Report on Wilton Park Conference WP778

DRUG ABUSE: HOW CAN IT BE REDUCED?

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Introduction

1. International policies currently aim to control drug use through reducing both supply and demand. Efforts to reduce supply concentrate on eradicating production and interdiction; those seeking to reduce demand focus on treatment and prevention. However, there are very different views nationally and internationally on what really works, the appropriate timings and sequencing of interventions, the level of funding needed and the appropriate balance between supply and demand reduction efforts. Much more evaluation is needed of the effectiveness of supply-side interventions and of reducing drug use, not least in developing countries. Given the widely varying cultural contexts of drug use, a policy to reduce demand in one country is unlikely to be effective in another. Many argue that effort should be focused on managing the harm of drug use, reducing the impact on public health and HIV/AIDS etc. There are many questions about how global drugs policies should be adapted, not least given the increasing use of synthetic drugs and the potential for long-term replacement of heroin and cocaine by synthetic products.

The current situation relating to production and usage

2. The global production of illicit opium and cocaine is now increasingly concentrated: almost 90% of the illicit opium comes from Afghanistan; Colombia produces 70% of the world's cocaine. By 2006 it is predicted that there will be significant reductions in levels of both coca leaf and opium harvested from Colombia and Afghanistan respectively. Availability of cocaine and heroin on the world "market", however, may not decrease so rapidly, given likely existing stockpiles.

3. Estimates suggest there are about 200 million drug users worldwide (a large number of whom are cannabis users) – less than 5% of the total world population (compared to about 30% of the population being tobacco consumers). 78% of injecting drug users live in developing or transition countries. Drug-related deaths are estimated at 200,000 per annum[1]; those of tobacco are estimated at 4.9 million. There is little knowledge of the long-term trend of drug use (given that the distinction between licit and illicit use of drugs and psychotropic substances was made only 50 years ago). If the base line of the early 1900s is used (which included opium use in China) then opium use has probably reduced significantly globally. Cocaine use has roughly stabilised over the last 10 years since the 1960s epidemic in the USA.

Future drug supply and use

4. Will heroin and cocaine be the problem drugs of 10-15 years time? Or will they be replicated or replaced by synthetic drugs such as pharmaceutical opioids, which can have 100% more potency than heroin and can be produced closer to the consumer without the need for inter-regional trafficking (apart from precursors). There is growing concern about the morphine-like pharmaceutical substances appearing on the prescription market and the increasing non-medical use of these prescription drugs, as reported from the USA in 2003. For example, preparations based on thebaine-rich poppy-straw concentrate are sold under brand-names such as OxyContin, dubbed the “poor man’s heroin” on American streets. In Afghanistan the burgeoning use of illicit pharmaceutical drugs is also noted where the use of pharmaceuticals is not regulated.

5. In future the use of electro-stimulation of areas of the brain is predicted which can produce similar effects as taking drugs. How will that be policed? Global trends such as changes in the population structure will also impact on drug use with increasing numbers of younger people, who are more vulnerable to drug-taking, and increased urbanisation; by 2007 more than half the population will be urbanised compared to just 29% in 1950. More use of synthetic drugs by an urbanised population is anticipated. Increased levels of synthetic drugs are already being transported from Europe to the Caribbean, reversing the cocaine route; in future

[1] WHO 2000 estimate

these are likely to be produced closer to the consumer avoiding the risks associated with their transit.

6. Criminal gangs will remain one step ahead, seeking new “products”, markets and methods of sale. Ways to tighten up the availability of pharmaceuticals, including through the internet, will be needed.

International policies

7. At a strategic level the international community seeks a balanced approach to international drugs control policies aimed at limiting the supply, use and demand for drugs and psychotropic substances. Whilst the international community aims to balance the focus on both supply (focusing on eradication and interdiction, and led by law enforcement agencies) and demand (focusing on treatment and prevention, usually led by health authorities), integration of these policies at local level is not always achieved. Simply reducing supply will not necessarily reduce drug usage, potentially leading instead to a negative impact on users in the absence of health care or treatment infrastructure when supplies are dramatically reduced.

8. Multilateral agreement ensured the introduction of the three international Drugs Conventions[2]. However there is little agreement about what constitutes "success" in implementing these conventions or how to measure success. Without true baselines of drug use many ask whether what has been achieved to date, effective "containment", is successful. There is also much debate about whether some aspects of the Conventions should be amended. Whilst the United Nations remains the custodian of the Conventions, international consent will be needed to change them. The way in which the International Drug Conventions are interpreted by different countries is causing some concern; some are perceived to be “breaking the spirit” of the Conventions; others may be interpreting aspects more strictly than is necessary (for example where reservations exist and adaptations are available).

[2] 1961 Single Convention on Narcotic Drugs focusing on plant-based drugs and obliging signatory nations to limit production, manufacture, export, import, distribution of, trade in, use and possession of drugs to medical and scientific purposes.
1971 Convention on Psychotropic Substances – any substances included in the 4 schedules must be licensed by governments for manufacture, trade and distribution etc.
1998 Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances was designed to deal with the growth of international trafficking in illegal substances. The Convention also required signatories to make the possession of drugs for personal consumption a criminal offence under domestic law.

9. At the international level there is a need for:

- *Further research* on the demand side with greater understanding of the decisions drug users make when there is a shortage of their preferred drug, greater insight into "consumer" behaviour, and enhanced knowledge about drug use in developing countries;
- More *evaluation* of policies, particularly on overall international efforts to reduce supply and on demand reduction efforts in developing countries.

10. There is also a need to recognise the *unintended consequences* and displacement factors of certain interventions. For example, controlling production in one country may lead to increased production elsewhere (the so-called “balloon” effect). Controls in China in the 1950s led to increased production (and some use) in the Golden Triangle of Laos, Myanmar and Thailand. Similarly, efforts to reduce production in Peru and Bolivia in the 1970s led to increased production in Colombia in the 1990s. Efforts to eradicate production of coca through spraying may have led to the development of newer, higher yielding, glyphosate-resistant varieties; and potentially provided a fresh supply of recruits for the paramilitaries who control the drug trade. On the supply-side therefore what intervention efforts really work? What is the effectiveness of eradication programmes and to what extent is spraying a disincentive to grow opium poppy or coca? Efforts are also needed at the international level for example to monitor where planting might move to if it is reduced in Colombia and Afghanistan.

11. Successful enforcement efforts can lead to an increase in the price of drugs, providing more profit incentives for criminals. It can also create greater health problems among users; in the Netherlands reducing the availability of lidocaine[3] has created a health impact given the use of a more harmful substance (eg fenacetine) to dilute cocaine; in India the non-availability of opium and an increase in price has led to the injecting of pharmaceutical opioids (such as spasmo proxyvon).

[3] A cocaine-like pharmaceutical substance often used in the adulteration of cocaine before it is sold.

Until recently, Russia had 70,000 drug users in prison because of a decision to criminalise possession[4]. Russia has amended its legislation as a consequence, now responding with administrative sanctions if a user possesses less than 10 doses of a drug.

12. Local culture and context also needs to be taken into account; for example in India there was no concept of "drug abuse" until 1961; instead the focus was on drug "addiction" and drug use management. Use of cannabis and opium was essentially culturally and socially controlled (through rituals and settings of use) and much of the traditional, rural-based, systems of medicine used cannabis or opium. More recent changes in Indian legislation, conforming with international conventions, brought use into the criminal code, and has led to changes in practice such as use of derivative substances, injecting methods of consumption, marginalisation and criminalisation of users, increased risk for injectors as local sellers seek to maintain profit by reducing purity and use of synthetic opiates. It is noted that this is more difficult to manage than traditional consumption.

13. Whilst considering reducing illegal production of opium and coca leaves some call for some increased legal production. Many developing countries, for example, have an unmet need for opiate analgesics. Some are concerned about the apparent "cartel-like" nature of the current licit production, with countries such as Australia and France leading production (in the UK trials are underway under strict regulation for local morphine production). Some question whether it would be possible for more "traditional" opium-cultivating countries, in addition to India, to seek licences for regulated production. Afghanistan and Myanmar might be obvious candidates. However, many think that regulation would be impossible and that, should Afghanistan be allowed to produce for the licit market, other neighbouring countries, in Central Asia for example, would be likely to restart their own poppy production. It would, however, be useful to understand better how the licit market functions, for example in India where 1000 tonnes is produced in three states and where regulation has proved difficult.

[4] In Russia the estimate of number of users is 3.5-7 million, with 2.3m heavy users injecting heroin.

14. There are also calls for studies into the possibility of moving coca, in its natural plant state, from Schedule 1 to Schedule 3 of the international treaties, thus allowing for medical scientific use and creating a licit market for coca products under regulation. Studying the size of the potential licit coca market and traditional coca use in Andean countries (and their neighbours) could be beneficial.

15. There is much discussion as to the manner in which consumer countries should intervene in reducing production and transit of illicit drugs. Any intervention, whether bilateral, regional (such as the European Union) or multilateral (eg UN) needs to: offer long-term commitment; be a comprehensive partnership (including support for intelligence sharing); provide support for alternative livelihoods of farmers as well as eradication; support successful prosecutions following arrests. Countries of source or transit want consumer countries to work in a joined-up and comprehensive fashion, rather than in "silo" organisations (for example law enforcement might only talk to their opposite numbers). Local political commitment and regional collaboration are important factors if external intervention is to be worthwhile. Care is needed, it is argued, to ensure that interventions to reduce supply do not impose harms on societies in countries of supply for the benefit of citizens of consumer countries.

16. External intervention should not focus solely on supply reduction. Demand reduction is also critically important where drug use is increasing and hindering economic development and where there is an existing or potential HIV/AIDS epidemic amongst injecting drug-users (IDU) (for example in Afghanistan, Iran, India or Brazil). Drug demand reduction (DDR) should therefore be factored into development assistance as well as supply reduction efforts. This needs to be "mainstreamed" rather than leaving a specific sub-sector of assistance. A multi-sectoral approach is also needed. Developed countries could support: increased research on DDR; capacity-building of local institutions and community organisations; assistance for health and educational services; more south-to-south exchange and provide financial and technical co-operation. Development agencies can and do play a key role in supporting prevention efforts (universal and targeted), treatment and rehabilitation and harm reduction, for example needle exchange.

Reducing supply through cutting production

17. There have been recent enhanced international and national efforts to reduce production of coca leaf and opium. In **Colombia** 130,000 hectares of coca plants were sprayed in 2003 with glyphosate (Round-up), although the hectares producing coca are estimated to have reduced by only about 15,000 hectares (costing about $8,000 to destroy one hectare). In total about 650 tonnes of cocaine was produced in 2003-4 compared to about 800-850 tonnes in previous years. World wide seizures of cocaine in 2004 were 340 tonnes. Despite this reduction cocaine prices have fallen and purity has not reduced. Bearing in mind complex narco politics, and control of the cocaine market, it is possible that stockpiles are being sold off, or that there has been increased "productivity" from the hectares planted (including in Peru and Bolivia where production seems to have gone up), or that crops are being planted in new areas not covered by satellite surveillance systems.

18. In **Afghanistan** a significant reduction in the cultivation of opium is now being seen, particularly in Nangarhar and Helmand, the two largest cultivation regions. Cultivation in 2004 had reached over 130,000 hectares and produced over 4,000 tonnes of opium, (a little under the 1999 peak).

19. Significant steps have been taken to reduce drug production in Afghanistan in recent months not least given that drug revenues have financed terrorist activities. The Counter Narcotic Implementation Plan of February 2005 is intended to be a comprehensive plan to counter the cultivation, production and trafficking of opium with the aim of reducing opium poppy cultivation by 70% in 5 years, and eliminating it over the next decade. The reduction in planting has so far been achieved through reduced planting rather than through eradication of already planted crops. Where poppy has been planted an eradication campaign will shortly begin with local and national teams (Central Poppy Eradication Force), and nationally-led verification teams will be disbursed. The key question is how sustainable any efforts to reduce production can be when the equivalent of 65% of Afghanistan's GDP has been earned through illicit opium poppy cultivation.

20. To ensure that farmers do not revert to planting opium poppy **alternative livelihoods** need to be provided for them through support for growing different cash-

crops (wheat is not a long-term alternative it is suggested); storing and marketing; and general rural development. In Afghanistan the aim is to extend alternative livelihoods and development projects to every province by 2006; early efforts have probably reached only 5% of opium farmers (and 20% of coca farmers in the Andes). The sequencing of alternative livelihood support is critically important, with moral obligations to offer alternative livelihoods before commencing an eradication programme. Securing an alternative means of income takes time and can be difficult to achieve within the timeframe of one growing cycle. Supporting overall rural economic growth is also a very slow process; the experience of highland development in Thailand is a useful example, also highlighting the importance of state-building in parallel to development assistance to reduce opium planting. Assistance for alternative livelihoods must be mainstreamed into national economic development programme, rather than done separately.

21. It is also important to ensure that reductions in planting in 2005 can be **sustained** in 2006 and beyond, and that planting is not just shifted to another region which is not yet receiving development support or which is backed by a particular dealer who seeks to continue his "trade" (based on the competitive nature of the "industry" in Afghanistan rather than cartel-like cocaine market of the Andes). Given the good market conditions in 2004 some traders and their sponsors could welcome reduced opium production in 2005 in order to run down their excessive stocks and ensure higher prices (apparently a key reason behind the **Taliban ban** on production in 2001). Lessons from the Taliban ban are important to learn if a rebound of production, as happened in 2003/4, is not to occur in 2006/7. The 2001 ban resulted in a reduction in off-farm income for Afghans (given opium harvesting is a labour intensive job) which led to sales of household goods including productive assets (such as land and oxen) in order to reduce debt to opium traders. The reduction in assets and income, and high levels of debt, led many farmers to replant in 2003/4 and could be the reasons for farmers deciding to replant in 2006 and beyond unless incentives are enough to prevent them.

22. A crucial aspect to success in Afghanistan will be the focus given to **interdiction** in parallel to reducing cultivation. Taking firm action against traders and removing people associated with the drugs industry from government and positions

of influence is potentially as important, or more so some argue, as persuading individual farmers to stop growing opium or engaging in forced eradication.

23. In the short-term the wider implications for the Afghan economy of reduced income from drugs also need to be taken into account; for example shoring up the balance of payments (given the potential reduction in GDP) and seeking to support non-drug economic growth. Afghanistan will continue to need significant international help for many years if there is to be long-term success in reducing opium production.

Reducing supply at the point of transit

24. Much effort is now being placed internationally on interdicting supply at the transit point between production and consumption. It is estimated that 110 tonnes of cocaine are trans-shipped through one such transit point, Jamaica, each year[5] (70% destined to the USA, the remainder for the European market, the majority of it for the UK). Significant national efforts, with international support, have been made in Jamaica: placing new and effective technology at airports (leading to a significant decrease in the number of "swallowers" of drugs) and ports; demobilizing illegal airstrips; new coastal patrols; targeting the leadership through intelligence-led policing (with 85 arrests, 40 boats seized etc); developing legislation to confiscate assets. Such interventions can lead, however, to: displacements - the "shippers" look for new transit locations; and an initial rise in gun crime. A regional approach to tackle the transit of drugs is necessary, as is being developed throughout the Caribbean through CARICOM[6].

Reducing supply at the level of consumption

25. Questions are asked about the national goals of enforcement to reduce the supply of drugs to the "consumer". Is the aim to interrupt supply, punish those using drugs, raise the street prices, lower the levels of violence, lower corruption, or a combination? To what extent is minimising harm now a driver of drug policy in some areas, particularly at the level of user or problem drug user (PDU)?

[5] International Narcotics Control Strategy Report 2003 (United States Government Report) (http://www.state.gov/g/inl/rls/nrcrpt/2003/vol1/html/29834.htm)
[6] The Caribbean Community (CARICOM) consists of 15 member states.

26. Whilst much effort has been put into identifying and arresting the "kingpins", such as importers, at national level the long-term effects have not been enough to reduce supply significantly over the longer-term or create a large-scale deterrence for the traffickers. For instance in the USA there may be 100-1000 importers of cocaine; targeting this level may deliver rewarding cases but they are harder to interdict as they invest heavily in securing themselves. At the next level there may be as many as 500,000 cocaine sellers in the USA.

27. Depending on where the most value is added to the drug (and thus "profit" gained) more disruption could be achieved further along the supply chain. For example, analysis of the cocaine market reveals costs of $300 in leaf form (per pure kg equivalent in 1997); $1000 at export (Colombia); $20,000 at import (Miami); $25,000 in Chicago (still at wholesale); $50,000 when it is converted into smaller units ready for selling; and $175,000 at retail level. Some argue that targeting middle markets could, therefore, be more beneficial to disrupting and reducing supply. Mid-level distributors are more likely to be "native-born" (as opposed to immigrant groups who play a more prominent role in importation), operating independently as niche operators who are not controlled by high-level dealers and have a few, usually regular customers. In many countries many "customers" may manage their own use by selling on to other users ("pyramid-selling" style).

28. At a law-enforcement level, it is noted in the UK that the top-level importer/distributor is targeted by the national Agency[7] whilst at the lower level there may be more focus around managing the harm of drugs and focusing on PDUs. Whilst not all drugs generate mid-level markets, (domestic marijuana and methamphetamine markets may have fewer links between producer and user), middle markets do produce a large number of targets and can ensure local disruption to supply (creating unreliability in the supply-chain). Greater analysis of the middle market, and its fragility, could therefore be beneficial.

29. If there is to be a reduction in heroin and cocaine available to users in the coming few years lessons from the Australian heroin "drought" may be applicable. In 2001 **Australia** saw a sudden decline in the availability of heroin, resulting from:

[7] In the UK the Serious Organised Crime Agency is about to take over responsibility.

significant police seizures (about 20-40% of the total annual supply, which created a deterrence effect for importers), intelligence-led policing (including working closely with regional and international partners); and a balanced government strategy begun in 1997 where the Department of Health became the lead agency. Changes in trading practices in South East Asia in opium might also have been a factor. Whether the efforts to reduce supply in Australia could be replicated in other countries is questionable, given Australia's unique geographical location etc. Supply reduction was not in itself a solution to reducing demand for drugs in Australia; however lessons of the impact of reduced supply and the response to it are valuable. Reduced supply resulted in: a reduction in drug use (about 50%); a decrease in opioid deaths; reduced purity (from 60% to 20%) reduction in injecting use (demand for needle exchange also reduced); health improvements (a decrease in hepatitis C in young people); increased numbers accessing and staying in treatment; reduced local crime (a small increase in acquisitive crime to start with followed by a reduction). This resulted in the public perception of improved safety. A joined-up government approach was critical to Australia's policy response, including managing the resulting changes in drug use. Government policy also addressed mental health issues of drug users. Little is known about differing drug users responses to reduced supply and the extent to which they turn to other drugs such as amphetamines, or the long-term health impact of sustained amphetamine use. In future cases of reduced supply, understanding how non-dependent users will respond is important. Will they stop using drugs or will they seek alternatives and, if so, with what consequence?

Reducing demand

30. The efforts to control supplies, however successful, need to be balanced with policies to reduce the demand for drugs if any supply reduction is to ensure a long-term decrease in drug use. Preventing drug use by non-users, helping existing users to manage their use better (including reducing health problems) and providing treatment are all recognised means to reduce overall demand. It is argued that policies to reduce drug demand need to be part of social policy rather than set in isolation.

31. *Preventing* the use of drugs remains a critical aspect of reducing the demand for drugs by potential and existing users. Understanding the reasons for drug-taking,

and therefore listening to drug users, and recognising the factors that make someone "at risk" from drugs is crucial before any effective efforts can be made to influence their behaviour. Many contributory factors can make a younger people susceptible to the risks of drugs: chaotic home environment; mental health problems (the Australian experience highlights mental health issues being a precursor to drug use); self-medicating with illicit drugs; parents who are users or suffer from mental illness; behavioural problems and poor coping skills; lack of parental guidance; school failure (and/or low commitment to school); the influence of peers; early age of initiation; being labelled as a drug misuser. Alcohol and tobacco abuse are increasingly recognised as a potential "gate-way" to drug use.

32. Risk factors are very resistant to government interventions; efforts at deterrence may have a marginal impact on an individual's decision to experiment with or use drugs. Targeted campaigns may however help to retain a negative cultural attitude towards drugs. One creative campaign in Sweden where drug prevalence is low compared to many European Union countries (about 2%), with 93% of young people never trying drugs, focused on the harm that buying cocaine could have on the conflict in Colombia rather than explicitly warning against the dangers of drug use. The negative public attitude to illicit drugs is an important factor; maintaining that attitude is critical. Scare tactics do not work however. In Hungary and other Eastern European countries, where drug use exploded in the 1990s, society has less experience and knowledge about drugs.

33. Recommended policy goals to reduce drug use are:

- working with those who are most at risk; targeting young adolescents, reinforcing the non-drug using norm with them, and training parents.
- preventing experimental use becoming regular use; and
- reducing the pool of non-dependent users (sometimes called "recreational users") who believe they can use drugs safely.

34. For prevention projects to work a number of elements are recommended:

- a multi-dimensional approach;
- use of the local media, using teachers (with adequate training) or medical experts to deliver messages can be beneficial;

- social skills development needs to be a component part in youth programmes; discipline is an important component for parental training (with the provision of parenting classes and family support);
- providing positive role models; mentoring programmes, and encouraging diversionary activities (eg sports, volunteering);
- programmes need to focus on preventing the onset of alcohol and tobacco use;
- treatment needs to be available for parental and young users' health problems;
- support offered for failing schools; help with school work;
- projects need to be sustained and evaluation must be integral to the programme. Measuring needle exchange uptake and return rates etc can be useful.

35. Studies and research about what works in drug prevention need to be documented and shared more widely. Lessons from tobacco and alcohol can be useful in the prevention field but the illicit nature of drugs means that certain strategies used in alcohol or tobacco prevention, such as labelling, are not feasible. Recent experience with tobacco needs more study; it took 40-50 years for the first evidence of the links between tobacco consumption and lung cancer to have a serious influence on tobacco consumption (and this only in certain countries). Schools-based education on its own has not been found to be successful to reduce tobacco consumption. Random breath-testing of drivers may have some benefits in reducing alcohol intake before driving but is extremely expensive; heavy drinkers may however be more influenced to reduce their intake by high prices. Random drug testing in schools has not yet proven to be effective.

36. Offering *treatment* to existing users is an aim many countries aspire to but cannot afford; Poland has about 30,000 opiate users with only 700 on methadone; the US offers substitution to 15-20% of users and has the resources to treat all who want it, including in federal prisons, rather than all who need it. Providing treatment for prisoners in local jails is more difficult given the rapid turnover of the prison population. Offering treatment instead of jail, or as part of a sentence is an option in some countries.

37. Projects at a local level involving the police, health services and social workers have been used effectively, for instance in Sweden, to deal with an open drug scene (rather than breaking it up so that it just moves to an alternative location). Offering help through detox and treatment, housing and employment and social and medical help is an expensive support but can be successful.

38. Managing the health impact is also regarded by many as a critical factor in dealing with drug users; in Russia 80-90% of users have Hepatitis C, and the estimate of drug users with HIV/AIDs ranges from 200,000 to one million. It is also important to recognise that mental health problems which can precede drug use.

39. Demand for drugs is increasing in certain developing countries often because of insecurity, poverty, lack of education, lack of access to health services, violent conflict and/or bad governance, chronic mental health, a history of opium use, indebtedness to opium dealers, peer pressure and coercion, for example. However, many governments are in denial, take a law-enforcement approach and have few resources available to deal with or provide treatment and encourage prevention. It is argued that a balance needs to be struck in developing countries between a law-enforcement and health approach. Those working on demand reduction recognise the advantages of getting local law-enforcement on board in order to help manage use, for example through methadone programmes and needle exchanges, rather than criminalising the problem. Increased drug use in Iran has led to significant efforts by civil society organisations to provide methadone substitution and needle exchange and advocacy to government and law-enforcement. For demand reduction to work it needs continuity of policy between successive governments, co-ordination, and evaluation to establish the most appropriate policy in a given situation. If demand reduction reaches only 10% of the population drug use will not be stopped and, it could be argued, is a waste of resources. In many countries HIV prevention amongst injecting drug users (IDU) is a critical factor in demand reduction. Of one million Russians with HIV 90% are IDUs.

40. In Brazil, government policy criminalises drug use but recognises alternatives to imprisonment are needed, and since 1998, has developed a large-scale harm-

reduction programme led by the Ministry of Health and driven by the HIV/AIDS epidemic. Syringe exchange has led to a reduction in HIV/AIDS infections and inhepatitis C. The programme centres on community-based treatment and is linked to mental health care and wider social policies, for example in Favelas (slums) where the drugs trade is dominant. Local social participation is a critical element. Many see Brazil's approach as forward-thinking.

Conclusions

41. Whilst there is more evidence about and increased understanding of the complexities of the issues surrounding illicit drug supply and demand, the international community has not, to date, succeeded in bringing about a sharp reduction in supply or usage. Production of heroin and cocaine may be reduced in the next year or so, particularly from Afghanistan and Colombia. However the question of how sustainable any reduction in supply will be, and the effects on demand have yet to be seen. In the coming years international drugs policy will also need to take into account the growing "recreational" use of many drugs in developed countries, changes in fashions of drug use, and increased self-medication of pharmaceutical opioids. The international community is likely to face increasing pressure to review existing policies. With the increased complexities around drugs one solution no longer "fits all"; different solutions are necessary for different situations.

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