Ethics and drug policy

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Abstract

During the 20th century, support for a deontological approach to illicit drugs grew steadily. As a deontological framework was invoked, how goals were accomplished was considered more important than what was achieved. Accordingly, global drug prohibition was considered right even though illicit drug production and consumption, deaths, disease, crime and official corruption increased steadily. In the last decades of the 20th century, consequentialist approaches to drugs began to receive increasing support. Drug policy was now considered morally right if it produced predominantly beneficial consequences. The advent of an HIV pandemic in the last quarter of the 20th century changed the nature of injecting drug use irrevocably, just as injecting drug use changed the course of the HIV epidemic. HIV spread among injecting drug users led to increased support for 'harm reduction'. The scientific debate about harm reduction, which is now over, has essentially been between consequentialists and their deontological critics. The paramount aim of harm reduction is to reduce the health, social and economic costs of drug use. Reducing drug consumption can be a means to this end. Harm reduction strategies have been recognized as being effective, safe and cost-effective for at least 15 years. The paramount need now is to overcome the conventional reliance on drug law enforcement, the major barrier to implementing harm reduction strategies in time and on sufficient scale. Because of the limited benefits, high costs and severe unintended negative consequences of global drug prohibition, increasing consideration is being given to possible alternative arrangements for drugs.

The ethical basis of drug policy

Ethics involves the systematizing, defending and recommending of concepts of right and wrong behaviour. It is usually divided into three areas: meta-ethics, normative ethics and applied ethics. 'Meta-ethics' involves consideration of the origins and meaning of ethical principles including their possible social construction or derivation from individual emotions. 'Normative ethics' attempts to identify moral standards which regulate right and wrong conduct, including good habits that should be acquired, duties

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that should be followed or the consequences of our behaviour on ourselves and others. 'Applied ethics' is the consideration of specific controversial issues using the conceptual tools of meta-ethics and normative ethics to try to resolve these issues. Normative ethics has been particularly important in the evolution of drug policy.

In deontological ethics, decisions are based mainly on the duties of an individual and the rights of others. This means that an individual's behaviour or decisions can be considered wrong even if quite acceptable outcomes eventuated. In a deontological approach, how goals are accomplished is considered more important than what is achieved.

In contrast in a consequentialist approach, the outcomes of a particular action or decision are regarded as the basis for proper moral assessment of that action. Thus, according to a consequentialist framework, morally right actions are those whereby an action produces predominantly beneficial consequences. A concern often expressed about consequentialism is that it appears to justify an 'ends justifies the means' approach.

The last century of drug policy

At the beginning of the 20th century, the international regulation[1] of psychoactive drugs was minimal to non-existent. This began to change with the convening by the USA in Shanghai in 1909 of the International Opium Commission,[1] the first multinational drug-control initiative. A major concern of the USA was the UK arranging for opium, originating from colonial India, being foisted upon an unwilling China. Many Chinese deeply resented this policy. This led to the two Opium Wars of the 19th century between China the UK, which China lost to its much more technologically advanced opponent.

The 1909 International Opium Commission led to a series of subsequent international meetings including a second International Opium Commission,[1] again instigated by the USA and this time held in Geneva in 1925 under the aegis of the League of Nations. This meeting laid the foundation for the global prohibition of opium, cocaine and cannabis unless required for medical or scientific purposes. Subsequently, three international drug treaties were negotiated and these were ratified and signed by almost all countries in the world.

Although a number of countries have over the years been important in the development, implementation and expansion of global drug prohibition, none has been more important than the USA. A network of organizations was established[2] within the United Nations (UN) to develop, implement and monitor drug policy. Countries that had signed and ratified the treaties were obliged to pass domestic legislation defining the cultivation, production, sale, purchase, possession and consumption of specified drugs as criminal activities attracting punishment. Those treaties[1] are: the Single Convention on Narcotic Drugs, 1961, which established the International Narcotics Control Board (INCB); that Convention as amended by the 1972 Protocol; the 1971 Convention on Psychotropic Substances; and the 1988 United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances. The treaties also required signatory nations to provide adequate treatment for drug-dependent persons seeking help, although this received very little emphasis from international authorities.

In 1971, as part of his campaign for re-election in 1972, President Richard Nixon initiated[3] a 'War on Drugs' giving drug law enforcement and supply control a central role in drug policy. Although this new approach did not result in reduced deaths, disease or crime, and the costs of this approach to government have been considerable, it was seen as politically effective and has been copied by political parties in many other countries.

In the drug policy that emerged from the process instigated by the first International Opium Commission and subsequently intensified more than 60 years later by the War on Drugs, the approach taken was predominantly deontological. Outcomes were considered much less important than the intent of policy. The rhetoric often used in the USA was 'sending the right message'. Drug consumption data were often scrutinized intensively while data about deaths, disease, crime and official corruption only received scant attention.

On 5 June 1981, the Centers for Disease Control in the USA announced the detection of a new epidemic, later termed 'AIDS'. AIDS was later attributed to the spread of a virus, now called 'HIV'. HIV/AIDS is the greatest threat to global public health since the Black Plague of the 14th century. This epidemic has had far-reaching ramifications. The sharing of injection equipment among injecting drug users now accounts for almost one-third of new HIV infections in the world outside sub-Saharan Africa. This means that injecting drug users now account for almost 1 in every 10 new HIV infections in the world. HIV has changed injecting drug use irrevocably just as injecting drug use has considerably shaped the spread of the HIV epidemic in many regions of the world.

In the last two decades of the 20th century, in response to the critical role of injecting drug users in the spread of HIV, drug policy began increasingly to be influenced by a concept called 'harm reduction'.[4] This means that 'reducing the health, social and economic problems of psychotropic drugs is considered even more important than reducing drug consumption'. Setting and achieving realistic but sub-optimal objectives is considered more effective than setting but failing to reach utopian goals. In other words, '80% of something is better than 100% of nothing'. The essence of harm reduction is well expressed in the public health maxim to 'never let the best be the enemy of the good'. Harm reduction is a consequentialist approach to drug policy, emphasizing the importance of outcomes[5] rather than the policy intent.

The impact of global drug prohibition

During most of the 20th century, global drug policy involved the prohibition of certain drugs specified in the international drug treaties. With the passage of time, global drug prohibition became progressively intensified. The War on Drugs in the USA was adopted by many other countries in policy, if not in name. Only in the last 15 years of the 20th century did harm reduction begin to modify drug policy in a growing number of countries.

In the first half of the 20th century, the USA was one of few countries in the world to experience significant problems from illicit drugs. In the third quarter of the century, most developed countries began to experience major problems from illicit drugs. By the final quarter, most developing countries had also begun to experience substantial problems from illicit drugs. In the

first years of the 21st century, nine or ten countries in Africa have begun to report injecting drug use. Global drug prohibition has clearly been unable to prevent the spread of illicit drug use around the world. At best, the almost universal implementation of drug prohibition may have slowed the spread of illicit drug use around the world. However, even that proposition is doubtful. In Asia, anti-opium policies proved[6] to have pro-heroin effects.

The problem of illicit drugs has also been worsening in many other ways. Many countries have reported increasing numbers of drug overdose deaths. Epidemics of HIV, hepatitis B and hepatitis C were detected among injecting drug users in many countries. Many countries reported mounting drug-related crime and official corruption linked to drug law enforcement. Growing reliance on drug law enforcement resulted in rising numbers of prison inmates serving sentences for drug-related offences. The increasing costs to government of customs, police, courts and prisons were not balanced by improving results. The more global drug prohibition seemed to fail as a policy, the more governments supported it politically and financially. A number of terrorist groups funded themselves using the lucrative profits from drug trafficking. In a number of countries ('narco-states') including Afghanistan, Burma, Colombia, Peru and Bolivia, and at times also in Pakistan and Mexico, drug traffickers seemed to have extensively infiltrated government.

The high water mark of global drug prohibition may well have been the UN General Assembly Special Session (UNGASS) on Drugs in 1998. The international community rallied behind the UN Office on Drugs and Crime (UNODC) and its slogan 'A drug free world: we can do it!' This was denial on a breathtakingly global scale. At a 5-year review in 2003, the UNODC claimed improbably to be making 'encouraging progress towards still distant goals'. A survey of 91 countries presented at the meeting reported[7] national comments on recent progress in relation to 16 different categories of drugs. More countries reported deterioration than progress for 14 categories of drugs.

Recent increasing support for harm reduction

For at least 15 years it has been known that a package of measures, required in both community and prison settings, are effective in controlling HIV among injecting drug users.
• First, injecting drug users need simple, explicit, peer-based and factual education about HIV.
• Second, needle syringe programmes are needed to increase the availability of sterile injecting equipment and decrease the availability of used equipment.
• Third, injecting drug users need a choice of effective, attractive and accessible drug treatments, especially substitution treatments (such as methadone and buprenorphine for heroin injectors).
• Fourth, community development of injecting drug users encourages drug users to become part of the solution rather than just being considered the crux of the problem.

The prolonged scientific debate[8] about harm reduction is over. Harm reduction is now accepted to be effective in reducing new HIV infections, free of any serious adverse effects (especially increasing illicit or injecting drug use) and is cost-effective. This evidence is overwhelming for needle syringe programmes[9] and methadone or buprenorphine treatment.[10] The earlier and

more vigorously harm reduction is implemented, the better the results. No country which has started harm reduction programmes has ever regretted that decision and then reversed their commitment.

Harm reduction is now accepted by most major UN agencies including WHO, UNAIDS, UNICEF, the World Bank and an increasing majority of UNODC staff. The International Committee of the Red Cross (ICRC) and an increasing number of diverse countries in Europe, Asia, Oceania and other regions have officially endorsed harm reduction. The number of organizations and countries accepting harm reduction is growing steadily.

In contrast, the number of organizations and countries that reject harm reduction is shrinking. Harm reduction is now opposed only by one UN organization with responsibility for drug policy, the International Narcotics Control Board (INCB), and is still rejected explicitly by the USA and a few other countries. At a critical meeting of UNAIDS in June 2005, 21 countries supported including references to 'harm reduction', 'needle syringe programmes' and 'substitution treatment'. Only the USA opposed including these terms. In the end, the majority opinion prevailed. All 25 members of the European Union now provide needle syringe programmes and methadone treatment. In Asia, home to more than half the world's population, harm reduction is today accepted in almost all of the most populous countries. Forty-eight countries now provide methadone treatment while 34 countries provide buprenorphine treatment. Global uptake of needle syringe programmes is also increasing rapidly, with 65 countries now providing at least some service. Although programmes are now being started in many countries, coverage is generally still very poor, especially where it is most needed in Central and Eastern Europe, and Central, South, South East and East Asia. Coverage in prisons worldwide is even worse.

Harm reduction still has some trenchant critics. This debate is essentially a conflict between 'consequentialists', more concerned to evaluate interventions by considering their impact, while the 'non-consequentialist' critics of harm reduction prefer to evaluate interventions by considering their moral worth. However, all participants in this debate have to consider the morality of ignoring clear scientific evidence and thereby condemning future generations to endemic HIV.

Legal aspects of drug policy

Criminal laws can be divided into two groups: '*malum in se*' ('wrong in itself') laws and '*malum prohibitum*' ('wrong by statute') laws.

Malum in se laws tend to involve violence, are generally very consistent from one jurisdiction to another, witnesses are often readily available (making prosecution easier), and the laws are fairly stable and are generally not controversial.

In contrast, *malum prohibitum* laws tend to involve consensual and non-violent activities, are very inconsistent from one jurisdiction to the next, witnesses are rarely available (making prosecution difficult) and the laws are often unstable and controversial. Drug laws are clearly of the *malum prohibitum* type.

It is salutary to remind ourselves of the recent fate of some other *malum prohibitum* laws. In many western countries, controversy about laws criminalizing homosexual acts slowly increased after the Second World War. The Wolfenden report

in 1957 in the UK recommended that consenting sexual acts between adults in private should not be subject to prosecution. In 1973, homosexuality was eliminated as a diagnosis from the Diagnostic and Statistical Manual of the American Psychiatric Association. Three decades later, a number of countries have begun to provide forms of legal recognition of couples in long-standing same-sex relationships. The repression visited so energetically and so recently against homosexual people and now slowly being removed should serve as a reminder of the dangers of enshrining behaviours criminalized by *malum prohibitum* laws into psychiatric diagnoses.

The economics of illicit drugs

Why has the illicit drug trade continued to thrive despite ever-expanding drug law enforcement and increasingly severe penalties for offenders? The answer appears to be candidate Bill Clinton's refrain in the 1992 presidential election: 'it's the economy stupid'. The value of the global illicit drug market at the retail level in 2003 was estimated at US$322 billion.[7] The lucrative profits of drug trafficking were estimated in a confidential report in 2003 to the UK Cabinet to account for 26–58% of turnover.[11] This report makes it clear that drug law enforcement faces a more than Herculean task. The financial size of the illicit drugs industry in the UK has recently been compared to British Airways. The costs of attempting to ignore powerful market forces are now well recognized. Yet global drug prohibition attempts to do just that.

The very high costs, limited effectiveness and often severely counter-productive effects of global drug prohibition are now being increasingly recognized.[12–15] There is growing support for re-defining[16] illicit drugs as primarily a matter for health and social interventions while still recognizing the need to maintain supportive drug law enforcement. The practical implication of this re-definition would be to increase the funding available for health and social interventions to the level enjoyed by drug law enforcement. This would allow expansion of capacity, broadening of the range of options and improvement in the quality of drug treatment. A century ago in western countries, small quantities of dilute concentrations of illicit drugs were available to the community through retail outlets. For example, *Coca Cola* contained cocaine until 1903. Edible opiates in small quantities were available in Australia until 1906. In the Andean countries of South America, coca is available now in 'tea bags' which enable infusions to be prepared.

Conclusions

While the international community adopted an increasingly deontological approach to illicit drugs during the 20th century, drug use spread extensively and health, social and economic outcomes worsened dramatically. Reliance on drug law enforcement to control drug problems became even more excessive after a War on Drugs was instigated in the USA in 1971 and was adopted by many other countries. The recognition of the HIV pandemic and the serious health, social, economic and national security threat this posed has caused many countries to assume a more consequentialist approach. Recently, increasing awareness of the high costs, limited effectiveness and serious collateral damage

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from drug law enforcement has also resulted in growing support for more evidence-based approaches emphasizing effectiveness, safety and cost-effectiveness. ◆

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