Have we seen the back of smack?

A sustained fall in the estimated number of heroin users; fewer people coming forward for treatment, an ageing heroin using population. So has the Trainspotting era run out of steam?
By **Roger Howard** and **Nicola Singleton**.

It is never easy to estimate the numbers of people who are dependent on heroin. The chaotic nature of the lifestyle of many of them means they are not included in most general population surveys, so indirect methods of estimation have to be used.

In the UK such methods, which make use of the fact that many people in this group have contact with treatment or the criminal justice system, have been used regularly over recent years to estimate numbers of 'problem drug users'.

Although the exact definition of problem drug use varies across the country, problem opiate use, mostly heroin, is generally an important component of it. Data from these estimates suggest that, while the UK still has comparatively high rates, the numbers are decreasing, largely driven by falling prevalence of problem opiate use in England. There are no equivalent series of estimates available in Wales or Northern Ireland while in Scotland the prevalence of problem drug use, which in this case is defined as problem opiate or benzodiazepine use, has not decreased

But this apparent decline in the numbers of people using heroin or other opiates in England is only part of the picture. Of at least as much significance is the change over recent years in the age profile of those people who are dependent on heroin.

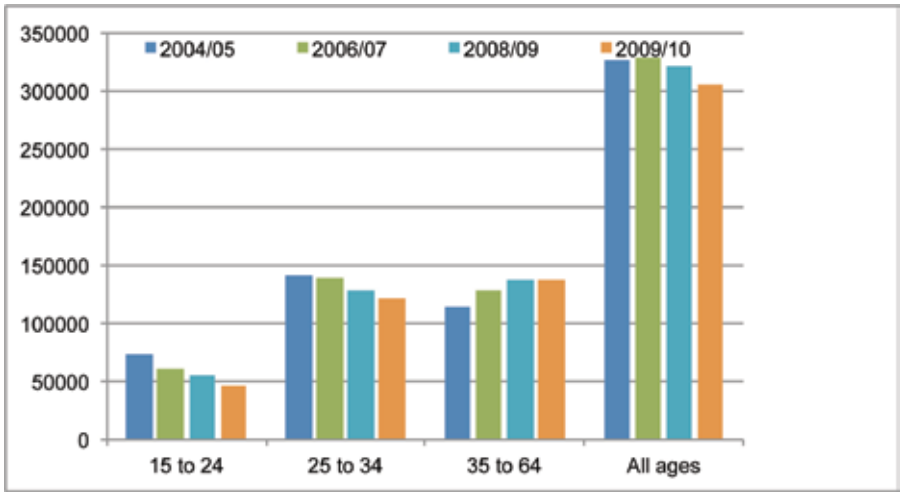
Between 2004-05 and 2009-2010 in England the estimated number of problem opiate users (which includes people in treatment) aged 16 to 24 years declined markedly, while a decrease is also seen in those aged 25 to 34 years. But the number aged 35 to 64 has increased (see Figure 1). A similar pattern is also seen in Scotland.

There are good published statistics on people in treatment and starting treatment episodes. In England, these show that from 2005-06 to 2010-11, the number of adults being treated for opiates use has increased from 139,544 to 166,221. However, the number of people aged 18-24 in treatment for opiate use fell from 22,581 in 2005-06 to 12,048 in 2010-11: a drop from 69% of all those in treatment in this age group in 2005-06 to 49% in 2010-11. At the same time the number of people in treatment for opiate use aged 40 and over almost doubled, from 25,687 to 50,933.

Over this six-year period, the total adult treatment population has become considerably older. The aging trend is even more marked among those in treatment for opiate use. Whereas, 16% of people in treatment for opiate use in 2005-06 were aged 18-24, in 2010-11 they made up only 7%. The equivalent proportions for those aged 40 or above were 18% in 2005-06 rising to 31% in 2010-11.

A similar trend can be seen among people starting a new episode of treatment. The proportion of new treatment episodes related to opiate problems fell slightly, from 72% in 2005-06 to 67% in 2010-11 but within this group the proportion aged 18-24 fell from 19% in 2005-06 to only 11% in 2010-11

Figure 1: Trends in problem drug use (opiates and/or crack) in England by age group



and the proportion aged 40 and above rose from 15% to 24%.

Scottish treatment statistics show a similar pattern with a decreasing proportion of young people and an increasing proportion of older people among new treatment entrants, while among the younger age groups those presenting for treatment for heroin are making up a smaller proportion of treatment entrants.

This is not just an British phenomenon; a similarly aging heroin-dependent population is seen in many Western countries including, for example the Netherlands, Switzerland and the United States, despite different policy stances.

So heroin dependency and the need for treatment and support is increasingly becoming an issue for older adult groups. In 2009 the NTA said 'we are seeing a shift away from the 'Trainspotting' generation'. It appears they are aging and new generation(s) are behaving differently. So how to explain this?

Clearly, an apparent decrease in the prevalence of heroin use and the numbers presenting for treatment is something to be welcomed. It suggests hope for the many individuals involved, and for their families and wider society.

Yet, not only is predicting the future difficult in this field but so is understanding the present. The myriad factors that influence drug use can be daunting, and in the changing patterns of heroin use we are undoubtedly looking at more than one explanation.

The reasons for this are a matter for speculation. The apparent decrease in the number of young people developing heroin problems may be due to heroin use becoming less 'fashionable' following the surges of the 1980s and 1990s. This would fit with the epidemic model of drug trends, with rapid escalation and gradual tail-offs.

But this still needs its own explanation. One possible answer is that, as with stories about crack use in the US in the mid-1980s, a younger generation saw their elder siblings or close friends using heroin and losing control or dying. The visible reality of heroin may have put off others from starting to use. Public information and educational programmes may have contributed too. Or perhaps an increased focus on early interventions may have helped some young people before their problems became too entrenched.

It might also be that the public are turning away from drug use more generally as part of a general shift towards less risky behaviour, also seen in some other trends such as a decline in the popularity of smoking and overall alcohol consumption. Certainly recent British and Scottish Social Attitudes Surveys suggest a hardening of attitudes towards decriminalisation of cannabis following a period of increasing support for such action.

Besides the reduction in new users, another plausible explanation for the aging population of opiate users in treatment is that expanded and improving treatment systems are leading to more people accessing and being retained in treatment for their heroin dependency. If this is the case, the recent focus on recovery may change this. But it might be that older heroin users have such entrenched problems that their lives are more difficult to rebuild.

Finally, some argue that supply-side interventions have helped reduce demand for heroin, either through affecting street prices or through edging some users out of the market with continual enforcement interventions, such as Integrated Offender Management or repeated neighbourhood busts. Yet the long term decline in heroin prices suggests the success of supply-side interventions may have been limited. However, the decline in purity of supplies may also have worked to make heroin use less attractive.

Perhaps we should reverse the question: rather than ask why heroin became less popular, we should be seeking to understand why it was as popular as it was in the first place. A plausible explanation is that the economic factors of the 1980s created a specific situation that led to the original epidemic. If that is the case, we should be concerned that there is a risk of similar problems re-emerging, although the toxic mix of deprivation and unemployment plus the arrival of smokeable heroin from Iran probably made a significant difference. Prior to that, heroin was largely injected which threw up a 'natural' barrier between heroin users and other drug users. Even so, serious, long-term economic decline has, of itself, the potential to fuel a rise in problematic substance use.

Whatever the explanations, we have an aging heroin-using population. Heroin dependency and the need for treatment and support is increasingly becoming an issue for older adult groups.

The drug field is constantly facing new challenges and needing to adapt, and this aging heroin-using population presents policymakers, local commissioners and service providers with some knotty problems.

Older users are likely to have tried different treatments, including residential, many times. Should we simply support recovery efforts at the risk of relapses, hoping to succeed with one last push, or should we also look to expand other evidence-supported solutions, like heroin-assisted treatment for this group?

In The Hague there is an experimental care home, which provides aging addicts with a safe place to live – and use drugs. The goals are different from the UK's treatment centres: to stabilise the health of residents and provide their days with structure. Many are likely to stay there for the rest of their lives. One can imagine the outraged response of local and national politicians to this in the UK.

Or look at the implications for the new benefits system. If there is a cohort of older heroin-addicted people who realistically stand little chance of finding work, it is hard to see how the new benefits system will cope with such people. The expectation that they find work may be unachievable and so we would be setting some people up to fail. The understandable desire to be ambitious potentially conflicts with what evidence and experience suggests can be achieved.

The criminal justice system will also be faced with the need to adapt if the prisons end up accommodating aging heroin users still committing crimes.. Like many systems, drug treatment and recovery is likely to face the law of diminishing returns, where each additional unit of effort becomes more expensive. The strain on our criminal justice and health systems will be significant if they are expected to pick up the slack where treatment finds progress difficult.

A renewed focus on recovery as a journey rather than a single destination (ie abstinence for all) is likely to be better suited to this group with long term problems, improving services and providing for a series of stepped and achievable outcomes. And new approaches, such as heroin-assisted treatment, may provide the first of these steps. Every policy needs to be ready for the times where it cannot succeed, by preparing a Plan B.

Roger Howard (Chief Executive) and **Nicola Singleton** (Director of Policy & Research) at the UK Drug Policy Commission