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POLICY COMMENTARY

The Elusive Search for Rights-Centred Public Health Approaches to Drug Policy: A Comment

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While it is common for United Nations member states in international meetings to espouse 'public health approaches' to drug policy, actual policies appear not to have caught up with this rhetoric. There is a lingering over-emphasis in narcotic drug policies on policing and incarceration at the expense of urgently needed investment in health and social services for people who use drugs. These policies have lethal consequences in the transmission of potentially fatal infections and preventable overdose deaths, and they impede progress in social and economic development. The experience of a number of countries, mostly in the European Union, highlights that bringing public health evidence into the center of drug policy decision-making can have broad social, economic and public health benefits.

Keywords: drug policy; opioids; overdose; public health; harm reduction

To judge by the rhetoric in United Nations discussions, the era of public health-friendly, evidence-based policy on control of psychotropic drugs is well enshrined. Declarations from the important United Nations meetings on drugs in 2016 and 2019 emphasize that addressing the 'world drug problem' must be undertaken 'with a view to promoting and protecting health, including access to treatment, safety and the well-being of all humanity' (UN Commission on Narcotic Drugs 2019). Lofty deference is also paid to human rights and the 'inherent dignity of all individuals' as part of drug control (Ibid.). At the 2016 United Nations (UN) General Assembly Special Session on drugs, numerous countries declared that they see people who use drugs as 'patients, not criminals' and that policies and programs would follow accordingly (Csete & Wolfe 2017). The UN Office on Drugs and Crime (2019) launched its 2019 annual drugs report under the slogan 'health for justice, justice for health' – a bit of a head-scratcher as a tag-line but certainly intended to be a nod to the importance of health and human rights in drug policy.

But in real life, the health-related harms of ill-conceived drug policy accumulate with lethal regularity. Drug policy in most countries undermines any commitment that those countries may have to the infectious disease reduction target of the Sustainable Development Goals (SDG), the reduction of mental illness (Target 3.4), access to essential medicines, the reduction of poverty, and of course the goal on prevention and treatment of 'substance abuse' (Target 3.5). Plainly there is a chasm into which policies fall on the way from the rhetoric to the reality.

There is no question that drug control policy could make a major contribution to the health of the public and to people's enjoyment of human rights beyond the right to health, and thus to the achievement of sustainable development. That contribution is evident in progressive drug policy in several countries, if not always at the desired scale. But it is politically easy for policy on drug control to morph into a tool for stigmatizing and criminalizing groups that are out of political favor, or scaring the populace into supporting repressive policing and inhumane sentencing, or simply missing the opportunity to relieve suffering by chasing after goals based more on moral judgement than on good policy sense. In an age when political leaders celebrate the denial of science, the espousal of intolerance for minorities and those marginalized by poverty, and the dismantling of social welfare systems, it is easy to see how repressive drug control can be an appealing policy direction.

This commentary suggests that there is an urgent need for pragmatic evidence-based policies that can undo the harms of politically expedient, criminal-law-heavy policies and demonstrate that drug control can be consistent with sustainable development, human rights and public health.

The challenges of reducing and preventing drug-related health problems

It is impossible to imagine what global drug-control policy discussions would consist of without the spotlight on drug use that was shone by HIV. People who inject drugs (PWID) lived with plenty of morbidity before HIV came along, but when they died in noticeably large numbers from AIDS, drug-related harms became a compelling policy concern. HIV may not be the best indicator of health-related success of drug-control efforts, particularly now that overdose mortality outpaces HIV mortality in so many places. But HIV outcomes related to drugs still tell an illuminating story.

As noted by UNAIDS, disproportionate incidence of HIV adds a lamentable element to the litany of 'widespread stigma and discrimination, violence and poor health faced by people who use drugs' (UNAIDS 2019: 2). A 25% reduction in new HIV cases was registered globally from 2010 to 2017, but among people who use drugs in many countries, especially outside of the European Union (EU), HIV incidence increased (Ibid.). The virtual elimination of HIV linked to drug injection as a public health problem in most of the EU (European Monitoring Centre for Drugs and Drug Addiction 2019) – even where drug injection is widespread – shows that the means are at hand to reduce this particular harm, if political decision-makers will only call on them.

The under-investment in effective and cost-effective HIV prevention services for people who use drugs is a public health crisis and a global scandal. The background noise in drug policy circles in too many countries is the grating repetition of the vapid assertion that reducing drug-related harms encourages drug use. Provision of sterile injection and smoking equipment to people who use drugs, furnishing them with a place where they can consume drugs in relative safety with medical intervention as needed, and ensuring that they have ready access to effective treatment for drug use disorders have long since proven their worth in cost-effective HIV prevention (Wilson et al. 2015), but they remain underutilized.

Reducing overdoses and their harm requires thinking beyond the package of HIV-related harm reduction measures, and that thinking is also handicapped by ill-informed fears. In a number of countries, including the United States (US), overdose mortality far exceeds the historical peak of HIV-related mortality among people who use drugs, thanks partly to the rapid expansion of markets for fentanyl and other synthetic opioids. In the US, overdoses were an important contributor to a decline in life expectancy among some age groups in the white population, a phenomenon rarely seen in the country's history (though possibly to be repeated in the coronavirus crisis) (Woolf & Schoomaker, 2019). Opioid-related overdose mortality increased six-fold in the US from 1999 to 2017 (Scholl et al. 2019). About 60% of overdose deaths in the US in 2017 were linked to synthetic opioids, mostly fentanyl, 45% more than in 2016 (Scholl et al. 2019). Similar increases in fentanyl-related deaths were seen in Canada in the same period (Government of Canada 2019).

Fentanyl and its analogs such as carfentanil are among the most lethal examples of new psychotropic substances (NPS) – relatively easy to manufacture, potent in tiny doses, and outstripping existing laws and law enforcement with their dramatic expansion. The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), a European Union body, noted in its 2019 report that while deaths related to fentanyl and other super-potent synthetic opioids have not yet reached North American levels in the EU, 20% of persons seeking treatment for opioid use disorders (OUD) in the EU now report a synthetic opioid such as fentanyl as their main drug consumption challenge (EMCDDA 2019: 12). Plainly Europe is not completely immune from North American-type overdose challenges.

A comprehensive response to overdose should include not just measures to mitigate the harms of overdose but also measures to prevent overdose episodes in the first place. For reducing the harms of overdose, some EU countries and Canada have led the way in establishing supervised consumption sites (SCS) in which people can inject with sterile equipment and ready access to emergency assistance in the case of overdose. As of 2018, there were an estimated 89 SCS in Europe, 25 in Canada and 2 in Australia (Harm Reduction International 2018a). The Insite SCS in Vancouver, Canada, one of the most intensively studied of these services, as of 2019 witnessed over 6000 overdose episodes with no reports of death or brain damage (Ibid.), a record similar to those of established SCS in EU countries. Some SCS also refer people to treatment for drug use disorders and other health services, and some refer or otherwise assist people in obtaining housing and other benefits. But among countries where injection drug use is prevalent, it still is the case that relatively few offer this service.

Provision and promotion of the use of naloxone, the medicine that reverses overdoses, is more widespread as an overdose harm reduction measure, but there remain many barriers to satisfying the demand for this

crucial intervention. The World Health Organization (WHO) recommends that 'people likely to witness an overdose' should have consistent ready access to naloxone and should be trained in its use (WHO 2014). This presumably should include people who use drugs themselves as well as friends and family members. Though a number of countries equip emergency medical personnel and sometimes police with naloxone, relatively few countries provide naloxone to people who use drugs themselves or their family members or peers (Harm Reduction International 2018b). Urgently needed access to naloxone remains blocked in too many places by the high cost of the product, particularly in the easier-to-use nasal spray form, prescription restrictions, and fears of intervening in an overdose episode in which police may become involved (Ibid.). In the US, in spite of the compelling nature of saving a life or preventing brain damage by the use of naloxone, the trope of 'harm reduction encourages drug use' has still been heard (Kamp 2018).

An overdose prevention measure is pill testing or drug checking, meaning the use of simple tests such as fentanyl strips or more sophisticated tools such as mass spectrometry to detect adulterants in unregulated drugs before they are ingested. In Canada and the European Union, numerous NGOs and some government agencies conduct drug checking, especially at night spots and festivals (EMCDDA 2019). Some state and local authorities in the US have invested in fentanyl testing strips (California Department of Public Health 2019), but ideological, legal, and political barriers persist in some locations (Boden, 2019). In addition, some people who use opioids may prefer fentanyl because of its strength (Morales et al. 2019), in which case detecting the presence of fentanyl in street drugs may not achieve the objective of curbing consumption of dangerous substances.

If preventing death and brain damage from overdose is so difficult in spite of very effective means of achieving it, preventing overdoses from happening is even more challenging. When the crux of the problem is that people find themselves having to seek and consume unregulated drugs laced with toxins that make overdose more likely, the solution must be to remove the toxins – definitely a long-term proposition – or to provide alternatives to having to seek drugs on the street.

Ideally ensuring access to traditional treatment for OUD, including methadone and buprenorphine maintenance, should be an adequate response for the majority of people at risk. But as effective as traditional treatments have been, some minority of people with OUD may not benefit optimally from them or may prefer not to receive them. Several European countries and Canada have offered this relatively small population the possibility of receiving medical-grade heroin daily under highly controlled conditions. Usually called heroin-assisted treatment (HAT), these programs have been shown to provide effective, humane treatment especially for people with longer-term intransigent OUD without causing diversion of the medical-grade heroin to non-medical use (Strang 2015). In spite of this good track record – HAT programs have been smoothly run since the 1990s in Switzerland and the UK – the optics of government provision of heroin poses an obvious political challenge to establishing such programs where harm reduction is already generally demonized.

Policy discussions in Canada in recent years have included debates about 'safe supply' measures such as HAT with the recognition that the overdose crisis boils down to a problem of too few safe alternatives for those who get opiates on the street. The Canadian Association of People Who Use Drugs (CAPUD), which helped to open these debates, defines 'safe supply' as a legal and regulated supply of psychotropic drugs 'that have been traditionally accessible only through the illicit drug market' (CAPUD 2019). Exemplifying this approach, Dr. Mark Tyndall, a professor and former director of the British Columbia Center for Disease Control, spearheaded a pilot intervention in the form of a biometrically controlled ATM-like machine that will dispense hydromorphone pills (hydromorphone is a strong opioid used for pain management) as a substitute for heroin (Bains 2019). Among other advantages, this dispenser does not require stigmatizing daily visits to clinics with rigid rules and limiting hours (Ibid.). The British Columbia Centre for Substance Use (BCCSU) (2019), which has an affiliation with the University of British Columbia, has called for consideration of heroin compassion clubs as a safe supply measure. Modeled on the cannabis social clubs that exist in several countries, a compassion club would be a members-only cooperative that would essentially create a closed market for heroin that is certified not to be adulterated with toxins. BCCSU asserts that these restricted-circulation clubs would be low-cost and would cut into the business of the criminal networks supplying unregulated heroin (Ibid.).

In addition to HIV and overdose, people who use drugs are disproportionately affected by hepatitis C and tuberculosis (TB). WHO estimated that 23% of new hepatitis C infections and about a third of hepatitis C-related deaths in 2017 were among people who use drugs (World Health Organization 2019). The treatment of hepatitis C entered a new era after 2013 when interferon-based therapies were replaced by a new generation of direct-acting antiviral (DAA) medicines as the treatment of choice (Beste 2019). But access

to DAA medicines for people who use drugs has been impeded in many ways. While WHO recommends low-threshold access to hepatitis C treatment for all people in need of treatment, including people who inject drugs, many jurisdictions require periods of abstinence, enrolment in drug use disorder treatment, or referral to treatment for hepatitis C from addiction specialists as prerequisites for DAA therapy (Ibid., Grebely et al. 2017). WHO cites policies in the United States as particularly unhelpful in imposing such pre-requisites (WHO 2019). These pre-conditions are discriminatory and contribute to stigmatization of people who use drugs, and they are ultimately counterproductive as they contribute unnecessarily to prevalence of advanced liver disease among those for whom treatment thresholds were too high.

People who use drugs are also at high risk of tuberculosis (TB), in some settings linked to high prevalence of HIV but also because they are over-represented in prison and pretrial detention, which are high-risk environments for TB transmission (Stop TB Partnership 2016).

Health problems associated with law enforcement and incarceration

The likelihood that people who use drugs deemed illicit will find themselves in conflict with the law and possibly in state custody at some time in their lives is itself a profound public health problem. Due to draconian drug laws that impose significant prison terms for minor possession, for example, people who use drugs and people with drug use disorders are over-represented in prison and pretrial detention (Penal Reform International 2018). In some regions, women are particularly over-represented among those imprisoned for minor drug offenses. It was estimated in 2017 that in eight Latin American countries more than 40% of women in prison had been convicted of drug offenses (Giacomello 2017). As of 2019, in six Latin American countries, more than 40% of the women in pretrial detention were charged with though not convicted of drug offenses – many times the percentage for their male counterparts – and use of pretrial detention for minor drug offenses was growing in these countries (Castro 2019).

Social, health, and economic consequences of incarceration for people who use drugs and their families are devastating, particularly where services to address drug use disorders and to provide social support for re-entering the community are absent. A number of European Union countries, Canada, and Australia are exceptional in offering a range of treatment for drug use disorders in prisons (Harm Reduction International 2018). The United States is a notably delinquent in this area with only one state (Rhode Island) and a few cities offering any agonist treatment to people in prison or pretrial detention (Csete 2019).

It is well established by research in many settings that requiring abstinence in prison of people who used opioids before incarceration puts them at very high risk of overdose in the early days after release (Binswanger 2019). Providing opioid agonist treatment in prison and ensuring that persons recently released can have immediate contact with OAT providers in the community can greatly reduce overdose risk. Ensuring access to naloxone for recently released persons and those close to them can mitigate the impact of overdoses, but there are too few consistent efforts at post-release naloxone provision (Harm Reduction International 2018). A notable effort in Scotland has systematized distribution of naloxone to persons leaving prison and has been associated with reduced overdose incidence (Horsburgh & McAuley 2016). Naloxone may be expensive where it is not subsidized by the state or well covered by health insurance, and program managers may not know how to prioritize distribution among family members and friends of a person to be released. An experimental program at the Rikers Island jail in New York City targeted those who visited prisoners about to be released to receive naloxone and be trained in the use (Huxley-Reicher et al. 2018). Follow-up with this population led the researchers to conclude that this approach effectively targeted people likely to observe overdose episodes and enabled them to intervene.

People charged with drug offenses may be especially likely to be held while awaiting any kind of hearing before a judge or even a meeting with a prosecutor because they may be unable to pay bail – or bribes – to secure pretrial release. It is often the case in pretrial detention that health services are minimal as it is thought that people will not be in these facilities for significant periods; starting extended treatment for tuberculosis, hepatitis C or HIV, for example, is not seen to be worthwhile if the patient will be released or transferred in the near future (Csete 2010). But the reality in many countries is that pretrial detention can turn out to be for long periods, and health risks are high. Police crackdowns and other relatively unplanned events may fill pretrial detention sites to capacity or more. Medical facilities and capacity may be minimal. In many countries, a significant percentage of people in state custody are awaiting trial or arraignment (charging), and overcrowding is a risk factor for TB and other infectious disease transmission (Castro 2019). The Global Fund to Fight AIDS, TB, and Malaria (2017) is willing to fund advocacy to reduce reliance on pretrial detention as a TB control measure. Pretrial detention should be limited to cases where people pose a risk to themselves or others or represent a flight risk – limitations too rarely respected.

The public health approach to drug use declared in international fora by many countries should in principle herald interventions to create alternatives to incarceration for non-violent drug offenses. In far too many countries, however, program activities that are trumpeted by authorities as health-oriented bear no resemblance to good public health practice. Non-governmental organizations and UN agencies have worked for years to shut down 'treatment' facilities in East and Southeast Asia, for example, that in many cases resemble forced labour camps more than any kind of health facility and rarely offer scientifically sound treatment of any kind (Lunze et al. 2018; Amon et al. 2013). Treatment for drug use disorders in most countries is one of the most unregulated and uninspected of health services. Chaining people to their beds or to trees, forcing them to undergo humiliating rituals, and requiring 'cold turkey' withdrawal without the benefit of medicines that could relieve suffering are among the many abuses documented in numerous countries (Wolfe and Saucier 2010). In 2013, the UN Special Rapporteur on Torture highlighted the likelihood of human rights abuses in the name of 'treatment' of drug use disorders and called for the closure of compulsory drug 'treatment' centres (Mendez 2013).

A number of countries cite specialized drug treatment courts as evidence of their espousal of a public health approach to drug control. Drug treatment courts (or 'drug courts') in theory replace criminal sanctions for certain categories of offenses with court-supervised treatment for drug use disorders, especially where it is thought that drug dependence may have spurred the infraction. The United States has gone to great lengths to develop and expand these courts in its own borders and also to support their expansion as part of its foreign policy, especially in Central and South America (Csete 2019b).

The idea of drug courts is appealing – it is clearly not good practice to send people living with drug dependence to prison – but their implementation has in many cases strayed from good public health practice. In the US courts, it is far from clear that people in the courts are being offered treatment appropriate to their needs. Many US drug courts do not permit opioid agonist therapy as an option for court-supervised treatment (Physicians for Human Rights 2017; Matusow et al. 2013), a lethally counter-productive policy in the middle of an opioid overdose crisis. The reason for this denial appears in many cases to be at least partly because of the view of judges or drug court managers that agonist therapy is just another form of addiction (Physicians for Human Rights 2017; Cherkis & Grim 2015). The Inter-American Commission on Human Rights (2017: 94–100) criticized drug courts in several countries in the Americas for requiring people facing cannabis-related charges to undergo long periods of residential treatment not appropriate to their condition. In the US, drug court participants who 'fail' treatment as indicated by a 'dirty' urinalysis may be punished by a jail sentence, as judges apparently dismiss the idea that relapse is a normal part of drug use disorders. Since most US drug courts require participants to plead guilty to whatever charge they face, if they 'fail' treatment and are thrown back into the regular court system, they will have forgone the opportunity to defend themselves or plea-bargain (Csete 2019b). A meta-analysis of 19 drug court studies from US jurisdictions by Sevigny and colleagues (2013) found that periods of incarceration meant to punish treatment failure could negate whatever diversion from prison the drug courts represented.

Practices by drug police can also undermine or facilitate public health approaches to drug control. It is encouraging, for example, that there is a Global Law Enforcement and Public Health Association that, among other things, has organized five global conferences to date at which police can exchange experiences in working with health officials to minimize harm to people who use drugs (see glepha.wildapricot.org). Unfortunately, it is still frequently the case that the performance of drug police is measured by meeting arrest quotas, which tends to encourage arrests of small-scale users who are the easiest to find – and are precisely the population that should be directed away from the criminal law system and toward health and social support (UNODC et al. 2015). Arrest quotas may encourage police to intensify their presence around syringe exchange programs and other services for people who use drugs (Ibid.), a savvy strategy for police but a sure way to discourage use by PWID of harm reduction and health services.

A number of countries have decriminalized or at least removed custodial penalties for a wide range of drug offenses, measures that plainly facilitate access to health and social support not readily available in the criminal legal system. As of 2019, heads of United Nations (UN) agencies committed their agencies to work toward the goal of decriminalization of drug possession for personal use as well as combating arbitrary arrest and over-incarceration for drug infractions (UN System Coordination Task Team 2019). Portugal and the Czech Republic, for example, have gone well beyond the UN common position by decriminalizing all offenses, even minor sales, involving quantities of drugs below a certain cut-off combined with good access to health and social services, with demonstrably good health outcomes as a result (Hughes & Stevens 2010; Csete 2012). The 2019 International Guidelines on Human Rights and Drug Policy – endorsed on a technical level (but not by their member-state governing bodies) by WHO, the UN Development Programme and the

Joint UN Programme on HIV/AIDS (UNAIDS) – notes that decriminalizing 'possession, purchase and cultivation of controlled substances for personal use' does not necessarily contravene state obligations under the UN drug conventions (International Centre on Human Rights and Drug Policy et al. 2019).

Access to controlled medicines: A tale of two opioid crises

While over-prescription and over-supply of opioid medicines have played a role in the dramatic increase in drug-related mortality in the US, in most of the world people in desperate need of opioids and other psychotropic medicines go without them at the cost of enormous and avoidable human suffering. As noted by the *Lancet* Commission on Palliative Care, with respect to opioids for pain management, there is a grotesque 'access abyss': low-income countries use only 0.1 ton of the approximately 300 tons of morphine used in the world for pain relief (Knaul et al. 2017). Millions die in needless pain, and millions suffer from chronic pain over long periods as essential medicines for palliative care and pain relief stay largely in high-income countries. As the *Lancet* Commission concluded, overzealous efforts to control non-medical use of opioids have resulted in lopsided policies that fail to achieve a balance between preventing diversion of opioids to non-medical use and ensuring their availability for those who need them (Ibid.) This is the policy balance that WHO has long espoused (WHO 2011), but it seems unattainable when drug laws are so harsh that doctors' fear of criminal sanctions overwhelms their desire to relieve their patients' pain.

It should be the business of the International Narcotics Control Board (INCB), created by the 1961 Single Convention on Drugs, to help countries to ensure a balance between drug control and availability of essential medicines. For much of its history, the INCB itself seemed unbalanced in this regard, in its analyses and recommendations, often giving far too much attention to diversion of drugs to non-medical use and far too little to helping countries set aside adequate opioids for legitimate medical purposes (Burke-Shyne et al. 2017). The INCB should have protested as country after country established draconian penalties against medical professionals who might face jail time for making a minor error in reporting, prescribing or storing controlled medicines, penalties often exceeding measures recommended in the UN drug conventions (Ibid.). Little was done to help countries avoid demonizing opioids and weakening scientifically sound training on opioid prescription for health professionals. But, as with denial of harm reduction services, over-incarceration for minor drug offenses, and repressive drug policing, it has been easier to adopt war-like positions against drugs than to grapple with addressing the human rights and health needs of people who use drugs or may benefit from controlled substances.

Conclusions

The high and quite visible mortality associated with overdose in the United States especially since 2015 has led some states and municipalities to take measures that seem to challenge the dominant historical reliance on warlike drug-control policies. An example is the rush of many states to pass 'good Samaritan' laws intended to protect from criminal liability or civil litigation people who may step forward to intervene, with naloxone or otherwise, when confronted with an overdose episode (Beletsky 2019). These laws differ in how they might protect people who are themselves drug sellers, but overall they are a positive development. They are, however, directly undermined by so-called drug-induced homicide laws, espoused by the Trump administration, which pose criminal sanctions against a seller of drugs if it can be determined that drugs sold by him or her were involved in an overdose death (Ibid.). Aside from the obvious evidentiary challenge of linking the drugs of a given overdose to a particular sale or seller, drug-induced homicide laws strike fear in the heart of the 'Samaritan' who would be inclined to help an overdose victim but is in possession of drugs or is otherwise fearful of being accused of selling drugs. About half of US states have laws allowing for prosecution of drug-induced homicide (Ibid.), hailed by a president who continually calls for capital punishment for drug dealers (Jacobs 2018).

The story of these dueling laws encapsulates the challenge of realizing the public health approaches to drug use so easily espoused in international meetings. The new health-friendly rhetoric may be a step forward, but the history of drug control is littered with policies energized by pious moral judgement, implemented by gross misapplication of criminal law, and exemplifying a rejection of science that is at times nearly inexplicable. Drug use disorders comprise a relatively small part of the global burden of disease – compared to cancers, cardio-vascular disease, conditions associated with tobacco and alcohol use, and certain infectious diseases for example – but bad drug policy punches above its weight as a health and social burden. Since drug policy can help to overload prisons, inspire repressive policing, contribute to racism and other discriminatory and stigmatizing attitudes, further marginalize low-income people, and cause enormous suffering through untreated pain, traditional 'burden of disease' measures may not capture the harm

of warlike drug policies. And that list does not even include the social costs – indeed lethality – of allowing drug markets to be controlled by criminal networks.

The dramatic spread of HIV linked to drug injection in the 1980s and 1990s led some countries, especially in Europe, to temper repressive drug policies with good public health practice, at least to some degree. These experiences demonstrate that by undoing historical harms, better drug policies can contribute to many dimensions of sustainable development. Decriminalization of minor drug offenses can be a crucial step to more development-friendly and certainly more health-based drug policy. It remains to be seen whether the overdose mortality crisis in North America will lead to an expansion of policy space in which scientifically sound drug control may emerge. The US has had outsized influence in global drug policies, not only through military and quasi-military official 'narco-assistance' in many parts of the world but through the example of its domestic laws and policies. Whether a history of misguided moral judgement, repression and pursuit of patently ineffective drug-control policy can be overcome with a demonstrable commitment to health-friendly policy is a signal test of national and global governance for our time.

Competing Interests

The author has no competing interests to declare.

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