RECENT TRENDS IN DRUG USE IN BRITAIN

How many? what? how? — simple questions about drug use with no simple answers. Research from the Drug Indicators Project has helped fill the information vacuum. Project co-ordinator Richard Hartnoll sketches recent developments in the pattern of drug use in Britain.

Richard Hartnoll

Recent trends in problem drug use should be viewed against wider socio-economic, cultural and political events in Britain. Economic growth, rising living standards and relatively full employment of the 1960s and early 1970s has given way to recession and economic stagnation. Unemployment has risen sharply, more so among the young, the unskilled and minority groups. Many inner-city areas have experienced steady deterioration in housing conditions, transport and other services.

Over the same period, the youth culture(s) of the late '60s and early '70s disintegrated, loosening informal constraints which helped define what drug use was acceptable to particular groups and what was not. Optimism has been replaced by cynicism, despair and anger, particularly among the young, unemployed working class and minority groups. Ageing 'hippies' have few options left.

Such a sketch of Britain sliding deeper into gloom is neither complete nor 'balanced'. Nor is it a sufficient explanation of problem drug use — the rapid expansion of non-medical drug use in the 1960s occurred at a time of boom. But it does provide part of the background against which some groups and individuals start or continue to use drugs.

This brief account of recent trends in non-medical drug use in Britain is based in part on our own research in London[1], in part on the available research and statistical evidence, and in part on experiences from around the country. Different regions of the country present a variable picture.

Cannabis

Cannabis is the drug most commonly used for non-medical purposes in Britain. Use increased dramatically during the early 1970s, may have stabilised in the mid-1970s and has since steadily increased. Eight out of ten drug seizures and convictions involve cannabis, usually small amounts.

Since the '60s cannabis use has diffused across all classes, though it is most common in the under-40s. In line with this development, cannabis use no longer functions as a symbol of affiliation to an 'alternative' culture.

Good quality 'hash' (cannabis resin) retails at around £20-£28 per quarter ounce; for some regular users this might last less than a week. Due to increased cost, cannabis is now bought in smaller quantities than it was ten years ago, a fact which may imply less heavy use by the majority of users.

*Richard Hartnoll and co-workers at the Drug Indicators Project have been researching the extent and pattern of problem drug use in north London since 1980. Their work has been the main source of recent government estimates of the prevalence of opiate use in Britain. The Project has published a manual — **Drug problems: assessing local needs. A practical manual for assessing the nature and extent of problematic drug use in a community** — available from ISDD at £5.75 inc. p&p.*

Cocaine

During the 1960s, cocaine use was largely restricted to heroin addicts receiving both drugs on prescription. After treatment of heroin addiction was transferred to special drug dependence clinics (in 1968), cocaine became relatively uncommon.

During the mid-1970s, cocaine gained popularity, especially where there was style, champagne and money. Cocaine also became widely used — though usually on an intermittent or occasional recreational basis — by a broad section of the drug using population from all classes. It is usually sniffed — smoking of freebase[2] is not common.

During the mid-1970s, cocaine gained popularity, especially where there was style, champagne and money.

Cocaine sells for £55-£70 per gram (typically 30 to 70 per cent pure). A couple of casual users might consume a quarter gram in an evening. Regular users with sufficient resources might use one to two grams a day. Since 1983, prices have fallen while Customs seizures have markedly increased. Coupled with fieldwork observations, these indicate increased supply, though not perhaps as dramatic as some American-inspired reports suggest. It is not used extensively by adolescents and is probably more common in London and the South.

Amphetamines

Amphetamine stimulants, once widely used for both medical and non-medical purposes, are rarely prescribed today. During the early and mid-1970s, illicitly manufactured amphetamine sulphate powder became available and fairly widely used. In the late '70s, it might appear from enforcement statistics alone that amphetamine use dropped considerably, but it remained available on the street, though at a higher price. Recent statistics suggest a considerable increase, an impression confirmed by fieldwork and a fall in price, indicating large quantities on the illicit market.

Amphetamine powder is usually sniffed; the exceptions are some opiate injectors and that group of multi-drug users who commonly inject opiates, barbiturates and stimulants. Although seemingly more of a working class drug than most controlled drugs, amphetamine is nevertheless used by various groups throughout society.

Amphetamine is common in some colleges, studios, construction sites, and in the music business. In some of these groups it it used as an aid to maintaining long periods of concentration or physical work, in others purely as a recreational drug. A minority of individuals are compulsive users. After cannabis, amphetamine is the drug most commonly used by adolescents.

Amphetamine sulphate powder 20 to 40 per cent pure retails at around £10-£12 per gram, similar to the price ten years ago. A compulsive user might get through several grams a day, while a casual user with no substantial tolerance to the drug's effects could take several weeks to consume half a gram.

LSD

Widely used in the late '60s and early '70s, LSD became less apparent through the '70s, though there are indications that use is increasing again. As with other controlled drugs, LSD has lost much of its mystique, and is now used less as a self-conscious instrument of 'mind-expansion' than as simply a 'fun' drug, a trend associated with the dissolution of the '60s 'counter-culture' movement.

Although used more casually than in the '60s, LSD is supplied, and therefore probably used, in units of lower average strength. Today a single, usually weak, dose of LSD costs around £2-£3.

Barbiturates and tranquillisers

During the early 1970s, barbiturate use by heroin addicts and young multi-drug users aroused particular concern. Changes in prescribing practices have steadily reduced availability, but 'barbs' remain a problem among some heavy multi-drug users. The sources are still physicians, pharmacy thefts and diversion from legitimate prescriptions. There is no evidence of illicit manufacture. In London, barbiturate use is now largely restricted to the more chaotic, multiple drug use scene in the centre of the city.

Attention has rightly been focussed on the issue of long-term prescribing of tranquillisers. However, they are also used as 'street drugs', replacing 'barbs' in poly-drug combinations.

Solvents

Glue sniffing gained much publicity a few years ago. Since solvent use is not illegal and is not recorded in any systematic way, it is hard to know its extent. It is likely that there has

been an increase, both in experimental use (which may involve quite high proportions of adolescents) and in regular use, and that this has *not* diminished in recent years. One change in some areas is a switch from glue to butane gas.

Solvent use appears to be concentrated in particular areas, such as an estate or a school (this may be partly an artefact of selective reporting), often fading quickly in the manner of other adolescent fads and reappearing elsewhere. A minority of youngsters 'at risk' because of personal, family or social difficulties, become heavily involved as a means of coping with their problems, rather than as the more common transient social activity.

Heroin

Heroin addiction first appeared as a 'problem' in Britain in the 1960s. The number of known addicts increased dramatically, though the absolute numbers were, by current standards, small. Excessive heroin prescribing by a small number of doctors was virtually the exclusive source until 1968, when heroin prescribing for addiction was restricted to licensed doctors, based in special drug dependency clinics or psychiatric units.

The early and mid-'70s witnessed a relatively small growth in heroin addiction. Illicitly imported heroin from South East Asia became the major source as heroin diverted from legitimate prescription became more scarce. Police activity and a later series of bad harvests appear to have temporarily limited supply, and prices rose steadily until 1977/78.

The first major increase in heroin supply was partly associated with the influx of Iranian refugees following the fall of the Shah. Since 1981, Pakistan and Afghanistan have become the primary source.

Since 1970, the number of people using opiates regularly has risen, probably by at least ten-fold. The primary drug involved is heroin.

The current price of illicitly imported heroin in London is £80-£100 per gram (typically 30 to 60 per cent pure) in gram quantities. In larger quantities (eg, a quarter ounce, approx seven grams) the price is lower, perhaps £60 per gram. Relative to inflation, the price has halved since 1978, though since late 1985, it has started to rise again. Prices are higher in other areas, such as Scotland.

Opiate addiction treatment clinics have reduced their prescribing of heroin. In 1977, 19 per cent of addicts attending London clinics received some heroin; by 1984, this had dropped to six per cent. Over 70 per cent of addicts attending London clinics received oral methadone only in 1984 compared to 29 per cent in 1977. Most of the remainder received ampoules of methadone for injection (21 per cent compared to 52 per cent in 1977).[3]

Since the late '70s, the incidence and prevalence of heroin use and addiction, as recorded by the Home Office and supported by numerous informal sources, have increased significantly. Illicitly imported heroin has become much more available. Intermittent, recreational use of heroin (usually sniffed or smoked rather than injected) has become more widespread.

Until 1980/81, heroin users and addicts were more likely to be in their mid- to late-20s or 30s than in the '60s, when heroin use was predominantly an adolescent/early adult phenomenon. Since then much younger people have become increasingly involved, and the proportion of females among known addicts has increased to 30 per cent.

Increased availability and use has been particularly noticeable outside London, especially in large urban conurbations such as Merseyside, Manchester, Edinburgh and Glasgow. It has also continued to increase in London. In the more depressed parts of some cities, heroin use appears to be developing into a pattern usually associated with the ghetto conditions in some North American cities. The major difference is that heroin use in the UK is still mostly restricted to the white British or Irish population. However, it appears that the situation in some black or other ethnic groups may now be changing, though information is not readily available.

As well as increasing in some working class urban communities, heroin use has expanded throughout a wide range of social groupings, including the children of the middle and upper classes.

A much smaller proportion of the total addict population is in treatment than 15 years ago. Then about half the heavy opiate users in Britain were seen and notified by doctors; now the proportion is likely to be a quarter or less. This implies that the total number of people in the UK who used opiates regularly (and were dependent, at least to some degree) at some stage during 1985 was in the order of at least 60,000 and perhaps 80,000. The numbers using regularly at any one time ('point prevalence') would have been lower, at least 30-35,000.

In London, the rate of increase of new heroin users may have levelled off.

Synthetic opiates

Use of synthetic opiates illegally 'diverted' from the legitimate medical market has remained relatively stable. They are used both as drugs of choice and as substitutes for heroin, though heroin's increased availability has diminished their relative importance.

Methadone is prescribed to addicts in treatment at drug clinics, and by physicians outside hospitals under circumstances that may or may not be considered part of a treatment programme. Since stricter prescribing controls imposed in 1984, Diconal use has diminished, but use of codeine and DF 118 appears to have risen.

Despite controversy over the prescribing of synthetic opiates, there can be little doubt that heroin is the major opiate involved in non-medical use.

Multi-drug use

Multi-drug use has become more widely recognised since the '60s, though this change may have as much to do with perceptions as with drug using behaviour, which for a long time has often included more than one drug.

THE MAIN FEATURES

- ► Since 1970, the number of people using opiates regularly has risen, probably at least ten-fold. Most of the increase has occurred since 1978. The primary drug involved is illicitly imported heroin. This increase may now be slowing down.
- ► The illicit drug market has expanded, especially for cannabis, heroin, amphetamine sulphate and cocaine. Sums of money involved have increased dramatically. It has also become more organised and attracted the attention of criminal groups who, several years ago, would not have wanted to become involved. This is particularly true of cannabis and amphetamine, and, in the past five years, of heroin.
- ► Very few addicts now receive heroin on prescription from drug dependence clinics. Methadone is usually prescribed instead. A few years ago, most methadone was prescribed in injectable form; now most clinics prescribe oral methadone only to the majority of new patients or to patients returning into treatment.
- ► Private doctors and GPs have re-emerged as a source of opiates other than heroin. Methadone and DF 118 are the most commonly prescribed (legal restrictions on prescribing to addicts apply only to heroin, dipipanone and cocaine). Similarly, prescriptions are the original source of most barbiturates and of some stimulants such as dexamphetamine, diethylpropion, Ritalin, etc.
- ► Boundaries separating subcultural patterns of drug use became blurred as the 'youth cultures' of the late 1960s and early '70s disintegrated. Multi-drug and combination drug use have become more apparent. Dealers are more likely to supply a variety of drugs, although some still supply only cannabis as a matter of principle.
- ► Younger drug users appear to be using cannabis, solvents, amphetamines, pills such as Valium, and alcohol. Apart from alcohol, these are inexpensive and unlikely to lead to convictions for drug offences, though the consequences of use may still be disturbing. In the past five years, a minority have started to use heroin. In areas such as Wirral or Glasgow, this is a substantial minority.
- ► Cannabis ('ganja') is integral to the culture of significant parts of black communities. Among Asian communities drug use is less apparent, though there is some opium and cannabis use. Depending on their degree of integration into British culture, other ethnic communities have assimilated to the general pattern of drug use in Britain. There are recent suggestions of some heroin use among blaek and Asian communities.

1. Hartnoll R., Lewis R., Mitcheson M., *et al.* Estimating the prevalence of opioid dependence. *The Lancet*, 1985. *I* (8422) p.203-5.
2. Freebasing cocaine involves chemically converting cocaine hydrochloride so that it can be smoked through a pipe, a route of administration that gives a much more immediate effect than sniffing. However, this is an exceptionally expensive method of taking cocaine.
3. Galton I. *A review of prescribing practices amongst London drug dependence clinics 1977-1984.* Unpublished. Middlesex Polytechnic, 1985.