SUBMISSION

To the Home Affairs Select Committee
Cocaine Trade Inquiry, June 2009

UKDPC
UK DRUG POLICY COMMISSION

Executive summary

This submission from the UK Drug Policy Commission[1] raises a number of issues which the Committee might wish to consider, focusing on evidence relating to the cocaine market, with occasional reference to crack cocaine to make comparisons.

We make a number of conclusions, for consideration by the Committee, to address harms from recreational and problematic cocaine use and markets:

1. Social norms marketing pilots should be considered as part of a multi-component approach to increasing resilience to cocaine use among young people. Very targeted interventions for small number of users and their immediate peers, could highlight, and provide tactics for reducing, health risks (such as the increased danger of using cocaine and alcohol concurrently) and how to recognise signs of, and seek help for, problem use. Responses might include interventions targeted through pubs, bars and clubs.
2. Problem cocaine users may require different or separate treatment pathways to heroin and crack cocaine users (who currently dominate treatment services) because of the different profiles of these two groups. Particular attention should be given to treatments that address problem polydrug use including alcohol. More could be done to foster support structures to aid recovery, including families.
3. Unlike heroin and crack cocaine, there is little evidence to suggest a strong link with prolific, acquisitive crime. Furthermore, far fewer cocaine-using offenders are considered to be dependent, or wish to seek treatment, compared to heroin and crack cocaine-using offenders. Further expansion of drug testing in the criminal justice system is likely to capture more cocaine users whose use is not problematic or linked to their offending behaviour, and therefore may be inappropriate and risks diminishing returns.
4. In tackling the cocaine market, evidence suggests that "crackdowns" have little or no long term impact on street-level availability and can sometimes do more harm than good. Recent "success" as reported by SOCA has not only been helped by many other factors (including changes in currency exchange rates), but is likely to be short-lived. However, evidence suggests enforcement can deliver a real and sustainable impact for communities by tackling the characteristics of drug markets that cause the greatest harms. Enforcement agencies need to develop new tools to measure their impact on drug harms. A forthcoming UKDPC report will seek to describe such an approach.
5. We urge the Committee to highlight the need for improved knowledge development and to recommend well-evaluated pilots for interventions where the evidence-base is promising but weak. Such evaluations should consider unintended consequences of interventions.

[1] For more information on the UKDPC and its outputs, see Annexes B and C and www.ukdpc.org.uk

The current cocaine picture

In reviewing the current cocaine situation in the UK, the Committee may wish to refer to the sources in Annex A. However, the latest Focal Point on Drugs (2008 edition) usefully summarises these as follows:

- *There has been increased **use** of cocaine powder reported within the general population in the United Kingdom over the previous few years. However, the most recent survey data, for England and Wales in 2007/08, show a decrease in last year use amongst 16 to 59 year olds from 2.6 to 2.3 per cent, and amongst young adults aged 16 to 24 the fall was from 6.0 per cent to 5.0 per cent. Amongst school children, last year use was 1.6 per cent in 2006 and 1.8 per cent in 2007.*
- ***Treatment** presentations for primary cocaine powder use have risen steadily over the previous four reporting periods, from 3,739 in 2003/04 to 8,372, with a 22 per cent rise from the previous year's figure (6,890). First ever presentations for cocaine powder have also increased over the last four years, the actual number of presentations increasing from 1,683 in 2003/04 (5.8% of all presentations) to 4,951 in 2006/07 (10.5% of all presentations). 13% (8,372) of those presenting to treatment in 2006/07 reported use of cocaine powder as either primary or other drug used, a number steadily increasing over time.*
- ***Deaths** associated with cocaine have also increased steadily over time, with 158 in 2003 and 243 in 2007. However, without being able to distinguish between crack cocaine and cocaine powder in autopsies, deaths could involve the former.*
- *The largest increase in **convictions** for drug offences in 2006 was for cocaine with 15,470 convictions, an increase of 28.6 per cent from 12,028 in 2005.*
- ***Seizures** increased by 36 per cent in 2006/07 although the quantity seized fell by 14 per cent. The price of cocaine powder at street level continues to fall, as does purity.*[2]

Who uses cocaine?

There is much diversity among cocaine users and distinctions should of course be made between cocaine and crack use, different routes of administration (smoking, injecting, snorting) and different patterns of use (recreational, problematic, dependent). However, available evidence shows us that:

- Cocaine use is most common among those in their twenties (6.3% of 20-24s reported last year use, 5.4% of 25-29s). Either side of this, prevalence quickly drops off. Males are more likely to be users. These people also report higher use of other drugs. [3]
- Most of those who use cocaine report relatively infrequent use; among users aged 16 to 25 over three-quarters reported using it less than once a month.[4]

All website links accessed June 2009

[2] Eaton, G. *et al.* (eds). *UK Focal Point on Drugs,* Department of Health 2008 (bold emphasis added): www.ukfocalpoint.org.uk/documentbank/UK_FOCAL_POINT_ANNUAL_REPORT_2008_MASTER_DOCUMENT_161208.pdf

[3] Hoare, J. and Flatley, J., *Drugs Misuse Declared: Findings from the 2007/08 British Crime Survey* Home Office 2008: www.homeoffice.gov.uk/rds/pdfs08/hosb1308.pdf
Fuller, E. (ed) *Drug Use, Smoking and Drinking among Young People in England in 2007* NHS Information Centre 2008: www.ic.nhs.uk/webfiles/publications/sdd07/SDD%20Main%20report%2007%20%2808%29-Standard.pdf

[4] *2007/08 British Crime Survey, op cit.*

- Socio-economic characteristics associated with cocaine use are complex, perhaps reflecting the 'two-tier market' hypothesis (discussed in more detail below). They include frequent visits to clubs and pubs, living in an area classified as "Urban Prosperity" and lower educational achievement (which may in part be due to age). Unemployed people were twice as likely as the average to be last year users, although by far the majority of users (76%) were employed.[5]
- There is particularly strong link between cocaine use and heavy use of alcohol. 12% of 16-24s who drank alcohol on three or more days a week also reported using cocaine in the last year.[6] Use of cocaine and alcohol together is common because the user can prolong the effects of cocaine and moderate the effects of alcohol. However, this significantly increases the health risks by creating the dangerous chemical cocaethylene within the body.[7]

Why has cocaine use increased in the UK?

UK cocaine use increased sharply at the turn of the century (from 0.6% last year use in 1996 to 2% in 2000[8]) but has since remained relatively stable, with many countries across Europe now 'catching up'. However, the UK still has among the highest levels of use (alongside Spain).[9] It is difficult to explain why this might be the case, although it should be noted that the UK appears towards the top of league tables for a range of drugs, not just cocaine. Internationally, there is little evidence that drug policies influence either the number of drug users or the share of users who are dependent. Countries with 'tough' and 'liberal' drug policies can have similar levels of prevalence. Instead, numerous other cultural and social factors appear to be more important.[10]

Despite the increase in cocaine use, overall stimulant use has remained largely stable, with a corresponding drop in the use of amphetamines and, to a lesser extent, ecstasy that suggests a move from these drugs to cocaine.[11] This relationship between cocaine and other stimulants is also seen when comparing countries across Europe: so where cocaine is the main illicit stimulant, low levels of amphetamine use is usually reported, and vice versa.[12]

There are also some indications that the increase in use may be partly explained by the creation of a 'two-tier' cocaine market, with drug dealers selling a cheaper, less pure product to a new market of consumers who were previously unable to afford cocaine (and were more likely to use other, cheaper, stimulants).[13]

Although cocaine may have a more 'glamorous' image among young people than other stimulants, there is little evidence to directly link celebrity drug use or the publicity surrounding it and the behaviour of young people. The 'cult of the celebrity' may be a

---

[5] Roe, S. and Man, L., *Drug Misuse Declared: Findings from the 2005/06 British Crime Survey*. Home Office 2006: www.homeoffice.gov.uk/rds/pdfs06/hosb1506.pdf
[6] *2007/08 British Crime Survey, op cit.*
[7] Shaw, C., *et al*. (eds) *Indications of Public Health in the Regions 10: Drug Use*. Association of Public Health Observatories 2009: www.apho.org.uk/resource/item.aspx?RID=70746
[8] *2007/08 British Crime Survey, op cit.*
[9] European Monitoring Centre for Drugs and Drug Addiction, *State of the Drugs Problem: Cocaine* EMCDDA 2008: www.emcdda.europa.eu/themes/drug-situation/cocaine
[10] Reuter, P., and Stevens, A., *An Analysis of UK Drug Policy*. UKDPC 2007: www.ukdpc.org.uk/publications.shtml#Analysis_Drug_Policy
[11] *2005/06 British Crime Survey, op cit.*
[12] *State of the Drugs Problem: Cocaine, op cit.*
[13] *Serious Organised Crime Agency Annual Report 2008/09.* SOCA 2009: www.soca.gov.uk/assessPublications/downloads/SOCA_AR_2009.pdf

dominant theme of youth culture but its influence should not be overstated. The predominant message reported in relation to celebrity drug use is a negative one, and young people are informed about drugs through a wide variety of conflicting sources. More research is needed to better understand the complex mechanisms at work that shape young people's drug attitudes and behaviours.[14]

Drug prevention schemes

Evidence for the effectiveness of advertising campaigns and other interventions to prevent drug use is very weak, particularly in relation to cocaine. There is some evidence (mostly from the US) to demonstrate that mass media campaigns can have an effect on tobacco and alcohol use. These campaigns appear to be most effective when they seek to challenge or reinforce social norms related to drug taking and do not simply rely on "shock tactics".[15] However, large-scale public information campaigns also risk increasing drug use by making it seem more commonplace than it is.[16]

In the UK, the Scottish Government's "Know the Score" campaign focused on the link between cocaine use and heart attacks to deter use. An evaluation found that over half (56%) of young people had not altered their likelihood of taking cocaine after being exposed to the campaign. Almost a third said they were less likely to take cocaine (30%), whereas 11% said they were *more* likely (although actual behaviour change was not measured).[17] More recently in England, the Government has launched a cocaine campaign under the "FRANK" brand, but no evaluations of this have yet been published.

The scant evidence available suggests that campaigns can be more effective if they seek to reinforce or direct an existing preference (e.g. 'safer clubbing' messages highlighting dangers of dehydration and polydrug use), or reassure non-users that most people do not take drugs. Campaigns can also increase knowledge, reposition associations with drugs (e.g. cocaine is 'glamorous') and encourage take-up of services.[18]

The evidence for school-based education programmes points to better outcomes derived from multi-component programmes, i.e. those involving families and the community, as well as those based on a social-influence model (providing knowledge and skills in a wider social context) rather than those that just provide knowledge or just say "no". The final evaluation

---

[14] Witty, K., *The Effects of Drug use by Celebrities upon Young People's Drug Use and Perceptions of Use* National Collaborating Centre for Drug Prevention: www.drugpreventionevidence.info/web/Celebrities244.asp

[15] See, for example, discussion of the Florida 'Truth' tobacco campaign in Stead, M. *et al.*, Changing Attitudes, Knowledge and Behaviour. Joseph Rowntree Foundation 2009: 'www.jrf.org.uk/sites/files/jrf/alcohol-attitudes-behaviour-full.pdf
Turner, J. *et al.*, *Declining Negative Consequences Related to Alcohol Misuse Among Students Exposed to a Social Norms Marketing Intervention on a College Campus*. Journal of American College Health 2008, Vol. 57, No. 1, pp. 85-93: www.alcoholeducationproject.org/education/DecliningNegativeConsequences.pdf

[16] Government Accountability Office, *ONDCP media campaign: Contractor's national evaluation did not find that the youth anti-drug media campaign was effective in reducing youth drug use.* GAO-06-818 2006: www.gao.gov/new.items/d06818.pdf

[17] *Know the Score: Cocaine Wave 3 2005-06 Post Campaign Evaluation*: Scottish Government 2006: www.scotland.gov.uk/Publications/2006/06/14152757/5

[18] *Let's Get Real: Communicating with the Public about Drugs*. Drugs Prevention Advisory Service 2001: http://drugs.homeoffice.gov.uk/publication-search/communications-campaigns/lets-get-real.pdf?view=Binary

report from the Blueprint[19] multi-component drug education research programme will no doubt add to our understanding when it is published, although it is unlikely to be big enough to identify impact on drug use despite being the largest project of its kind in the UK.

Based on large scale US studies, drug testing in schools and the use of sniffer dogs appear to have little impact on young people's drug taking behaviour or prevalence rates and may strain relations between staff and pupils.[20] Caution should also be exercised when considering workplace drug testing due to the limitations of available studies, although such measures may be important in safety-critical industries.[21] A recent report also raised concerns over accuracy of roadside testing mechanisms and highlighted the fact that low doses of cocaine may even improve driving performance[22]

Yet again there is only limited evidence for effectiveness of prevention programmes delivered in non-school settings. The best evidence is for family interventions, such as the Strengthening Families Programme, and for motivational interviewing.[23]

Conclusion 1:
Social norms marketing pilots should be considered as part of a multi-component approach to increasing resilience to cocaine use among young people. Very targeted interventions for small number of users and their immediate peers, could highlight, and provide tactics for reducing, health risks (such as the increased danger of using cocaine and alcohol concurrently) and how to recognise signs of, and seek help for, problem use. Responses might include interventions targeted through pubs, bars and clubs.

Problem cocaine use and drug treatment

Despite the fact that cocaine is the second most popular drug in the UK (after cannabis) only a very small number present themselves for treatment, although the number and proportion of those in treatment for cocaine use has been rising. In 2007/08, the primary drug for most people in treatment was heroin (61%). Cocaine was the primary drug for only 6% of all persons in treatment.[24]

There are indications that cocaine is less likely to cause dependence than other drugs. In one study of people seeking treatment, the mean severity dependence score (SDS) for those whose primary problem was cocaine was 4.22 compared with 6.10 for crack and 9.09 for

[19] Baker, P.J., "Developing a Blueprint for evidence-based drug prevention in England". *Drugs: education, prevention and policy* 2006 13(1) pp17-22: http://drugs.homeoffice.gov.uk/publication-search/blueprint/DevelopingaBlueprint?view=Binary

[20] *Drug Education: an entitlement for all*. Advisory Group on Drug and Alcohol Education 2008: www.drugeducationforum.com/images/dynamicImages/documents/documents_12312_610102.pdf

[21] Ramchand R., *et. al.*, *The Effects of Substance Use on Workplace Industries*, RAND Corporation, 2009. www.rand.org/pubs/occasional_papers/2009/RAND_OP247.pdf

[22] Raes, E., *et al.*, *EMCDDA Insights 8: Drug use, impaired driving and traffic accidents*. EMCDDA 2008: www.emcdda.europa.eu/attachements.cfm/att_65871_EN_Insight8.pdf

[23] Gates S *et al.,* "Interventions for prevention of drug use by young people delivered in non-school settings" *Cochrane Database of Systematic Reviews* 2006, Issue 1: www.cochrane.org/reviews/en/ab005030.html

[24] *Statistics from the National Drug Treatment Monitoring System (NDTMS) April 07 – March 08* National Treatment Agency for Substance Misuse 2008: www.nta.nhs.uk/areas/facts_and_figures/0708/docs/ndtms_annual_report_2007_08_011008.pdf

heroin.[25] Similarly within the offending population, 23% of cocaine users are considered to be dependent on the drug, compared to 85% of heroin users and 55% of crack users.

Whilst crack is strongly associated with heroin use, this is much less the case with cocaine. 46% of treatment seekers whose primary problem drug was heroin also considered crack use to be a problem, whereas only 14% said that cocaine use was a problem (and only 13% had used cocaine in the past 4 weeks).[26] Although cocaine is sometimes injected, only 8% of primary cocaine users in treatment had ever injected a drug.[27]

As yet there are no prescribed maintenance medication options (such as methadone for opiate users) to aid recovery from non-opiate drugs. However other treatments and behaviour change strategies such as cognitive behaviour therapy, residential rehabilitation, contingency management and motivational interviews are available, alongside recovery support structures such as families and Cocaine Anonymous. Overall 'successful discharge rates' are higher for cocaine treatment than for heroin (or crack) use although this may be distorted by a greater use of brief interventions for cocaine users. Data is not available to demonstrate cocaine treatment outcomes such as reduced illicit drug use or sustained abstinence.[28]

A study of non-opiate substance use in the North West of England also demonstrated that problem alcohol, amphetamine, cannabis, cocaine and ecstasy ('AACCE') use may be increasing, particularly among under 25s where AACCE accounts for 75% of those in treatment. The report found that this group was very different to opiate users and questioned whether it should be treated separately.[29]

Across the EU, alcohol is shown to be the most likely secondary drug for primary cocaine users[30] reinforcing the link between these two drugs. Similarly, arrestees who had used cocaine in the last year were more likely than heroin and crack cocaine users to be dependent on alcohol. 78% of those who had used cocaine in the past year were considered to be dependent alcohol users.[31]

Conclusion 2:
Problem cocaine users may require different or separate treatment pathways to heroin and crack cocaine users (who currently dominate treatment services) because of the different profiles of these two groups. Particular attention should be given to treatments that address problem polydrug use including alcohol. More could be done to foster support structures to aid recovery, including families.

---

[25] *Drug Treatment Outcome Research Study (DTORS) Baseline Report Appendices*, Home Office 2008: www.dtors.org.uk/
[26] *DTORS op cit.*
[27] *NDTMS op cit.*
[28] *Ibid.*
[29] Hurst, A.*, et al., NDTMS Themed Report on non-opiate substance use in the North West of England - The changing profile of substance users engaged in treatment and its implications for future provision*: Liverpool John Moores University 2009: www.cph.org.uk/showPublication.aspx?pubid=542
[30] EMCDDA Table TDI-23: www.emcdda.europa.eu/stats08/tditab23a
[31] Boreham, R., *et al., The Arrestee Survey 2003-2006.* Home Office 2007: www.homeoffice.gov.uk/rds/pdfs07/hosb1207.pdf

Cocaine and crime

What little evidence is available suggests limited links between cocaine use and criminality: 23% of arrestees had taken cocaine in the last year with 5% considered to be dependent.[32] However, more arrestees are considered to be dependent on heroin and crack (13% and 8% respectively) and unlike these drugs, the causal link between cocaine use and prolific acquisitive crime to fund the drug dependency is much weaker. Rather than being an aggravating factor or cause of offending, the prevalence of cocaine use is better explained as a simple association with deviancy. Arrestees have higher levels of drug use generally, and often share the same risk factors associated with such use (e.g. social deprivation, poor educational attainment and truancy, etc).

However, there is suggestion of some link between cocaine use and violent offences but, crucially, this is associated with heavy consumption of alcohol. In a drug testing pilot by Greater Manchester Police, the force took samples from about 1,000 people arrested for offences such as assault, wounding and affray in the seven months to March 2008. Figures suggest that 41% of people arrested for violence had taken cocaine or crack cocaine, by itself or with other drugs. The police considered that cocaine use had enabled heavy sessions of alcohol consumption and this may have contributed to or aggravated the violent behaviour.[33]

Drug testing is widely used by police in custody suites for those arrested for certain trigger offences but it cannot distinguish between crack and cocaine use. This means that a significant number of recreational and non-dependent cocaine users are picked up. The arrestee survey shows that whilst only 9% of frequent heroin users did not want treatment, 65% of cocaine users did not want it. Coupled with the fact that cocaine use is unlikely to be directly linked to offending, the efficacy and appropriateness of using the criminal justice system to direct cocaine-using offenders into treatment might be questioned.

Conclusion 3:
Unlike heroin and crack cocaine, there is little evidence to suggest a strong link with prolific, acquisitive crime. Furthermore, far fewer cocaine-using offenders are considered to be dependent, or wish to seek treatment, compared to heroin and crack cocaine-using offenders. Further expansion of drug testing in the criminal justice system is likely to capture more cocaine users whose use is not problematic or linked to their offending behaviour, and therefore may be inappropriate and risks diminishing returns.

Tackling drug markets

Efforts to tackle drug markets are traditionally measured by seizures, arrests and price and purity levels (as a proxy for availability):

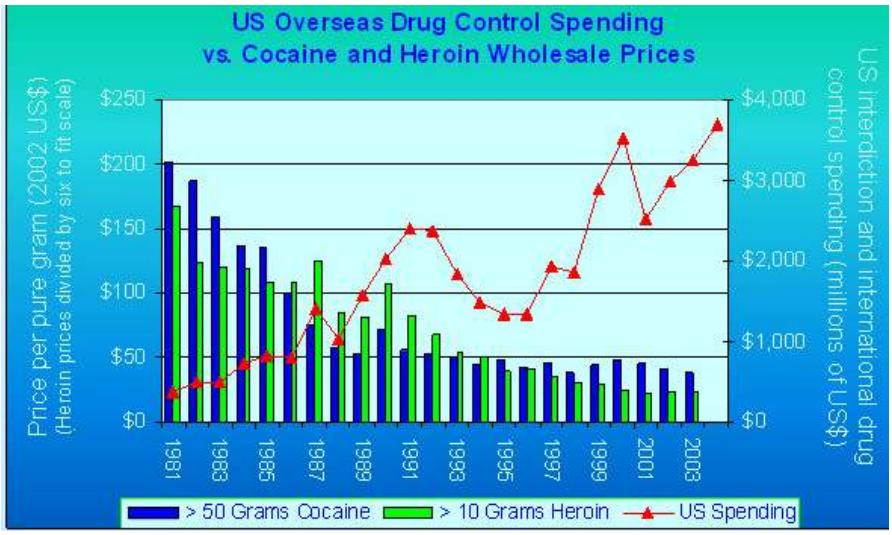
- The Serious Organised Crime Agency (SOCA) interdicted 85.5 tonnes of cocaine in 2008/09, up marginally from the previous year (note most crack cocaine is thought to be trafficked as cocaine powder too).[34]
- Domestic seizures of cocaine by HM Revenue and Customs (HMRC) and police forces fluctuate year on year, but 2007/08 figures are only slightly below the average over the past decade (3,433kg against an average of 3,667kg). [35]

[32] *Ibid.*
[33] Daly, M., "The hidden mixer" *Druglink* March/April 2009, Vol. 24, Issue 2: www.drugscope.org.uk/publications/druglink/druglinkarchive.htm
[34] SOCA Annual Report 2008/09 http://www.soca.gov.uk/assessPublications/downloads/SOCA_AR_2009.pdf

- SOCA reported a rise in wholesale prices from about £36,000 a kilo in the summer of 2008 to up to £45,000 a kilo in March 2009, although acknowledged that the weakness of sterling was a factor.[36]
- However, the price of cocaine powder at street level continues to fall, as does purity.[37]

Rather than demonstrating any affect of enforcement on availability, these trends add credence to the 'two-tier' market hypothesis where less pure, cheaper cocaine is being sold to a new market. Purity levels are stable for HMRC but have fallen for police seizures suggesting adulteration in the UK, made easier by the emergence of more sophisticated cutting agents.[38]

Yet in its 2008/09 annual report, SOCA claimed it had made a discernable difference to cocaine accessibility, purity and price, and suggested the market may be in some measure of retreat.[39] Our own review of the international evidence for tackling drug markets concluded that, at best, even substantial drug seizure and significant arrests of drug traffickers or dealers will only have a temporary impact on availability. For established and large drug markets such as cocaine, increasing enforcement levels was unlikely to significantly reduce the size of the market in the long term, although a continued level of supply-side activity does 'keep a lid' on drug markets.[40] This is confirmed by a recent report on the US market which shows that, while price and purity levels fluctuate in the short term, viewed over a longer time period (since the early 1980s) the trend has been a significant increase in purity and fall in price levels.[41] However, WOLA go on to question particularly the impact on domestic drug markets of US overseas drug control programmes as illustrated in the graph below.



Source: Washington Office on Latin America

---

[35] Smith K., and Dodd, L., *Seizures of Drugs in England and Wales 2007/08*, Home Office 2009: www.homeoffice.gov.uk/rds/drug-seizures.html
[36] *SOCA annual report 2008/09, op cit.*
[37] *UK Focal Point on Drugs 2008 edition, op. cit.*
[38] *The United Kingdom Threat Assessment of Serious Organised Crime 2008/09*, SOCA 2008: www.soca.gov.uk/assessPublications/downloads/UKTA2008-9NPM.pdf.
[39] *SOCA Annual Report 2008/09 op. cit.*
[40] McSweeney T., *et al., Tackling Drug Markets and Distribution Networks in the UK* UKDPC 2008: www.ukdpc.org.uk/resources/Drug_Markets_Full_Report.pdf
[41] Walsh, J., *Lowering Expectations Supply Control and the Resilient Cocaine Market*: Washington Office on Latin America 2009: www.wola.org/media/Lowering%20Expectations%20April%202009.pdf

There are also at range of negative and often unintended consequences associated with law enforcement, including displacement to other drugs and locations.[42] With renewed enforcement efforts on the Mexican-US border, it is not unreasonable to think that traffickers might seek out even more penetration of the European drug market.

While seizures and arrests risk delivering limited reductions in availability or problems experienced by communities, enforcement can affect the way that drug markets operate. By targeting their most harmful characteristics, it may be possible to change the nature of markets to make them less harmful and reduce their 'collateral damage' such as violence (gun violence is particularly associated with the crack market[43]), corruption, prostitution and the exploitation of vulnerable people (for instance as drug mules).

However, the traditional indicators (arrests, seizures, etc) are insufficient to demonstrate a reduction in drug problems at an individual and community/national level. Indeed, such activities may even increase these problems Arrests and seizures have come to represent a sort of virility test for drug enforcement yet we need a 'smarter' debate about ways to achieve and demonstrate 'real-world' reductions in drug problems.

Conclusion 4:
In tackling the cocaine market, evidence suggests that "crackdowns" have little or no long term impact on street-level availability and can sometimes do more harm than good. Recent "success" as reported by SOCA has not only been helped by many other factors (including changes in currency exchange rates), but is likely to be short-lived. However, evidence suggests enforcement can deliver a real and sustainable impact for communities by tackling the characteristics of drug markets that cause the greatest harms. Enforcement agencies need to develop new tools to measure their impact on drug harms. A forthcoming UKDPC report will seek to describe such an approach.

Research and evaluation
The Committee is likely to find that there are many areas of drug policy where we know surprisingly little about what works and why. This is particularly true of drug enforcement and prevention interventions where there is a lamentable dearth of quality evaluations.

Conclusion 5
We urge the Committee to highlight the need for improved knowledge development and to recommend well-evaluated pilots for interventions where the evidence-base is promising but weak. Such evaluations should consider unintended consequences of interventions.

[42] Reuter P., *The Unintended Consequences of Drug Policies*. RAND 2009: www.rand.org/pubs/technical_reports/2009/RAND_TR706.pdf
[43] *SOCA Threat Assessment, op. cit.*

Annex A – Sources for further data and statistics

Information type	Sources
Prevalence and patterns of adult drug use	• Drug Misuse Declared: Findings from the 2007/08 British Crime Survey: www.homeoffice.gov.uk/rds/pdfs08/hosb1308.pdf • Drug Misuse Statistics Scotland 2008: www.drugmisuse.isdscotland.org/publications/08dmss/08dmssb.htm • Drug Use in Ireland and Northern Ireland 2006/07: www.dhsspsni.gov.uk/phirb-drug-prevalence-survey-2006-2007.pdf
Prevalence and patterns of drug use among secondary school pupils.	• Drug use, smoking and drinking among young people in England in 2007: www.ic.nhs.uk/webfiles/publications/sdd07/SDD%20Main%20report%2007%20%2808%29-Standard.pdf • Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS): www.drugmisuse.isdscotland.org/publications/abstracts/salsus.htm
Prevalence of heroin and crack cocaine use.	• National and regional estimates of the prevalence of opiate use and/or crack cocaine use 2006/07: a summary of key findings: www.homeoffice.gov.uk/rds/pdfs08/horr09.pdf • Statistics from the Northern Ireland Drug Addicts Index 2008: www.dhsspsni.gov.uk/addicts_index_report_2008.doc • Estimating the National and Local Prevalence of Problem Drug Misuse in Scotland – 2003: www.drugmisuse.isdscotland.org/publications/abstracts/prevalence3.htm
Demographics of cocaine users.	• Drug Misuse Declared: Findings from the 2005/06 British Crime Survey: www.homeoffice.gov.uk/rds/pdfs06/hosb1506.pdf
Statistics on those accessing drug treatment.	• Statistics from the National Drug Treatment Monitoring System (NDTMS) April 07 – March 08 www.nta.nhs.uk/areas/facts_and_figures/0708/docs/ndtms_annual_report_2007_08_011008.pdf • Statistics from the Northern Ireland Drug Misuse Database: April 2007 – March 2008 www.dhsspsni.gov.uk/dmd_bulletin_2007-08.pdf • Working Together to Reduce Harm Performance Management Framework: Substance Misuse in Wales 2007-08: http://wales.gov.uk/topics/housingandcommunity/safety/substancemisuse/stats/?lang=en • Drug Misuse Statistics Scotland 2008: www.drugmisuse.isdscotland.org/publications/08dmss/08dmssb.htm • Drug Treatment Outcome Research Study (DTORS) www.dtors.org.uk
Morbidity data.	• Hospital Episode Statistics www.hesonline.nhs.uk
Mortality data.	• National Programme on Substance Abuse Deaths (np-SAD) annual report: https://portal.sgul.ac.uk/services/news/drug-deaths-report.html • Office for National Statistics, Healthy Statistics Quarterly no. 39: Deaths from Drug Poisoning (p82-88) www.statistics.gov.uk/downloads/theme_health/HSQ39.pdf
Prevalence among offenders.	• The Arrestee Survey 2003 – 2006: www.homeoffice.gov.uk/rds/pdfs07/hosb1207.pdf • The Drug Interventions Programme (DIP): addressing drug use and offending through Tough Choices: www.homeoffice.gov.uk/rds/pdfs07/horr02c.pdf • HM Prison Service Annual Report: www.hmprisonservice.gov.uk/assets/documents/10003D1CHMPS_AR_main_2007-08.pdf
Seizure, price and purity.	• Seizures of Drugs in England and Wales, 2007/08 (Home Office): www.homeoffice.gov.uk/rds/drug-seizures.html • UK Focal Point on Drugs 2008 edition (Department of Health): www.ukfocalpoint.org.uk
Arrests and	• Sentencing Statistics (Ministry of Justice):

sentencing data.	www.justice.gov.uk/publications/sentencingannual.htm • UK Focal Point on Drugs 2008 edition (Department of Health): www.ukfocalpoint.org.uk
European comparisons.	• European Monitoring Centre for Drugs and Drug Addiction: www.emcdda.europa.eu/stats08
International production data	• UN Office on Drugs and Crime, World Drug Report 2008: www.unodc.org/unodc/en/data-and-analysis/WDR.html
Trafficking into the UK	• SOCA Threat Assessment 2008/09: www.soca.gov.uk/assessPublications/UKTA0809.html • Monitoring the Supply of Cocaine Into Europe (EMCDDA): www.emcdda.europa.eu/attachements.cfm/att_64546_EN_TDS_cocainetrafficking_rev.pdf

Annex B – UKDPC Commissioners

The UK Drug Policy Commission (UKDPC) is an independent charitable body that uses evidence to scrutinise current UK drug policies and to influence policy decision-making. The Commission aims to be objective in its approach, allowing its conclusions to be led by the evidence, and it is not a 'campaigning' body. Commissioners are listed below:

Dame Ruth Runciman (Chair).
- Chair of the Central and North West London NHS Foundation Trust

Professor Baroness Haleh Afshar OBE
- Professor of Politics and Women's Studies at the University of York.

Professor Colin Blakemore FRS
- Professor of Neuroscience at the Universities of Oxford and Warwick
- Chair of the Food Standard Agency's General Advisory Committee on Science.

David Blakey CBE QPM
- Former President of the Association of Chief Police Officers and Chief Constable of West Mercia.

Annette Dale-Perera
- Strategic Director of Addiction and Offender Care for the Central & NW London Mental Health Foundation Trust.

Daniel Finkelstein OBE
- Comment Editor and a weekly columnist of The Times

Baroness Finlay of Llandaff
- Consultant in palliative medicine and honorary professor of Cardiff University's School of Medicine

Jeremy Hardie CBE
- Research Associate of The Centre for Philosophy of Natural and Social Science at the London School of Economics, Treasurer of the Institute for Public Policy Research and a trustee of Somerset House and International House.

Professor Alan Maynard OBE
- Professor of Health Economics at the University of York

Adam Sampson
- Chief Ombudsman (designate) Office for Legal Complaints and former Chief Executive of Shelter.

Professor John Strang
- Director of the National Addiction Centre, Institute of Psychiatry, King's College London.

John Varley (Honorary President)
- Group Chief Executive of Barclays Bank Plc
- Chair of Business Action on Homelessness and President of the Employers' Forum on Disability.

Annex C – List of UKDPC published review reports

An Analysis of UK Drug Policy (2007)	Although drug policy appears to have a limited effect on overall levels of drug use, it has a more significant role in reducing the impact of drug use on individuals and communities.
Reducing Drug Use, Reducing Reoffending (2008)	We risk causing more harm than good by sending significant and growing numbers of problem drug users to prison, especially for relatively short sentences, rather than using community sentences to address their drug-related offending.
Tackling Drug Markets and Distribution Networks in the UK (2008)	Even the most significant drug seizures and dealer/trafficker convictions usually fail to have a sustainable impact on street-level supply and demand due to the scale of the markets and their ability to adapt quickly. However, enforcement agencies can contribute towards reducing the impact of drug markets on communities.
Working Towards Recovery: Getting problem drug users into jobs (2008)	Employment is an important component of rehabilitation and reintegration, yet two-thirds of employers would not employ a former heroin or crack cocaine user even if they were otherwise suitable for the job. More support for employers is needed to encourage them to engage with this group.
Developing a vision of Recovery (2008)	"The process of recovery from problematic substance use is characterised by voluntarily-sustained control over substance use which maximises health and well-being, and the participation in the rights, roles and responsibilities of society." This UKDPC Consensus Group statement challenges services and wider society to consider what it means to be recovery-oriented.

All reports and other materials are available without charge at www.ukdpc.org.uk/reports.shtml