me and he  
refuses, I hesitate to ask him again . . . . . 1 2  62
- (16) I think fame is more rewarding than friendship . . . . . 1 2  63
- (17) I am cautious about expressing my opinions until  
I know people quite well . . . . . 1 2  64
- (18) I prefer working alone to working with others . . . . . 1 2  65
- (19) I enjoy discussing controversial topics like  
politics and religion . . . . . 1 2  66
- (20) When I see someone I know walking down the street,  
I am usually the first to say hello . . . . . 1 2  67
- (21) I feel uneasy about asking someone to return  
something he borrowed from me . . . . . 1 2  68
- (22) I criticise people openly and expect them to  
do the same . . . . . 1 2  69
- (23) I join clubs because it is such a good way of  
making friends . . . . . 1 2  70
- (24) I can still enjoy a party even if I find that I  
am not properly dressed for the occasion . . . . . 1 2  71
- (25) I sometimes take criticisms too hard . . . . . 1 2  72
- (26) I don't believe in showing open affection  
towards friends . . . . . 1 2  73
- (27) If someone dislikes me, I tend to avoid him . . . . . 1 2  74
- (28) I would rather go to sleep at night than talk  
to someone about the day's activities . . . . . 1 2  75
- (29) It seldom embarrasses me to ask someone for a  
favour . . . . . 1 2  76
- (30) I have very few close friends . . . . . 1 2  77
- (31) I seldom contradict people for fear of hurting  
them . . . . . 1 2  78
- (32) When I'm with people I don't know, it doesn't  
matter much to me if they like me or not . . . . . 1 2  79
- (33) If I had to choose, I would rather have strong  
attachments to my friends than have them regard  
me as witty and clever . . . . . 1 2  80

END CARD 4  
 CARD 5  
 I.D.No. \_\_\_\_\_

46.

	<u>AGREE</u>	<u>DISAGREE</u>		
(34) When I go to a place where I don't know anybody, I always like to have a friend come with me . . . . .	1	2	<input type="checkbox"/>	4
(35) I am much more attracted to warm, open people than I am to stand-offish ones. . . . .	1	2	<input type="checkbox"/>	5
(36) I enjoy going to parties where I don't know anyone . . . . .	1	2	<input type="checkbox"/>	6
(37) I would rather read an interesting book, or go to the movies than spend time with friends . . . . .	1	2	<input type="checkbox"/>	7
(38) When travelling, I prefer meeting people rather than enjoying the scenery or going to places alone . . . . .	1	2	<input type="checkbox"/>	8

SECTION 9

ATTITUDES TO DRUG USE ETC.

(N.B. These items are taken verbatim from a recent Department of Health Survey. Although one or two answers would be obvious for this specialised survey, the format is followed for comparative purposes. Please answer all questions.)

Thinking about marijuana. (Circle a number).

In your opinion should the smoking of marijuana be made legal or remain illegal.  
 Legal . . . . . 1  
 Illegal . . . . . 2  
 (Undecided) . . . . . 3

9

Should the possession of small amounts of marijuana be... (Circle a number)

a jailable offence . . . . . 1  
 a minor, finable offence but not jailable . . . . . 2  
 not an offence . . . . . 3  
 (don't know) . . . . . 4

10

For each of the following activities would you indicate (by circling a number) whether you think that the activity is increasing at present, decreasing at present or not changing very much?

	<u>INCREASING</u>	<u>DECREASING</u>	<u>NOT CHANGING</u>	<u>DON'T KNOW</u>	
Marijuana use . . . . .	1	2	3	4	<input type="checkbox"/> 11
Tobacco smoking . . . . .	1	2	3	4	<input type="checkbox"/> 12
Excessive use of Barbiturates . . . . .	1	2	3	4	<input type="checkbox"/> 13
Cocaine use . . . . .	1	2	3	4	<input type="checkbox"/> 14
Excessive drinking of Alcohol . . . . .	1	2	3	4	<input type="checkbox"/> 15
Excessive use of Tranquilisers . . . . .	1	2	3	4	<input type="checkbox"/> 16
Sniffing Glue/Petrol/Solvents/ Rush . . . . .	1	2	3	4	<input type="checkbox"/> 17
Use of Amphetamines . . . . .	1	2	3	4	<input type="checkbox"/> 18
Heroin use . . . . .	1	2	3	4	<input type="checkbox"/> 19
Use of Hallucinogens/LSD/ magic mushrooms . . . . .	1	2	3	4	<input type="checkbox"/> 20

What proportion of Australians, about your age, do you think would be doing each of these things. (Indicate your estimate by circling one number for each activity.)

	Most	About Half	About a Quarter	1 in 10	1 in 20	1 in 50	1 in 100	Less/None	Don't Know
--	------	------------	-----------------	---------	---------	---------	----------	-----------	------------

1. Smoking Marijuana . . . . .	1	2	3	4	5	6	7	8	9	<input type="checkbox"/> 21
2. Smoking Tobacco . . . . .	1	2	3	4	5	6	7	8	9	<input type="checkbox"/> 22
3. Taking Barbiturates excessively	1	2	3	4	5	6	7	8	9	<input type="checkbox"/> 23
4. Taking Cocaine . . . . .	1	2	3	4	5	6	7	8	9	<input type="checkbox"/> 24

50.

Most	About Half	About a Quarter	1 in 10	1 in 20	1 in 50	1 in 100	Less/None	Don't Know
------	------------	-----------------	---------	---------	---------	----------	-----------	------------

- 5. Drinking excessive amounts of Alcohol . . . . .  25
- 6. Taking Tranquilisers excessively  26
- 7. Sniffing Glue/Petrol/Solvents/Rush . . . . .  27
- 8. Taking Amphetamines excessively  28
- 9. Taking Heroin . . . . .  29
- 10. Using Hallucinogens/(eg. LSD/magic mushrooms/trips) . . . . .  30

51. Please read this series of statements, and indicate (by circling a number) whether you think they are true or false. Try not to use many 'Don't Knows'.

True	False	D/K
------	-------	-----

- 1. The excessive use of analgesics and pain killers is causing more hardship than illegal drugs. . . . .  31
- 2. There is little that the ordinary person can do to help solve the drug problem . . . . .  32
- 3. It is difficult for parents to know if their children are taking drugs . . . . .  33
- 4. Most regular marijuana users eventually end up using cocaine, heroin or some other hard drug . . . . .  34
- 5. Alcohol causes more deaths in Australia each year than heroin, marijuana and all the other illegal drugs put together . . . . .  35
- 6. There is little that parents can do to stop their children taking drugs . . . . .  36
- 7. I don't like drugs and avoid taking them even for small things like headaches . . . . .  37
- 8. Almost all Australians are regular drug users . . . . .  38
- 9. People should try things like drugs that affect the way they feel.  39
- 10. Drink driving is more of a problem for Australian society than is taking heroin . . . . .  40
- 11. Too much marijuana can lead to very severe illness or even death .  41
- 12. The real drug problem that bothers me, is under age drinking . . .  42
- 13. Parents would have more chance of stopping their children taking drugs if parents knew more about drugs . . . . .  43
- 14. You shouldn't take drugs for pleasure . . . . .  44

And now some statements about more general things. Again please say whether you think they are true for you, or false for you.

True	False	D/K
------	-------	-----

- 1. With everything in such a state of disorder, it's hard for a person to know where he stands from one day to the next . . . . . 1 2 3  45
- 2. What is lacking in the world today is the old kind of friendship that lasts for a lifetime . . . . . 1 2 3  46
- 3. The trouble with the world today is that most people really don't believe in anything . . . . . 1 2 3  47
- 4. With everything so uncertain these days, it almost seems as though anything could happen . . . . . 1 2 3  48
- 5. Everything changes so quickly these days that I often have trouble deciding which are the right rules to follow . . . . . 1 2 3  49
- 6. I often feel awkward and out of place . . . . . 1 2 3  50
- 7. It seems to me that other people find it easier to decide what is is right than I do . . . . . 1 2 3  51



How old were you when you left school? (When you left primary/secondary school?).

WRITE AGE . . . . . \_\_\_\_\_

I'm still in school . . . . . 88

60

61

In all, how many years of tertiary education have you completed since you left secondary school? Count universities, CAEs and such but not apprenticeships. (If part-time give the number of years of full-time study that would be the equivalent.)

WRITE NUMBER OF YEARS . . . . . \_\_\_\_\_

None (no education, beyond secondary school). . . . . 00

62

63

Have you obtained a trade qualification, a degree or diploma, or any other qualification since leaving school? What is your highest qualification?

Qualification Name (Examples of qualification names are: trade certificate, diploma in science, B.A.)

Name: \_\_\_\_\_

64

65

Thank you for your co-operation. The interviewer will arrange to collect this from you at the start of the interview (or earlier) and will also arrange the payment of the completion fee at the end of the interview.

APPENDIX TWO

COCAINE USE : INTERVIEW PROTOCOL

SECTION I GENERAL PATTERNS OF ILLICIT DRUG USE

1. I'd like to begin this interview by getting a general picture of how and when you started using cocaine. Could you tell me first whether you have also used other drugs such as marijuana, heroin, LSD and so on?

IF YES

2. And which of these did you use first?

3. How old were you when you first used (substance named in Question 2)?

4. Once you started using (substance named in Question 2) did you find your social life changing? I mean, for example, did you find yourself getting closer to some people and more distant from others? (Did this relate to being/not being users?)

5. Could you tell me now about the first few times you used cocaine? How did you get started and who (if anyone) helped you get it, showed you how to use it and so on? Was it, for example, a friend, a workmate or what? (May be useful to explore role of significant others who turned them on to (a) illicit (b) cocaine)

6. And how old were you then?

7. (If used other drugs, e.g. marijuana etc.) How did you feel about the effects that you got from cocaine compared to the others? Were they different? Were they better or worse?

8. And once you began to use cocaine, did that have any effect on your social relationships? For example, did it bring you closer to or further from anyone? (Explore whether family/friends/workmates became closer or more distant; frequenting 'coke' scenes)

9. I'd like now to turn to the present. Could you describe the general pattern of your use of cocaine over the last few months. How often, for example, would you use cocaine in an average week and how much on each occasion? (If the answer here is in 'dollars-worth', this may be a time to lead into questions of price etc.)

10.(a) Is your level of use at the moment pretty steady, or would you say it's increasing, or decreasing? (Probe: Does your use fluctuate much? Why/how?)

(b) What method do you use for taking cocaine? Do you snort it, inject it or smoke free base? Are your methods and types of cocaine used changing at all?

11. And when you use cocaine nowadays, would you use any other drugs (including alcohol) at the same time? (Probe: Always or sometimes? When/what?)

## SECTION 2 SUPPLY AND PRICE

Can we turn now to a few questions about supply and prices and so on. I'm not going to ask you any details about names of suppliers, or the specific places you get cocaine. What I am interested in is the general pattern.

12. First, could you tell me in general terms how you obtain supplies. Is it always from the same source or do you use a variety of sources? (Probe: about general locations, 'the pub' etc.)
13. Have you always obtained your cocaine from this/these person/people? (If not, how has this changed?) Do these people also supply you with other drugs.
14. Do you have any difficulties in arranging supplies? (What would you do if your regular source dried up? Would you use other drugs? What/how obtained?)
15. What sort of quantities do you buy at one time and what sort of prices are you paying at the moment?
16. How much would you reckon to spend on cocaine in an average week?
17. And do you ever sell any cocaine to others at all, even if only in splitting some with friends? (Probe: How much, how often, what profit etc.)

## SECTION 3 GENERAL VIEWS ON COCAINE AND THE LAW

Let's turn for a moment to legal questions.

18. Using cocaine is illegal, and you could face quite serious penalties. How much do you worry about getting caught or about the penalties if you did? (Probe: e.g. loss of 'face'; loss of job; family repercussions; inability to afford large fines etc.)
19. (a) And what sorts of precautions - if any - do you take to avoid detection, both when buying and when using?  
(b) Have you ever been arrested for any drug offence or had any close brushes with the law?
20. Some people imply that trafficking in illegal drugs is made easier because officials (police, customs and so on) are corrupt. What is your view of that? Do you know for sure of things such as police taking bribes from dealers? If not, do you believe such things happen?
21. Do you think cocaine should be legally available? If so, under what conditions? (Open sale, prescription, etc.)
22. What about opiates, like heroin, what's your view of these? Should they be legal? In what ways?

## SECTION 4 PROS AND CONS OF COCAINE

Obviously if you use cocaine you must have some views about its good and bad effects. I'd like to talk about them now. Perhaps I'll begin just with an overall question.

23. What are, in your view, the good things and the bad things about using cocaine? (Probe: here ONLY to pick up if they miss one 'side' e.g. if they talk about 'good' only come back with 'And what about 'bad' effects?')

24. Let's pick up now on some specifics. Do you ever have any problems or worries about the purity of the cocaine you get? (If so, what are these?)
25. The official governmental line on cocaine portrays it as a very dangerous drug, highly addictive and damaging to health. What's your view of that? Do you agree at all? (Probe: If not, why not? Also push the 'addictive' and 'health problems' angles to get clear cut responses.)
26. A lot of 'ordinary people' would condemn you for using cocaine. What do you think of that and of them?
27. Do you know about anyone in your circle of contacts who has or has had any problems with cocaine? (If yes, who, what problems?)
28. I'd like you to try, as best you can, to describe the positive and pleasant feelings you get from using cocaine. How do you feel when you take it?
29. (a) And when you come down - how does that feel, do you get any bad feelings after?  
(b) [If bad feelings]. And what do you do about that? Do you take more, or take other things to make you feel better?
30. What limits the amount of cocaine you use? Is it the amount you can afford, the amount of time you have free, worries about doing yourself damage or what?
31. Do you know anyone who, in your view, uses too much cocaine? (Who, how much etc)

#### SECTION 4 COCAINE AND SOCIAL CONTACTS

I'd like now to turn to some questions about the times and places where you usually use cocaine, and who you use it with (if anyone).

32. First, would you tell me about some times and places where you would be fairly likely to use it. For example, would you use it at parties, at home alone, at work and so forth? (If varying typical contexts of use pick up on these in following questions)
33. Are there any other situations where you might use it, even if only occasionally
34. (For each typical context)
  - (a) when you use cocaine at (a party, work etc.) what benefit do you think you get from it?
  - (b) and who would you use it with? I mean both who, if anyone, would you share taking it with and who else might know, whether or not they use it themselves?
35. Think about your close friends for a moment. How many close friends would you have who you would take cocaine with, and how many not?
36. (If close friends they don't take cocaine with) Do the friends that you don't share your cocaine with have any idea you take it? What do you think they think of it?
37. (If close friends they do take cocaine with) Looking at the friends you do take cocaine with, how important is that to the group? I mean, is this a vital thing you share and perhaps brought you together, or is it something that you now do with people you knew long before?
38. Do members of your family know you take cocaine?  
If yes Does this cause any difficulties in the family?  
If no How do you keep the information from them?

39. Since you first started taking cocaine, have you introduced any others to using it?

If no Why not?

If yes Could you tell me a bit about this. Have they all enjoyed it or have there been hassles? Have you lost (or made) any friends over this?

40. Finally, can I ask you what pattern of use you see in the future. Do you think, for example, you will still be using it 5 years from now, if so, will you be using more or less? And if not, why do you think you would stop?

## THREE

(An attempt to locate upper SES users)

After eight months of intermittent attempts to locate cocaine users among upper socio-economic people in Melbourne, one overwhelming conclusion may be drawn:

There appears to be many, infrequent, users in the upper SES category but they are extremely reluctant to discuss their usage.

Through mutual acquaintances, numerous attempts were made to obtain respondents and while many people said they knew other people who used cocaine they were apparently unable to induce them to be interviewed.

The methodology adopted was to contact friends and acquaintances and to ask them if they knew anyone who used cocaine and, if so, if they would ask those people to participate in the project. Two methods of contact were offered: either through the intermediary or direct contact with the researcher.

Telephone calls were the main method of contact: the available funds did not permit more time and travel to be undertaken in attempts to locate respondents.

Worth noting is that while many people contacted were full of support for the project, only two returned phone calls to the researcher: in all other cases the researcher had to make follow-up calls, often more than once.

Only two respondents were obtained. Neither could be said to be in the upper SES group, although one was closely associated with the "glitterati". One other potential contact, a medical practitioner, was spoken to several times but cancelled the interview the night before it was scheduled. Another potential respondent, employed in the film industry, agreed to an interview, but cancelled one hour before it was scheduled to be conducted.

Both respondents claimed to know more than 50 people who used cocaine. One claimed to have attended a party where an estimated 160 people were using cocaine.

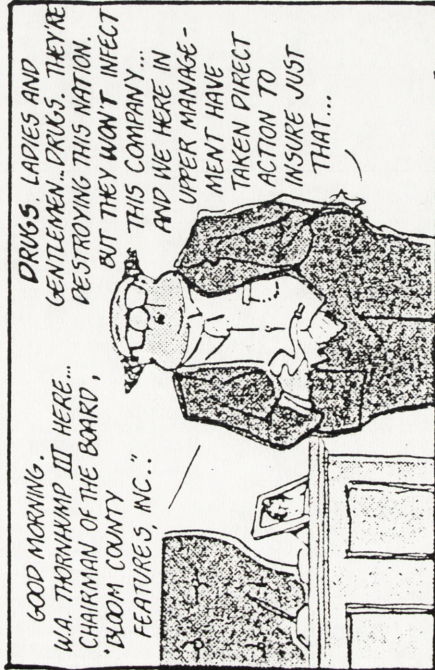
One respondent would not provide names because at the time she was making a determined attempt to stop using all drugs and because, having been a dealer, she was fearful of reprisals. Also, she had left the city and was living in the country in a deliberate attempt to sever all contacts with her former friends and associates. The other respondent, after being interviewed, said she would ask several friends if they would participate. She later reported that none of them was prepared to be interviewed.

The \$50 interview fee was regarded by most contacts as inadequate, given the nature of the topic. Several suggested that no fee would be better than \$50 which, to upper SES people, would mean little. I tend to agree.

Given funds which would enable a researcher to be employed full-time for 4-6 weeks, respondents probably could be located by the researcher socializing in locations where cocaine is believed to be sold and/or used. For example, one hotel was reported to be "the local" for a number of users and if a researcher was able to spend a few evenings at that hotel and able to establish associations, then contact probably could be made.

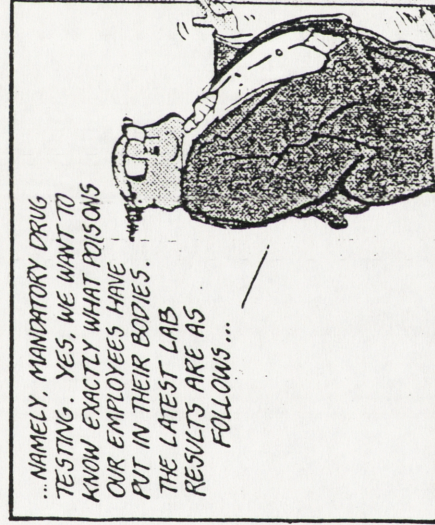
BY BERKE BREATHED

# BLOOM COUNTY

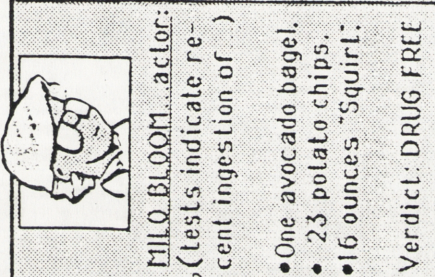


GOOD MORNING, W.A. THORNHUMP III HERE... CHAIRMAN OF THE BOARD, 'BLOOM COUNTY FEATURES, INC.'...

DRUGS, LADIES AND GENTLEMEN... DRUGS. THEY'RE DESTROYING THIS NATION. BUT THEY WON'T INFECT THIS COMPANY... AND WE HERE IN UPPER MANAGEMENT HAVE TAKEN DIRECT ACTION TO INSURE JUST THAT...



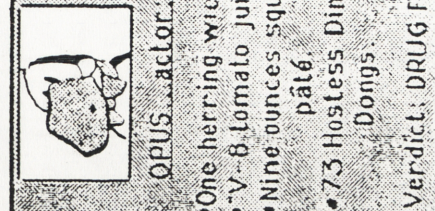
...NAMELY, MANDATORY DRUG TESTING. YES, WE WANT TO KNOW EXACTLY WHAT POISONS OUR EMPLOYEES HAVE PUT IN THEIR BODIES. THE LATEST LAB RESULTS ARE AS FOLLOWS ...



MILO BLOOM...actor:  
(tests indicate recent ingestion of...)

- One avocado bagel.
- 23 potato chips.
- 16 ounces "Squirt."

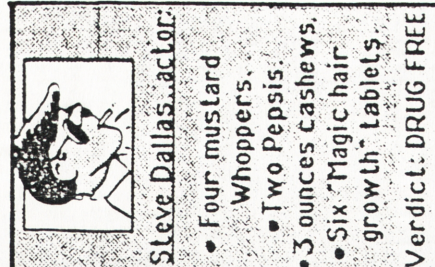
Verdict: DRUG FREE



OPUS...actor:

- One herring wiener.
- 7-8 tomato juice.
- Nine ounces squid pâté.
- 73 Hostess Ding Dongs.

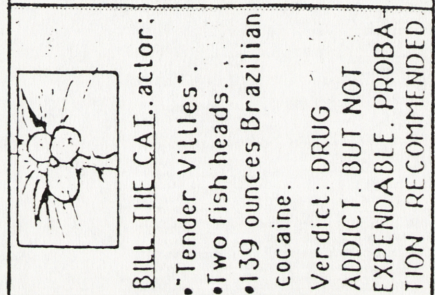
Verdict: DRUG FREE



Steve Dallas...actor:

- Four mustard Whoppers.
- Two Pepsis.
- 3 ounces Cashews.
- Six "Magic hair" growth tablets.

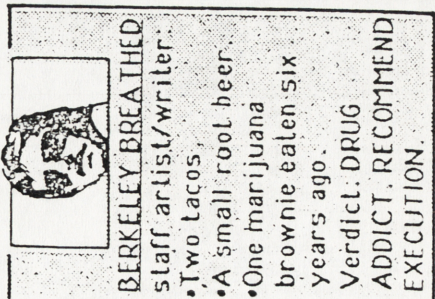
Verdict: DRUG FREE



BILL THE CAL...actor:

- Tender Villes.
- Two fish heads.
- 139 ounces Brazilian cocaine.

Verdict: DRUG ADDICT. BUT NOT EXPENDABLE. PROBATION RECOMMENDED



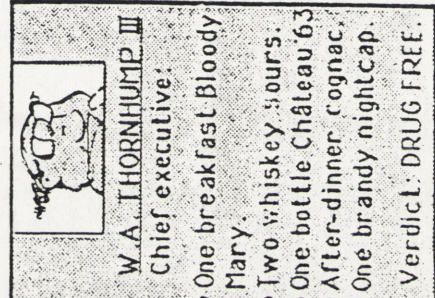
BERKELEY BREATHED

staff artist/writer:  
• Two Tacos.  
• A small root beer.  
• One marijuana brownie eaten six years ago.

Verdict: DRUG ADDICT. RECOMMEND EXECUTION.



AND IN THE INTEREST OF BASIC FAIRNESS, WE IN UPPER MANAGEMENT WERE TESTED AS WELL. AND AS YOU CAN SEE, WE HAD NOTHING TO HIDE...



W.A. THORNHUMP III  
Chief executive:

- One breakfast Bloody Mary.
- Two whiskey sours.
- One bottle Chateau '63.
- After-dinner cognac.
- One brandy nightcap.

Verdict: DRUG FREE.



YES, WE'RE THE NATION'S TOP CORPORATE EXECUTIVES: THE VALIANT FRONTLINE IN THE BATTLE FOR A PURER AMERICA!

YOUR SIX-MARTINI LUNCH, SIR.

Similarly, a researcher with some connections in the upper SES group could probably make contacts by spending considerable time developing associations among that category of people.

A researcher with stronger contacts in the "fast lane" professions and occupations might have more success in locating respondents (the researcher, while having some contacts, had lived in Melbourne for slightly more than one year when the project began and while not devoid of "fast lane" and upper SES contacts, could not claim to have a vast array of them).

Finally, I believe that cocaine is widely, if infrequently, used among the "fast lane" and upper SES groups of people in Melbourne. However, the rather more conservative nature of these groups, when compared with, say, Sydney, makes them extremely wary about taking part in projects such as the cocaine typography study. Many of the people spoken to occupy senior positions and most cocaine users they know - assuming they were honest in saying that they knew users - would stand to lose much if the confidentiality provisions (which were stressed as being extremely stringent) were breached.

However, the tendency to say "I know some who uses cocaine" simply because people believe they ought to know someone who uses it, cannot be overlooked.

The following is a log of the research activities:

1. Journalist. Provided a list of seven drug agency officers and counsellors. Spoke by telephone during researcher's presence to one and arranged for researcher to telephone.

2. Film industry. Knew of a colleague who was a user and transferred phone call to that person. Arrangements made for interview and for questionnaire to be delivered. Potential respondent telephone one hour before interview was due to begin and cancelled. One further request, by phone, about two weeks later met with definite rejection.

(a) Same person knew of two users and said he would ask them. Several phone calls over a period of several months resulted in report that one user had been contacted and given the researcher's phone number. No phone call was received.

3. Medical GP, associated with drug agency. He takes a fairly detailed drug history of patients, but did not know of any cocaine addicts. He had seen one about two years previously - she had come to Melbourne from Sydney for treatment. Cocaine, he said, was not a users' choice drug, mainly because of the poor quality. He did not hear about cocaine runs and, in fact, did not hear much about it. There were, he said, long periods before users became addicted. He believed it was widely used in Sydney among the "international set" ie airline employees and cultural performers. Unable to help in locating potential respondents.

4. Agency counsellor. Cocaine has formed part of poly-drug usage and police say that it is entering the country. No potential respondents.

5. Publishing industry. He knew of someone who might be able to help and would ask that person. Two further phone calls in the next few weeks each met with the response that the potential respondent was not interested in being interviewed.

6. Television industry. Knew of a potential respondent and would ask. When contacted a week later he said that the potential respondent did not want to be interviewed as she had previously lived in Canberra and knew the researcher.
7. Journalist. Did not know of anyone but would ask within his organization. Two subsequent phone calls met with response that no potential respondents had been located.
8. Radio industry. Did not know of anyone, but referred researcher to two other people in industry (Nos. 9 and 10).
9. Radio industry. Knew of one potential respondent. Researcher phoned back about two weeks later and was referred to medical GP (No. 11).
10. Radio industry. Knew of three or four potential respondents. When contacted a week later said that none wanted to take part in the project.
11. Medical GP. Agreed to be interviewed three days later, but phoned researcher the night before the interview and cancelled. Contact was made by phone three weeks later and respondent asked to be contacted again in two or three weeks. Contact made at that time but respondent declined to be interviewed.
12. Medical practitioner. Believed that there was widespread usage in the outer eastern suburbs, or at least cocaine users were being treated there. Referred researcher to a medical GP. (No. 13). Also referred researcher to GP in Gippsland and to a medical specialist in north of state both of whom, he said, were involved in treating cocaine users. Both leads proved largely "fruitless". Numerous other contacts suggested in northern Victoria. One led to a respondent. (No. 16).
13. Medical GP. Eastern suburbs. Seen personally but reported that there was little cocaine usage in the area, having indicated by phone that he could probably locate potential respondents, including "a couple of surgeons". He had said that there was wide usage in outer south eastern suburbs, but despite several phone calls after the initial visit was unable to provide any contacts. Referred researcher to another GP in adjacent area. (No. 15). Also referred researcher to an agency counsellor (No. 16).
14. Counsellor, northern Victoria. Said two potential respondents would be contacted. One refused, but the other agreed to be interviewed and was.
15. Medical GP, eastern suburbs. Did not know of any potential respondents.
16. Agency counsellor. Knew of one potential respondent who had an appointment for one week later. When re-contacted the counsellor said that the potential respondent had failed to meet the appointment. Two subsequent phone calls resulted in similar story.
17. Journalist. Knew of a person in advertising industry who "almost certainly" would know some cocaine users, but who was overseas at the time. Contact made after due date of return but the report came back that the advertising industry contact did not know of any users.
18. Insurance industry. Did not know of any users but referred researcher to a solicitor. (No. 19).

19. Solicitor. Referred researcher to a person in the entertainment industry who, he said, knew of users. Person was contacted and agreed to ask the potential respondents. Contacted one week later but said that the potential respondents were not interested in being interviewed.

20-23. Four medical practitioners in northern Victoria were contacted after the researcher had been told that it was a likely area in which to locate respondents, but none knew of any potential respondents.

24. Hospital counsellor in northern NSW. Very little cocaine usage in the area although it was sometimes used as a secondary drug.

25. Treatment centre. No-one undergoing treatment had been using cocaine.

26. Management recruitment executive. Knew of a couple of teachers who were users. When contacted several weeks later said that they were not interested in being interviewed.

27. Popular entertainment industry. Knew of people who were paid in cocaine and knew that cocaine was often offered at parties. When spoken to several weeks later said that no potential respondents had been located.

28-29. Entertainment industry. Two contacts did not know of any users, but said they knew of users of many other drugs.

30. Entertainment industry. Agreed to interview and was. Agreed to ask several friends who were users if they would be interviewed. Reported two weeks later that none wanted to participate.

31. Politician. Widespread usage in sport and at tertiary institutions, but could not provide contacts. Referred researcher to a woman who was committed to fighting drug abuse (No. 32).

32. Housewife. A son had died of heroin overdose and another son was a heroin addict. She had been fighting drug abuse for years. She was convinced that there was widespread usage of cocaine and that the police knew of it. However, she could not provide any contacts. She was ~~one of the~~ <sup>one of the</sup> ~~people~~ spoken to who returned the researcher's telephone call, albeit to say that she could not locate any users.