

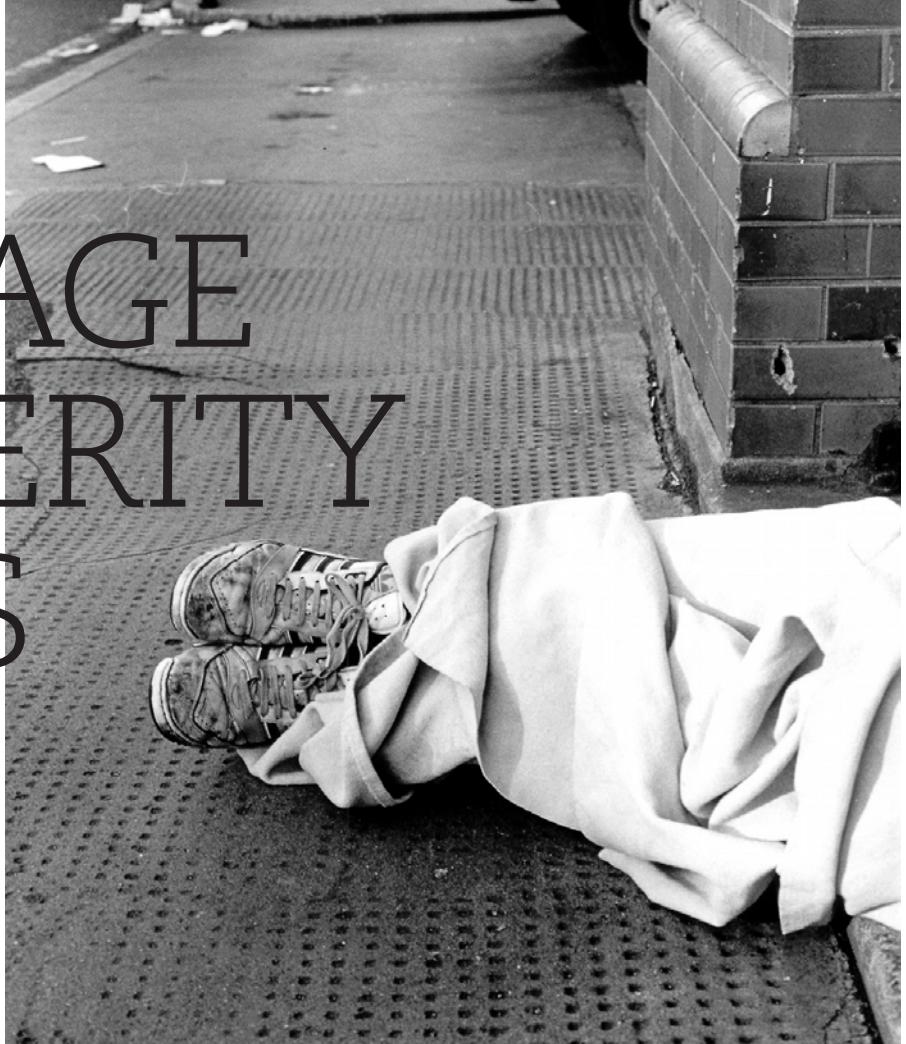
# NEW AGE AUSTERITY HIGHS

In the 1980s heroin use rocketed alongside spiralling deprivation. So why, now we have returned to an era of austerity, is heroin use falling?

**Steve Wakeman and Toby Seddon have some answers.**

Thirty years ago, in the early 1980s, the social and political outlook in Britain was bleak: economic recession, public spending cuts, youth unemployment and inner-city disorder. Making a bad situation worse – most notably in the post-industrial cities of the North and Scotland such as Liverpool, Manchester and Glasgow – arrived cheap, brown heroin. It spread like wildfire amongst young people in the most deprived neighbourhoods. Many commentators claimed this heroin 'epidemic' to be a symptom of the country's wider socio-economic malaise.

Rather depressingly, much of this is familiar today in the austere climate that



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has followed the global financial and banking crisis, with deep cuts in public services, a flat-lining economy and the 2011 riots all echoing the troubled times of three decades ago. However, there is a curious exception here: heroin. Contrary to the expectations of many, according to NTA's statistics, the number of heroin users, far from exploding, appears to be falling, as is the use of crack. The accepted wisdom that there are strong connections between drug problems and deprivation suddenly no longer seems quite so secure.

Faced with this puzzle, we have been attempting to re-evaluate the use of heroin in today's 'austerity Britain' through an ongoing ethnographic research project on a housing estate in North West England. And, we have made several small but significant observations that provide some clues as to what might be going on. We focus here on one of these emerging findings: the sharp rise in the use of two prescription-only painkillers, pregabalin and gabapentin.

As anticonvulsants, these drugs are primarily used to treat neuropathic pain,

but like most pharmaceuticals they have multiple uses. While robust and reliable national data regarding prevalence of their use in heroin-using communities is non-existent at present, in the locale of our research we have observed it to be commonplace, with considerable demand developing for these drugs.

Recently, whilst waiting for a heroin dealer to arrive, 'Ryan' (a long-term heroin and crack user in his early forties) explained the current situation:

*Ryan: People can't get them [pregabalin] as much as they'd like to really. I can, but I keep that quiet, you know? If everyone gets on them they'll [the doctors] stop giving them out. It's like there's more demand than supply just now.*

*SW: So how much do they sell for then?*

*Ryan: Depends on the tab, the 60mg ones not much, they're not that good, you need quite a bit of it you see, but the 150mg ones, they're like a quid a pill or something like that, you can do alright with them if you've got loads.*

This particular individual was prescribed pregabalin as a result of pain caused by methadone withdrawal, but

he has subsequently started sourcing them from elsewhere too (mainly from a non-heroin-using amputee prescribed pregabalin for 'phantom' pains in an amputated leg).

Despite his claim to be 'keeping things quiet', we have witnessed the use and sale of these two drugs spread across the whole heroin-using population on this estate. They have quickly become established components of the drug market here, especially pregabalin, and this – in our estimation at least – might represent a significant development regarding the *real* nature of reported falls in heroin use.

As we will explain, it is possible that the use of drugs like pregabalin is affecting the recorded rates of heroin use. Our interviews and observations suggest this drug has been adopted so feverishly because of its 'dual utility'. Pregabalin enhances the desired effects of heroin in that it helps the user 'gouge out', but it also has the capacity to reduce the undesirable effects of withdrawal symptoms too. That is, for the heroin users we have been spending time with, pregabalin maximises pleasure and minimises pain concomitantly. Illustrating this, 'Anton' (a male heroin user in his early thirties) gave the following response to a question about the effects of pregabalin:

*They do the job, they smash me right in. On top of a smoke [of heroin] like, they're like being pissed, except you know what you're doing and that.*

However, during a subsequent meeting whilst he was attempting to withdraw from heroin (again), he was still consuming pregabalin (in large quantities too). When asked about whether or not this 'worked', he responded:

*It's not perfect, but nothing's ever going to be it? It does do the trick though in a way, it deffo helps, like really helps you know? One of the main things for people is the cramps and twitching legs and that, and it really helps with them, but also with sleep, I'd say that's the main thing for me, it lets me sleep – if I take enough of them that is.*

So pregabalin has attractive qualities on two fronts; this is not simply a matter of pleasure seeking, or pain-avoidance, but both at the same time. Whilst pregabalin is not the cheapest black-market pharmaceutical in circulation, it is not the most expensive either, and it has become highly sought after in this area – a regular supply like Ryan's is something to be coveted. It is clear that developments such as this – as marginal as they may be at present – have implications for the ways in which local

drug markets are structured, and in turn, for what we know about them and the levels of drug use they contain.

Despite national estimates indicating a decline in 'problem drug use', our research suggests there may be more going on here than first meets the eye. Based on our observations, there is a case for considering the role of substances like pregabalin in the reported falls in heroin use, especially because of its dual functionality for users. The use of pregabalin to enhance the effects of heroin means one requires less heroin to maintain a habit.

## FAILING TO MONITOR NEW PATTERNS OF DRUG TAKING BEHAVIOUR DOES NOT MEAN THEY DO NOT EXIST

But this does not necessarily equate to less problematic drug use. At the same time, on a number of occasions we have witnessed heroin users utilising pregabalin's opposite capacity by detoxing themselves at home with an illicitly sourced supply. We leave aside the question of whether or not this 'works'. What is critical here is that this behaviour can preclude a user's contact with treatment agencies and as a result, their appearance in treatment data. We certainly acknowledge this is speculative at the moment, but if similar shifts are happening elsewhere then a potential distortion of national drug trend data becomes conceivable at the very least.

In other words, what appears to be a decline may actually be a more complex process of diversification. And, given the fact that there are currently no accurate quantitative measures of this diversifying picture, we have no way of knowing whether drug markets as a whole are growing or shrinking. All we can say is that our own qualitative observations actually run counter to the quantitative measures we do have. If we also consider the fast-moving market in 'legal highs', only some of which are on the policy and monitoring radars, then reports of a shrinking drug problem seem less than convincing. It may be more plausible to suggest that our monitoring systems are simply falling behind rapidly evolving drug markets.

Our findings resonate strongly with earlier studies on the 1980s heroin epidemic, *Living with Heroin and The New Heroin Users*.<sup>1,2</sup> We have found heroin to be an important commodity within the informal economy on this estate (an economy that is flourishing in these

times of economic hardship). However, our project reveals more complex intersections between illicit drugs proper and various pharmaceutical drugs that are being used and sold illicitly, than those that went before it.

This presents an obvious challenge for conventional approaches to policing and law enforcement, which are predicated on more clear-cut divisions between legal and illegal commodities. There may also be implications for health. The problems associated with the illicit use of benzodiazepines and other similar drugs are well documented; it is possible that what we are looking at with pregabalin is the start of something similar. On a number of occasions users have expressed to us their belief in the 'harmlessness' of pregabalin due to it being 'non-opiate'. Whilst it is true that it is not an opiate-based substance, we are less convinced it is necessarily harmless, particularly when used in the quantities we observed and alongside other substances. From a public health perspective, this has the potential to be problematic.

What are we to make, then, of this emerging picture of heroin in austerity Britain? It seems to us, first of all, that politicians (and others) have been far too hasty in celebrating drug policy 'successes': failing to monitor new patterns of drug taking behaviour does not mean they do not exist. We would suggest that any complacency now would be ill-judged and irresponsible – David Cameron's assertion in December 2012 that "we have a drug policy that is actually working, drug use is coming down" may be more like political wishful thinking than it is an evidence-based fact.

Announcements of the death of the drugs-deprivation link may also be premature. Our research suggests that illegal substances remain important commodities circulating within the 'shadow' economies that thrive in the most disadvantaged neighbourhoods, and that they grow in stature and appeal in close correlation with the decline of legitimate economic opportunities. What is now urgently needed is further ethnographic research in areas such as this to build our understandings of their rapidly evolving local drug markets. Only then will we be able to develop policies and services that can fix today's problems rather than yesterday's.

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