

ETHICS, PROFESSIONAL STANDARDS AND DRUG ADDICTION

Report

**Seminar organised by
the Co-operation Group to Combat Drug Abuse
and Illicit Trafficking in Drugs
(Pompidou Group)**

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Drugs and addiction

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The Pompidou Group

The Co-operation Group to Combat Drug Abuse and Illicit Trafficking in Drugs (Pompidou Group) is an inter-governmental body formed in 1971. Since 1980 it has carried out its activities within the framework of the Council of Europe. It provides a multidisciplinary forum at the wider European level where it is possible for policy-makers, professionals and experts to discuss the exchange of information and ideas on the whole range of drug misuse and trafficking problems. Its current work programme includes the promotion of global drug strategies at national, regional and local level; the improvement of data collection systems in Europe; the stimulation of transfer of knowledge and experience between the relevant administrations and professional groups in Europe on issues, policies and programmes for drug demand reduction; the promotion of effective implementation at European level of international drug control treaties and the improvement of cross-border collaboration against trafficking.

The opinions expressed in this publication are those of the authors and do not necessarily reflect those of the Council of Europe / Pompidou Group.

THE EXPERIENCE OF THE COUNCIL OF EUROPE IN DRAWING UP STANDARDS IN BIOETHICS

Carlos de SOLA, Head of the Bioethics Division, Council of Europe

I realise that I have to keep to the time I have been allotted. I have been told I have fifteen minutes and I shall do my best not to be any longer. No doubt my presentation will be very much an outline presentation, but I wanted to give you some idea – in the most appropriate way possible (given that I have only a little time) – of our experience in this field. Some of this experience may not be totally relevant to your spheres of interest, but some aspects will be and could perhaps be adapted to other activities.

In my view, the Council of Europe's Bioethics Committee is part of the broader picture of ethics committees. In general terms, the aim of ethics committees is to serve as a forum for deliberation and debate. Out of this deliberation and exchange of views might come, for example, a written opinion.

However, it may also lead to the drafting of standards; these may, for example in the field of medicine, be clinical in nature, or more general, in the form of principles, or legal in nature. I think that such committees also have a role in anticipating problems, at least with regard to modern technologies. It is important to try and remain up to date (this is not always possible but it is what we should be aiming at). Equally, it is essential for the work of such bodies to contribute to social cohesion. In areas where there may be a significant divergence of views on problems which are often held to be fundamental, it is important for the various sectors of society to be able to feel part of the debate and have their legitimacy acknowledged. In that connection, the input of even minority views clearly contributes to social cohesion.

One of the particular features about the composition of ethics committees (and here I am not just talking about the Council of Europe's Bioethics Committee) is their multidisciplinary nature. There are doctors, legal professionals, experts in ethics, sociologists, psychologists, etc. This is very important. Although it may be difficult at times, from the technical point of view, to find a common language – and especially a common meaning to the terminology used, this type of composition undoubtedly has a considerable added value.

The second distinctive feature is ideological plurality. Just now I mentioned minorities, but it is clearly also extremely important, even before addressing the issue of social cohesion, to take on board the fact that by allowing for account to be taken of all the various currents of thought, it will be possible to formulate an idea which ultimately will be shared to varying degrees by everyone. In fact, everyone will have been given the opportunity to provide some input.

Furthermore, the participation of non-specialists is, at least at certain levels, considered to be vital. This is so that it is not just experts who put forward their views. It is also important for those in the political sector to be able to submit their contribution, whether from the outset or later on in the process.

These are some of the features which are common to ethics committees, at both international and national levels, and I would like now, still very briefly, to mention some of the main points of conflict that emerged when the Oviedo Convention on Human Rights and Biomedicine was being drafted.

I think there were various categories of conflicts. First of all, substantive conflicts of which there were basically three in our field: research on people incapable of giving their consent, research on embryos and gene therapy. Obviously, I do not have time now to go into detail, however small, on this points.

There were other types of differences, perhaps a little less substantive, namely cultural differences. There were a number of these; for example the role of the family in society, which in some cases plays a big part and in others a much smaller one. In addition, the importance of an individual's autonomy in relation to the legitimacy of the social norm. There is a clear divergence of views in this respect (which could be described as cultural) in Europe. This derives from traditions and is very often reflected in law.

Lastly, there were a number of difficulties, more genuinely legal in nature. For example:

- the problem of, on the one hand, science which is constantly evolving and, on the other, regulations which, to a certain extent, are more fixed because they cannot be changed so quickly;
- the conflict occasionally perceived, at least by a number of practitioners, between (i) legal standards and principles, and (ii) clinical practices;
- the ambiguity of terminology – not only at national level but occasionally resulting from a difference in meaning attached to the same word by people working in different disciplines;
- lastly, national legal systems which diverge on a whole series of questions or which quite simply have different approaches, all of which must be taken into account.

A few words now about working methods. In view of the aims referred to above, first of all, there was an approach focusing on not only debating ideas but also drafting norms. I think it is extremely important to begin, not by drafting a text, but by discussing ideas and not to simplify the issue by seeking at the outset to reach a compromise but to examine the problem in depth, before turning one's attention to the norm.

Next, the involvement of a number of partners:

- there were of course, the official experts, representing governments, the public authorities or authorities in general;
- then, professionals. In our field, this was primarily health-care professionals; in your field there will be professionals from other disciplines;
- lastly, the patients and the general public.

Clearly, it is essential for everyone, in one way or another, to be involved. This holds true not only for the drafting stage but also for the acceptance of the results of the work. To that end, consultation can be undertaken, which may take a variety of forms:

- this may be symposia, congresses, conferences, whatever you might wish to call them, open to all;
- occasionally (and indeed nowadays quite regularly), we undertake direct consultation of associations at both national level (here it is governments who have responsibility for this) and European level (we organise this at Council of Europe level);
- lastly, we can declassify texts and publish the draft version in advance to enable people who have not been involved in the first drafting of the text to be able to influence the future and subject matter of the texts concerned.

The outcome of all that can be a number of practical results in the form of:

- reports. Reports can sometimes have considerable impact, even if they are not norms in the strict sense.;
- reference texts, either for the legislature or other associations;
- declarations, termed “soft law”, which very often in the Council of Europe can be in the form of recommendations. These can also be influential;
- lastly, binding standards, when it has been possible to identify and give shape to a number of principles and rules.

I hope I have not overrun too much. I have attempted to keep to my allotted time, and I would apologise for the somewhat broad-brush nature of this presentation.

Thank you.

THE RIGHT TO INFORMATION: INTRODUCTORY STATEMENT

René PADIEU (France)

The organisers of this seminar have done me the honour of mandating me to contribute an introduction to the ethical aspects of the right to information in the field of drug addiction. I understand that this seminar is aimed not at producing formal conclusions but rather at identifying various problems which might subsequently be covered by further discussions and debates. And so I would like to present a panorama of the criteria for listing the themes and subjects for future discussion.

We might preface our debate with the observation that although the European Convention on Human Rights recognises the right of everyone to express his opinions and to *disseminate* information, it does not mention any right to *receive* information. The idea that we are entitled to know certain things - with the corollary that someone, usually the State, is required to inform us - is in fact fairly recent. The emergence of this right to knowledge was accompanied by the formulation of legislation on the obtaining, possession and utilisation of information. However, this legal framework is not sufficient to settle the whole issue, and ethics - both general and professional - has a major role to play.

I propose to begin by discussing this concept of the “right to information” and attempting to gauge its scope. In so doing we shall see that it brings a huge range of persons and situations into play. The question therefore breaks down into and revolves around a multitude of problems involving ethics. Having initially identified this fact in broad terms, I shall go on, in the second part, to address a number of more specific problems which require an ethical solution.

I. The concept of information and the aim of ethics

A. *Who should be informed of what, and why?*

Information breaks down into three parts:

- Content: who or what is the subject of the information, and what does the latter say about this person or object?
- Addressee: who is to be informed?
- Purpose: what is the point of the information?

When discussing the right to information, we also come upon three different aspects, which correspond to the three elements mentioned above, although there is no exact one-to-one mapping, and I shall give them in a different order:

- The *subject* or holder of this right: who is to be informed?
- The *object* of the right: what information does the right refer to, and when and how is it to be provided?
- The *basis* of the right: what are the reasons or legitimation for granting the subject this right?

The use to be made of the information (the purpose of a communication) must be recognised if we are to legitimate a right to this information. Moreover, the use identified leads us to include in the content of the right not only the information itself (its substance), but also specific further details concerning its date, the requisite accuracy, clarity or technical nature of the formulation, etc. Conversely, non-recognition of certain uses would prompt us to withhold the right to receive the information in question, or else to surround the right to

receive it with an obligation to use it exclusively for one specified purpose, to the exclusion of all others, and the a prohibition of retransmitting it to third persons.

This purpose in respect of the information imparted (providing the basis for the right to request and receive it) leads us on to consider the use to which the person informed will put it. This person may be *required* to do or say something: he/she accordingly *needs* appropriate information. A's right to information may provide the grounds for B's obligation to supply him/her with this information; however, it is primarily A's obligation to do something that justifies his/her right of access to the information.

To take one example, in order to treat a patient a doctor needs to know how he/she feels, what he/she is suffering, what he/she has been doing and what he/she wants; the physician also needs to know what treatment or medication is available and the attendant benefits and risks, etc. As a second example, a police officer or judge responsible for apprehending and punishing a criminal must know who the offender is, what he/she has done and also what legal rules he/she is supposed to have infringed. Thirdly, politicians or administrative officers who are responsible for developing public health or safety policies, setting up the corresponding bodies, earmarking a budget for the purpose and supervising operations, need to know all about these bodies and their doings. They also need to know the extent of drug consumption and such diseases as AIDS or hepatitis. Furthermore, they must be informed of the physiological or socio-psychological mechanisms at work and the effectiveness of the resources available to the operators involved.

Similarly, if therapists and social welfare assistants are to keep drug addicts or their families informed about the potential risks or the resources available to them, politicians and journalists should be able to report to the public on the evolution of the drugs phenomenon and progress in drugs policy, and must therefore have the relevant information at their fingertips. Consequently, they have the right to receive such information from those who hold it or are capable of formulating it. The duty incumbent upon researchers or statisticians to provide politicians and journalists with this information in turn creates the right for such researchers or statisticians to gather data with a view to analysis. I think that the fifth theme of this seminar will bring us back to this issue of collecting personal data for research purposes.

In short, we can see that the act of informing and the basic right underpinning this act are seldom both a matter for one single person involved in informing another person of (a) specific fact(s). There is a whole *network* of players who are obliged to do something or who delegate to each other the obligation to do something. Right along this chain of obligations to do things runs a parallel chain of rights to be informed of what is useful and necessary for an ability to do these things (and do them well).

B. *Complying with the right to information: an array of ethical problems*

The foregoing very broad overview shows that information is part of an extremely complex social system that embraces a multitude of persons and private and public institutions, and a wide variety of possibly conflicting aims and health, economic, legal, cultural and other aspects. Furthermore, the right to information pertaining to specified persons can easily conflict with such other rights as respect for the individual, his privacy and/or interests.

So we must expect the right to information to raise not just *one* problem but a huge range of different problems, with information intended for a variety of addressees and aimed at very different purposes. This means that the right to information takes on different forms and is based on different foundations depending on the category of actions or persons under consideration. Possible target groups are drug addicts and their families, the officials involved with addicts (counsellors, physicians, youth workers, psychotherapists, police

officers, etc), the general public and the media, and also the public authorities, politicians and administrative officers. All these groups are entitled to information. However, they are all entitled in different capacities. Moreover, some of the information they require comes from observers of society (statisticians, epidemiologists, etc) and researchers (pharmacologists, sociologists, etc), who therefore in turn have a right to obtain data on individuals.

Each of these rights corresponds to a specific obligation: the obligation to secure accurate information and the obligation to provide information to all those entitled to it. This is both a collective and an individual responsibility for all. The ethical dimension begins with acknowledgment of this fact. Proper respect both for the human being and for the aims and smooth functioning of society necessitates this feeling of obligation on which ethics are in fact based. This holds true even before some of the obligations are formally set out in explicit rules (legislation, orders, etc), although the obligations obviously also include these formal rules.

However, as we have just said, in view of the complexity of the social systems and the intertwining of objectives and actions, implementation of ethical obligations will inevitably lead to conflicts or incompatibilities. The task of identifying these difficulties and finding an acceptable solution to them is a further ethical responsibility. When I use the word “conflict” it should not be understood in a polemical sense: contradictions are inherent in the nature of things and the ethical attitude precisely consists in *dealing with* these conflicts without letting them degenerate into confrontations involving power, authority or money.

II. A number of specific problems

In order to move on from this general overview I would like to list some of the actual problems that arise, showing their diversity, although the list obviously cannot be exhaustive.

A. *Conflicting aims*

Let me describe two examples of such conflicts:

We are endeavouring to reduce drug addiction. Now, should we inform current or potential drug-takers of the risks they are running? Given that the risks vary in accordance with the drug and the manner or time of its consumption, should we place the emphasis on particularly dangerous types of behaviour? Would this not be interpreted *a contrario* as an encouragement to take the drug in a different manner or at a different time? (“Do not smoke hashish before driving” would then become “if you do not have to drive you can smoke it!”). Even more tricky: a person injecting heroin is exposed to AIDS or hepatitis infection. Should we explain how to inject the drug in sterile conditions? In so doing, in an attempt to prevent the more immediate mortal danger, are we not teaching people how to take drugs?

Respect for the human rights of employees requires their employers to avoid certain types of discrimination. Accordingly, employers are often prohibited from having access to specified items of information (the question of the “right to information” does not always mean affirming his right: on the contrary, it may sometimes be a case of a prohibition, a desired and desirable denial of this right). However, the safety of workers and local residents or of passengers being transported presupposes ensuring that the worker in question is not under the influence of alcohol or drugs. How can the employee be checked on in this way without the information thus collected leading to illicit types of discrimination?

I mention these two problems not in order to solve them but in order to point out that there is no easy solution. We are therefore faced with a debate which has a fundamental ethical dimension. Ethics does not present a list of pre-established solutions to suit all occasions, but is rather a means of tackling problems which lack any prior solution in order to identify a

solution liable to be accepted by the parties involved, under one specific set of circumstances. The desired balance between contradictory objectives must be well understood and well explained, otherwise communications get jammed, thus disqualifying the message and/or its transmitter!

B. *Separation of aims*

Given that one piece of information can have several different uses, it is sometimes necessary to specify that the addressee is entitled to a certain item of information for one specified purpose only. For instance, physicians have the right to know about their patients' physical or behavioural characteristics, but not to communicate these to the police or an insurance company. That is common knowledge, in terms of medical professional ethics. However, the new capacities for storing and processing information that have emerged from the boom in information technology have intensified this compartmentalisation phenomenon. In 1981, just when a number of countries were passing legislation on this issue, the Council of Europe adopted Convention No. 108, which stipulates that personal data on individuals must be obtained fairly and lawfully for a specified and legitimate purpose and then used exclusively for that purpose. Data which has been obtained in accordance with a right to information must not be used in any context where such a right does not exist. I have already mentioned that the basis of the right lies precisely in the purpose of the information: two separate uses must derive from two separate rights, and one of these rights may be granted and the other not. This separation requirement is reinforced in the case of "sensitive" data (opinions, state of health, etc).

In fact it would be unreasonable always to separate data uses in an overly strict manner: the Convention merely states that the use must not be "incompatible" with the purpose originally set out. If the same data are to be reused for a completely different purpose, the same fairness and lawfulness that governed their collection requires the persons concerned to be informed of such reuse and, if necessary, their authorisation must be sought. Broadly speaking, people must not be exposed to a prejudice stemming from a use of their personal data of which they have not been apprised and which is liable to be unlawful. Furthermore, they must be given free access to personal information held on them by any individual or body.

One interesting case of purpose separation arises in scientific research and statistics. Gauging and describing social situations (through statistics) and highlighting the permanent and general properties of physiological, psychological or social processes (through research) presuppose access to data on a number, which is often large, of individuals. However, such activities never specifically target an individual person. The results are comprehensive and anonymous. Such impersonal use of personal data is therefore quite different from individualised use, which occurs when a person is undergoing medical treatment, when his/her administrative file is being processed, or when he/she is the subject of a court trial. But the fact is that it is very convenient and economic, in establishing these anonymous, general results, to have access to data already gathered for the purposes of medical, administrative or judicial activities. The Council of Europe has held that such scientific use of data is, in principle, compatible with the purpose of the original data-gathering exercise. Conversely, where personal data have been obtained specifically for research or statistical purposes, it is forbidden to reuse them for personalised purposes (administration, medical treatment or prosecution). This link-up between personalised and scientific uses is fleshed out in a 1983 Council of Europe recommendation, and expanded upon in a further recommendation adopted in 1997.

Other recommendations have been adopted to specify how Convention 108 should be applied to various sectors (insurance, etc).

C. *Independence of information*

Information is aimed at and has the effect of changing representations and judgments. It can therefore modify beliefs. That is even its main advantage. However, this is where it comes up against two different types of obstacle: ideologies and interests.

It is almost a universal law of psychology that we are more attached to our beliefs than to the truth. To challenge our beliefs is to deprive us of the comfort of prejudice. Few of us nowadays are able to say, with the biologist Jean Rostand, "I prefer being wrong myself to accusing others of being wrong: it is more interesting". This presents informers with a quandary: should they give their interlocutors the means of changing, or should they rather attempt to please them? Have these interlocutors a right to non-information? Or have we the right to inform them, as it were, against their will? If we regard the addressees of the information as its final users, we can conclude that it is strictly their own business to decide whether they wish to delude themselves. However, where the informer has responsibilities because he/she is framing a public policy or treating an individual, does not the latter's right to know or not to know become an obligation to know? In other words, the persons for whom he/she is responsible arguably have a right to expect that this responsible person will be informed, rather than a right to be informed themselves. This right is therefore exercised through, or if necessary despite, the responsible person. Under these conditions the informer's ethics demand that he/she ascertain the basis on which his/her interlocutor should receive the information. It also involves finding a way to ensure that the interlocutor accepts and understands the information.

Obviously, this ethical stance on the part of the informer vis-à-vis the ideology of the informed parties begins with monitoring one's own convictions, because even if he/she directly addresses the person holding the right to be informed, respect for this right implies supplying honest information rather than taking advantage of his/her authority or expertise to give credence to something which is but a prejudice on his/her part.

Information objectivity is a tricky matter, because information must be based on evidence to certify its accuracy. However, we have also said that information must be provided on the basis of the aims pursued by the person to be informed. The trouble is that such aims derive from a moral choice which this person is called upon to make. He/she must decide whether drugs are a good or bad option, whether death must be avoided or not, whether public order must be upheld and how such order is to be defined. What scientific contribution can we provide for purposes which lie outside the field of science? If we nevertheless attempt to do so, must we remain indifferent to such purposes, or must we not sometimes decide whether or not we should be contributing to them?

The second question I would like to mention on the matter of information's power to challenge opinions is that of the interests of persons or bodies working in the field under consideration. Institutions and professionals dealing with drug addiction derive income from this occupation, an opportunity to secure power or consideration. If the information we are talking about were to demonstrate the futility or inefficacy of their activity, they would be liable to lose their legitimacy, resources and prestige. This might lead them to act, usually openly but often unknowingly, in such a way as to eliminate such importunate information. This is what I refer to as "fear of evaluation". It is easy to find local or more generalised instances of this phenomenon. It ranges from doctoring statistics to prohibiting the publication of a report, through commissioning an opinion from an "expert", who also happens to be a friend. Here again, would not the responsibility towards the presumed beneficiaries of the action in question militate for channelling accurate information to its rightful addressees?

D. *Appropriately formatted information*

In conclusion I will briefly mention this point, as Mr Baptiste Cohen might possibly be discussing it later on. A person who is entitled to information is also entitled to accurate information and also information relevant to his/her aim. Moreover, although we must make an effort to accede to and understand the information, we also have a right to receive it in a form which we find comprehensible. The informer therefore has a duty to tailor his/her message to the recipient. But the informer may actually be dealing with a range of interlocutors, and must consequently ascertain what each one wishes to know and is capable of understanding. He cannot just provide a catch-all message and shirk any responsibility for ensuring that it is appropriate and understood.

Conclusion

I hope to have shown the multifaceted nature of the right to information. This right varies in accordance with the person who is to be informed, his/her position in the social and professional arena, the objectives he/she is pursuing and the obligations incumbent upon him/her. In this necessarily brief statement I have simply outlined a number of examples of this diversity. If I have understood the aim of this seminar aright, it is simply a case at this stage of identifying a number of areas for possible future work by the Pompidou Group.

Above and beyond this diversity I would like to stress, on the one hand, that the issue of a *right* to information can be dealt with partly by legal instruments and partly by discussions transcending, anticipating or complementing the formal legislation, and on the other, that the *ethics* of this right consists not in mechanically applying any particular rules but rather in constantly re-examining the principles underpinning the choices made and periodically reassessing the contradictions inherent in community life and politics.

Bibliographie

- ASSOCIATION DES EPIDEMIOLOGISTES DE LANGUE FRANCAISE, *Déontologie et bonnes pratiques en épidémiologie*, Paris, 1998
- BONTE (P.), *Questions d'éthiques en anthropologie*,
- COMMAILLE (J.), *Ethique et droit dans l'exercice de la fonction de justice*,
- LEBLEUX (D.), *Bénévoles et professionnels de la réinsertion sociale : conflits éthiques et conflits pratiques*,
- PADIEU (R.), *Le déontologie des statisticiens*,
- TERRENOIRE (G.), *L'éthique du généticien*,
- TERRENOIRE (J-P), *Sociologie de l'éthique professionnelle*, in « *Ethique Professionnelle* », *Sociétés Contemporaines*, no 7, L'Harmattan, Paris 1990
- CONSEIL DE L'EUROPE, Recommendation R(97) 18 concernant la protection des données à caractère personnel collectées à des fins de statistiques, Strasbourg, 1997
- FIENBERG (S.), *Conflicts between the Needs for Access to Statistical Information and Demands for Confidentiality*,
- PADIEU (R.), *Statistiques et vie privée*, in Séminaire International sur la confidentialité statistique, Eurostat, Dublin, 1992
- INTERNATIONAL STATISTICAL INSTITUTE, *Declaration on Professional Ethics*, Amsterdam, 1985
- LAMBERTERIE (I. de), LUCAS (H-J.), *Informatique, libertés et recherche médicale*, CNRS Editions, Paris, 2001
- PADIEU (R.), *La clinique sociale entre enquête et évaluation*, communication aux XI^e Journées pour une clinique du toxicomane, Reims, 1992 (*mimeo*)
- PADIEU (R.), *L'information statistique sur les drogues et les toxicomanies*, La Documentation Française, Paris, 1994
- PADIEU (R.), *Right to Ask and Obligation to Answer – Balance of Interests or Balance of Loyalties*, 3rd International Seminar on Statistical Confidentiality, Eurostat, Bled, 1996

INFORMATION ON DRUGS AND DEPENDENCE: AN ETHICAL AND POLITICAL RESPONSIBILITY

Baptiste COHEN (France)

In science, proof is required to distinguish true from false. In the public policy field, it is debate which distinguishes information from propaganda. But when it comes to discerning, in the human person, what needs to be protected and what the focus of our attention and preventive action should be, neither proof nor debate is really sufficient. You have to believe in humankind and human dignity. Everyone has the right to dignity and freedom. That is the reason for our concern about the use of drugs, legal or not, which endanger people's health and may lead to dependence. With regard to today's discussion, I therefore propose adding to our three initial keywords (addiction, information and ethics) another three: prevention, person and politics.

Information on drugs and dependence is a major concern in official prevention policies: first, the use of psychoactive substances carries significant risks which it is essential to try to avoid or reduce; secondly, the illegal nature of drug use deprives users of information they require to be aware of those risks and adjust their behaviour accordingly.

It probably needs to be determined whether the goal of prevention is to eliminate all forms of human behaviour carrying risks or whether the goal is to reduce the incidence of risks and damage by calling on individual and collective responsibilities and freedoms. But that is not the subject of the seminar, although these considerations do underlie it. Why discuss drug addiction or dependence if the aim is not to gain a better understanding of how to treat it and, if possible, how to avoid it?

The anthropological reference to the "person" concerns the choice of the keys to understanding which are needed to address this subject. The exact sciences, from epidemiology to neurology, on which medicine and public health policies are usually based, cannot suffice either to gauge the dangers of drugs or to prevent them.

A drug is not first and foremost a substance, or even a psychoactive substance. Man has the ability to turn everything which gives him pleasure or eases his tensions into a drug: substances, machines, persons, money, power. If man's freedom constitutes his dignity, it is also the source of his weaknesses, his attachments to things of no importance, and his most painful dependencies. Because man is free he can give and lose himself. Freedom and dependence constitute the human condition.

But freedom is not only an individual asset. It is also a shared asset whose preservation calls for collective responsibility. The freedom of some is meaningless without the freedom of others. And today's constraints are sometimes the breeding ground for tomorrow's freedoms. Freedom is not only a fact, but also a future asset, which is built up and passed on, within the family, in education, in vocational learning, etc. Accordingly, the prevention of dependence is not concerned solely with confirmed addiction. It must also concern itself with future addictions, those which are developing and have not yet taken shape. Everyone knows how difficult it is to predict the future and, above all, to identify, among the various forms of individual behaviour, those which might in due course put the person at risk.

In the drug addiction field, therefore, the primary purpose of prevention is to detect signs of vulnerability and, more precisely, identify the situations in which vulnerability is greatest. For example, the everyday consumption of beer or wine does not carry the same risks at 13 as at 35 years of age; the occasional use of sleeping tablets at 55 years of age does not carry the same risks as at 16. At 20 years of age, cannabis use at the weekend does not pose the same problems as everyday use, etc.

That brings us to politics, because, generally speaking, the protection of the weakest is a politician's first responsibility. Nevertheless, that protection must not be organised solely by the strongest. There is a risk that those who hold the keys to power, those who know both the strengths and weaknesses of law, in short those who hold the keys to information and control our institutions, might take sole responsibility for organising the life of the weakest and most vulnerable, dependent people, people living alone, those who have no power, so that they are excluded from choosing the kind of society they want.

Firstly, that would be undemocratic. Democracy is an ethical component of the organisation of power because it requires everyone to be given an equal right of political expression. The identification of vulnerable groups and of the means to protect them forms part of these major choices. Ethics play an eminently political role in public life. And that includes the information field.

Secondly, the strong, those who decide, also experience a very large number of dangerous dependencies. For a long time, however, the message was put across that legal drugs had nothing to do with illegal drugs and that dependence on the former had nothing to do with dependence on the latter. It is now known that the main drawback of this arbitrary distinction is to trivialise the use of legal yet dangerous substances. From an epidemiological point of view, first tobacco use at 14 years of age is much more dangerous than first cannabis use.

Still on the subject of tobacco, from October 2003 it will be obligatory to place the message "Smoking Kills" on all cigarette packets in all the EU countries. In this way, states shoulder their responsibility by ensuring that the information is disseminated. But their main concern is not to expose themselves to criticism for failing in their duty to inform. The ethics of information and prevention might have led to more pro-active choices, aimed at restricting the right of access to tobacco. Here, information on the risk of death is an obligation, but use of the substance in question is fully authorised.

With alcohol, the road accident risk accepted by our societies goes up to a coefficient of 2. A blood alcohol level of 0.5 g/l, which is permitted in many European countries, multiplies the accident risk by 2. During pregnancy, the tolerated risk of congenital malformations due to alcohol consumption by pregnant women is 0.3%: this is the rate of foetal alcohol syndrome (FAS) observed at birth in the absence of public information and prevention programmes on that subject. The risk tolerance could be different. If an everyday consumer product other than alcohol carried a 0.3% risk of congenital malformations, would that be accepted? Certainly not. At present, however, the information chain on alcohol-related risks stops there. Why? What are the ethics of government information policies on the risks associated with substance use?

If the social tolerance thresholds were different, the information given to the public would be different. It is almost as if public acceptance of information were a precondition for government action to disseminate information. A piece of information could then only be given if the target public were prepared to receive it without rejecting it. The boundary between the veracity of information and the desirability of disseminating it is not always clearly defined. That is one of the ethical issues underlying government policy on prevention of the risks associated with drug use.

For example, it is against the law in France to sell alcohol to minors under the age of 16, but as there is no demand from public opinion for enforcement of this legislation, there are no checks, no penalties and, obviously, no systematic steps to provide information.

This choice is diametrically opposed to that made with regard to narcotic drugs, whose use is prohibited and on which the information provided by the public authorities has for a long time been insufficient. Where drugs are concerned, the chain of responsibility for providing

information is broken by the fact that their use is illegal. This being the case, information on how to reduce the related risks is not regarded as an obligation of the public authorities. For example, young people are not told the quantity above which or the circumstances in which cannabis becomes more dangerous. The information provided in the case of alcohol, namely that it is possible to drink subject to certain conditions, is not used in the case of drugs in order to avoid conveying the message that their use might carry greater or lesser risks, depending on the circumstances. The ethical issue here is whether this information is effective in reducing the risks associated with illegal substance use.

On another level, the law itself is a piece of information, even if people are not very familiar with it. When the law makes drug use an offence that may carry a prison sentence, it conveys a message of extreme seriousness whose effects, especially on family and friends, can be profoundly demotivating. This can be seen in the parents and teachers of young drug users (and not necessarily large-scale users) who think or say that they are incompetent to deal with a situation which has become so serious that, without clemency on the part of the judges, it would lead to prison. They see drug use as something fully outside their area of responsibility and their capabilities because that is the impression given by the law. For example, we receive calls about pupils expelled from school for taking drugs. Whereas teachers and head teachers may be fully aware and responsible in the face of other risks such as alcohol or driving, the appearance of DRUGS in their "field of vision" seems an insurmountable difficulty.

To my way of thinking, the aim in dedramatising drug use should not be to trivialise it, because it can be genuinely dangerous. The aim is to change the images which parents and teachers have of drug use in order to help them to harness their energy and skills naturally. It is essential not to give the impression that drug use is a matter for "specialists" on the pretext that it carries very severe penalties.

This approach is based on an overall view of the use of substances carrying a risk of dependence. Drug addiction and dependence are not realities coming from outside society or from its fringes. Dependence on substances which are dangerous to health, safety and freedom is not an evil from elsewhere. It is a risk we all face, by which many families are affected, as can be seen every day with tobacco or alcohol.

The aim of these comments is not to trivialise certain forms of substance use which may also be excessive and dangerous. They are intended to show that debate on the danger posed by drugs, and hence on prevention, calls for the provision of a wide range of information both to the public and to institutions and to decision-makers.

By way of a conclusion, I should like to cite the example of a recent advertisement which shows clearly that we are living in a world of questionable values. But I am not talking about the "rebel" values of young ecstasy or cannabis users. I am talking about the values which inform our everyday lives, more specifically when we are in front of our bathroom mirror. The advertisement (for the leading international cosmetics group) says: "I'm loyal, but if I find something better, I'll change". In theory this applies only to shampoo or lipstick. But this slogan suggests quite simply rejecting the fundamental values of loyalty and commitment in order to be modern, attractive and pleasing.

If there were just one key point to remember, just one moral to our story, I would say that the fight against drugs is above all a fight against indifference and that ethics are first and foremost a call to join together in thinking about our ways of life and our reasons for believing in humankind. Thank you.

THE RIGHT TO CARE AND ACCESS TO SOCIAL WELFARE SERVICES

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In caring for drug users we must always pay close attention to the ethical and medico-legal issues before being confronted with serious, and often acute and stressful, practical situations.

Initially, drug use is simply a chemical manipulation of the healthy person's brain. The brain protects itself by initiating adaptation processes, and at that point it ceases to be organically "normal". Whether these changes are reversible or not is unclear. A new pathological balance is generally established. To maintain that balance, the person must continue to take drugs. He usually tries to ignore the serious dangers, the fact that continued drug abuse causes more extensive brain damage, which may in turn lead to a deterioration of the intellect and slow dementia. The use of psychotropic substances will obviously be reflected to a greater or lesser extent in damage to other organs (lungs, myocardium, kidneys), which complicates detoxification treatment because it is difficult to identify within the therapeutic group those patients who require a multidisciplinary medical approach.

If the drug is withheld, the pathological balance between its effects and the mechanisms of neuro-adaptation to it is generally interrupted. The cause of this breakdown is the domination of the protective function performed by neuro-adaptation when the drug is unavailable. This breakdown is manifested in withdrawal symptoms and also, from the psychological point of view, depression and anxiety.

The importance of biological mechanisms in creating and maintaining drug dependence does not detract from the importance of the social and psychological factors. Interaction between biological and socio-economic factors may facilitate the development of drug dependence, but it may also reduce the risk of its occurrence. Stress related to social circumstances lowers the threshold for the choice to take drugs while leaving open the possibility of choosing between behaviour leading to happiness or being rewarded through activity in the real world (eg work), on the one hand, and taking drugs, on the other. Another major consequence of drug addiction is increasing crime and violence associated with the search for money to buy drugs.

Ethical issues

Until the 1960s, a fundamental guiding principle was the Hippocratic Oath, according to which the pillar of professional ethics is to work for the good of the patient and avoid taking steps which might harm him. In this approach, the prognosis of the patient's overall condition **was not taken into consideration**.

In the second part of the 20th century, the ethical and legal environment underwent far-reaching changes due mainly to the influence of certain factors:

- Care provision became team work. Now the treatment decision is taken not by one, but by several consultants.
- The patient is now free to accept the treatment or not, because the patient's qualified consent, informed consent or non-consent forms an integral part of the therapeutic process.
- Medical care is more and more expensive and it is now necessary, especially where intensive care is concerned, to provide treatment only **in the appropriate cases and to a reasonable extent**.

As a rule, care for drug users necessitates medical care - ranging from intensive care to medical social care - at every level. The **economic aspects** are more important in intensive care medicine than in the other areas of medicine, which are less expensive. From the ethical viewpoint, these aspects represent the fair distribution of resources and their effectiveness is assessed in terms of preferences.

There is also much discussion of ethical issues in connection with these economic aspects:

- The appropriateness of intensive care admission (respiratory insufficiency, loss of consciousness after an overdose)
- Predicted outcomes: death or survival in intensive care
- Non-commencement or cessation of treatment
- Validity of forward-looking decisions with regard to treatment (requested or refused)
- The limits to decision-making by patients who temporarily lack mental capacity
- Quality of life during and after intensive care
- Superfluous and excessive care, the appropriate amount of treatment, demands for unnecessary care
- Resources allocated to excessively costly intensive care and how they could be properly allocated and used.

Care for drug users may be placed under the following two headings:

1. **treatment of intoxication** (accidental, suicide attempt)

- intensive care
- psychiatric care
- rehabilitation

2. **treatment of dependence** (accepted, enforced)

- psychiatric care
- rehabilitation

As may be inferred from this outline, a high degree of team work is very important in care for drug users and it is impossible to define responsibilities precisely in the case of overlapping problems. It follows that it is difficult to define standards for good clinical practice and operating procedures. Even specialist associations and hospital managers have difficulty in agreeing on what the correct procedure should be. One of the fundamental requirements is therefore professional confidence and a constructive agreement aimed at co-operation to solve these problems and reduce ethical and legal conflicts to a minimum.

The need for standards is most marked in intensive care medicine.

The main aim of intensive care medicine is to save lives among the acutely ill, the injured or patients with serious exacerbation of a chronic disease. Measures in the field of intensive care medicine are designed to support the patient in the crisis period leading up to his convalescence.

This main function of intensive care medicine - to save lives - contrasts with that of other medical specialties, which is to improve quality of life. Assessments of intensive care medicine, the criteria for its success, its economic aspects and the measures taken are difficult to compare with the results of other medical specialties and disciplines.

All medicines, all forms of treatment and all operations which offer prospects for the patient and which it is possible to acquire or carry out easily and at no additional cost are **standard measures and standard resources**.

On the other hand, **extraordinary resources** are those which cannot be used without an excessive financial outlay or other burdens, or which do not offer the patient any hope.

In practice, this means that the good represented by the saving of lives is a moral obligation only where achieving that aim does not call for the use of disproportionate resources.

As a result of the above definitions, medical personnel dealing with drug users are faced with a dilemma: the frequent recurrence of intoxications (accidental or deliberately induced) raises the question of the effectiveness of the use of financial resources for intensive care of drug users, and in particular the fair distribution of those resources. In the inefficient economies of central and eastern Europe, the funds available for medical care are limited, as are intensive care resources. By treating drug users we are reducing access for patients suffering from other conditions.

One of the reasons for intoxication could be the underdeveloped state of substitution treatment. Because of the centralisation of substitution treatment, regions with large numbers of drug dependent patients are disadvantaged. Experience in France shows the effectiveness of substitution treatment in reducing rates of death by overdose.

On the basis of recommendations from the national committees for intensive care medicine, the European Society for Intensive Care Medicine has accepted the following criteria for admitting a patient to intensive care:

1. The patient must be in an unstable condition and his vital functions must be threatened.
2. There is a significant risk of serious complications and it is possible to prevent them through intensive treatment. Patients with no hope of attaining a good quality of life are not accepted. Although the prognosis for patients already admitted to intensive care is getting worse in Europe, they cannot be moved to another department, even if the quality of life is probably very low. **It is impossible to draw any legal conclusions or take any decisions because there is no legislation defining unacceptable quality of life.**

In its initial stages, care for drug-dependent patients requires treatment of different durations, whose aims, conditions and rules would should be clearly defined. This definition of treatment should meet with the agreement not only of the specialists participating in the treatment, but also of the insurance institutions paying for the treatment, to ensure that treatment is neither abused nor under-estimated. It is always very difficult to assess the amount of treatment required because of the very broad range of conditions: overdoses, acute withdrawal symptoms, additional complications, and the painstaking task, with its uncertain outcome, of achieving abstinence. This outcome is uncertain, and that leads to discussion of the cost/benefit question. Neither the individual nor the state is able, or will be able, to answer that question. It is therefore for the international community to define these issues and these needs, to lay down the correct procedure for dealing with this important problem while taking due account of economic factors.

ETHICAL ISSUES IN WORKPLACE DRUG TESTING IN EUROPE

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Introduction

Workplace drug testing remains a sensitive issue because of the difficulty of balancing safety and productivity requirements against the essential need to prevent the invasion of privacy and discrimination. The contentiousness of workplace drug testing (WDT) arises out of the collision between workers' and employers' interests. Definitions of personal liberty and dignity clash with questions of social responsibility and economic productivity. In addition there are data protection issues and strict requirements for the assurance of reliable test quality.

In this paper drug testing is defined as 'the process of obtaining samples of body fluids or tissues (e.g. urine, blood, hair, breath) from job applicants and employees and conducting laboratory analyses to detect the presence of certain drugs, including alcohol, and their metabolites' (Hanson 1993: 5).

The range of testing carried out in the workplace includes the following:

- Pre-employment testing;
- Probable cause testing;
- Reasonable suspicion testing;
- Periodic testing;
- Random testing;
- Testing on return from treatment;
- Testing related to transfer or promotion; and
- Voluntary testing (Mørland 1993).

While all these forms of drug testing raise issues of concern, it is random testing that is the most controversial and is accompanied by vehement arguments for and against. For this reason, this paper focuses mainly on random testing in the workplace.

To guide employers and workers through the dilemmas surrounding the issue of WDT, in 1993 the ILO instituted a tripartite meeting of experts which resulted in the creation of the ILO Guiding Principles on Drug and Alcohol Testing in the Workplace. They were published as an annex to the ILO Code of Practice on the management of alcohol- and drug-related issues in the workplace.

Despite the controversies surrounding WDT, laboratories carrying out tests, for example in Ireland, the Netherlands, Norway and the United Kingdom report ever increasing demands for their services. Given the wide range of sensitive issues involved, WDT is handled in a variety of ways in European countries. This paper will give an overview of the ethical questions concerning WDT and related arguments for and against testing. It will include some impressions of the current extent of WDT in different European countries and how the level and frequency of testing is connected with the ethical stance. The paper will also summarize the outcomes and pose certain questions on the more controversial aspects for discussion in the workshop.

Safety

The most frequently used argument for WDT and one of the least controversial is to ensure safety. Workers in “safety-sensitive” positions should not be under the influence of drugs¹ because of the danger to themselves, their colleagues and third parties. There is however no universally accepted definition of what constitutes a safety-sensitive job. As a result, the employer has some leeway in deciding which workers should be subjected to tests for safety reasons. This leeway is open to interpretation in different European countries and in various branches of industry. In a case in Denmark, and in the transport industry where safety concerns are paramount, the labour court agreed with a ferry company’s definition of “safety-sensitive” covering the entire crew of their ships and rejected the unions’ complaint. In Switzerland on the other hand, the Data Protection Commission ordered a major pharmaceutical company to end their testing programme for trainees because of a lack of safety interest, although work with chemicals is often seen as typically safety-sensitive.

The safety argument has been extended from the traditional question of health-related safety to “business-related safety”. It is argued that inappropriate use of drugs and alcohol can create “business-critical” situations, in which poor decisions could cost the company large amounts of money. However this argument is not accepted in all European countries, which is reflected in the varying extent of testing and the legal restrictions on testing. For example in France, Norway and the Netherlands, only workers in “traditional” safety-sensitive positions are subjected to testing in any form. Accordingly there is less testing and there are more legal restrictions in these countries. In the Netherlands pre-employment testing is illegal, and in France only the occupational physician may decide to conduct drug tests, not the employer. On the other hand in British and Swedish companies where testing takes place WDT is often applied to workers in all types of jobs in order to ensure “business-safety”.

The legal liability for health and safety is the basis for a further argument for the introduction of testing programmes. The legal responsibility for ensuring occupational safety and health lies in the majority of European countries with the employer, who has a “duty of care” to exercise “due diligence” to make sure that the workplace is safe.² Any tightening of corporate liability could increase testing prevalence. For example in the United Kingdom for the past two years the government has been trying to introduce a “corporate manslaughter” bill which would make company directors personally liable for preventable occupational accidents (Bright 2002). If passed, this bill could lead to an increase in the number of testing programmes.³

The Moral Argument

A further motivation for WDT comes from quite a different angle. Some proponents of WDT take a moral stance based in part on the illegal status of some of the drugs and in part on a value judgement that drug use of any sort is morally reprehensible. In such cases the employer assumes a social responsibility to influence the values of the workers. Employers often maintain that testing is the only way to tell if a worker is using drugs. This argument reveals that the moral argument differs considerably from the safety, business and prosecution arguments in that it is not related to performance. In the words of a director of a human resources department quoted in the British journal *Personnel Today*:

¹ For ease of reference in this paper the term “drugs” will be used to refer to both alcohol and illegal drugs such as cannabis, cocaine and heroine, unless otherwise specified.

² This principle is also espoused in ILO Convention 155 on Occupational Safety and Health.

³ It should be noted that there are alternatives to WDT, such as other clinical tests, better trained supervisors, etc. for managers wishing to ensure safety at the workplace.

“A main reason why drug abuse is difficult to spot is that it can contradict the myth of deteriorating performance. Some abusers can perform consistently well over long periods” (Personnel Today 2001)

In moral arguments usually no distinction is made between drug use and abuse. Whilst this may be appropriate for the moral point of view, the consequences for the worker of a positive drug test should be relevant to the drug use pattern of the individual.

The question of who should be tested has already been touched on concerning the business-critical argument for WDT. For business-critical and morally based testing programmes to be plausible everybody working in the company or organization should be tested. Every employee's work is relevant to the productivity of the company and moral concerns apply to every human being. For this reason testing programmes which only apply to trainees are open to the accusation of being discriminatory to youth.

As an alternative to testing all people working in an organization, a policy can be introduced of only testing in case of suspicion of drug use. Many union organizations, for example in the Deutscher Gewerkschaftsbund (DGB) in Germany, the Österreichischer Gewerkschaftsbund (ÖGB) in Austria and the Confédération Générale de Travail (CGT) in France favour this approach, which is compatible with performance-based reasons for testing i.e. for safety, for business and for fear of prosecution. However in Sweden, where testing is more widespread, a test case concerning the issue of suspicion failed to convince the labour court. A member of the cleaning staff in a nuclear power plant objected to being tested because there was no suspicion against her and she was not in a safety-sensitive position. The labour court ruled that she was compelled to comply with the written company policy to test all staff, which had been formulated with the agreement of both trade unions represented in the plant.

Deterrence

Increasingly the aim of introducing a testing programme is deterrence from drug use of any kind. This contrasts with the attitude in the late 1980's when drug testing was perceived as a tool to detect and dismiss drug-abusing workers. Deterrence as the aim of a WDT programme is compatible with both performance-based reasons and the moral motivation to test outlined above, because of its inherent preventive component. The current stance of many employers' organizations, for example in the Schweizerischer Gewerkschaftsbund (SGB) in Switzerland, Svenskt Näringsliv in Sweden and the London Chamber of Commerce in the United Kingdom, is to recommend adopting a deterrence programme (i.e. including sanctions) but to frame it in a package of assistance for those with drug problems.

Reliable evidence that the deterrent approach works is difficult to produce but there are some indications that a WDT programme is an effective deterrent to drug use. For example the European Workplace Drug Testing Society (EWDTS, a pro-testing group) reports rather cautiously that where testing has been introduced, the percentage of positives “seems to decrease with the years following the introduction of WDT” (Verstraete and Pierce 2001: 2).⁴

Privacy

A major ethical consideration put forth by opponents of drug testing is that the process amounts to an unwarranted invasion of privacy. WDT impacts on privacy in relation to the right to personal i.e. bodily integrity. National legislation on this matter is often the same as

⁴ This article also reviews the data on which this statement is based.

that for searches, which requires the consent of the person concerned to be lawful. The question of consent is, however, a thorny one. Most guidelines for WDT (such as the ILO Guiding Principles on Drug and Alcohol Testing, 1996) require that informed consent be obtained before testing. Opponents of WDT, such as the German DGB and the Swiss Data Protection Commissioner, contend however that because workers are dependent on their employers, free consent to WDT is not possible. Consequently signing a contract containing a testing clause cannot constitute a free and informed decision by the person concerned. On the other hand, in the United Kingdom failure to comply with drug testing which is included in the employment agreement can be interpreted as a disciplinary offence (Alcohol Concern 2002). Some European constitutions, for example in Belgium and Finland, hold that fundamental rights such as the right to privacy are indivisible and that the individual cannot consent to waive such rights. In order to make WDT legal in Finland, a new law had to be introduced.⁵

An extension of the privacy debate is related to whether employers have the right to dictate employees' conduct during off-duty periods. One situation in which WDT is held to impact on privacy is when performance-based arguments for testing are used. Employers contend that if the workers' free-time activities have a negative influence on their work performance, the employer is justified in controlling this. The moral argument for testing in any case assumes the employers' right to influence the workers' private sphere as part of the employers' responsibility to society. Proponents of WDT argue consistently that privacy issues are less significant than the gains for the individual, the company and for society resulting from reduced drug use (see for example Cabrero and Luna 1999 or Dixon 1998).

The counterargument asserts that employers who control what employees do in their own time are overstepping the mark of their social responsibility (e.g. Trades Union Congress 1996). Opponents of WDT point to articles guaranteeing the right to a private life in most international charters of human rights, such as of Universal Declaration of Human Rights (article 12) and the European Convention on the Protection of Human Rights (article 8). Such rights are however open to interpretation, and may be subject to limitations. For example the European Convention on the Protection of Human Rights guarantees the right to privacy, except:

“in the interest of national security, public safety or the economic well-being of the country, for the prevention of disorder and crime, for the protection of health and morals, or for the protection of the rights and freedoms of others” (Article 8)

This leaves openings for employers to argue for testing for health and safety reasons, for business productivity and also for moral reasons. Nevertheless, in 2002⁶ the first test case in the United Kingdom referring to article 8 of the European Convention on the Protection of Human Rights to oppose dismissal on a drugs charge found in favour of the complainant. An employee at a sports centre was sacked for having marijuana in his pocket on the company car park. The British employment tribunal ruled that the dismissal was unfair and an inadmissible intrusion into his private life according to article 8 quoted above.

Labour courts are sometimes however misused by governments who wish to avoid the thorny issue of drug testing. Instead of legislating for or against testing, they refer employers to the courts. However labour courts frequently do not have the technical expertise to judge on the complex issue of testing. They are reliant on expert witnesses, who may well be pursuing their own agendas, and in some cases the labour court may not in fact have the power to call expert witnesses.

⁵ In June 2001 the Finnish parliament passed the Act on the Protection of Privacy in Working Life

⁶ The European Convention was signed in 1950, but British legislation explicitly based on the Convention was not introduced until October 2000. The case mentioned refers to the British adoption of European law.

Data protection

The privacy issue links WDT to the question of data protection. WDT involves collecting sensitive data both on use of drugs, sometimes illegal drugs and also information on medication taken which might influence the test result. Legislation pertaining to WDT has often been concerned with the data protection issue. The collecting and holding of such information is therefore not only subject to strict controls in many European countries but also the subject of international agreements such as European Union Guidelines 95/46 and 97/66 on data protection and the ILO Code of Practice on the Protection of Workers' Personal Data (1996)⁷. In some European countries this issue is resolved by strengthening the role of the occupational physician. In Finland, France, Belgium, Germany and Austria the result of the test is communicated to the occupational doctor, not to the employer. The doctor is only allowed to inform the employer whether the person is fit for work or not, but not what the result of the drug test was.⁸

In terms of rights, there is a further argument which particularly applies to any kind of systematic testing programme (as opposed to testing only on suspicion). Arguably one of the greatest achievements of Western European culture is that legal systems are based on the assumption "innocent until proven guilty". However if someone refuses to take a drugs test, they are largely assumed to "have something to hide". Thus the method to prove someone's innocence is turned on its head and believed to prove their guilt.

Pre-employment testing

A further rights-based controversy in WDT is the question of pre-employment testing. Around 80 per cent of WDT conducted in the world is carried out as part of the recruitment process, i.e. before an employment relationship exists between worker and employer. Legally in many countries the protection which is afforded to workers does not apply to job applicants. Opponents of WDT however claim that a job candidate is even more precariously placed vis-à-vis the employer, because their only alternative to taking the test is effectively to withdraw from the job competition. It is also argued that human rights apply equally to all people, regardless of employment status.

Discrimination

Concerns pertaining to WDT are often aimed at the moral arguments for testing which can potentially be discriminatory. The moral stance can lead to discrimination of people with drug dependencies⁹, but the current policy emphasis on aid programmes is intended to counter this bias. The moral argument can also lead to discrimination of people with a certain lifestyle rather than a health problem, because it does not distinguish between use and abuse. Unions are also concerned that WDT can be misused as a convenient method for getting rid of unwanted workers. A recent case of unfair dismissal in the United Kingdom illustrates the point. A rail worker received much publicity after (correctly) fining the wife of a very high-

⁷ See in particular paragraph 6.13.

⁸ The confidentiality of test results is an integral part of international recommendations in other areas, for example guidelines on HIV/AIDS. See the ILO code of practice on HIV/AIDS. See ILO 2001, paragraphs 4.7, 5.2(g) and 5.3(j).

⁹ If drug dependency is defined as a health problem, then discrimination on these grounds can contravene national legislation and internationally agreed principles. The ILO General Survey on Convention 111 on Employment Discrimination conducted in 1996 notes that while the original Convention (1958) does not specifically mention health as an inappropriate reason for discrimination, there is a tendency by a growing number of states to legislate against discrimination on health grounds (paragraph 239).

ranking government official for travelling without a ticket . He soon found himself mistreated by colleagues and was subsequently moved to a desk job. He was sacked after allegedly failing a routine drug test and refusing to take a second one. The worker claimed that the company was afraid of bad publicity and therefore sacked him. The company claimed that the dismissal was unrelated to the fine, but the employment tribunal found in favour of the worker.

The moral argument interacts very closely with a further criticism of WDT. Urine analysis, like the moral stance, does not distinguish between users and abusers as it does not give any indication of impairment. It only shows that drugs have been consumed, but not what effect they may have on a worker's performance. In view of this drug and alcohol policies should be very carefully worded to ensure that the aim of the testing programme can be achieved by the methods used.

Testing in the transportation sector

One area in which testing is much less controversial is the transportation sector. There are strict regulations concerning drug use by pilots including a mandatory eight hour period of abstinence before flying. All European Union countries have a legal limit for alcohol for drivers, and Spain and the United Kingdom even have lower limits for commercial drivers than for private individuals. Even in countries where workplace drug testing is conducted with difficulty, testing of drivers is carried out routinely. For example, Dutch, French and Belgian legislation is very restrictive concerning WDT, but all three countries permit and frequently use random roadside testing.¹⁰ By contrast in the United Kingdom, where WDT meets with more support, random roadside testing is illegal. A police officer must have grounds for suspicion before a driver can be tested for alcohol use. There are however significant differences between alcohol testing and testing for other drugs. The breath test for alcohol (and subsequent blood tests) is accepted as a measure of impairment, and from this it is possible to set a limit under which it is considered less dangerous to drive. There is also a significant public safety aspect to testing drivers, and alcohol is consumed more frequently and by more people than illegal drugs. As far as driving and drugs other than alcohol is concerned, there have been several inquiries in recent years (both national ones, for example in the United Kingdom and Austria, and also the European Union project ROSITA) on the possibility of introducing a limit for drug use similar to the one for alcohol. Experts universally conclude that for drugs other than alcohol there is insufficient evidence relating drug test results to impairment. The recommendations are therefore either not to test drivers for drugs other than alcohol, or to establish a zero drug limit for drivers, as is already the case in Germany.

Quality

Finally, many reservations about WDT are based on doubts about the quality of tests and testing procedures. The danger of "false positives" is a real one. Consuming large amounts of poppy seeds may lead to a positive test for heroin, or taking ibuprofen can result in a positive test for cannabis. It is generally agreed that the initial immunoassay technique of urinalysis must be confirmed by a more reliable test such as gas chromatography, which can only be done in a properly equipped laboratory. In addition to this, a positive test result should only count as such after a Medical Review Officer has considered all the medical information relative to the individual case and ruled out any other possible source of the test

¹⁰ Concerns about the legal principle of "innocent until proven guilty" are in this case deemed secondary to public interest.

result. There are various guidelines for reliable testing which aim to eliminate any doubts about procedural and technical difficulties.¹¹

Conclusions

To sum up, workplace drug testing is an issue beset with technical, legal and ethical controversies. WDT policies may be unclear about the motivation for testing, which however determines what type of testing programme should be used. The most serious challenges to testing are based on privacy and data protection arguments. Employers however face a legal responsibility to provide a safe workplace and meet obligations to their shareholders which may not be possible if drug use is rife. How far should they go to meet these obligations? Do such obligations represent adequate grounds for employers to determine what employees do in their free time? What kind of sanctions should be in place and how should these relate to health care initiatives which may also be part of a drugs and alcohol policy? Should employers' policies distinguish clearly between the consequences for the use of different drugs? Should policies distinguish more clearly between users, abusers and people with chemical dependencies?

These are just some of the controversial questions surrounding the issue of workplace drug testing. In the course of the workshop on WDT we hope to make some headway in the discussion of these matters and to be able to present to the other participants in the seminar some reasoned conclusions.

¹¹ The ILO Guiding Principles on Alcohol and Drug Testing in the Workplace (1996) address issues relevant to the introduction of testing programmes and give guidance on policy and implementation. For detailed implementation advice as well as more technical laboratory information, see the European Laboratory Guidelines for Legally Defensible Workplace Drug Testing (EWDTS) or the Drugs of Abuse Testing Guidelines by AGSA, the Swiss Working Group for the Analysis of Drugs of Abuse.

BIBLIOGRAPHY

- Alcohol Concern (2002) "Glancesheet 6. Alcohol and drug testing in the workplace"
- Bright, M. (2002) "Fury over delay to 'corporate killing' law", *Observer Newspaper*, 21st July 2002
- Cabrero, L. and Luna A. (1999) "Etica y medicina del trabajo", *Medicina del Trabajo* vol. 8, no. 2, pp.77-83
- Craig, J.D.R. (1999) *Privacy and Employment Law*, Hart: Oxford
- Dixon, P. (1998) *The truth about drugs*, Hodder & Staughton: London
- Hanson M. (1993) "Overview on drug and alcohol testing in the workplace", *Bulletin on Narcotics: Drug testing in the workplace* (United Nations International Drug Control Programme), vol. XLV, no.2, pp.3-44
- International Labour Organization (1993) *Conditions of Work Digest: Workers' privacy: Part III: Testing in the workplace*, Geneva
- International Labour Organization (1996) "Guiding principles on drug and alcohol testing in the workplace as adopted by the ILO Interregional Tripartite Experts Meeting on Drug and Alcohol Testing in the Workplace, 10-14 May 1993, Oslo (Hønefoss), Norway, in ILO 1996 *Management of alcohol- and drug-related issues*, Appendix V, pp.44-55
- International Labour Organization (1996) *Management of alcohol- and drug-related issues in the workplace. An ILO code of practice*, Geneva
- International Labour Organization (1996) *Code of Practice on the recording and notification of occupational accidents and diseases*, Geneva
- International Labour Organization (1997) *Code of practice on the protection of workers' personal data*, Geneva
- International Labour Organization (2001) *An ILO code of practice on HIV/AIDS and the world of work*, Geneva
- Mørland J. (1993) "Types of drug-testing programmes in the workplace", *Bulletin on Narcotics: Drug testing in the workplace* (United Nations International Drug Control Programme), vol. XLV, no.2, pp.83-114
- Personnel Today (2001) *Firms put staff to the test as legislation looms*, 7th August 2001
- Personnel Today (2001) *Drink, drugs and work: the figures*, 7th August 2001
- Shahandeh B. and Husbands R. (1998) "Case Study: Drugs and Alcohol in the Workplace – Ethical Considerations", *Encyclopaedia of Occupational Safety and Health*, 4th edition, Vol.1, ILO: Geneva, pp.19.22 – 19.26
- Stewart K. (2000) *On DWI laws in other countries*, National Highway Traffic Safety Administration: Washington DC
- Trades Union Congress (1996) "Hazards Factsheet 55: Just say no to ... Drugs testing"
- Verstraete, A.G. and Pierce A. (2001) "Workplace drug testing in Europe", *Forensic Science International* vol. 121, pp.2-6

DRUG TESTING IN THE WORKPLACE

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Many of the issues involved in drug misuse are common to those in alcohol misuse and many workplace policies combine the two. There is an important difference, however, and that is the question of legality. The consumption of alcohol is legal in our society and is widely accepted as part of our normal way of life. Alcohol misuse is still widely tolerated. However, the possession and use of certain drugs is, of course, illegal. Even when drugs being taken are for legal medical purposes they are viewed differently - an indication of some other physical or psychological weakness. Whether there are individual policies on alcohol and drugs or a combined one, the issue of illegality and the responsibilities of the employer arising from misuse of drugs legislation have to be addressed. At the core of any policy should be health education and the role of and access to occupational health services. An option may be to introduce the policy as part of an overall health promotion package covering a number of general health issues.

A policy on drugs and alcohol in the workplace should be developed along the following lines.

There must be commitment from the top, at the most senior management level in the organisation. Without such a commitment the policy is unlikely to be successful.

The aims of the policy should be four-fold:

to recognise that alcohol/drug misuse is a health problem;

to prevent drug/alcohol misuse

by developing awareness programmes;

to identify employees with a problem at an early stage; and

to provide assistance to employees with drug/alcohol related problems.

What is the scope of a policy?

The scope of the policy should apply to all staff without exception and should not discriminate on grounds of status, sex or race at any level. Management and employees should be covered by all aspects of the policy and should have the same opportunities for counselling and referral and the same consideration at every stage. If the policy also refers to alcohol then, for example, a requirement to remove drinking facilities from the workplace must apply equally to the boardroom and the works canteen.

The policy must set out clearly who has overall responsibility for implementing the policy. It must also set out the responsibilities of managers, line managers and supervisors for implementing the policy on a day to day basis.

The policy must clearly state the procedures for dealing with drug and alcohol problems. It must make clear that the procedures for assisting employees with substance misuse related problems are separate from the disciplinary procedure. The procedures for referral by the supervisor, by management or by the occupational health department should be set out, as should the procedures for self-referral. The policy must recognise that relapses are not uncommon and must provide procedures for cases to be reviewed on their merits.

It must also make clear at what stage or in what circumstances the disciplinary procedures will be invoked, for example if an individual with a drug or alcohol related problem refuses assistance, denies the problem, or discontinues a course of treatment and reverts to unsatisfactory levels of performance and conduct. Also where certain tasks are agreed as 'safety critical' and therefore being under the influence of drugs or alcohol becomes an immediate disciplinary offence.

There is general agreement among drug treatment centres that many drug misusers are employed, have a controlled, rather than a chaotic drug taking habit, and have the financial means to support their drug use. It can be argued, therefore, that someone on a course of methadone does not have a problem because their addiction is under control and is being dealt with in a satisfactory way both for the individual concerned and for the employer in terms of that individual's work.

There will be employees who are taking prescribed drugs or misusing prescribed drugs. There are at least one million people at any one time using prescribed tranquillisers many for reasons which are personal and that they would not readily wish to reveal to their manager or personnel officer. All the employer needs to know in such circumstances is whether the person is fit for work. However, the policy does need to cover the circumstances in which the employee should inform their employer that they are taking prescribed medication and how that may effect they way they are able to carry out their work.

The procedures must include the right at all stages for the individual to be accompanied by a trade union representative.

The policy should, of course, provide for strict confidentiality. No individual or agency involved in the diagnoses and treatment of an employee with a drug or alcohol problem should disclose any details or records to the employer without the employee's written permission. An employer should not enter details of the problem or the treatment on an employee's personal file or employment record. The only thing the employer really needs to know is whether the employee is fit to work and undertake the tasks for which they are responsible.

The policy must also guarantee a no-blame, non-judgemental approach so that employees are encouraged to come forward.

There must be guarantees safeguarding job security, pension rights and all other benefits and employment rights of any individual who is undergoing counselling or treatment for a drug or alcohol problem.

A policy should not be used to get rid of people but rather to support an employee and ensure that they continue to be a contributing member at the workplace. Wherever possible the person should be allowed to resume work in his or her original post.

Where it is considered inadvisable for the employee to return to the original post a suitable alternative should be offered on no less favourable terms.

Counselling and treatment also has to be part of the policy. Where possible this should be provided by an independent outside specialist agency agreed by all sides. There has to be confidence right across the workplace in the services being provided otherwise staff will avoid using them and the policy will fall into disrepute. Again confidentiality must be absolute. It is important also that the treatment and counselling should be at a place and time acceptable to the employee and that absences to attend for treatment should be treated as sick leave and paid accordingly.

As with all aspects of health, safety and welfare training is a priority. The training should be for all those who are responsible for implementing the policy. But there also needs to be training for all the staff so that they understand the policy and their role in it. It is colleagues who will be the first to notice if there is a problem and they need to know how to ask the right questions and how to encourage their workmate to seek assistance. So training for staff and their commitment to the policy is essential. Training and education also needs to be on going and under regular review ensuring that new members of staff are included at the earliest opportunity.

To Test or Not to Test?

Studies are lacking on whether testing programmes reduce possible work difficulties resulting from alcohol and drug use. The available data do not produce sufficient evidence to show that alcohol and drug testing programmes improve productivity and safety in the workplace. Alcohol and drug testing only recognise the use of a particular substance. It is not a valid indicator for the social or behavioural action caused by alcohol and drugs. There are over one million people at any one time using prescribed tranquillizers to maintain an equilibrium to cope with work and everyday life.

No adequate tests currently exist which can accurately assess the effect of alcohol and drug use on job performance.

Nor do analyses exist which support the cost benefits of introducing a testing regime. The 'positive results' found in the use of screening do not necessarily outweigh the cost of setting up and maintaining a reliable testing programme, using properly accredited testing laboratories.

The use of drug testing may reveal the legitimate wide-spread use of drugs for a range of short term and on going illnesses which, for the most part, are of no interest to, or no business of, the employer. This too will add to the ineffectiveness and high costs of the testing programme.

There are other major problems arising from testing.

Problems such as:

industrial relations - possibly alienating the majority of the non-drug using workforce;

discrimination - targeting certain groups of employees because of assumptions about who uses drugs;

legal problems - informed consent for urine or hair samples can not be given if an employee is under duress eg. loss of job if they do not comply;

the unreliability and competence of the screening process - very few of the laboratories carrying out this work are accredited by a legally recognised accreditation service;

security of the samples from tampering and;

medical confidentiality.

A good drug testing system is not cheap. The main cost is due to ensuring that the system used is safe, secure and reliable. But even the International Olympic Committee has doubts about the effectiveness and security of its own regime which most people would consider a

highly developed system. Testing regimes are in themselves no guarantee that the workplace will be remain drug-free.

An employer's resources may be better employed in working with their workforce and trade unions in reducing work related accidents and ill health. A well developed and effective health and safety management policy, and the confidence that brings, is the best way of dealing with drugs in the workplace.

However, if an employer is determined to go ahead with a testing regime this should only take place within the context of a workplace alcohol and drug policy developed in consultation with the trade unions and the work force. Only when the policy is developed and 'owned' by all those concerned does it have a chance of being successful.

Screening and testing are only elements of such a policy, they are not a policy in themselves.

Pre-employment testing could be used, but that only tells you that the person was drug or alcohol free at the time of the interview. It does not control the employee's social habits afterwards. Pre-employment testing does not keep substance misuse problems out of the workplace.

Testing may also run the risk of being used in a discriminatory way with racist assumptions being made about the use of cannabis, for instance, in certain ethnic communities. Or people being falsely accused by bullying managers or colleagues. Employers may also run the risk of falling foul of Disability Discrimination legislation. Individuals need to be protected from being unfairly singled out.

Education, information and training alongside a disciplinary system which has separate but clear links to the alcohol and drug policy are much more likely to be effective.

COMPULSORY TREATMENT AND COMPULSORY ADMISSION TO CARE

Andreas KAPARDIS (Cyprus)

1. Introduction: the contradiction with drug-offenders

Even when one takes into account possible changes in crime reporting trends and changes in policing methods and crime-recording practices by police as far as drug offences are concerned, official criminal statistics in European countries attest to the fact that ,

- (a) The incidence of such offences continues unabated (South, 2002).
- (b) Drug-addiction acts as a catalyst for spiraling crime rates as the proportion of the population in general and the young ones in particular goes on rising (Davies et al, 1998:55-57). It should be noted in this context that there are conflicting schools of thought as to how the relationship between drugs and crime is to be interpreted. Some authors maintain that some offenders who are not addicts or even users commit crime to purchase drugs to sell to others; another view is that drug offenders commit crime (e.g., burglaries, armed robberies) to fund their own addiction; finally, other authors have argued that drug offenders commit crimes generally and also take drugs as part of the thrill and buzz of a subcultural lifestyle. One could argue, of course, that each of these explanations could well apply to some drug offenders; in other words, drug offenders are very heterogeneous, a factor that is very crucial when it come to treatment programmes.
- (c) The number of drug-offenders sentenced to long terms of imprisonment continues to increase, for example, in France, the Netherlands, Germany and Switzerland (Ashworth, 2000:249-250). A factor which has contributed to this is that some countries have introduced mandatory sentences for drug offenders. To illustrate, in England and Wales, the 1997 the Crime (Sentences) Act introduced minimum custodial sentences of seven years for those re-convicted of trafficking in hard drugs. Imprisonment has little effect on drug or drug-related criminal behaviour. What is certain, however, is that prison is a criminogenic environment that would be expected to increase one's commitment to a drug-using lifestyle (South, 2002:931).

The increasing use of long terms of imprisonment for drug-offenders is of interest in view of the fact that the Council of Ministers of the Council of Europe in 1992 adopted recommendations by a Select Committee of Experts on sentencing (Established in the wake of the Council's 8th Criminological Colloquium in 1987 devoted to *Disparities in Sentencing: Causes and Solutions* –See Council of Europe, 1989) that a major principle underlying the sentencing of offenders be a restraint in the use of custodial measures.

The emphasis on drug demand reduction is reflected in such international accords as the UN Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances (1988), the Council of Europe Convention on Laundering, Search, Seizure and Confiscation of the Proceeds of Crime (1990), the European Community directive on money laundering and the Schengen treaties and Maastricht treaty (Ashworth, 2000:349). As would have been expected, most EU member States have increased their expenditure on demand reduction. Furthermore, there is general consensus within the EU that demand reduction is a multi-disciplinary, community responsibility, a philosophy reflected in the predominance of decentralized initiatives, the wide use of non-custodial measures with drug offenders by the courts and a broader concept of "treatment" today than in the past.

It is obvious that sentencing practices internationally evidence, on the one hand, an emphasis on retribution in dealing with serious drug offenders (e.g., recidivists), especially those who sell drugs. On the other hand, there is a plethora of non-custodial measures that

are being used to (a) save drug-addicts the side-effects of imprisonment and (b) to offer them an opportunity to rid themselves of, inter alia, the addiction and not only. Treatment opportunities are offered within a broad range of community-based orders (e.g., probation, community-service) where such treatment is a condition of the court order. In addition, of course, drug-addiction treatment is provided in many countries in prison settings and in therapeutic communities.

2. Conflicting penal aims and the drug offender

As a penal aim, rehabilitation was popular in the west until the early 1970's. Then, for two decades or so, it became very unpopular as its critics argued that:

- indeterminate sentences imposed in its name are indefensible.
- it allows judges an excessive amount of discretion when it comes to sentencing.
- it results in disparities (i.e. unjustifiable inconsistencies) in sentencing.
- The apparent failure of rehabilitation to live up to its promise. As Davies et al (1998) have put it, "it became a faith dashed on the rocks of the unprecedented rise in the post-war years' (p.282). At the same time, it became clear that social welfare was not the panacea that would reduce or at least control the crime problem.

A modern form of retribution, namely *just deserts* (see von Hirsch, 1976; 1993) then came to be widely adopted on both sides of the Atlantic in an attempt to structure judicial discretion by emphasizing punishment for one's deeds and not his/her needs. Not surprisingly, given rising crime rates, the astronomical and increasing cost of the criminal justice system, the pressing need to reduce the public deficit and the apparent failure of rehabilitation as a penal aim, *just deserts* found many a supporter among both politicians, academics and the public alike. It is beyond the scope of this paper to discuss the case for just deserts. Suffice it to point out that it did not displace rehabilitation but conflicting penal aims continue to characterize the treatment of offenders by the courts in most countries.

3. The rebirth of rehabilitation

The prohibitive financial cost of imprisonment, the undisputed fact that prison significantly increases the risk of recidivism and an emphasis on the importance of diversion has focused interest in and governments have come to invest more resources into custodial alternatives. As a result, rehabilitation has gradually become an acceptable penal aim again, especially in view of the empirical evidence that some treatment programmes do produce desirable results.

4. Is compulsory treatment justified?

Without ignoring the debate about (a) addiction to legally-available drugs (e.g., tranquilisers) and (b) the processes by which and the reasons why drug-taking has been criminalised, as opposed to having dealt with the phenomenon in some other way outside the criminal law, the fact of the matter is that it is most unlikely that illicit drugs will be decriminalised in the foreseeable future. With this caveat in mind, it could be argued that the moral justification for compelling a person who is addicted to illegal drugs to undergo treatment lies in:

- The fact that society has a right to compel its members to do things in the name of the general good (e.g., education is compulsory in most countries up to a certain age, people with serious contagious diseases are isolated in hospitals etc) and no harm is done to the individual in the process; in fact, it can be argued that the individual being compelled stands to gain something (e.g., to acquire knowledge and skills essential for them to be competitive in society, gets rid of a life-threatening disease).

- The fact that the person themselves, for various reasons, are incapable of getting rid of the addiction.
- Because of the relationship between illicit drug-addiction and crime, the individual poses a risk to the society.

Only a person who has pleaded guilty or has been given a fair trial and found to be guilty of crime/s in the causation of which his/her addiction plays an important role should be compelled to undergo treatment. Consequently, drug addicts who have not been processed by the system of criminal justice can only be encouraged to undergo treatment but cannot be compelled. Finally, one cannot convincingly argue for compulsory treatment if a treatment programme does not achieve its stated aim to a reasonable degree.

5. Treatment of drug users

Drug-use treatment programmes are an essential part of a country's strategy to reduce demand for drugs. Treatment programmes for drug addicts are possible in communities and in a system of justice with a penal philosophy that does not value retribution as the only penal aim but considers it desirable to achieve crime reduction (Utilitarian). By definition, the concept of treatment from a penologist's point of view centres around the needs of the offender and the ability of a court to individualise the sentence. Thus, in the classic sense, crime reduction is to be achieved by ridding the individual of his/her addiction and an individualised sentence means tailoring it to the offender's needs and not focusing on his/her crime. Of course, in most countries sentencing principles and judicial practice enables the courts to justify a term of imprisonment for a drug addict on the grounds that the deprivation of liberty is the punishment that reflects the seriousness of the crime committed and the offender can take advantage of drug-use treatment programmes that are often available within the prison.

The classic approach to helping drug users basically involves making it possible for them to get rid of the habit by, for example, putting them on a methadone programme in order to, eventually, achieve abstinence. In recent years, however, the drug-use treatment concept has given way to more flexible and differentiated services. Such services include a broad range of community-based care services that supplement prison, hospital and residential services. At the same time, the number of therapeutic communities has been increasing. Increasing professionalism means the drug users need to stay for shorter periods of time, there is greater emphasis on the individual's needs and on equipping the individual addict to maintain abstinence in the community at large after the treatment. In other words, the contemporary approach to drug-use treatment in western Europe is more sophisticated, multidisciplinary and more long-term, requiring greater investment by state and local authorities. Furthermore, the basic notion and philosophy underlying clinical and social work practice tends more and more to be harm-minimisation, i.e. "to reduce health, legal, social and financial harms associated with drug misuse" (South, 2002:933). It would not be an exaggeration to say that for two decades now, in a number of western European countries the twin pillars of drugs-related health and social care service delivery have increasingly been "Harm minimization and new community partnerships placing stress on prevention" (p.933). Finally, for such an approach to drug-misuse to succeed it is imperative that the police service of a country adopts the rights policies (Dorn and Lee, 1999).

6. The impact of treatment programmes

There is no consensus on what is meant by "success" of a drug-misuse treatment programme. The lack of a generally-agreed upon operational definition of "success" means it is very difficult, if not impossible, to ascertain the efficacy of such programmes. Most authors, however, would agree that the best prognostic factor is whether someone completes the programme and, also, the longer he/she abstains from illegal drug use, the better the

prognosis. At the same time, criminologists and penologists are interested in other issues raised by *treatment* such as (a) has a programme reduced a drug addict's reliance on the illegal market for his/her supply and (b) has the programme reduced significantly the drug-addict's criminal behaviour in order to fund his/her supply?

Drawing on the existing literature, it can be said that: the proportion of clients who complete treatment programmes successfully varies tremendously; the rate of programme completion increases significantly if a person is legally required to stay in treatment; a combination of approaches (e.g., therapeutic and social work, long probation and social support) is more effective than one approach only; family and/or community support is essential. According to MacGregor (1998), in Great Britain, the Department of Health Task to Review the Effectiveness of Drug Treatment Services (1996) concluded that treatment works. While a similar conclusion was reached by the National Treatment Outcomes Research Study (1996), the safe conclusion one can draw based on the existing literature is that, as Jarvis and Parker (1989) put it in the late 1980s, "evidence of the efficacy of medical treatment, whatever form it might take, is neither plentiful nor conclusive" (cited in South, 2002:931).

Returning to the issue of making treatment for drug users compulsory, as already mentioned above, there is empirical evidence that if staying in a treatment programme is a legal requirement, then an addict is more likely to complete the programme which, in turn, correlates with abstinence after treatment. Developments in penal measures such as drug testing and treatment orders, introduced in Britain not that long ago, have in fact been around for much longer as have drug courts. To illustrate, the intensive correction order (ICO) was introduced in the Sentencing Act of 1991 in Victoria, Australia, and it is suitable for offenders who are being rejected for community-based orders on the basis of their high risk and/or recidivism (e.g., drug users) and who would have received short terms of imprisonment. An evaluation of the impact of ICOs by Tomaino and Kapardis (1996) found that they fulfill their stated aim of providing a credible sanction to fill the gap between community-based orders and short-term imprisonment. An ICO is in effect a sentence of imprisonment served in the community and consists of both core conditions (e.g., that the offender shall not commit another offence punishable by imprisonment during the period of the order and that he/she will attend a specific community corrections order for a certain number of hours every week) and special conditions such as having to attend prescribed programmes and to be subjected to random drug testing.

7. Conclusions

Drug users are a heterogeneous population and flexibility in treatment programmes is warranted. While there is not overwhelming empirical evidence that treatment programmes reduce significantly drug-related behaviour (Bachus et al., 2000), the fact remains that in a number of countries within the EU treatment is still narrowly conceived and inadequately resourced. As South (2000:932) reminds us, for a tailor-made treatment programme to be said to be efficacious means achieving a high proportion of successful programme completions, achieving the goal of abstinence after treatment and to do so needs to include practical measures that improve the social conditions and personal relationships but, also, labour market skills, housing, financial and personal circumstances. It is very encouraging to note in this context that, "Increasingly, treatment, rehabilitation, and diversion schemes are incorporating opportunities for gaining vocational skills-training and qualifications" (South et al., 2001). For treatment to be effective the concept needs to be broad enough to encompass the risks and difficulties after treatment and to be adequately resourced in order to be effective.

It is not possible to sustain the argument for compulsory treatment of drug users, whether in prison or in the community, when a treatment programme offers but a false hope.

BIBLIOGRAPHY

Ashworth, A. (2000). *Sentencing and Criminal Justice*. London: Butterworths.

Bachus, L., Strang, J. and Watson, P. (2000). Pathways to abstinence: two-year follow-up data on 60 abstinent former opiate addicts. *European Addiction Research*, 6:141-147.

Davies, M., Croal, H. and Tyrer, J. (1998). *Criminal Justice: An Introduction to the Criminal Justice System in England and Wales* (2nd ed.). London: Longman.

Dorn, N. and Lee, M. (1999). Drugs and policing in Europe. In, N. South (ed.), *Drugs, Cultures, Controls and Everyday Life*. London: Sage.

European Monitoring Centre for Drugs and Drug Addiction (1996). Annual Report on the State of the Drug problem in the European Union. European Commission.

Jarvis, G. and Parker, H. (1989). Young heroin users and crime. *British Journal of Criminology*, 29:175-185.

MacGregor, S. (1998). Reluctant partners: trends in approaches to urban drug-taking in contemporary Britain. *Journal of Drug Issues*, 28(1), 185-198.

South, N. (2002). Drugs, alcohol and crime. In, M. Maguire, Morgan, R. and R. Reiner (eds), *The Oxford Handbook of Criminology* (pp.914-944). Oxford: Oxford University Press.

South, N., Akhtar, S., Nightingale, R. and Stewart, M. (2001). Idle hands: the role of employment in addiction treatment. *Drug and Alcohol Findings*, 1(6), 24-30.

Tomaino, J. and Kapardis, A. (1996). A criminological study of the use of intensive correction orders in Victoria, Australia. *International Journal of Offender Therapy and Comparative Criminology*, 40(1), 63-73.

Von Hirsch, A. (1976). *Doing Justice*. Hill and Wang.

Von Hirsch, A. (1993). *Censure and Sanctions*. Oxford University Press.

ETHICAL CONSIDERATIONS IN DRUG ABUSE EPIDEMIOLOGY AND RESEARCH

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INTRODUCTION

- All research must conform to the ethical standards prevailing in the community and the country where it is conducted.
- The details may vary from country to county and time to time, but the broad ethical principles remain the same .
- The overall guiding principle should be to do no harm to the research participants (subjects , researchers and community).
- The international guidelines for ethical review of epidemiological studies are available from the Council for International Organizations of Medical Sciences (CIOMS; 1991).
- This guidelines do not provide an account of professional duties and ethical concerns in epidemiology subspecialty areas such as drug abuse epidemiology and other research.

BACKGROUND, ACKNOWLEDGEMENTS AND REFERENCES

- The World Medical Association : Declaration of Helsinki 1964 , 1975.
- The Council for International Organizations of Medical Sciences (CIOMS) : International Ethical Guidelines for Biomedical Research Involving Human Subjects, 1982, 1993, 2002;
- International Guidelines for Ethical Review of Epidemiological Studies, 1991.
- American College of Epidemiology. Ethic Guidelines, 2000.
- UNAIDS, other WHO , the Government of Finland, the Government of Switzerland, the Swiss Academy of Medical Sciences, the Fogarty International Center at the National Institutes of Health, USA, and the Medical Research Council of the United Kingdom and many others.
- WHO. Guide to Drug abuse Epidemiology and other publications (1980-2002).
- UNODCCP, GAP Toolkit Modul. Developing an Integrated Drug Information System , 2002.
- Pompidou Group and EMCDDA publications.

ETHIC GUIDELINES

- Include a description of the **ethical principles** that should be applied, together with **ethical review procedure** undertaken prior to initiating the research.
- Epidemiology has been described as a »liberal art« or one of the humanities, because it can be **an instrument for social justice**. Thus, drug abuse epidemiology has a crucial role to play, not only in determining what needs to be done, but also as an instrument of advocacy on behalf of affected communities.
- Ethic guidelines in drug abuse epidemiology and other research should describe core **values, duties, and virtues** serving as the basis for the thoughtful reflection and sound judgment that pursuit of knowledge through scientific research of drug abuse calls for.

VALUES

Drug-use epidemiologists not only pursue knowledge about the distribution and determinants of drug use and related consequences in populations, but also uphold the value of improving the public health through the application of scientific knowledge.

DUTIES

Duties are the obligations researchers have towards various research participants, professional colleagues, sponsors, employers and society.

VIRTUES

Professional virtues are those traits of character that dispose us to act in ways that contribute to achieving the good that is internal to the practice of epidemiology.

Examples include: a virtue of benevolence, honesty, humility, fidelity, patience, veracity, prudence, excellence, justice, integrity and the need to treat colleagues and other parties with respect and courtesy.

GENERAL ETHICAL PRINCIPLE

*»All research involving human subjects should be conducted in accordance with four basic ethical principles, namely respect for persons, beneficence, non-maleficence and justice«
(Declaration of Helsinki)*

Respect for persons

a) respect of autonomy / capacity for self-determination; b) protection of persons with impaired autonomy, vulnerable, dependent or addicted to drugs.

Beneficence

Obligation to maximize possible benefits and to minimize possible harms and wrongs (**Non-maleficence** / "Do no harm")

Justice

Requires that cases considered to be alike be treated alike, and that cases considered to be different be treated in ways that acknowledge the difference.

Distributive justice

Individuals/ groups bearing the burden should receive an appropriate benefit, and groups primarily intended to benefit should bear a fair proportion of the risks and burdens of the research.

Procedures that are unethical at one level cannot be justified merely because they are considered ethically acceptable to the other.

Weaker members of communities should not bear disproportionate burdens of studies from which all members of the community are intended to benefit, and developing communities/countries should not bear disproportionate burdens of studies from which all communities /countries are intended to benefit.

«**Microethics**»: governs how one person should relate to another and the moral claims of each member of a community.

»**Macroethics**«: how one community relates to another, and how a community treats each of its members and members of other groups with different values.

ETHICAL PRINCIPLES APPLIED TO DRUG ABUSE EPIDEMIOLOGY

1. ACCOUNTABILITY IN DRUG USE EPIDEMIOLOGY /RESEARCH;
2. SUBMITTING PROPOSED STUDIES FOR ETHICAL REVIEW;
3. MINIMIZING RISKS AND PROTECTING THE WELFARE OF RESEARCH PARTICIPANTS;
4. PROVIDING BENEFITS AND ENSURING AN EQUITABLE DISTRIBUTION OF RISKS AND BENEFITS;
5. OBTAINING THE INFORMED CONSENT OF PARTICIPANTS;
6. PROTECTING CONFIDENTIALITY AND PRIVACY;
7. MAINTAINING PUBLIC TRUST AND RESPECTING CULTURAL DIVERSITY; ;
8. AVOIDING CONFLICTS OF INTEREST AND PARTIALITY;
9. COMMUNICATING ETHICAL REQUIREMENTS TO COLLEAGUES, EMPLOYERS, AND SPONSORS ;
10. CONFRONTING UNACCEPTABLE CONDUCT
11. REPORTING RESULTS;
12. PUBLIC HEALTH ADVOCACY;

THE IMPORTANCE OF ADHERING TO THE HIGHEST SCIENTIFIC STANDARDS (1)

The standards of practice for epidemiologists

- choosing an appropriate study design;
- writing a clear and complete protocol;
- using proper procedures for the collection, transmission, storage, and analysis of data;
- properly interpreting and reporting results.

*(i.e. using a range of methods and sources; valueing of local research; integrating both quantitative and qualitative approaches; interpreting data within the historical, cultural, economic, political and philosophical context- **Pompidou Epidemiology Subgroup, 1991**).*

THE IMPORTANCE OF ADHERING TO THE HIGHEST SCIENTIFIC STANDARDS (2)

Professional accountability

- assuring scientific soundness of research;
- reporting of results to the scientific community, research participants and society;
- teaching, consulting, and administrating;
- promoting evidence-based drug abuse prevention, treatment, policy .

SUBMITTING PROPOSED STUDIES FOR ETHICAL REVIEW (1)

Epidemiologists should submit protocols for review by an independent (multidisciplinary) ethics committee when research involves human subjects.

The purpose of review is to consider the research in the light of scientific and ethical principles.

SUBMITTING PROPOSED STUDIES FOR ETHICAL REVIEW (2)

Scientific review

Research must conform to generally accepted scientific principles, and be based on a thorough knowledge of the scientific literature, other relevant sources of information, and adequate laboratory

»Adhering to the highest scientific standards includes choosing an appropriate study design for the scientific hypothesis or question to be answered; writing a clear and complete protocol for the study; using proper procedures for the collection, transmission, storage, and analysis of data; making appropriate interpretations from the data analyses; and writing up and disseminating the results of the study in a manner consistent with accepted procedures for scientific publication » (American College of Epidemiology. Ethic Guidelines 2000).

SUBMITTING PROPOSED STUDIES FOR ETHICAL REVIEW (3)

Ethical review

- Scientific review and ethical review cannot be considered separately (scientifically unsound study is unethical exposing subjects to risk or inconvenience and achieving no benefit in knowledge).
- Normally, therefore, ethical review committees consider both scientific and ethical aspects.
- If a review committee states that a proposal is scientifically sound, it will then consider whether any risk to the subject is justified by the expected benefit, and whether the proposal is satisfactory with regard to informed consent and other ethical requirements.

SUBMITTING PROPOSED STUDIES FOR ETHICAL REVIEW (4)

An exception may be justified when rapid reaction is necessary :

- alert systems for drug-related overdoses /deaths; new drugs, additives, risk behaviors; infectious diseases ;
- program evaluations;
- surveillance/ routine drug-use monitoring .

MINIMIZING RISKS (1)

Preventing psychological, economic, legal, or social harm to drug users , other individuals and groups

Harm may occur:

- when drug users suffer further stigmatization, prejudice, loss of prestige or self-esteem, or economic loss as a result of taking part in a study;
- when, unknown to a community, its health-care priorities are changed because of research results;

- when risk- behaviors (i.e., unsafe injecting practices) are detected it is unethical not to propose harm –reduction measures .
- when scarce health personnel are diverted from their routine duties to serve the needs of a study.

MINIMIZING RISKS (2)

Harmful publicity

Conflict may appear between, on the one hand, doing no harm and, on the other, telling the truth and openly disclosing scientific findings.

Harm may be mitigated by interpreting data in a way that protects the interests of those at risk, and is at the same time consistent with scientific integrity.

Respect for social mores and sensitivity to different cultures

Investigators must respect the cultural expectations of the societies in which epidemiological studies are undertaken,

Drug users and representatives of community should be in a position to participate in designing the study and in its ethical assessment.

MAXIMIZING BENEFIT

- Communication of study results in a timely fashion (research findings and advice to drug users and communities should be publicized by whatever suitable means are available);
- Training of local health, social personnel and volunteers;
- Providing health care and/or referrals for the drug users under study;

»When HIV-prevalence studies are conducted by unlinked anonymous screening, there should be, where feasible, provision for voluntary HIV-antibody testing under conditions of informed consent, with pre- and post-test counseling, and assurance of confidentiality« (UNAIDS, 1999)

OBTAINING THE PRIOR INFORMED CONSENT OF RESEARCH PARTICIPANTS

Elements of informed consent

- purposes of the study;
- investigators and sponsors;
- scientific methods and procedures;
- any anticipated risks and benefits;
- any anticipated inconveniences or discomfort;
- individual's right to refuse participation or to withdraw from the research at any time without repercussions.

Avoidance of manipulation

Research participants must voluntarily consent to the research without coercion, manipulation or undue incentives for participation.

Conditions under which informed consent requirements may be waived

- in some studies involving the linkage of large databases routinely collected for other purposes;
- in studies involving minimal risks only ;
- when epidemiologists investigate drug use emergency outbreaks (new drugs and acute risks), evaluate programs, and conduct routine drug use monitoring as part of public health practice activities.

Selective disclosure of information

For certain studies (i.e. ethnography) non-disclosure is permissible, even essential, not to influence the spontaneous conduct under investigation, and to avoid obtaining responses that the respondent might give in order to please the questioner.

In such circumstances, research participants generally need protection in other ways, such as through confidentiality safeguards and appropriate review by an independent research ethics committee.

PROTECTING CONFIDENTIALITY AND PRIVACY

Epidemiologists should:

- comply with the laws regarding confidentiality and privacy, including those pertaining to data sharing or pooling of data.
- take appropriate measures (aggregating data so that individual identities are obscured; omitting information that might lead to the identification of individual subjects; limiting access to the data, or by other means) to protect the privacy of individuals and confidentiality of all information about individual research participant, during and after a study.

(when under a legal obligation to make disclosures that invade privacy, an epidemiologist should carefully weigh an obligation to the law against the moral importance of preserving the privacy of research participants...).

MAINTAINING PUBLIC TRUST AND OTHER OBLIGATIONS TO COMMUNITIES: (1)

- Adhering to the highest ethical and scientific standards;
- Avoiding conflicts of interest and partiality (*maintaining honesty and impartiality in the designing, conducting, interpreting, and reporting of research*);
- *Respecting cultural diversity and involving drug users and community representatives in research;*
- Reporting results (*communicating all research findings and other information important to public health in a timely, understandable, and responsible manner*).

MAINTAINING PUBLIC TRUST AND OTHER OBLIGATIONS TO COMMUNITIES: (2)

- Following relevant laws and regulations

(but compliance must be balanced with the recognition that sometimes existing rules may be immoral or inappropriate and therefore must be challenged ; i.e. prohibition of methadone or needles distribution for IDUs);

- **Public health advocacy**

In confronting drug-use-related problems, epidemiologists sometimes act as advocates on behalf of drug users and members of affected communities.

Advocacy should not impair scientific objectivity.

MAINTAINING PUBLIC TRUST AND OTHER OBLIGATIONS TO COMMUNITIES: (3)

Ensuring an equitable distribution of risks and benefits

- Epidemiologists have ethical and professional obligations to minimize risks and avoid causing harm to research participants and society.
- Researchers must be able to demonstrate that the benefits outweigh the risks for both individuals and groups
- Epidemiologists should make sure that the potential benefits and burdens of epidemiological research and public health practice activities are distributed in an equitable fashion.

Externally sponsored research and collecting internationally comparable data in developing countries

- Many international agencies administer drug abuse epidemiology research in developing countries

(there is a need for international comparable data on patterns, trends, health and social consequences of drug use...there are plenty of data available...however, the contribution of scientific research results to drug policy decisions has been minimal).

- This need should be seen in the context of local applicability, availability of adequate mechanisms for management of research and cultural appropriateness.
- Such international research efforts should be closely linked to the establishment of related national mechanisms for drug-use research management and national capacity-building for ethical review.

COMMUNICATING ETHICAL REQUIREMENTS TO COLLEAGUES, EMPLOYERS, SPONSORS

Communicating ethical requirements

Epidemiologists, as professionals, should provide training and education in ethics for students of the discipline as well as for practicing scientists. They should demonstrate appropriate ethical conduct to colleagues and students by example.

Giving proper credit for intellectual property

Epidemiologists are obliged to protect the integrity of intellectual property. Specifically one must not take credit for other's ideas or work, even in cases where the work has not been explicitly protected by copyright.

Confronting unacceptable conduct

Epidemiologists should confront unacceptable conduct such as scientific and/or ethical misconduct, even though confronting it can be difficult in practice.

Conclusion

The priority ethical consideration in drug abuse epidemiology/research is that it should be scientifically objective and free from moral judgement because of the powerful emotive and moralistic reactions that drug use often provokes.

I hope this report has provided a useful account of some ethical considerations in drug abuse research which may serve as a starting point for further discussions of the core values, obligations and virtues and as a tool for advocacy and learning.

"We evolve general ethical guidelines or principles (which differ, however, in different societies) in order to avoid having to think out the rights and wrongs of every possible alternative before taking everyday decisions; however, these guidelines must always be open to challenge..."
(John Wing)

A) Social epidemiology accentuate behavioral and cultural explanations of trends and patterns and focus more on social context and consequences.

B) Psycho-medical epidemiology is oriented towards explanations in psychological dependency and psychiatric disorders and focus more on physiological and mental health consequences.

- Ethical issues often arise as a result of conflict between the rights of individuals and needs of communities.

REPORT FROM WORKSHOPS

Report from Workshop A by Ms Lyons (Ireland)

The right to care and access to social welfare services

Chairman: Mr Masar (Slovakia).

In addition to those listed to attend, the following also participated:
Professor Marie Jo Thiel representing the Holy See
Mme Claire Ambroselli
A delegate from Greece (Ms Zagoura Paraskevi, I think).

The report is set out firstly according to the topics introduced and the shape of the discourse and secondly, summarising the key issues as presented.

DAY ONE

The Chairman opened by addressing this question: what are the most important ethical problems for each of you?

Each representative gave replies noted as follows:

The Holy See

So many young people are using drugs and so many are addicted. Adults are sceptical, they can't believe it is such a big problem and it must be exaggerated. Prof Thiel is amazed by how much this problem is underestimated. It is difficult to plan if no-one is looking for help. Information is needed but what information do you provide?

Italy

There are increasing concerns relating to issues of consent. There is new and changing legislation that will influence private and public services.

Ireland

How to manage and reduce waiting lists?
Are the individual's choices respected?
Power of communities exerted to resist establishment of treatment centres
Should addiction services be a general or specialised in climate of poly drug use?

Sweden

Programme for substitute treatment is under threat from resource issue
There is a lack of co-operation between social and medical care and greater co-ordination is needed.

Slovakia

Cannot escape the economic problems
There are not enough resources to implement therapies
Treatment is considered expensive and conflict arises over resource choices
Results from treatment are exaggerated or inflated in order to attract resources
Need to have an economic transformation
The cultural changes experienced by the population and the political community are significant. For example they have a history of having medical specialists for a large variety of conditions, yet the Western influence is to have large number of generalists.

Austria

Some countries in Europe have had to address these issues outlined by our colleague from Slovakia but now we are seeing the influences of America. The drug problem is looked at through American eyes. Is drug addiction a medical problem? Then if it is we have an ethical obligation to treat patients with harm reduction approaches. However, if others consider drug addiction to be self inflicted in that it is not the people who are sick it is the drug that makes them sick then this influences a range of other approaches. So the illness question is a very real question which influences the outcomes for the drug user. The above attitudes and conflicting opinions are a problem and an ethical challenge.

Switzerland

There are several pillars to drug policy in Switzerland and several layers of planning and intervention. There are 26 Cantons with multiple plans and policies and no consistency. Access to services varies and the many professionals involved have difficulty in recognising who intervenes first or at what stage.

United Kingdom

The National Treatment Agency was established and is influencing services in Wales and England. If you live in one area you have better access than if you live in another area. Some services are selective about who they treat i.e. highly motivated, less complex individuals. There are tensions between existing treating agencies, health (state) and NGOs. There is a need to enhance access for those with complex needs such as people who have just left prison.

Germany

Right to care, treatment and social welfare services, is a right that must be implemented. We need the right legal and social conditions and this is being developed in the Ministry with new laws, changes to policies, drug consumption rooms are legislated for in order to ensure proper functioning. Mr Masor raised a series of very good questions and he highlighted many problems in his presentation. So its time to find the answers.

Holland

We are successfully providing substitute and other treatment for many, many years. What has worked for us are the many different programmes we provide. The image of heroin has changed and is no longer a taboo subject. When you provide treatment for many opiate addicts there are still many more who are not in treatment and who are not in contact with any services. The heroin addict is now getting older and living longer. The heroin prescription pilot has been successful, yet, 60% of people do not benefit from treatment. What do we do about this group of people who are hard to reach. Now, Holland is seeing more crack and cocaine problems with young people, they are not shooting up but there is a high increase in crime and anti-social behaviour. Thinking only of addiction treatment is too small/restrictive to move forward when anti-social problems are so great, especially, if there is no substitute drug as in the case of cocaine.

Turkey

They have many institutional problems, lack of co-ordination and understanding of the problem. They have only a small number of known drug users. There are studies being carried out by the UN and EU to identify known addicts. Currently they have 6 centres providing treatment.

Germany

Problems for Eastern European Countries are huge by comparison to West European countries. It seems impossible to try and compare at any level as the differences are so great. In Germany, there are particular emerging problems with immigrant populations such

as those from Russia, Turkey and Islamic countries. In the region where this doctor locates his practice there are only two social workers and only one doctor who speak Russian. This presents an enormous challenge to meet the needs of these groups when language and culture are barriers. There is a new challenge being presented, one of discrimination against injecting heroin users. Another is how to contact the very young drug users.

Greece

Limited system in place. They have one therapeutic community established in 1993 and now 15 such communities exist. Their programmes are based on withdrawal or detoxification. They have only started talking about substitute programmes as late as 1995. As the problem grew they were allowed to introduce methadone. They are still unable to respond to the problem of drugs with only about 1000 places and between 40,000 and 100,000 estimated problem heroin users. The public is very hostile to drug users and related issues. Harm reduction is not popular. Financial resources are limited, availability of qualified personnel is limited. Problem of managing drug addiction in the prison also. Detoxification is available in prison but not methadone. they have a problem also of drug related prison deaths. Getting a methadone programme into prison is vitally important.

This ended the first topic of discussion. Dr Masar suggested all drug patients should be treated the same. Again views from the group were invited.

Switzerland

Problem with this concept of widespread equality as not every patient is the same and there are choices about priority. Again the professions are also not consistent.

Luckrett

Principle is fine but then do we give substitute treatment to all who want it or all who need it and who decides. Gave example of Norway providing substitution treatment in high threshold centres and was overwhelmed with demand which they had underestimated. Are we ready for this?

UK

We know what we mean by treatment, it is not just a medical model. Young people may have very different treatment needs one size does not fit all. People use different drugs and have different needs.

Austria

Cannot compare addiction to different drugs such as cocaine and opiates. It is about their needs and problems as they present. So why do we ask what is the problem of underestimation. If the medical model of care was accepted then harm reduction would be part of that model and clinicians would have authority to implement a range of services for people at different stages of drug use.

Holy See

We need to look at the person who is using drugs and the problems they have, the background to these problems and deal with the problems if we are to successfully manage the addiction. We need to look at family problems, bullying and social problems that could lead to the young person using drugs.

Austria

There is no other field where we are selling ideology as treatment but we do so in addiction. Some people, we know, mature out of addiction but if we highlight this we would be considered to be promoting drug use as it is not always harmful.

Holland

We have over 25 years experience of providing wide range of services. One lesson stands out – there is no one golden rule, no one solution to drug problems. If we want change then we, the people contributing to the Pomipdou meeting have the power to make the change. This power is not with some unseen body or in a building housing a body, it is with those people who make up this body – it is with us.

Italy

Tailor treatment to the individual needs. Manage methadone so that it becomes an option but only part of a progressive approach to rehabilitation. Methadone substitution should not dominate.

Ireland

We have made huge progress in the last six years. We have all party support for the National Drug Strategy since 1996 and even though the Government changed the strategy did not. We have adopted an approach that involves the communities worst affected in the decision making at local and national level. Local committees called task forces were set up and these have been very successful in improving and increasing the services available in the worst affected areas. The statutory services have increased from a small number of treatment centres to over 50 in the Dublin region. These centres have been established in areas with heroin problems in a decentralisation of services to improve access. Waiting lists have been greatly reduced and by December 2002 we have about 6,500 registered on methadone treatment programmes. This number excludes those who have started and dropped out. But we know there is still a big problem. We have been fortunate in that our economic situation improved dramatically and funds were committed to expanding services.

Some discussion took place on prevention in general terms

Holy See

We must look at prevention in schools and in families. It is important that young people are informed and that parents are informed.

Holland

It is important to separate the drug markets and not treat all drugs the same. The drug user ultimately determines the image of the substance. Cannabis is readily available in Holland and they know young people avoid heroin but now they are seeing that young people are choosing to use cocaine more so than cannabis. Cocaine is not sold in coffee shops so there is something about the image of the drug that attracts people also.

Austria

Prevention is focussing either on the person that they are somehow damaged, or it is the drug we focus on. Our prevention programmes ignore hedonism, which is why many people use drugs in the first place.

After the coffee break we opened with a desire to find solutions. In this section I neglected to note which country people speaking represented.

Let's find solutions, we can't solve the problem of the different countries but we should focus on the ethical considerations and reach solutions.

Objectives of this atelier, do not reinvent the wheel that public health have already considered. What are the areas where there continues to be a problem?

- ✓ Care according to needs
- ✓ Do not expect a comprehensive text. Pinpoint a few important items
- ✓ Not like CPR, it is difficult to have a practical guide everyone in every country can use.
- ✓ Treatment needs in each country is different and variance occurs.
- ✓ Development of guidelines may not be possible
- ✓ Problem is so great and has been with us so long
- ✓ People cannot come up with a consensus
- ✓ Over 5000 dead from opiate overdose, thousands with AIDS, this is a medical problem so therefore, people should be able to avail of treatment
- ✓ Scarcity of resources influences actions in Eastern Europe.
- ✓ Advice on how to use money in scarce context should be made
- ✓ Arguments of the cost benefit should be provided
- ✓ Evidence is there from research and should be used more
- ✓ Tackling the problems of drug users also enables progress on HIV and Hepatitis prevention and intervention.
- ✓ Need to identify strategies that will secure resources, drug users are also part of the public health strategy. This means additional resources from another domain could be available.
- ✓ We need specialist treatment units for some addictions such as cocaine and we need to inform general psychiatrists on managing addiction so as to spread the burden.
- ✓ Use existing facilities involve GPs, old problem new coat
- ✓ Need to provide support to generic professionals to assist in the care of individuals.
- ✓ Don't have to have just specialist workers can give training to general staff also.

Final discussion of the day outlined key points:

1. Identify key principles
2. follow public health focus
3. be targeted
4. work with families
5. work with communities
6. right to care - treatment should be provided
7. recognise drug abuse
8. Eastern European countries are faced with an epidemic because of political policies we have many people now with drug problems. Alcohol is highly tolerated, every child can drink alcohol and has access to it. When they talk about drugs in these countries they mean alcohol. Their health systems are used to having specialists not generalists so this would mean a significant cultural change. Training is needed.

DAY TWO

The morning started with a recap over discussions of the previous day:

- Issue of prevalence amongst young people
- Consent and personal rights
- Changes to legislation and impact of this
- Lack of co-operation across services and integration of services
- Lack of resources, economic constraints, need for transformation, cost of care, misinformation of results, history of specialism
- Changing perspectives on how drug use is viewed
- American influences,
- Drug problems have a social or medical base – the latter influences the decisions on service i.e. harm reduction is an obligation if medical base, conflicting attitudes and opinions

- Multiple layers of power, multiple plans and policies, confusion over roles
- Tension between treating agencies
- Access for people with complex needs a new challenge
- Right to care and treatment and social welfare services must be respected and implemented
- Changing image of heroin use
- Many drug users are not in treatment or in contact with any services
- Drug users are surviving, now an older population to be cared for
- Institutional challenge, lack of co-ordination
- International organisations providing care and conducting research
- Challenge of meeting needs of new populations with cultural and language differences
- Drug use is still a very large problem and public are still quite hostile

The following key points of convention on human rights were raised to stir ideas:
Human rights is about dignity,

respect for integrity,
other rights and fundamental freedoms;
privacy of the human being;
equitable access to health care;
professional standards;
consent.

Key points from the presentation by Carlos de SOLA on biomedical ethics were highlighted:

- Cultural differences
- Role of the family
- Social cohesion
- Diverging legal systems
- Ambivalence
- Debate

Pieter MIERZEWSKY identified the key challenges in health policy:

Ethics
Economics
Equity
Evidence

The diversity of experiences needed to be linked to the ethical issues and this was the challenge for Day Two. There are, it seems, several questions?

1. Can we examine these principles with regard to the drug user and his/her rights;
2. What this means for the drug addict and what this means for treatment?
3. Can these rights be translated into action on care provision?
4. What are the obstacles? How do we achieve this in practice?

Obstacles listed first as people felt this was most familiar to everyone in each country. The obstacles fell under the headings: politics, fear, law and information.

Politics

- No political benefit from helping drug addicts as there are very few votes;
- On the other hand in some countries you can get points for helping drug addicts;
- Overall there must be a political will to address the problem of drug use;

- Corruption in the world of politics is also an obstacle to progress;
- Politicians are influenced by several issues hence the need to look at the rights issues;
- Outcomes for drug users in Sweden are not good so the decision makers are not happy and increasingly choices over money for drug treatment versus money for the elderly for example, are having to be made;
- Treatment works, there is overwhelming evidence to support this;
- When the prognosis is not good for a drug addict then politicians immediately think of cost benefit and which resources should be allocated

Fear

- Public afraid of what it doesn't know or understand;
- Societal view of drugs influences how we approach the problem;
- When we addressed TB we did not wait for politics or laws;
- Not everyone who uses drugs becomes addicted;
- Drugs are forbidden because they are harmful;

Law

- Narcotics laws drive treatment and other services;
- International conventions against drug use hold influence;
- These legal constraints influence how we evolve strategies;
- This legal and moral conflict hinders treatment hence the need for ethics;
- Need a legal text that will enable drug addicts to go to court if their rights are ignored;
- Some countries allow that treatment can be determined at a local level in each municipality

Lack of information

- Illness such as drug addiction and mental health are associated in the public mind, so society through lack of information does not take an interest hence the politicians will do as they feel and win over society to their views;
- We need to inform society drug users are not dangerous and in so doing grant them their rights;
- A campaign is needed to inform people about drug use and addiction
- There are a range of treatments needed, not just one;
- The longer someone is in contact with services of any kind the better they do and the better for the society;

Disease debate

- If drug addiction is seen as an illness then like any other illness we can provide the appropriate care;
- Drug addiction is a disease and therefore politicians cannot decide whether care should start or end;
- How is the objective of treatment decided? Who decides? There can be several goals?
- Insurance debate has happened in Germany in other words who pays for the care of the drug user, especially substitute treatment? They managed to gain agreement with the Department of Health that insurance schemes would pay for treatment but this is extremely restricted. Some prerequisites such as presence of a second disease were looked for but now they want these to be removed;
- Quality must be maintained and high professional standards
- There is a large focus on methadone maintenance. It is seen to be cheaper than residential care/treatment but what are the social costs?

- Need to focus on the evidence
- Drug addiction is not just a medical problem and must be seen in a broader context. A doctor cannot prescribe housing or social care.

SOLUTIONS

- ✓ Normalisation of use
- ✓ Information campaign to involve families and new decision makers
- ✓ Start dialogue about addiction and the rights of the drug addict to care; legal framework to be created to enable a right to care
- ✓ Look at Quality, facilities, training of staff, budgets,
- ✓ Waiting time from when people present for treatment and when they actually receive care should be better. We need a text access to care with time limit.
- ✓ Family should be involved in care as research shows early involvement assists with recovery
- ✓ Keep medical influence at the forefront although this was argued against by several participants who said the cross cutting nature of drug addiction requires several departments and several specialists to be involved in policy and care
- ✓ To maintain a disease model would significantly hamper the progress that has been made so far on addressing the real needs of drug users which are also psycho-social
- ✓ Drug addicts want care, some want to give up drugs some do not. But they are equally marginalized in society
- ✓ There is ignorance and prejudice not just among the population but also among the professionals
- ✓ The Drug addict is a citizen like any other
- ✓ They have a need for medical/social care and support
- ✓ They should have treatment for all layers of need
- ✓ Treatment with results according to the individual's needs
- ✓ Combined, comprehensive approach most important.

NOTE 'Addict' is term used by some participants and not a term commonly used in today's climate. Drug user or problem drug user is more common.

Report from Workshop B by Ms Bugeja (Malta)

Drug Screening

Chairman: Mr Shahandeh (ILO) & Mr Mellish (TUC)

Countries participating in workshop:

Italy, France, Ireland, Croatia, Estonia, Portugal, Belgium, Austria, Poland, Slovenia, Malta and the European Commission.

Introduction

After the participants were asked to introduce themselves and also to speak about their background, salient points for the discussion were put forward and participants were also asked to react to the papers presented in the morning.

Drug Testing in Schools

The issue of drug testing in schools was raised several times by various participants, and the discussion around this issue constantly retorted to the fact that there were no services available after testing. This raised the questions of:

- What is done then with a positive result?
- Who has access to these tests?
- For what purpose? etc....

Parental consent was also mentioned as not being part of this approach, wherever it was being applied.

The point that testing is only indicating use and not abuse, was also raised.

Multi-national Companies

The Multi-national companies were mentioned almost centrally in this discussion, as the ones that were changing the norms of using testing as a therapeutic tool in a doctor / patient relationship. It was attested that this was a U.S. practice, but which is coming to Europe rather strongly.

A point of the two approaches used was raised and was said to be in conflict with one another. The approaches are based on drug policies and road traffic safety.

It was attested that the current situation was only providing fodder for the media, but no proper comprehensive approach had been developed.

After hearing the comments from all the participants, the issues were brought together under five headings:

1. Social issues involving families, students, road safety, etc.;
2. Occupational Health – ways, means, access to testing by whom and why?
3. Impact of the multi-nationals – their influence, pressures;
4. Political Aspect – role of the EU, Pompidou Group;
5. Drug addiction as a health issue and not as a criminal offence.

It was agreed that scientific evidence was not conclusive therefore research should be commissioned to study this situation and come up with suggestions.

The need was highlighted to see the other side of testing – how it can be counterproductive and not achieving the aims it was set out to achieve. It was pointed out that the real issue at the workplace is alcohol and not drugs.

The question was asked of what is then the responsibility of the Pompidou Group? In response it was specified :

- To provide direction to policy makers
- To suggest specific measures and help with the legislation.

The attention was focused on Convention 161 on Occupational Health and Safety – including the other factors that could be affecting the workforce, and not just substances.

The Guiding Principles on Drug and Alcohol Testing in the Workplace, as adopted by the ILO in 1993 was consulted, and it also transpired that no feedback / evaluation is in place about these guidelines. It was thus suggested that this aspect could be researched and some conclusions drawn.

It was attested that the Pompidou Group could have a clear position on this aspect and help governments stop any unethical practices, after having collected the proper data. This should not be achieved via the usual questionnaires sent out to countries, but by a multidisciplinary piece of research that merits proper funding.

It was considered obvious that ethical consideration should be based on scientific evidence, nevertheless common knowledge attests that policy is not always driven by science.

Therefore, COE could

- (i) express views of testing;
- (ii) establish parameters;
- (iii) state principles and guide situation.

What was being discussed was considered, in reality, a continuum between safety on one hand and privacy of the individual on the other, and all the implications in between.

Undoubtedly, different countries stand at different positions, therefore it was deemed important to be practical enough to take all situations on board.

Conclusions

More questions were raised and few answers found:

- What legislative framework exists – that puts limitations on testing? In the various European countries, probably most countries focus on road safety.
- What is the purpose of testing and is there any scientific evidence that confirms that the objectives are met?
 - Should existing literature be consulted?
- There is no legal cut-off point regarding limits on drugs – unlike alcohol.
- Is the technology available for testing on the roads?
- Has there been a joint assessment of the problem by the concerned stakeholders? Could there be a joint policy? – (a lot of ethical considerations)

- If decision to test - (after considering privacy issues, etc.) – will it be part of a comprehensive programme – leading to care and support according to the individuals' needs?
- Testing cannot be considered as a stand-alone technique – purely ethical.
- Is there a system of accreditation that makes sure that the labs that do the tests are using a standardized method and are reliable?
- The issue of informed consent needs to be underlined – this goal is not easily achieved, especially if employment is at stake. This could be seen as discriminatory against youth – while employment could help them mature and change their lifestyle.

Report from Workshop C by Mr Kapardis (Cyprus)

Compulsory treatment and compulsory admission to care

Chairman: Mr Kapardis (Cyprus)

1. WORKSHOP PARTICIPANTS

During the afternoon session of 6/2/ and the morning session of 7/2/03 the following participated in discussion with the aim of arriving at some conclusions and suggestions:

- a. Ms. Anokhina (Russia).
- b. Mr. Baumgartner (Austria)
- c. Mr. Gravier (Switzerland)
- d. Mr. Bgech (Malta).
- e. Ms. Grimalauskiene (Lithuania).
- f. Mr. Maddalena (UK)
- g. Ms. Markellou (Greece).
- h. Mr. Martins (Portugal).
- i. Ms. Nilson (EMCDDA).
- j. Mr. Padieu (France).
- k. Mr. Vasiliev (Bulgaria).
- l. Mr. Ward (Ireland).
- m. Mr. Wihlborg (Sweden).
- n. Ms. Zagoura (Greece).
- o. Ms. Goppel (Netherlands).

2. INTRODUCTION: THE CURRENT SCENE IN EUROPEAN COUNTRIES

The following are some of the dominant features of the European landscape as far as illicit drug use and addiction is concerned:

- Existing legislation and practices in different members of the Council of Europe reflect historical factors, the role of different professions (e.g., doctors, lawyers, psychiatrists, judges) in each country, the type of challenges posed by drug use and drug addiction and, finally, the role of the Ministry of Justice and the Ministry of Health and the degree of co-operation between them.
- The concept of treatment for drug users and drug addicts covers a broad range of approaches.
- The concept of “treatment” goes beyond just medical intervention and nowadays the notion of “harm minimisation” is gaining in popularity. “Harm minimisation” refers to the provision of medical care, psychological care, improving a client’s condition as far as housing and employment are concerned and so forth.
- There are very few countries indeed where care is provided not only in the short term but also in the medium and long term.
- In all countries there is a pressing need for personnel in the relevant Ministries (usually the Ministries of Health and Justice/Police) to work harmoniously together
- There are significant differences between member states as far the composition of the drug users’ and drug addicts’ population is concerned. The heterogeneity is evident in terms of age (e.g., juveniles vs adults), gender, and whether clients are within the criminal justice system or not.

3. PARTICIPANTS' AGREEMENT ON THE FOLLOWING

As far as available legislation and practice in member states is concerned, a distinction can and should be made between the following notions: "compulsory", "semi-voluntary" and "voluntary" admission to care and treatment. More specifically,

- Many member states have Mental Health legislation that provides for **compulsory** (i.e. **involuntary**) admission to care for up to six months for such cases as: (a) persons suffering serious psychiatric problems and/or, (b) there is a serious risk of causing serious physical or mental harm to themselves and/or (c) there is a serious risk of harming others or, finally, (d) persons who persistently refuse care for serious and persistent psychological problems.
In such cases, the aim seems to be to get them to be able soon to make an informed decision and to benefit from voluntary care.
A concern in this context, however, is the apparently high failure (i.e. relapse) rate.
- **Semi-voluntary admission to care** with a person's informed consent is available, for example, in both France and the UK. In both countries it is used as a way of diverting offenders. In France, such admission to care is used as an alternative to prosecution for drug users and in the UK as an alternative to imprisonment for a broad range of offenders.
- Semi-voluntary admission to care with a person's consent can be accommodated within both the criminal law and the civil law.
- **Voluntary admission to care** and treatment is available for persons who use drugs and come forward and ask for such care but not as a result of having committed an offence and been apprehended.
- Participants unanimously agreed that **compulsory admission to care is unethical if**, in practice, it means no treatment as such is available.
- **Compulsory treatment should not** prevent a person from opting for a different form of treatment at a later stage
- Participants were also unanimous that **no person should be coerced** to be admitted to care and to undergo treatment for drug use and drug addiction if they are not suffering from serious mental health problems and/or they have committed no criminal offence.
- It was also agreed that **informed consent** is essential in both voluntary admission to care and treatment as well as in semi-voluntary admission to care and treatment

Workshop participants also reached agreement that drug users and drug addicts have a right to care: if they come into contact with the criminal justice system, there is an opportunity for them to get help/ to benefit from a treatment programme but with their free consent in the case of adult persons and with the consent of their parent or legal guardian in the case of juveniles; there is a strong argument for diverting such persons from the criminal justice system in general and incarceration in particular and, also, not sending persons under the age of 18 to institutions etc where they can mingle with adult drug users or drug addicts. There is a need to provide drug-offenders with pre-release care to prepare them for successful reintegration into society.

There is also a need in most member states to provide multi-faceted post-release care and support.

In the case of drug-offenders who come into the criminal justice system, it was felt by the participants that a legal requirement that they comply with certain conditions in the context of their drug treatment is imperative if such programmes are to have a good chance of success. It should be noted in this context that (a) a legal requirement that someone complete a treatment programme correlates significantly with the successful completion of treatment and also, (b) that successful completion of a drug-treatment programme correlates significantly with abstinence thereafter.

4. FOUR WORKSHOP RECOMMENDATIONS

- **A more detailed picture is needed and should be obtained** regarding the existing situation in member states (i.e., legislative provisions and facilities, for example) as far as compulsory admission to care and compulsory treatment is concerned.
- **More work is needed to reach agreement on the precise definition of** such crucial concepts as “**treatment**” and “**care**”. This additional work could, perhaps, be undertaken by a sub-committee of experts who have participated in the Pompidou Group Seminar.
- **Ethical issues** pertaining to compulsory admission to care and compulsory treatment **cannot be resolved unless** precise definitions of crucial terms are agreed upon first.
- Finally, that serious thought be given by member states to the **introduction** of the concept of ***Drug Court*** (that exists, for example, in the United States), comprising specialists from a number of disciplines such as law, psychology, sociology, social work who are sensitive to ethical questions in dealing with drug users and drug addicts.

GENERAL REPORT

SEMINAR PROCEEDINGS: AN OVERVIEW

Claire AMBROSELLI (France)

1. Welcome by Council of Europe representatives

The participants were welcomed by two Council of Europe representatives, the Head of the Bioethics Division and an administrator from the Department of Health (Directorate General III – Social Cohesion). Their presentations put the work of the seminar in a European context by outlining recent developments at the Council in the fields of bioethics and ethics, within the framework of this international human rights organisation's legal affairs and health activities. It is true that the ethical problems which arise in combating drug addiction are not a direct focus of recent developments in bioethics – itself a problematic concept, concerned as it is with human ethical issues that cannot be dissociated from internationally recognised human rights. Nonetheless, this initial presentation of European-level efforts to promote internationally recognised rights in the Council of Europe member states, rapid though it was, remains an important point of reference in planning work with the Pompidou Group – an aim outlined by the seminar organisers in their opening remarks. Some 50 participants of more than 20 different nationalities attended this, the first seminar held by the Pompidou Group on the problem of ethics, professional standards and drug addiction.

The experience of the Council of Europe in the elaboration of standards in bioethics - Carlos de Sola, Head of Bioethics Division, Council of Europe

Mr Carlos de Sola, Head of the Council of Europe's Bioethics Division, opened the seminar with a presentation of his division, referring to the important *Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine (Convention on Human Rights and Biomedicine)*, commonly known as the Oviedo Convention.

Noting that the routine tasks of national ethics committees⁽¹⁾ were to discuss problems, give opinions and propose rules, Mr de Sola added – in relation to the work of the Council of Europe's Steering Committee on Bioethics – that it was also possible to anticipate, and thus prevent, certain problems posed by the development of medical techniques. The Steering Committee aimed to contribute to social cohesion, notably by taking account of minority opinions and positions on the issues discussed. International consultations were highly valuable, particularly when they gave members of the public a voice and were informed by studies in which no single discipline dominated and a range of approaches was recognised.

Preparation of the *Convention on Human Rights and Biomedicine* – which was opened for signature in 1997 in Oviedo – had been marked by a certain amount of conflict, chiefly on the questions of consent, research using human embryos, and gene therapy. In fact, the Convention was "the first binding international legal instrument to seek to impose a number of principles and rules safeguarding the dignity, integrity, rights and freedoms of human beings against misuse of biomedical advances".⁽²⁾

General problems posed by differences in medical, legal, civil and political practice also had to be addressed. Most obviously, it was difficult to organise the international consultations that were essential for tackling the ethical issues and discussing differences in practice (problems of custom and doctrine, language, terminology and concepts, as well as the question of nationally recognised rights and national laws conflicting with directives on medical ethics and international human rights).

The method of consultation between the various national bodies that cooperated in the Steering Committee on Bioethics was proposed as a possible model for the different phases of the seminar's work. Participants would also have to learn about the different types of work done by the committee – which inevitably covered many aspects of the ethical problems raised in combating addiction – with a view to discussing them, assessing the application of established principles and taking those principles into account in subsequent deliberations.

⁽¹⁾ Since 1992 the Council of Europe has organised a European Conference of National Ethics Committees (COMETH) which meets regularly. *"The purpose of the Conference is to promote cooperation between national ethics committees through activities such as the exchange of information and experience, the development of a European database, the initiation and supervision of studies relating to subjects of common interest, and the preparation of meetings at a European or regional level; to assist countries seeking to establish a national ethics committee to implement and operate such a committee; and to promote, on a pluralist basis, public debate addressing the ethical issues arising from developments in the biomedical sciences and public health."* (Council of Europe website)

⁽²⁾ Introduction to the Convention, taken from the Council of Europe website: *"The Convention's starting point is that the interests of human beings must come before the interests of science or society. It lays down a series of principles and prohibitions concerning bioethics, medical research, consent, rights to private life and information, organ transplantation, public debate etc [...]"*

"The Convention states the principle according to which a person has to give the necessary consent for treatment expressly, in advance, except in emergencies, and that such consent may be freely withdrawn at any time. The treatment of persons unable to give their consent, such as children and people with mental illnesses, may be carried out only if it could produce real and direct benefit [...]"

"The Convention recognises the importance of promoting a public debate and consultation on these questions. The only restrictions are those prescribed by law and which are necessary in a democratic society in the interest of public safety, for the prevention of crime, for the protection of public health or for the protection of the rights and freedoms of others. "Additional Protocols are foreseen to clarify, strengthen and supplement the overall Convention."

"The Steering Committee on Bioethics (CDBI) or any other committee designated by the Committee of Ministers or the Parties may request the European Court of Human Rights to give advisory opinions on legal questions concerning the interpretation of the Convention."
The task of the CDBI (set up in 1997) is to study the set of problems posed for law, ethics and human rights by progress in the biomedical sciences.

Health for all? Ethical and human rights challenges in health policy - Piotr Mierzewsky, Department of Health, Directorate General III – Social Cohesion, Council of Europe

In outlining the ethical and human rights challenges involved in health policy, and the problems they pose in terms of economics and equity, Mr Mierzewsky drew on a number of cultural references including Hippocrates' principles and certain ideas of Aristotle and Roger Bacon, which he linked to the first code of conduct for researchers, drawn up in 1890 by the Prussian Ministry of the Interior. This embodied the idea that human well-being depended just as much on respect for rights and morality as on scientific and medical progress. Unfortunately, in the 20th century, these professional principles ceased to be observed, and new international organisations such as the United Nations and the Council of Europe had to draw up new instruments and agreements, notably the *Universal Declaration of Human*

Rights (UN, 1948) and the *European Convention on Human Rights* (1950), which was followed by a whole battery of texts, agreements, resolutions and recommendations that necessarily address many of the ethical problems entailed in bringing health policies into line with human-rights commitments. Mr Mierzewsky recalled the principles of the World Health Organisation's 1978 *Alma Ata Declaration on the protection and promotion of health*.⁽¹⁾ He outlined some recent examples of professional codes of conduct such as the Tavistock Principles" (*BMJ*, 2000) and the principles expounded by Jonathan Mann, as well as several extracts from opinions delivered by the French national consultative committee on ethics. He also highlighted a number of Council of Europe recommendations which merited examination, notably those relating to citizen participation in policy making on health care,⁽²⁾ and indicated the thrust of future work.⁽³⁾

The presentation gave participants a clearer picture of the direction being taken by Council of Europe member states in their efforts to improve health-care policies and systems in an expanding Europe. Emphasis was placed on the importance of applying agreed principles in order to ensure greater equity and fairness in these areas. The participants could thus make better use of the work done by the Council's various bodies and the agreements and recommendations they had produced, and could study and build on them in subsequent stages of their own work.⁽⁴⁾

(1) "The people have the right and duty to participate individually and collectively in the planning and implementation of their health care." (Article IV of the Declaration)

(2) The following Council of Europe recommendations and sources were referred to and may be consulted on the Council's website:

1980, *Recommendation No. R(80) 4 on active participation of the patient in his own treatment*

1997, *Recommendation No. R(97)4 on securing and promoting the health of single-parent families*

1998, *Recommendation No R(98)7 concerning the ethical and organisational aspects of health care in prison*

1998, *Recommendation No R(98)11 on the organisation of health care services for the chronically ill*

2000, *Recommendation Rec(2000)5 on the development of structures for citizen and patient participation in the decision-making process affecting health care*

2000, *Recommendation Rec(2000)18 on criteria for the development of health promotion policies*

(3) Seventh Conference of European Health Ministers on "Health, dignity and human rights - the role and responsibility of Health Ministers", Oslo, Norway, June 2003

(4) The Council of Europe's first publications on alcohol, smoking, the abuse of medication and drug abuse date from 1970 – see *Public health implications of recent developments in drug dependence* (Kielholz, P.), which was followed by many resolutions and recommendations, notably the 1986 *Recommendation R (86) 14 on the drawing up of strategies to combat smoking, alcohol and drug dependence in cooperation with opinion makers and the media*.

2. The right to information

Following the presentations and welcome by Council of Europe and Pompidou Group representatives, the seminar participants tackled the first topic on the agenda, the right to information, with two complementary presentations. First, Mr René Padiou introduced the theme, outlining the main ethical considerations and the inevitability of conflict between them, given the many people and types of information involved in transmitting messages with a

specific meaning and intended effect from originator to recipient. The second speaker, Mr Baptiste Cohen, focused on some of the difficulties inherent in the right to information, concentrating on the ethical and political responsibility of those in charge of policies for information about drugs and dependence.

These two presentations on the basic right to information, which tackled key policy issues, were not followed up by a workshop. It is to be hoped that further work will be done in this area either by a group constituted for that purpose or by the inclusion of the topic on the agenda for a forthcoming working party meeting.

The right to information, an introduction - René Padieu (France)

With reference to the *European Convention on Human Rights*,⁽¹⁾ Mr Padieu analysed the connections of entitlement and obligation created between people who wish to exchange information, forging between them a relationship that is an essential element in the human condition. He identified the circumstances in which this relationship between informers and addressees permits exchanges of information on a basis of reciprocal rights, constituting the complex entitlement that is the right to information. "The basis of the right lies precisely in the purpose of the information," he explained.

The importance of the right to information could be undermined by the circumstances in which those exchanging information found themselves. Information was defined by its content and purpose and thus by the ability of those concerned to structure and exchange it in a manner appropriate to their needs. This process of structuring and exchange had to be approached with circumspection and intelligence, with mutual respect between the parties involved, respect for their capacity to exchange information, and the keenest possible awareness of that capacity. The capacity for exchange was based primarily on the reciprocity created between the parties by the information they wished to exchange, and thus on a shared responsibility which depended on the individuals concerned (their ages and circumstances), the nature of their relationship (personal, civil, professional or political) and also on the information they were exchanging, the purpose of the exchange, and the actions or reactions with which the information-exchanging relationship was concerned. Respecting the two-way requirements of persons who entered into an information-exchanging relationship meant taking account of the multiplicity of persons and purposes potentially involved. Information-exchanging relationships between individuals generated knowledge, expertise and capabilities which could be shared and which determined the right to information and the conditions in which it was exercised. All this depended on the ability of those involved to come to an understanding and thus to act together. In this way, the right to information determined people's right to extend their knowledge and their right to form opinions and thus learn to reflect, evaluate and take action.

In satisfying the right to information within this complex web of human relationships, it was to be expected that individuals and rights would come into conflict. Both the complexity and the conflicts were evident in the various layers of political and professional, civil and personal relationships that played a part in the fight against drug addiction. It was necessary to learn to understand and address the conflicts. This meant that the persons concerned had to assume mutual responsibility for "identifying these difficulties and finding an acceptable solution to them, [...] the ethical attitude precisely consists in *dealing with* these conflicts without letting them degenerate into confrontations involving power, authority or money". There were no off-the-peg solutions or rules for dealing with such conflicts: "Ethics [...] is a means of tackling problems which lack any prior solution in order to identify a solution liable to be accepted by the parties involved, under one specific set of circumstances." To enable us to confront and overcome these difficulties and conflicts of rights in day-to-day practice, we needed training and education that addressed our specific problems, so that we might begin by understanding them.

Another factor underlying conflict was the great volume of information that we faced in our daily lives. Processing all this information on computer systems had created new requirements. Mr Padieu spoke of the problem of separating aims and of the new compartmentalisation of information that had come with the development of databases and the storage of personal, professional and political data. In relation to the problems of scientific research and statistics he mentioned the importance of Convention n° 108 for the Protection of Individuals with regard to the Automatic Processing of Personal Data, adopted by the Council of Europe in 1981, with its stipulation that: "Personal data [...] shall be obtained and processed fairly and lawfully, stored for specified and legitimate purposes and not used in a way incompatible with those purposes." ⁽²⁾ The Convention had to be seen in association with a series of Council of Europe recommendations adopted between 1983 and 1997 which set out criteria for making the distinction between personal and scientific use of information.⁽³⁾

The speaker also discussed two further problems: how to ensure that information was independent and objective, given the threat of ideologies and abuse by individual interest groups, particularly professionals who could potentially misuse their authority without any attempt to evaluate their actions and policies; and the problem of tailoring information to suit the relationship established between informer and recipient. Attempting to convey a catch-all message was pointless: "information must be provided on the basis of the aims pursued by the person to be informed", which implied that informer and recipient would determine what common purpose they might have in sharing the information.

⁽¹⁾ *The Convention for the Protection of Human Rights and Fundamental Freedoms*, generally known as the European Convention on Human Rights, sets forth a list of rights and fundamental freedoms including freedom of thought, conscience and religion and freedom of expression. Article 10, on freedom of expression stipulates:

"i. Everyone has the right to freedom of expression. This right shall include freedom to hold opinions and to receive and impart information and ideas without interference by public authority and regardless of frontiers. [...]

ii. The exercise of these freedoms, since it carries with it duties and responsibilities, may be subject to such formalities, conditions, restrictions or penalties as are prescribed by law and are necessary in a democratic society, in the interests of national security, territorial integrity or public safety, for the prevention of disorder or crime, for the protection of health or morals, for the protection of the reputation or rights of others, for preventing the disclosure of information received in confidence, or for maintaining the authority and impartiality of the judiciary."

⁽²⁾ This Convention, N°108, is "the first binding international instrument which protects the individual against abuses which may accompany the collection and processing of personal data and which seeks to regulate at the same time the transfrontier flow of personal data". (Council of Europe Legal Affairs website)

⁽³⁾ *Recommendation R (83)10 on the protection of personal data used for scientific research and statistics* contains principles and guidelines which "apply to the use of personal data for scientific research and statistics in both the public and private sectors, irrespective of whether such data are processed automatically or manually". These principles and guidelines concern respect for privacy, consent by persons who furnish information, use of the data, access by persons concerned to the data, and data security, publication and conservation.

Recommendation R(97)5 of the Committee of Ministers to the member states on the protection of medical data is structured around the same points, with particular reference to the various circumstances of medical research and the problems specific to it. Its final article,

n° 12, concerns "scientific research" and stipulates that medical data used for research purposes should be anonymous: "Personal data used for scientific research may not be published in a form which enables the data subjects to be identified, unless they have given their consent for the publication and publication is permitted by domestic law."

Information on drugs and dependence: an ethical and political responsibility - Baptiste Cohen (France)

Following Mr Padiou's introduction to the problems and conflicts raised by the right to information, Mr Cohen focused on the ethical and political responsibility entailed in the provision of specific information about drugs and dependence. He examined the implications of this responsibility with reference to three key points for discussion, which were critical in terms of effectively combating addiction: namely prevention, anthropology and politics.

His first point was that information on drugs and dependence had, first and foremost, a preventive purpose. This did not mean seeking to eliminate all forms of human behaviour carrying risks, but to address such risks by reducing their incidence.

Secondly, given the remarkable ability of human beings to turn everything that gave them pleasure or eased their tensions into a drug, it was important to make greater use of appropriate keys to understanding. Beyond the traditional tools of medicine and public health policies, the speaker proposed recourse to anthropology. In order to prevent dependence that would ultimately threaten those caught up in it, it was important to understand the nature of human freedom and human dignity, of human fragility and vulnerability. "Freedom and dependence constitute the human condition." Preventing ills becomes meaningful within the meaning of that condition. "The sole purpose of prevention is to protect the most vulnerable, or, more precisely, identify the situations in which vulnerability is greatest."

Thirdly, participation in this task was a political problem because the aim was to give everyone a say in choices made by the societies in which everyone hoped to find their place. Analysis of certain aspects of anti-drugs information policy, however, threw up contradictions that could not be reconciled with the aims of prevention or making the policies effective.

These contradictions, which would feature in other presentations and discussions during the seminar, concerned the ambiguity inherent in the distinction, in terms of information policy, between legal and illegal drugs – an arbitrary distinction trivialising the use of legal substances and masking the real threats they posed, while at the same time depriving people of necessary information about the nature of dangers with regard to prohibited illegal drugs, which politicians simply did not discuss. The speaker urged debate, for example, about information policies on smoking and alcohol: in the case of smoking, it had become compulsory in the EU to provide information, and tobacco consumption was permitted; in the case of alcohol, provision of information stopped where political responsibility stopped, and legislation prohibited alcohol consumption by minors, although the law was neither enforced nor backed up by penalties. In the case of illegal substances, on the other hand, families could be affected by the dramatisation of "drug-taking" without having any information about why certain substances were prohibited and what real the risks were.

These issues needed to be debated with a view to reducing risks through an approach that took account not only of the specific nature of the risks but also of people's ability to understand them. The debate had to involve people from different European countries, comparing their different practices, and this could not be envisaged in the absence of an information policy tailored to the specific nature of the risks in question, nor in the absence of a prevention policy served, as a matter of priority, by the information policy, and based on anthropological data reflecting the reality of our human condition and the fundamental rights inherent to it.

3. Problems posed by the right to care, and medical and epidemiological research

The rights to health and access to care and to research are internationally recognised and enshrined in undertakings given by the United Nations and the nations of Europe. Applying these rights in relation to combating drug addiction poses particular ethical problems: the need to prevent risks; the effectiveness of treatment in cases of dependence due to abuse of legal or illegal drugs; the issues of freedom raised by compulsory treatment; the danger of death by overdose; the difficulty of obtaining informed consent.

The seminar included two presentations and two workshops on the problems of treating drug users: the first speaker discussed the right to treatment and access to intensive treatment while the second tackled the issue of compulsory treatment and compulsory admission to care. A third speaker addressed the problems raised by medical and epidemiological research. There was no workshop on this topic.

The right to care and access to social welfare services - Oto Masár (Slovakia) and Francis Schimek (France)

Mr Masár's presentation dealt with the ethical problems involved in treating drug users and the difficulty of caring for them. After outlining certain physiopathological facts about the effects of drugs and drug withdrawal, the speaker pointed out that the problems posed in this respect should not be divorced either from common psychological phenomena such as depression and anxiety or from socio-economic and cultural realities that could influence treatment negatively or positively. The ethical problems he discussed (concerning patient consent, decisions on the choice or discontinuance of treatment, the cost and effectiveness of treatment, quality of life and risk of death) were mainly those encountered in intensive care facilities. The problems were tackled differently depending on whether they arose in respect of emergency treatment or in the treatment of dependence. Consideration also had to be given to the political, economic and social circumstances in different countries, and this entailed assessing such circumstances in relation to desired and actual results.

In Eastern European countries, like Mr Masár's, these problems were all the more pronounced because national economic difficulties meant that "the funds available for medical care are limited, as are intensive care resources". While recommendations from the European Society of Intensive Care Medicine could serve as reference points in difficult medical situations, they did not call into question the essential right of universal access to care, nor lessen the need for political efforts in Europe to achieve health care systems that gave everyone access to care on an equitable basis, in one country as in another.

Workshop summary

During the workshop the current situation in the different countries was outlined. Participants seemed to feel, given the multiplicity of different circumstances, that they could not draw up guidelines or common rules to address problems that were associated with national legislation. Moreover, in this situation, greater consideration had to be given to the requirements of internationally recognised rights. It became clear, from surveying the various public health policies and the disparities in political, economic and cultural resources between different countries, and indeed within countries, that it was hard to assess the need for medical care in combating drug addiction, given the problems of dependence and recidivism, in relation to people's other health needs. The problems of intensive treatment, of death by overdose, of the risk of AIDS or hepatitis infection and of substitution treatments were tackled differently in different countries and remained the greatest cause of concern. The seminar participants said they wished, at a later stage, to consider the most appropriate joint strategies for addressing these serious situations. They expressed a wish to receive

more training about the health problems associated with drug dependence, and to see closer cooperation not only between professionals but also with families and those responsible for providing treatment. The further point was made that provision of such treatment was not properly integrated into hospitals and clinics, prisons and other establishments where drug users lived. Better cooperation between those with the relevant policy responsibilities was also called for.

A need was identified to compare the requirements of basic rights – to integrity of the person, to privacy, to consent to treatment and to have fair access to treatment – with current practice, and it was suggested that an in-depth study could explore these rights and requirements and consider the Council of Europe's work in relation to them. In the current situation with regard to European Union enlargement and developments in treatment and treatment policy, as efforts to combat drug addiction evolved, this work would be particularly appropriate and could be undertaken by the Pompidou Group. Such a step would facilitate exploration of the different policies that came into play in developing treatment, and of current legislation in this field. It could also help to dispel certain ill-founded fears which continued to find expression in arbitrary and often contradictory levels of tolerance in political positions with regard to legal and illegal practices, authorisations and prohibitions, as well as risks and dangers that had consequently become hard to prevent. It was felt that the various working groups set up should also discuss research in these areas.

Compulsory treatment and compulsory admission to care - Andreas Kapardis (Cyprus)

Mr Kapardis began with a presentation of European crime statistics which showed a worrying situation, characterised by: an unchanged incidence of drug offences; the fact that drug addiction acted as a catalyst for spiralling crime rates, with drug offenders (involved in drug trafficking, drug use and activities to finance addiction) presenting a very heterogeneous profile; and an increase in the number of drug offenders sentenced to terms of imprisonment, despite the criminogenic effects of the prison environment.

This situation flew in the face of recommendations by the Select Committee of Experts on Sentencing, which were adopted by the Committee of Ministers of the Council of Europe in 1992,⁽¹⁾ to the effect that restraint in the use of custodial measures should be a major principle of sentencing. Nonetheless, a number of other international institutions had taken a similar line with a view to reducing illegal demand for drugs. This was clear from texts such as the United Nations *Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances* (1988),⁽²⁾ the Council of Europe *Convention N° 141 on Laundering, Search, Seizure and Confiscation of the Proceeds of Crime* (1990),⁽³⁾ the European Union's *Council Directive 91/308/EEC on prevention of the use of the financial system for the purpose of money laundering*,⁽⁴⁾ the Schengen Agreement and the Maastricht Treaty.⁽⁵⁾

Although the treatment of drug addiction in prisons had improved, the development of non-custodial sentences transformed the nature of treatment problems, combating the pathogenic effects of imprisonment and enabling better treatment of dependence and recidivism. In this context Mr Kapardis highlighted certain treatment programmes aimed at reducing the demand for drugs by helping drug users to end their dependence. Alongside substitution programmes, which had been the form of treatment most developed in recent decades, various types of grass-roots care services were currently being established in hospitals, prisons and residential facilities, and therapeutic communities were being set up. These developments required fresh investment by national and local government.

It was still hard to evaluate the results and effectiveness of programmes for treating drug addiction. Certain studies were inconclusive. The problems posed in the different countries by the multiplicity of approaches adopted – compulsory treatment, treatment orders or the

use of special drugs courts, for example – should be studied by a Pompidou Group working party, as should problems relating to rehabilitation policies or programmes to increase the courts' role in combating drug addiction in the same countries. The speaker concluded that: "It is not possible to sustain the argument for compulsory treatment of drug users, whether in prison or in the community, when a treatment programme offers but a false hope."

⁽¹⁾ The Select Committee was set up after the Council of Europe's 8th Criminological Colloquium in 1987. Cf. N. Jareborg, *Disparities in sentencing: causes and solutions*, Council of Europe, 1987; *Recommendation n°R(87)3 of the Committee of Ministers to the member states on the European Prison Rules*, and *Recommendation n°R(92) 17 of the Committee of Ministers to the member states concerning consistency in sentencing*.

⁽²⁾ Article 2, Scope of the Convention: "The purpose of this Convention is to promote cooperation among the Parties so that they may address more effectively the various aspects of illicit traffic in narcotic drugs and psychotropic substances having an international dimension. In carrying out their obligations under the Convention, the Parties shall take necessary measures, including legislative and administrative measures, in conformity with the fundamental provisions of their respective domestic legislative systems."

⁽³⁾ This Convention, which was opened for signature in Strasbourg on 8 November 1990 and entered into force on 1 September 1993, aims to facilitate international cooperation and mutual assistance in investigating crime and tracking down, seizing and confiscating the proceeds thereof. The Convention is intended to assist States in attaining a similar degree of efficiency even in the absence of full legislative harmony.

⁽⁴⁾ In 2001 the European Union amended the Directive of 1991. The purpose of the new Directive (*Directive 2001/97/EC of the European Parliament and of the Council of 4 December 2001 amending Council Directive 91/308/EEC on prevention of the use of the financial system for the purpose of money laundering*) was to extend the scope of the existing Directive on money laundering (91/308/EEC). In particular, Member States were to be required to prohibit the laundering of money generated by any form of serious crime (including defrauding the Community budget), whereas the provisions of the 1991 Directive applied only to the profits of drugs crime.

⁽⁵⁾ Under the Schengen system, liaison officers were appointed in the signatory states to coordinate exchanges of information about terrorism, drugs, organised crime and illegal immigration networks.

The Treaty of Maastricht set out those questions of common concern in respect of which cooperation had to be encouraged: notably terrorism, drug trafficking and other types of international crime. A European Police Office (Europol) was also provided for, alongside a system of information exchange covering the entire European Union. See European Parliament website information on police and customs cooperation.

Workshop summary

Participants in this workshop highlighted the contradictions that exist in every country between medical and psychiatric practices, on the one hand, and judicial and penal practices on the other. A whole range of problematic areas – the uneasy cooperation between members of different professions with their differing codes of practice, the unsatisfactory links between the relevant ministries (not only those of justice and health but also education ministries), and the requirements of international and European law, which were not yet well known – ought to be tackled at domestic level in each of the countries studied, and the different countries should be prepared to share their work in this field.

These exchanges should be tied in with a study of Council of Europe work on a number of issues about which too little was known and on which more debate was needed. The concepts of treatment and care, of distinguishing between legal and moral obligations, and of free will, as defined in the various national laws and in respect of specific practices, needed to be studied and, if necessary, criticised. This conceptual work would have to be seen in the light of problems posed by current practices, including voluntary and semi-voluntary admission to care, compulsory admission to care – which had been called into question in a critical history of psychiatry because of the ethical issues it raised – or the more recent and as yet unfamiliar concept of courts specialising in drugs crime.

The seminar participants came down against certain practices on ethical grounds, arguing that they conflicted with basic internationally recognised rights, from which no derogations were possible, such as the right to humane treatment and the right to give or withhold consent to treatment. They defended the existence of a universal right to treatment. In their recommendations, the participants urged that these issues be taken up by a working group, which should be able to draw on a more detailed summary of the current situation in the member states.

Ethical issues in epidemiology and research into drug abuse - Dusan Nolimal (Slovenia)

This presentation concentrated on the various medical ethics directives drawn up in the 1960s and more recently by national and international medical bodies (the World Medical Association, the American College of Epidemiology, the Council for International Organisations of Medical Sciences (CIOMS) and the World Health Organisation (WHO), the specialised organ of the United Nations). These "ethical principles" tended to take the form of specific codes of conduct for the different professions involved in research and were applied by different types of supervisory bodies (eg medical ethics committees and the Institutional Review Board) in order to obtain funding for research. They were distinct from the principles of international human-rights law, which had universal application.

The principles of medical ethics introduced in order to further research have been heavily influenced by moral principles laid down by the US Administration in this field. These moral principles – concerned with values, duties and virtues – have been incorporated into rules on medical ethics adapted to the various practices of medical research, taking the place of the more rigorous principles of fundamental rights which preceded them and were based on the legal capacity of human subjects to consent to research having been informed in a way that they can understand, and on the obligation to take legal proceedings against researchers who failed to respect the principle of consent. Nonetheless, this principle was the first of ten rules of medical ethics laid down by US judges in the 1947 Nuremberg trials of German doctors who had committed crimes.

Mr Nolimal did not discuss this critical history of medical ethics, but moved on to analyse the principles set out by professional medical bodies in the Helsinki Declaration (the key points being respect for persons, beneficence and justice). These principles made sense only when they were applied in a manner that did not obscure the reality of all research, based as it was – like any medical procedure – on human beings entering into a relationship in the context of specific actions, in this case based on experimentation and research with potentially unforeseeable results. In the various specialisms concerned, this research and experimentation had been the subject of numerous risk and benefit analyses and had raised problems concerning confidentiality, the right to privacy and conflicts of interest. Mr Nolimal presented an effective analysis of such conflicts with reference to specific aspects of epidemiology and to the directives issued and applied by the relevant specialised bodies. Nonetheless, whatever the quality of such rules, however well they were applied – striking the right balance between minimising risks and maximising benefits – and whatever the

scientific quality of the research monitored by specialised committees, the key underlying factor was rigorous application of the principle of consent, coupled with a right to information for the would-be subjects of research or experiments. In many cases the most difficult questions – well covered by earlier speakers – concerned the right to information.

Because this presentation was not followed up in a workshop, the important issues raised with regard to the impact of professional ethics principles on the development of research should be taken up and discussed in the Pompidou Group's working parties. Such discussion should focus on the problems of consent – requiring that people be properly informed in order to understand the commitments they make when they agree to be involved in research – and these problems are particularly difficult in relation to the role played by different types of medical, epidemiological and social research in policies for preventing and combating drug addiction.

4. Ethical questions raised by drug screening

Two speakers explored the ethical issues raised by workplace screening as a means of combating drug addiction, tackling the theme from complementary perspectives: that of the International Labour Office and that of the trade unions. A significant aspect here was the distinction between legal and illegal drugs, with different positions being adopted in relation to screening for legal drugs such as alcohol. Attention was also drawn to the specific problems of multinational companies' policies and emerging conflicts between workers' and employers' rights. These issues were discussed in a workshop.

Ethical issues in workplace drug testing in Europe - Behrouz Shahandeh and Joannah Caborn, ILO, Geneva

Drug testing had become an issue in corporate policies, particularly the policies of multinational companies that were concerned more with financial and commercial objectives than with the ethical problems posed by testing. The employers' agenda and interests conflicted with workers' rights, and their health responsibilities had to be set against commercial considerations. Were companies entitled to interfere in the personal lives of employees if certain of their choices impacted on the workplace?

The speaker began by defining drug testing as "the process of obtaining samples of body fluids or tissues (eg urine, blood, hair, breath) from job applicants and employees and conducting laboratory analyses to detect the presence of certain drugs, including alcohol, and their metabolites". He pointed out that, of all the forms of workplace drug testing, random testing was the most controversial.

To address these problems, the ILO had instituted a tripartite meeting of experts in 1993, which resulted in publication of its *Guiding Principles on Drug and Alcohol Testing in the Workplace*.⁽¹⁾ These principles served as a reference in different types of situation, and ought to be the subject of joint study by the ILO and the Pompidou Group.

Recourse to drug screening raised legal problems with regard to employers' responsibilities for safety within their companies and for employees' health. Occupational health services also had role to play in how such issues were addressed. In certain countries, doctors specialising in occupational health were responsible for the tests. In fact, the legal situation varied widely from country to country and also according to whether employees were being screened for use of legal drugs (as in the case of testing drivers' alcohol levels) or for illegal drug use.

Employers often used screening to deter employees from drug abuse, and in problematic situations fell back on moral arguments placing less emphasis on the corporate interest and workers' output levels. Using drug testing in this way posed many legal problems. The

speaker dealt with some of these, such as the question of trainees tested under recruitment procedures (pointing out that the legal protection afforded to workers did not always apply to job applicants) and the use of labour tribunals to settle disputes on a case-by-case basis as an alternative to drafting new legislation. On top of the legal issues, screening also raised very real ethical problems.

One of the main ethical arguments put forward by opponents of screening was that it constituted unwarranted infringement of the right to privacy, a right enshrined in various national constitutions and in international law: eg in Article 12 of the *Universal Declaration of Human Rights* (UN, 1948)⁽²⁾ and Article 8 of the *European Convention on Human Rights* (Council of Europe, 1950) which guaranteed the right to respect for private life except in the case of measures "necessary [...] in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others". The ILO's *Guiding Principles on Drug and Alcohol Testing in the Workplace* required that individuals give their informed consent prior to testing.

With regard to respect for privacy, workplace drug screening also raised directly the question of protection of sensitive personal data as provided for in various international instruments: in the EU's data protection Directives Nos 95/46/EC and 97/66/EC and in the ILO *Code of Practice on the Protection of Workers' Personal Data* (1996). It was also possible that testing would be used for discriminatory purposes.

The final problem considered by the speaker was the quality of drug tests, with its implications for the reliability of screening. Tests provided no detailed information on drug use or abuse and doubts persisted in relation to their results.

⁽¹⁾ *Management of alcohol- and drug-related issues in the workplace*, ILO, 1996. "Contents of this ILO code of practice: duties and rights of employers and employees; development of an alcohol and drug policy; restrictions on alcohol and drugs in the workplace; prevention through information and training programmes; identification and testing of workers with problems; treatment and rehabilitation programmes; intervention and disciplinary procedures. In appendices: physical effects of alcohol and drugs, and indicators of potential problems; ILO guiding principles on drug and alcohol testing." (From ILO website)

⁽²⁾ "No one shall be subjected to arbitrary interference with his privacy, family, home or correspondence, nor to attacks upon his honour and reputation. Everyone has the right to the protection of the law against such interference or attacks."

⁽³⁾ *Directive 95/46/EC of the European Parliament and of the Council, of 24 October 1995 on the protection of individuals with regard to the processing of personal data and on the free movement of such data*, (OJ L 281, 23 November 1995, p.31) stipulates that "Member States shall protect the fundamental rights and freedoms of natural persons, and in particular their right to privacy, with respect to the processing of personal data".

Directive 97/66/CE of the European Parliament and of the Council, of 15 December 1997, on the processing of personal data and the protection of privacy in the telecommunications sector (OJ L 024, 30 January 1998, p. 0001 – 0008) "provides for the harmonisation of the provisions of the Member States required to ensure an equivalent level of protection of fundamental rights and freedoms, and in particular the right to privacy, with respect to the processing of personal data in the telecommunications sector and to ensure the free movement of such data and of telecommunications equipment and services in the Community".

Drug testing in the workplace - Tom Mellish, Trades Union Congress (UK)

Mr Mellish opened his presentation by referring to the differences – in terms of workers' rights and employers' responsibilities – between the consumption of legal substances such as alcohol and the illegal use of other drugs. He proposed addressing these legal difficulties by including anti-addiction programmes within an overall health promotion package. Such a policy would have four aims: to recognise that alcohol and drug misuse was a health problem; to prevent alcohol and drug misuse; to identify employees with a problem at an early stage; and to assist them. The policy would have to provide for confidentiality, and the persons concerned would have to be entitled to be accompanied by a trade union representative and to have access to counselling and the possibility of treatment. All those responsible for such a programme ought to receive training in health problems.

With the regard to the question of whether or not to introduce testing, the speaker made the point that the relative inefficiency and unreliability of tests, coupled with the fact that large numbers of people use drugs in many different ways, rendered testing programmes ineffective, and they were also very costly. The problems of working relationships, discrimination, legal issues and medical confidentiality were further considerations that should dissuade employers from introducing such programmes. "Education, information and training alongside a disciplinary system which has separate but clear links to the alcohol and drug policy are much more likely to be effective."

Workshop summary

Participants in this workshop discussed the complex nature of workplace situations and the relevant legislation in different countries. These considerations were then set against the principles of internationally recognised rights, which were not widely known and required further evaluation. It proved difficult to explore in depth the problems posed by worker-employee relations and existing case law and legal provision: lacking experience in the particular environment of the multinational companies most directly concerned, the seminar participants spent more time discussing problems familiar to them from their regular experience in combating drug addiction outside the corporate world. Workplace testing was being introduced into Europe from the United States under powerful pressure from market forces. Its development ought to be studied in greater depth in consultation with professionals directly concerned and with representatives of the ILO and the Pompidou Group.

Discussions in the seminar thus focused on social aspects of the employer-employee relationship (including issues affecting students and families), the role of occupational health services in different countries, the pressures exercised by multinationals, the role of European political institutions (including the Pompidou Group and the European Union) and the importance of addressing health issues in the fight against drug addiction.

In discussing the question of multinational companies and developing policies in this regard, internationally recognised rights should be the point of reference. International conventions should be studied, notably the ILO's *Occupational Health Services Convention* of 1985 (No. 161) and its *Guiding Principles on Drug and Alcohol Testing in the Workplace* (1993). Experience with the development of anti-addiction policies directly based on fundamental rights should reinforce efforts to ensure that workers' rights were respected.

The first problem mentioned – that of drug screening in schools – remained the thorniest, and raised once again the underlying issue of prevention. The problem of internationally recognised rights in the corporate environment needed to be seen in a broader perspective embracing the question of rights education in schools.

Conclusion

All the work done during the seminar and the proposals for tackling the various themes in greater depth – through working groups on the right of access to treatment, the use of screening and, more specifically, on ethical issues surrounding the right to information, rights in relation to research, and the problems of preventing drug abuse – demonstrate the importance of this initial look at ethical issues in combating addiction. The scope of the work now has to be widened to take in areas already considered by the Pompidou Group, such as drug addiction in prison, the situation of pregnant women, and more generally the questions of preventive measures and the framing of policies that do not reinforce an unhelpful distinction between legal and illegal drugs.

From the work done it is quite clear that in order to tackle the many ethical questions that arise in combating drug addiction – and whatever the specific focus of the Pompidou Group's efforts in the next three years – the main tasks of the working groups must include the following: studying the differences between problems of professional codes of conduct and problems of ethics; developing a better picture of the situations in different countries, taking account of their respective languages, concepts, practices and political histories; and studying these situations in depth in relation to the system of internationally recognised rights and the commitments made by European nations and member countries of the United Nations with regard to education about rights, their application, and evaluation of their implementation in current and future policy developments. The internationally recognised rights constitute a body of reference in addressing ethical issues.

This awareness of the need to study different countries' situations implies that individuals will learn more about their own countries of residence, something that is never an easy process. One of the great strengths of the Pompidou Group is the ability of its members from different countries to engage in exploration and debate on European issues – as proven by the valuable exchanges between participants in this seminar. To be better informed about the problems that need to be addressed is to understand them better.

As the EU stands on the brink of unprecedented enlargement, with the European Convention working to give it a constitution based on the new European Union Charter of Fundamental Rights,⁽¹⁾ the Council of Europe remains the institution of reference that will help us rise to this political challenge in a democratic manner by continuing to build on the commitments made by the United Nations and reaffirmed in the European Convention on Human Rights. These commitments are based on the principles of courage, sharing and a common will to build a peaceful world in which war is a crime, a world where war criminals will be prosecuted in the new International Criminal Court.⁽²⁾

Policies for combating drug addiction already have their own history which is part of a broader and more complex picture that includes the fight against drug trafficking as well as policies for prevention and health care, ensuring that people have more rights to complex information – with appropriate school and college courses and relevant debate – in addition to a universal right to treatment. It is clear from evaluations of these policies that they are essential but also that they are inadequate in some respects, and present contradictions. Critical studies need to be carried out and space and time needs to be made available, with working structures and consultation processes that reflect people's needs, in order to address the ethical questions raised. Policy developments in the fight against drug addiction need to be seen in the context of Europe's political ambiguities and the fact that citizens still lack effective means of participating, as they must do, in such policies. Until people have the sort of civic education that reflects the ethical and political challenges of their own freedom, their own knowledge and thus their own existence – the sort of education that will help them

to cope in our crisis-ridden societies – they must continue fighting with courage and commitment against all the forces that threaten their potential of the vulnerable human condition.

⁽¹⁾ European Union Charter of Fundamental Rights. At the Cologne summit on 4 June 1999 it was decided that a Charter on Fundamental Rights of the European Union should be drawn up. The European Council stated: *"There appears to be a need, at the present stage of the Union's development, to establish a Charter of fundamental rights in order to make their overriding importance and relevance more visible to the Union's citizens."* In December 2000, the European Commission joined the Council and Parliament in solemnly proclaiming the Charter of Fundamental Rights. Since then it has taken a number of steps to give practical expression to this commitment. The Nice European Council adopted a Declaration on the Future of the Union (Declaration 23) calling for further consideration of the status of the Charter of Fundamental Rights. Article 52 (3), on the scope of guaranteed rights, links the Charter to the European Convention on Human Rights: *"Insofar as this Charter contains rights which correspond to rights guaranteed by the Convention for the Protection of Human Rights and Fundamental Freedoms, the meaning and scope of those rights shall be the same as those laid down by the said Convention. This provision shall not prevent Union law providing more extensive protection."* (European Commission "Justice and Home Affairs" website)

⁽²⁾ Cf. the various international texts referred to in the course of the seminar.

International texts referred to in the seminar⁽¹⁾

UNITED NATIONS (UN)

UN Charter (1945), Universal Declaration of Human Rights (1948), and International Covenants on Economic, Social and Cultural Rights, and on Civil and Political Rights (1966)
United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, UN, 1988

International Labour Organisation (ILO)

ILO Occupational Health Services Convention, 1985, No. 161

Guiding Principles on Drug and Alcohol Testing in the Workplace, 1993-1996

World Health Organisation (WHO)

Alma Ata Declaration on the protection and promotion of health, WHO, 1978

International Criminal Court, 1998

COUNCIL OF EUROPE

Convention for the Protection of Human Rights and Fundamental Freedoms, (European Convention on Human Rights), 1950

Convention n° 108 for the Protection of Individuals with regard to Automatic Processing of Personal Data, 1981

Convention n° 141 on Laundering, Search, Seizure and Confiscation of the Proceeds from Crime, 1990

Convention n° 164 for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine (Convention on Human Rights and Biomedicine, commonly known as the Oviedo Convention), 1997

Recommendations

1980, Recommendation n° R (80) 4 on active participation of the patient in his own treatment

1986, Recommendation n° R (86) 14 on the drawing up of strategies to combat smoking, alcohol and drug dependence in cooperation with opinion makers and the media

1987, Recommendation n° R(87)3 of the Committee of Ministers to the member states on the European Prison Rules

1992, Recommendation n° R(92)17 of the Committee of Ministers to the member states concerning consistency in sentencing

1997, Recommendation n° R(97)5 of the Committee of Ministers to the member states on the protection of medical data

1997, Recommendation n° R(97)4 on securing and promoting the health of single-parent families

1998, Recommendation n° R(98)7 concerning the ethical and organisational aspects of health care in prison

1998, Recommendation n° R(98)11 on the organisation of health care services for the chronically ill

2000, Recommendation n° Rec(2000)5 on the development of structures for citizen and patient participation in the decision-making process affecting health care

2000, Recommendation n° Rec(2000)18 on criteria for the development of health promotion policies

Conferences

European Conference of National Ethics Committees (COMETH), has met since 1992

Steering Committee on Bioethics (CDBI), 1993

7th Conference of European Health Ministers on "Health, Dignity and Human Rights - the role and responsibility of Health Ministers", scheduled to take place in Oslo on 12-13 June 2003

EUROPEAN UNION

Maastricht Treaty, 1992

Schengen Agreement, 1995

European Union Charter of Fundamental Rights, 2000

Directives

Council Directive 91/308/EEC of 10 June 1991 on prevention of the use of the financial system for the purpose of money laundering

Directive 95/46/EC of the European Parliament and of the Council of 24 October 1995 on the protection of individuals with regard to the processing of personal data and on the free movement of such data

Directive 97/66/EC of the European Parliament and of the Council of 15 December 1997 concerning the processing of personal data and the protection of privacy in the telecommunications sector

Directive 2001/97/EC of the European Parliament and of the Council of 4 December 2001 amending Council Directive 91/308/EEC on prevention of the use of the financial system for the purpose of money laundering

⁽¹⁾ This list of texts on international rights referred to in the course of the seminar could form the basis of an compendium of internationally recognised rights, to be examined in addressing the ethical questions raised with regard to rights education and to the application of these rights in combating drug addiction. The list should be extended with the addition of other international instruments identified by working groups set up under the aegis of the Pompidou Group, which could then publish a collection of relevant texts on internationally recognised rights produced by the Council of Europe and the UN and its various subsidiary bodies.

Sixty people from 24 European States and 4 International Organisations took part last week in Strasbourg in the European Seminar on "Ethics, professional standards and drug addiction", organised by the Pompidou Group of the Council of Europe. Participants came from different professional fields and backgrounds: experts in ethics and in professional standards; professionals working in the field of drug abuse; legal experts; prison officers; police officers; epidemiology researchers and journalists.

The main subjects discussed, both in plenary sessions and workshops, were the following:

- the right to objective information
- the right to care and access to social welfare services
- drug screening
- compulsory treatment and compulsory admission to care
- epidemiological and other research.

In accordance with the aim of the Seminar, several new activities were proposed for inclusion in the forthcoming Pompidou Group 3-year work programme. Amongst them, the problems of drug screening (in particular in workplaces and schools), data protection linked to epidemiological research, the accuracy and effectiveness of information related to illegal drugs, the availability of social and health care systems adapted to the needs of the patients and the diversity of regulations on compulsory treatment between different environments and countries.