

**A Review of the UK drug strategy PSA targets
and Drug Harm Index**

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1. Drug strategy targets

Targets have three core components – that is, they can be defined as (1) performance indicators, i.e. measures of drug-related risks, harms or interventions which specify both (2) the level (or, at least, direction) of change, and (3) the timeline of change – including both a baseline year and a deadline year by which this change should be achieved. A fourth component, which is useful but not always essential, is the sub-group of people targeted (eg. young people, injectors, offenders). Clearly, all concepts in targets require operational definitions to be of use.

UK drug strategy targets have evolved through a number of stages (Appendix A). By 2006, they had been whittled down and revised into three, two-part PSA targets (additional specifications in square-brackets were derived from ‘2004 PSA Targets – Technical Notes’):

(1) (a) reduce the harm caused by illegal drugs, as measured by the Drug Harm Index [by 2007/08, from 2002 baseline] including (b) to substantially increase the number of drug misusing offenders entering treatment through the CJS [from a baseline of about 700 in May 2004];

(2) (a) increase the participation of PDUs in Tier-3 drug treatment programmes by 100% [by 2008, from a national 1998/99 baseline of about 100,000] and (b) increase year on year the proportion of users successfully sustaining or completing treatment programmes [from a local baseline of 2003/04 for future PCT targets];

(3) (a) reduce the use of Class A drugs among under-25s [from a 1998 baseline of 8.6% among 16-24s, and 2.4% among 11-15s], and (b) reduce frequent use of any illicit drugs among under-25s [from a 2002 baseline] – with ‘vulnerable under-25s’ having a 2003/04 baseline

The fourth target in the previous set of targets – reducing the availability and supply of drugs - is now subsumed under Target 1 – along with the general crime reduction target of the Home Office. Similarly, the target introduced by the DH’s Priorities & Planning Framework in November 2004 – to reduce drug-related deaths by 20% by 2004 (against a 1999 baseline of about 1,500 drug-deaths) – has also been incorporated under PSA Target 1. Target 1 has also become one of the seven general Home Office PSA targets set out in the Spending Review. But the PSA targets are by no means exhaustive or even comprehensive in their coverage – particularly compared with the numerous targets presented in strategy documents in 1999 and 2002. More specifically, though they offer fairly good coverage of intervention-related targets (making and maintaining contact, and delivery of services) and harm-reduction targets of all types, they neglect risk-reduction targets (other than frequency of use) – that is, drug consumption behaviour. For instance, the pioneering drug strategy target presented in the Health of the Nation in 1991 – reducing needle-sharing among drug injectors (to 10% by 1997 and 5% by 2000) – has not been updated or incorporated. Nor are there any targets aimed at methods of use, amounts used, settings of use, use of mixtures of drugs (multi-use and poly-use), etc..

The Home Office has lead responsibility for the first target; the Department of Health for the second (and fourth) target; and the Department of Education & Skills for the third target (sharing responsibility for delivery with the Home Office). Targets 1 and 3 pertain to England & Wales, while target 2 pertains to England only (excluding prisoners). The Consultation Document states the main sources of data for assessing target 1 are the various official statistics and surveys relevant to the Drug Harm Index, and DIP statistics; the main source of data for assessing target 2 is the National Drug Treatment Monitoring System; and the main sources of data for assessing target 3 are the annual British Crime Surveys (16-25s), Schools

Surveys (11-15s), and Crime & Justice survey (vulnerable young adults). In May 2006, the PSA consultation document stated that the PSA framework from 2008/09 to 2010/11 would be set in 2006/07 as part of the 2007 Spending Review.

Two key questions are described as central to the present consultation: (1) what are the key learning points from previous targets? and (2) what opportunities exist to improve upon previous targets? Other relevant questions include: (3) are the number of targets and their proposed measures adequate? (4) Do they provide sufficient flexibility for local decision-making? (5) Are there more effective levers for incentivising delivery of drug strategy objectives than the targets?

The third question leads to the first criticism of the PSA targets. That is, their number (three - or six, if we count the sub-targets in each) is far smaller than in previous strategy documents (see Appendix A). The consultation document also stated that “*we aim to have a small number of targets that are specific, measurable and ambitious*” (p.3), and that targets should “*incentivise achievement*” and be “*stretching yet realistic and achievable*” (p.8). The document also argues that the principles from which PSA targets should be developed should include having “*specific numerical values attached where possible*”, and being “*set for the most appropriate time period*” (p.10). This brings us to the second criticism of the PSA targets. That is, what ‘appropriate’ means is unclear, because no explanations are given for why particular time periods (from baseline to deadline) are chosen, other than practical considerations – for example, the collection of relevant data began in a particular year (baselines), or the drug strategy ends in 2008 (deadlines).

Other criticisms of the PSA targets are better understood within a broader conceptual framework. A conceptual analysis of the three PSA targets revealed that each indicator – PI, change and deadline – can be described with a core set of concepts and related terms (see Chart). Focusing on PIs, risks are (aspects of) drug consumption behaviours, and harms are the negative consequences of drug use (see Appendix B for details). Interventions are responses by organisations designed to either reduce drug-related risk (one or more of seven components), and/or reduce drug-related harm (in one or more of nine categories) – or to meet two preconditions for these two objectives, namely making and maintaining contact with drug users, and effectively delivering services and products to them. In short, interventions have four logical stages of objectives: (a) increasing contact, (b) maximising delivery of services, (c) reducing risk, and (d) reducing harm. The change indicator ideally requires a numerical value (notably percentage change), though a directional value is the minimum acceptable (increase or decrease). This brings us to the third main criticism of the six PSA targets – five specify only the direction of change, and just one specifies proportionate change. Returning to the two key questions of the consultation, this does not amount to an improvement on previous targets, which were *more* likely to specify “numerical values” for levels of change (proportionate or absolute).

Finally, the conceptual analysis presented in Chart 1 also shows that the performance indicators selected focus on intervention preconditions (targets 1 and 2 - making contact and service delivery) and harm-reduction (target 1 - see next section). With the exception of Target 3, which is aimed at reducing Class A drug use and frequent drug use among young adults, risk-reduction targets (safer consumption behaviour) and demand-reduction targets (notably lower prevalence levels) are clearly neglected.

Chart 1: Conceptual analysis of three PSA targets for UK drug strategy (2006)

<u>Target</u>	<u>Type of Performance Indicator</u>	<u>Change</u>	<u>Baseline</u>	<u>Deadline</u>
1a	Harm (as in Drug-Harm Index) [all]	reduce	2002	2007/08
1b	Interv (treatment - contact)[offenders]	increase	2004	each year
2a	Interv (treatment - contact) [PDUs]	inc. 100%	1998/99	2008
2b	Interv (treatment - delivery) [PDUs]	increase	2003/04*	each year
3a	Risk (product) [U25s]	reduce	2003/04~	2007/08
3b	Risk (pattern) [U25s]	reduce	2003/04~	2007/08

Interv = intervention inc. = increase U25s = under-25s (especially vulnerable groups)

[] = sub-group at which target is aimed () = type of risk, harm or intervention type/stage

Performance indicators: **Harm** = one or more of nine categories (level/type)

Risk = one or more of seven components (product/access/amount/pattern/ method/mixture/context)

Intervention = type (treatment/control/prevention) and stage (contact/delivery/risk/harm)

Change: directional change: reduce or increase

Proportionate or numerical change: in percentages (%) or absolute numbers (N)

Baseline: year from which change is measured

~ initially 1998 for BCS, and 1999 for Schools survey

* SHA target for PCTs

Deadline: year by which change should be achieved

Source: UK Government (2004). *PSA Targets: Action against illegal drugs – technical notes.*

In short, the PSA drug strategy targets (T1a to T3b) are inadequate for several reasons:

(1) the performance indicators are selective and narrowly focused – though they are linked to strategic aims, they do not reflect the full range of risks, harms and interventions, mainly because they lack a conceptual framework within which targets can be properly formulated.

Harm-related PIs are focused too heavily on crime (T1a), risk PIs are restricted to ‘frequency of use’ and one prevalence target only (T3), and intervention PIs are restricted to treatment (Tier-3) interventions (T1b & T2)

(2) the six proposed changes have ‘partial’ rather than ‘full’ status – that is, with one exception, they are directional (increase/reduction), not proportional/numerical (eg. ‘25% drop’, ‘5000 more’)

(3) although the deadlines (and baselines) are clearly linked to practical milestones (notably 2008, the final year of our present drug strategy), there is no broader rationale for why the proposed time periods are suitable to achieving the specified directions/levels of change

2. Drug Harm Index

2.1 Description and overview

The third question listed for the consultation asked whether the number of targets and their proposed measurement were adequate. Though the formal count (three/six) suggests a relatively small number of targets, the Drug Harm Index (DHI) is intended to integrate several targets into one measurement. Whether the DHI provides ‘adequate measurement’ is the main question dealt with in this section.

The Home Office has released two reports describing the DHI (McDonald et al., 2005, 2006). The first noted that “*the Drug Harm Index captures the harms generated by the problematic use of any illegal drug by combining robust national indicators into a single-figure time-series index ... [including] drug-related crime, community perceptions of drug problems, drug nuisance, and various health consequences ... (HIV, overdoses, deaths, etc.)*” (MacDonald et al., 2005: v). Their relative importance “*is captured by the economic and social costs that they generate*” – which are partly based on a Home Office study of the costs of Class A drugs in 2000 (Godfrey et al. 2002). Annual changes in the Index will reflect two trends: (1) changes in the volume of harm (eg. number of HIV cases), and (2) changes in the unit economic and social costs of the harms (eg. NHS costs of treating HIV). Because of the diversity of harms and associated rates of change, “*it is recommended that the DHI should be considered alongside a ‘basket’ of individual indicators in order to determine which particular types of harm are becoming dominant, or are being moderated*” (2005: v). The consultation document noted that “*now that the Index has been in operation for a year, we will look to see whether we have learnt enough to start estimating the likely impact of our interventions on the index and whether we can set a specific numerical target*” (2006: 29). A model has also been developed to predict future drug-related crime and death rates from trends in the number of people entering treatment.

Chart 2: Calculation of Drug Harm Index:

- (1) Determine the total costs (harm) for each year by (a) multiplying each harm’s volume by its unit social cost, and (b) adding together the products for each harm;
- (2) For each harm in a given year, express the unit social cost of the harm as a percentage of the total cost (1);
- (3) For each harm, multiply the percentage share of the total cost (2) by the year-on-year growth in the volume of the harm;
- (4) Add together the weighted growths (3) to get the overall change in the year-on-year growth of overall harm;
- (5) Express (4) as an index, in which the 1998 value is 100.

First, regarding the generation of harm variables, McDonald et al. (2005) note that “*the DHI does not capture all the harms that illegal drugs might possibly generate, but rather a subset of harm for which robust data are available*” (2005: v) – which makes a better index of relative harm (change over time) than absolute harm at any one time. The 19 harm variables included in the DHI fall into three groups - crime, health and drug dealing – and are focused either on all drug users, sub-groups of drug users (eg. injectors), or the community. First, the 7 drug-related health harms include (a) deaths, mental disorders, and overdoses among all users

(Hospital Episode Statistics), (b) the incidence of HIV, HBV and HCV among injecting drug users (CDSC) – and sexual transmission of HIV from IDUs to others - and (c) drug problems in neonates (HES). Second, the 10 drug-related crime variables are divided into 6 domestic crimes (number of offences involving burglary of dwelling, theft of vehicle, theft from vehicle, bicycle theft, other theft, and robbery) and 4 commercial crimes (number of offences involving shoplifting, burglary of commercial premises, theft of vehicle, theft from vehicle). Third, drug dealing (called ‘community harm’) is based on two indicators: the number of drug trafficking offences (intent/supply/etc.), and community perceptions of drug dealing as a local problem. McDonald et al. (2005: 5) also noted that there are two other ‘measures of impact’ for the drug strategy in addition to the DHI, namely (1) estimates of the number of problem drug users, and (2) the economic and social costs of Class A drugs.

Second, turning to weighting, *“the DHI allows for not all types of harm being costly to society. It uses weighted averages, giving greater weight to harms which make a relatively large contribution to total social cost”* (2005: 5). The DHI *“is constructed by first determining the share of total social cost in any one year of each individual harm, then using the share to ‘weight’ the year-on-year growth in the volume of harms”* (2005: 5). Annual trends (rising/falling) in the DHI are based on two components: the volume of harms (number of cases) and the unit economic or social cost (average cost). Thus, a particular harm may fall/rise either because of a lower/higher annual number of cases/incidents, or because the cost of each case/incident was reduced/increased. Or, the value of a particular harm may stay level because, for instance, the annual number of incidents/cases was higher, but this was offset by a reduced cost. The ‘weight’ for a particular harm is calculated *“as its total social cost (unit cost x volume) expressed as a share of the grand total across all categories of harm”* (p.5). Since unit costs are generally fairly stable over time, and the harder of the two to measure, *“the main driver of the DHI is the change in the volumes of incidents generating those harms”* (2005: 5) – i.e. risky consumption behaviour. Also, *“there is a tendency for the volume indicators to follow broadly similar trends, since they are the outcomes of common underlying movements in the extent of drug abuse”* (2005: 5). In their 2006 report, McDonald et al. also comment that *“weights ... dampen the effect of large percentage changes in volume”* (p.3).

McDonald et al. (2005, 2006) have reported the typical average cost shares (weights) for both 2003 and 2004, and there were only minor changes between the years. Chart 3 shows that *“the leading contributors”* to the index were drug-related deaths (just over a fifth in both years), commercial burglary (about a sixth), domestic burglary (about a sixth), shoplifting (one in ten), and robbery (around one in ten) - with all other harm variables having a weight below 10%. Growth rates ranged from +0.13 (deaths) to -0.38 (domestic burglary). The index started from a baseline of 100 in 1998, then fell 10 points between 2002 and 2003, and a further 16.9 points between 2003 and 2004 (from 105 to 88) – a drop of 16%.

Chart 3: Weights of 19 drug-related harms in 2003 and 2004, and growth rates

	<u>Weights (%)</u>		<u>Growth rate</u>	<u>Impact on DHI</u>
	<u>2003</u>	<u>2004</u>		
<u>Crime indicators (n=10)</u>	<u>67.8</u>			
Commercial burglary	18.0	15.6	-0.31	-4.77
Domestic burglary	14.9	16.5	-0.38	-6.24
Shoplifting (commercial)	10.4	9.6	-0.23	-2.22
Robbery (domestic)	9.3	12.4	-0.18	-2.19
Other theft (domestic)	4.6	7.1	-0.26	-1.82
Theft from domestic vehicle	4.5	5.4	-0.27	-1.53
Theft of domestic vehicle	4.4	2.9	-0.28	-0.81
Theft of commercial vehicle	1.1	1.0	-0.34	-0.33
Theft of domestic bicycle	0.4	..	..	..
Theft from commercial vehicle	0.2	..	..	..
<u>Health indicators (n=7)</u>	<u>27.6</u>			
Deaths	21.8	21.1	+0.13	+2.71
HCV	2.8	1.8	-0.12	-0.22
HIV	1.5	1.8	-0.13	-0.23
HBV	1.1	..	..	..
Mental disorder	0.3	..	..	..
Neonatal	0.1	..	..	..
Overdose	0.0	..	..	..
<u>Community indicators (n=2)</u>	<u>4.5</u>			
Perceptions of dealing	3.5	..	..	..
Dealing offences	1.0	..	..	..

Harms: drug-related incidents or cases during year

Growth rates: changes in volume of harms, where '+' stands for increase, and '-' for decrease (based on differences in natural logarithms within general method)

Impact on DHI: weighted growth rates (index points)

Weight: share of total harm (to one decimal place), i.e. "total social cost (unit cost x volume) expressed as a share of the grand total across all categories of harm" (McDonald et al, 2005, p.5).

0.0 = less than 0.05% .. not reported

Sources: McDonald et al. (2005, 2006)

2.2 Criticisms of DHI

The Drug Harm Index is a noble effort to pin down the slippery and complex concept of drug-related harm, and has many present merits and much future potential. For instance, it is based on an impressive mathematical foundation, it accesses and utilises a wide range of data sources, and it provides a pioneering attempt at monitoring drug-related harm in a more scientific manner. However, its present formulation has several conceptual and technical problems, and there are one or two critical flaws in its foundations. The following critique is presented as a constructive contribution to theory and research on the DHI.

McDonald et al. (2005) note three main limitations of the DHI, i.e. *“at the highest level there are three important areas of uncertainty that have required certain assumptions to be made”* (p.7). These limitations, along with suggested solutions, are as follows:

(1) there is no time-series data on the proportion of crimes that are drug-related (*“the calculation of drug-related proportions of crimes is believed to be one of the most likely sources of errors”*, p.19). The suggested solution is to estimate this proportion using data from the NEW-ADAM and Arrestee Survey;

(2) there is no source to infer the trend in the number of commercial crimes – the suggested solution is to assume that there is a constant recording/reporting rate for each type of commercial crime, so that their volume is proportional to recorded crime within that type;

(3) estimates of most unit costs are available only for a single benchmark year – the suggested solution is to assume unit costs are proportional to an appropriate price index (assumed annual rate of 3% for health, crime and other cost elements).

Other weaknesses in the DHI are also identified by the 2005 report. First, *“some of the available indicators of harm clearly involve substantial delay”* (p.9). For example, most HIV cases remain undetected by the healthcare system/statistics for about five years. Second, *“the most pressing area of work is to ensure consistency between the health and crime unit cost estimates”* (p.10) – in short, measurement of the volume of health-harms is not as well developed as the methodology for crime-harms. Third, *“further research is also required surrounding the inclusion, and reflective weighting, of other possible health indicators”* (p.10). In addition to such health harms as bacterial infections, this includes *“indicators that capture excessive risk, such as the proportion of intravenous drug users that share needles”* (p.10). Indeed, as mentioned in the previous section, risk variables (aspects of drug consumption behaviour) are conspicuously neglected by both the PSA targets and the DHI.

In addition, limitations in available data mean that the DHI’s trajectory model can only predict the impact of treatment on future crime and death rates. That is, it cannot predict trends in health harms other than death: *“therefore average growth rates in the last three years have been applied to all other harms in the DHI trajectory”* (2006: 2). Another unjustified assumption, adopted for the sake of ‘simplicity’, is that *“the unit costs for all the harms were estimated to increase by three per cent every year”* (p.2).

The government developed the DHI to produce a single numerical indicator of drug-related harm from several component variables – which theoretically permits objective measurement of the level of change in drug-related harm. However, subjectivity creeps back into any such model at two critical points:

- (1) the generation (identification, selection, definition, and labelling) of harm variables
- (2) the assignment of numerical weights (importance) to these variables.

First, the generation of the DHI's harm variables has limitations at each stage of the process: identifying the full range of harms, selection the most 'important' harms, operationally defining each harm, and naming (labelling) each harm. The DHI neglects many relevant harms, selecting only those on which official statistics or survey data were available. Official statistics are subject to many biases and limitations, and would not usually be described as 'robust data'; and survey data, though useful, has to be interpreted in the context of its inherent limitations (eg. self-report). Many harms were excluded from the DHI "*because they cannot be measured consistently or because of conceptual ambiguities*" – in short, "*there does not exist a consistent time-series dataset that directly captures these harms*" (McDonald, 2005: 3). Those excluded harms mentioned in documentation include occupational status, (eg. unemployment), educational qualifications, financial status, accommodation status (eg. homelessness), work productivity and absenteeism, and parenting/child issues. Thus, though the model retains its mathematical validity as a 'time-series index', it does so at the cost of neglecting many highly relevant variables (see Appendix C for a simple model).

Rather than excluding them, the DHI should have incorporated estimates for key harm variables lacking 'robust data', either by constructing best-estimates from available routine/research data, or by directly linking the exercise to efforts to introduce the procedures needed to generate the relevant data (eg. inclusion of new questions in the BCS, developing official health/crime monitoring systems). The emphasis on 'robust data' is also suspect: data needs to be valid (accurate) as well as reliable (robust). But the DHI employs official statistics as a key data source, and these are typically of limited validity, reflecting organisational policies and practices as much as trends in drug-related incidents (eg. offence rates)

Moreover, attempts to develop such a framework may well find that variables such as crime, disease, social disorder and societal costs are inherently incomparable (the 'apples and pears' problem). For instance, such an enterprise may be akin to producing a single-figure indicator for the weather, based on an equation which incorporates temperature, wind, rain and other meteorological variables. Not only are these weather systems arguably far too different to be integrated into an overarching variable, but a single-figure indicator telling us how good or bad the weather is would not indicate whether or not it was going to be cold, windy and/or rainy (and thus whether we should take a coat, hat or umbrella out with us).

Ultimately, value-judgements (moral, political and cultural viewpoints, norms and sentiments) determine both (a) whether a consequence is defined as a harm or benefit, and (b) the importance (selection and weighting) of particular harms - as well as practical constraints such as the availability of adequate indicators for measurement (meaning valid, reliable, etc.). Though there is great consensus on the classification of many consequences as harms (eg. deaths, overdoses, crime), the classification of some consequences as harms or benefits is more clearly an issue of morality and ethics – for instance, personality changes, formation of sub-cultures, and substitution of drug use for more dangerous activities (eg. alcohol use, risky sports).

Turning to specific areas of neglect, the DHI conspicuously under-represents both harm and risk variables. Major harms neglected in the pursuit of 'robust data' include: (i) drug-related offences involving prostitution, begging, violence and fraud/deception; (ii) various health-harms involving injecting (flesh wounds, bacterial infections, etc.) and other kinds of drug use notably accidents, injuries, STDs and mental disorders); and (iii) social harms other than dealing, such as drug use/paraphernalia in public places, stress and stigma to relatives of users, impact of homelessness and unemployment, workplace issues, etc.. In addition, risks are totally

neglected by the DHI – including products, access, patterns, amounts, methods, mixtures and settings of use. As the source of all drug-related harm, consumption variables (7 risk concepts) should be central to the DHI model – for example, needle sharing (method), use of ‘drug houses’ (setting), heavy use (amount), speedballing (mixture), and method of funding drug use (access). The DHI is also heavily focused on Class A drugs, and within that group, heroin and cocaine/crack - harms associated more with ‘dance drugs’, cannabis, tranquillisers or steroids seem to get less attention; and the predictable exclusion of alcohol and tobacco is ultimately as unjustifiable as the exclusion of our two most harmful drugs from the national drug strategy.

Second, the assignment of numerical **weightings** to risk/harm variables is riddled with subjectivity. Deciding upon the inclusion or salience of a risk/harm requires taking a particular political (non-scientific) position on their evaluation. In short, human value-judgments lie at the foundations of any such approach – any drug-related risk/harm model employing such equations would need to clearly identify the political and socio-cultural values on which the selection of variables and determination of associated weightings are based (Newcombe et al., 1989). Second, there is the ‘apples and pears’ problem – it is difficult to conceive of a conceptual model which is sophisticated enough to cover and compare such distinctly different drug-related harms as ‘social problems for family/partners of users’, ‘health harm to user’ and ‘economic harm to society’. This would require the integration of concepts from the biological, psychological and social sciences – a biosychosocial model. Such approaches are in their infancy, though pioneering efforts have been made to apply them to the aetiology of drug use (eg. West 2004).

For instance, “*crime is the most significant drug harm within the Harm Index*” - apparently because “*drug-related crime represents about a half of all acquisitive crime*” (p.28). Indeed, the total harm calculated for 2003 was based on a share of 38% for domestic crime, 29% for commercial crime, and 28% for health harms (with 5% allocated to drug dealing/community indicators). A similar profile was found in 2004. This clearly illustrates the subjective, value-based nature of the DHI, because drug-related crime may be the (or one of the) most important harms in a model based on inadequate generation of variables, or from the perspective of governments or even the community (non-users) - but to drug users and their families and friends, drug-related death would surely be a more significant harm – possibly along with HIV infection and overdose. Whatever the views of different interest groups on these issues, the broader point is that the DHI is not grounded in a broader conceptual framework within which the generation and weighting of harms could be more objectively and systematically determined.

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Appendix A: Evolution of drug strategy targets in UK

The first ever drug strategy target was introduced by the Health of the Nation report in 1991: *reducing the rate of past-month needle-sharing among drug injectors from the 1992 level of 20% to 10% in 1997, and to 5% by 2000*. In 1998, the 10-year drug strategy (Tackling Drugs to Build a Better Britain) was introduced by the new UK Drugs Tsar, and in his first annual report in 1999 he presented the first set of drug strategy targets, corresponding to the four aims (and linked objectives) of the strategy:

(1) Protecting communities from drug-related anti-social and criminal behaviour

Targets: to reduce levels of repeat offending amongst drug misusing offenders by 25% by 2005 and by 50% by 2008 – including:

(a) reducing the proportion of arrestees testing positive for Class A drugs from 18% (1998/99 baseline) to 15% by 2002; and

(b) doubling the number of face-to-face arrest referral schemes and the number of arrestees referred to and entering treatment programmes by 1999/2000;

(2) Enabling problem drug users to get treatment, and to lead healthy and crime-free lives

Targets: to increase the participation of problem drug users, including prisoners, in drug treatment programmes which reduce crime and ill-health by 66% by 2005 and 100% by 2008, including: (a) providing treatment to 5,000 drug misusing prisoners a year by 2002; and

(b) reducing injecting, needle sharing, and drug-related deaths among treatment clients by 2002;

(3) Helping young people resist drug misuse to achieve their full potential in society

Targets: to reduce the proportion of under-25s reporting drug use in the last month and previous year substantially – including:

(a) reducing use of heroin and cocaine among under-25s, by 25% by 2005 and 50% by 2008;

(b) reducing the numbers of 11-16s who use Class A drugs by 20% by 2002; and

(c) delaying the age of first use of Class A drugs by 6 months by 2002;

(4) To stifle the availability of drugs on our streets

Targets: to reduce access to all drugs amongst under-25s significantly – including

(a) reducing access to heroin and cocaine by 25% by 2005 and 50% by 2008;

(b) increasing the percentage of heroin and cocaine seized by 2002;

(c) increasing the amount of assets identified and secured from drug traffickers by 10% by 1999/2000 and one third by 2002;

(d) reducing the rate of positive results from random drug tests from 20% in 1998/99 to 16% in 2002;

(e) increasing the prevention and seizure of Class A drugs over all enforcement agencies by 10% by 1999/2000;

(f) increasing the disruption or dismantling of trafficking groups (primarily involved in Class A drugs) by 5% by 1999/2000; and

(g) increasing the number of offenders dealt with for supplying Class A drugs by 10% by 1999/2000.

These four aims – labelled Communities, Treatment, Young People and Availability - roughly correspond to four basic principles of drug strategy: community harm reduction, individual harm reduction, demand reduction and supply reduction.

However, this four-category set of targets was regarded by government officials as far too ambitious – for instance, halving use of heroin and cocaine among young people by 2008. So, after ‘removing’ the Drugs Tsar, the Home Office published the new 5-year Updated Drug

Strategy (2003-08) in 2002 – with a revised set of about two dozen targets, with ten of these identified as key targets, organised under the four strategic aims:

- (1) Protecting communities by reducing drug-related crime – by (a) reducing drug-related crime, including (b) the annual proportion of arrestees testing positive for drugs;
- (2) Reducing drug-related harm, and reducing the number of PDUs – based on two targets:
 - (a) increasing the participation of PDUs in drug treatment programmes by 55% by 2004, and 100% by 2008 (i.e. 200,000); and
 - (b) increasing, each year, the number of PDUs successfully sustaining or completing treatment programmes
- (3) Preventing young people from using drugs – based on reducing among under-25s, by 2008,
 - (a) the use of Class A drugs, and
 - (b) frequent use of all drugs;
- (4) Reducing the supply of drugs at all levels – based on four targets:
 - (a) increasing the proportion of heroin and cocaine supplies to the UK which are seized;
 - (b) disrupting criminal groups involved in supplying large amounts of Class A drugs to UK;
 - (c) doubling the amount of criminal assets recovered from drug traffickers from £29 million in 1999/2000 to £60 million by 2004/05; and
 - (d) reducing Afghan poppy cultivation by 70% by 2009, and 100% by 2013.

Many of the dozen or more secondary targets (their precise count depends on how they are organised and categorised) derived from treatment objectives put forward by the NTA – including “*increasing the number of heroin addicts prescribed heroin*” - from the baseline of about 500 in 2002 (though no level of change or deadline was indicated).

By 2006, these four groups of key targets had been whittled down and revised into three, two-part PSA targets, with the fourth ‘supply reduction’ group dropped altogether (see main text).

Appendix B: Summary of Newcombe's model of drug-related risks and harms

Risk is defined as (a) drug consumption behaviour (CB) with the potential to cause harm or (b) the probability that a given CB will lead to harm

Harm is defined as the negative consequences of drug use (benefits are positive outcomes)

Risk consists of seven consumption factors, each with two key components:

Product: type/toxicity & purity/adulterants

Access: sources (eg. doctors/dealers) & resources (funding of purchases)

Amount: per dose/session & per time-period (week/month)

Pattern: frequency of use (eg. daily/weekly) & stability of use (eg. bingeing, consistent)

Method: route of administration (four types) & and style (eg. needle-sharing/cleaning)

Mixture: multi-use (drugs taken at same time) & poly-use (drugs taken over period of time)

Context: set (mental/personal factors) & setting (social/situational factors)

Harms can be categorised according to two dimensions - level and type:

Level: individual (drug users), community (social groups linked to drug users – family/friends/neighbours/etc.) & societal (organisations & institutions)

Type: health (damage); socio-legal (problems), economic (costs)

This 2-dimensional model produces 9 categories of harm – for instance, individual socio-legal harm (eg. criminalisation for drug possession), health harm to community (eg. spread of HIV from IDUs to others), & societal economic harm (eg. cost to NHS)

[related terms which could be used to label categories of harm include: loss, disadvantage, hurt, injury, & disorder]

The measurement of the extent of a drug-related risk or harm requires three orthogonal concepts. Focusing on risks and harms to the individual drug user, these are:

(1) prevalence: the number/proportion of users who experience the risk/harm (eg. all, most, half, some, none)

(2) frequency: how often users' experience the risk/harm (eg. never, rarely, yearly, monthly, weekly, daily)

(3) intensity: the level of risk/harm (eg. major, moderate, minor) – eg. fatal & non-fatal overdose

Harm-Reduction Interventions are services and products provided to potential or actual drug users by statutory or non-statutory organisations, with the aim of reducing drug-related harm. HR interventions have four stages: contact, delivery, risk reduction and harm reduction:

<u>CONTACT</u>	<u>DELIVERY</u>	<u>RISK-REDUCTION</u>	<u>HARM-REDUCTION</u>
Attracting users to and retaining them in drug services	Providing users with services and products	Changing users' drug-taking behaviour toward lower risk	Minimising the negative consequences of drug use - & maximising benefits

Key disciplines relevant to development of biopsychosocial models of drug-related risk/harm:

Biological: genetics, biochemistry, psychopharmacology, medicine

Psychological: cognitive science, psychodynamics, behaviourism

Social-scientific: economics, politics, sociology, anthropology, history

APPENDIX C: Drug-related harms associated with eight types of drug

	<u>Alcohol</u>	<u>Heroin/ Opiates</u>	<u>Crack/ Cocaine</u>	<u>MDMA etc.</u>	<u>LSD etc.</u>	<u>Amphet- amines</u>	<u>Solvents</u>	<u>Tranquil- lisers</u>
<u>SOCIAL PROBLEMS</u>								
Violence/disorder	**		*					*
Acquisitive crime	*	**	**					
Prostitution		**	**					*
Drug dealing		**	**	*				
<u>Social/family/work</u>	**	**	**	*		*	**	*
<u>PHYSICAL HEALTH</u>								
OD/poisoning	**	**	*	*		*	**	**
Organ damage	**		*	*		*	**	
Infectious disease		**	*			*		
Trauma/injuries	**	*		*	*		**	**
<u>Deaths</u>	**	**	*				*	**
<u>MENTAL HEALTH</u>								
Dependence	**	**	**			*		**
Cognitive deficits	**	*		**	*		**	**
Drug psychosis	*		*	*	*	*	*	
Mood disorders	**	*	**	*		**	*	
<u>Anxiety/panic/etc.</u>			*	*	*	*		
TOTAL POINTS	20	19	19	10	4	9	13	13

A problem is regarded as associated with a drug if

- (1) a significant proportion/number of its users (or people around them) experience the problem; &/or
- (2) it requires a significant or costly response from official services – health, law enforcement, etc.

** problem for significant proportion/number of users of the drug, placing very high cost on society

* less significant but still notable problem (or possibly of debatable significance), with costs to society

Crack/cocaine: these problems are largely caused by cocaine freebase (crack/rocks) – though cocaine hydrochloride powder results in similar problems to a lesser degree (particularly if injected)

MDMA (methylenedioxymethamphetamine) etc. = ecstasy and related drugs (eg. MDA, MDE, 2CB)

LSD (lysergic acid diethylamide) etc. = and other hallucinogens (eg. psilocybe mushrooms, DMT)

Tranquillisers causing most problems are temazepam and diazepam - also Mogadon, Rohypnol (date-rape)

Popular drugs not listed include: tobacco (dependence, organ damage, and deaths – 6 points), cannabis (cognitive deficits and psychosis – 3 points), and caffeine (none)

Violence/disorder: including assault, homicide; public nuisance; rape and sexual assault; drink/drug-driving.

Acquisitive crime: burglary, theft (cars/shops/persons), robbery (person/place), fraud/deception, etc.

Prostitution: particularly female prostitution - including soliciting, loitering, pimping & kerb-crawling

Drug dealing: supply, production, import/export etc – dealing problems mainly linked to heroin/crack use

Social/family/work: experience of deprivation and social exclusion from being or being labelled ‘drug user’ - including convictions, imprisonment, etc. – and stress/problems for family members/partners/children

OD/poisoning: overdose or toxic poisoning (esp. unconsciousness, fits, agitation) – usually admitted to A&E

Organ damage: long-term organ damage (eg. cancers, heart disease, damage to liver/brain/etc.) – also, most of the listed drugs can, in excess, damage unborn babies (probably excepting LSD and cannabis)

Infectious disease: viruses (HIV, HAV, HBV, HCV) and bacteria (eg. botulism) - linked to sharing ‘needles’

Trauma/injuries: mainly caused by accidents (eg. drugged drivers) – identical pattern to cognitive deficits

Deaths: from all direct causes (poisoning, accidents) and indirect causes (disease, murder, etc.)

Dependence = physical dependence (mainly depressants) and psychological dependence (all drugs) – including withdrawals, tolerance, and craving (‘addiction’ usually reserved for physical dependence)

Cognitive deficits: working memory, LT memory, & thinking/reasoning abilities (usually temporary)

Drug psychosis: hospital admissions diagnosed as psychotic (schizophreniform) due to the use of drugs

Mood disorders: depression, mania, bipolar, mood swings, affective disorders – following from drug use

Anxiety/panic: neurotic reactions - to drug’s effects or after-effects (including panic attacks)

Compiled by Russell Newcombe, 2004

