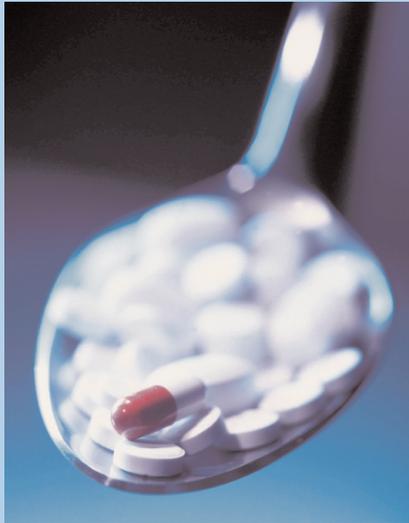


# Drug addiction



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# **Drug addiction**

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### **A. Lourenço Martins**

Public prosecutor and judge Lourenço Martins has been Director-General of the Criminal Investigation Department of Portugal (1977-1982). He was Deputy Principal State Prosecutor from 1983 to 1998 and Supreme Court judge from 1999 to 2003. Responsible for the drug law reforms of 1983, 1993 and 1995, he was a consultant to the United Nations on drug issues. He was elected member (1995-2000) and president of the International Narcotics Control Board. He also co-ordinated the computerisation of the judicial system, taught data processing law at university (from 1993) and has published books and various articles on drug laws, information processing and criminal law and procedure.



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Tom Mellish is the Trades Union Congress health and safety policy officer promoting the role of trade unions in workplace health and safety issues in the UK. He is also spokesperson for the Workers' Group on the European Commission's Advisory Committee on Safety, Hygiene and Health. His remit includes psychosocial issues such as alcohol and drugs in the workplace,



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## Introduction – Ethics and drug addiction

by Patrick Sansoy

“Drug addiction” tends to be an umbrella term which lumps together disparate consumption practices, embracing the nature of the substances, the patterns of consumption, the consumers themselves and the disorders brought about by the habit of consumption. Properly speaking, the term should only designate the factors which go together to characterise a subject’s dependence on the consumption of a drug:

- compulsion to engage in this behaviour with a loss of pleasure potential;
- persistence in this behaviour despite its adverse effects;
- obsession with procurement of the substance;
- presence of symptoms when administration stops abruptly.

Substances regarded as drugs are those classified as such by the three UN international conventions dating from the twentieth century. The classifications stem from the recommendations made by WHO; one cannot help thinking that had tobacco appeared in recent years, it would certainly have been classified.

The Pompidou Group, backed by the Council of Europe, is the first international forum to have addressed drug-related issues from a multidisciplinary angle.

By casting a unique light on a highly complex question, it has contributed to more satisfactory adaptation of official responses from the preventive, health and penal standpoints. Through its trans-sectoral handling of issues like drug addicts in prison, women and drug addiction, drugs and driving, etc., the Pompidou Group has succeeded in promoting unconventional thinking in other international arenas.

Achieving convergence of views among the countries participating in the Pompidou Group is a protracted undertaking which has been marked by many milestones such as extending the range of its analysis to all psychoactive substances;<sup>1</sup> also,

1. Pan-European ministerial meeting at Sintra in 2000.

evidence-based action increasingly features in the stance of the Group.

### The Pompidou Group

The Council of Europe's involvement in the fight against drug misuse and drug trafficking is carried out through the work of a multidisciplinary co-operation group known as the Pompidou Group. The Group was set up in 1971 at the suggestion of the late French President Georges Pompidou and was incorporated into the Council of Europe in 1980. It provides a forum for European ministers, officials, specialists and other professionals to co-operate and exchange information.

The Group currently has 34 member states. The European Commission is also a member. Technical co-operation or activities on an ad hoc basis also involve other countries which are not members of the group.

The clearly apparent diversity of the respective national responses has been a source of enrichment for the participating countries. Little by little, they have made the effort to build themselves a common foundation, especially by producing their epidemiological data on the same methodological patterns. Today, although differences remain, the trend is towards a more uniform approach to the responses delivered, one that respects the diversity of cultures but we trust also abides by an ethical outlook on the phenomenon of addiction.

The ever-delicate linkage between punishment and therapy has benefited from conclusive evaluations particularly in the field of damage containment, so that it has been possible to make viewpoints evolve. Recognition of drug addiction for what it really is, a state of dependence, means that the availability of care must be such as to give the drug-using population back its freedom to accept or refuse treatment.

Viewing the drug-addicted population "more medically", so to speak, still does not exempt us from wider reflection about the place held in our societies by habits of psychoactive drug consumption and the kind of responses we try to bring to it.

Accordingly, an attempt at a perception of drugs and addiction which is informed by ethics and standards of professional conduct will enable us to found our appraisals and positions more firmly.

One of the chief difficulties of harmonising viewpoints is that users of psychoactive substances have to be distinguished from drug addicts, but if there are no solutions based on continuity the options as to the norm, social acceptability and dangerousness are inconstant. Assurance in the actions to be undertaken can only come from common reflection on the basic ethical and professional standards inspiring our countries.

The recent rapid growth of consumption, reaching younger and younger sectors of the public, is now focusing the priorities of official action on concerns that for a long time only mattered to a handful of political and professional players.

The altered paradigm resulting from a therapeutic rather than punitive outlook does not excuse us – quite the contrary – from being very careful with the type of preventive, therapeutic and research schemes we introduce. Freedom to have treatment, access to the facilities, preservation of anonymity, choice of treatment, continuity of care in prison, treatment of female addicts during pregnancy and availability of the latest research findings are our main subjects of enquiry. The knowledge-based information to be passed to citizens must continually absorb a rapid turnover of research findings. Any collective expertise and consensus conferences which may have developed must be regularly reassessed in the light of scientific advances.

Confidentiality of the data collected in epidemiological survey work from addicted or non-addicted subjects must be preserved. This quite obviously complicates the organisation of research, especially in cohort<sup>2</sup> tracking.

The new prominence of the concept of vulnerability makes the target group concept, perhaps also the differentiation of the messages to convey and the care to administer, a perennial question which, while a current issue in the preventive and

2. Group of individuals part of the same epidemiological study.

medical field, retains a special connotation in the drugs field as these continue to be prohibited substances.

The difficulty of experimentation (with therapeutic modes or actions for limiting damage consequential to the effects of the substances) places us in awkward positions vis-à-vis the ethics bodies whose approval is indispensable for any study.

Prevention is not the straightforward outcome of better information and an effort to educate; it is also subtended by a change of attitude to the drug-dependent population and its dependence. Drug addicts are very sensitive to the attitude of public agencies; authorisation of free access to syringes has radically changed the behaviour of intravenous drug users, altering their habits in a more preventive direction as soon as this measure was taken.

The strong increase in the number of persons using psychoactive substances over the last twenty years, and the diversity of the possible health-oriented responses to it, inevitably prompt us to think about the right financial investments. Policy directions cannot be taken in this area unless we can demonstrate the correctness of our choices at all times. Where public authorities want to make costly approaches with uncertain results generally applicable, at the expense of other more effective approaches, their choices also have to be thought out along ethical lines.

Steering the drug-addicted population towards a care facility as early as possible is plain common sense, but creating constraints in order to achieve it is debatable. In the specific field of psychiatry these arguments about referral under constraint are constants for the drug-addicted population (possibly having psychiatric disorders as well) whose dependence is at the core of clinical theory and practice, while elsewhere coercive referral still prompts debate.

But the question of casual drug consumers and their guidance remains unresolved (dependence not proven by tests). For them, assessments of this type of coercive approach are divided.

The dangerousness of drug-taking “for others” is a question thoroughly understood in all societies, as is the need to place effective limits on it (testing drivers for blood alcohol and drugs, for instance), but “preventive” screening of other groups (schoolchildren) is a vexing question.

Many situations need to be analysed and scrutinised with an ethical mind-set; this obviously applies to imprisoned drug addicts and their treatment (continuity of care), provision for drug-addicted pregnant women, mother and child welfare, systematic screening at the workplace and the concept of a risk-prone job, type of support to dependants, and so on. But apart from these avenues already taken by some thinkers, the posture of states involved in production of illicit substances and the resultant traffic requires more general approaches that cannot elude the ethical eye cast on international relations between essentially producing and essentially consuming countries.

The fundamental rights of drug-addicted persons must be preserved, as stigmatisation and criminalisation of drug addicts are still current in many countries. The participation of drug-using or drug-addicted subjects in our discussions must be sought.

The texts collected in this work will, I hope, assist in sketching out answers to the various questions raised.



## Questions raised by drug use: responses of our society

by Claire Ambroselli

“The fundamental deprivation of human rights is manifested first and above all in the deprivation of a place in the world which makes opinions significant and actions effective.”  
(Arendt, 1951)

Efforts to combat drug abuse and illicit drug trafficking have become a prominent feature of everyday life in recent decades, particularly in Europe; however, the results achieved sometimes fall short of expectations, if the progress of policies in the regional, national and international agencies<sup>1</sup> is any indication. These bodies are at times overwhelmed by the sheer complexity of the task, and cannot always tailor their policies to the individuals and social groups affected.

### An ethic of universal rights

The struggle to prevent drug abuse and drug-related crime raises ethical questions which affect everyone and need to be generally discussed. At some time or other, we all use one of these “drugs” – for medical purposes, to help us relax or for other reasons. What factors make them a source of abuse and of crime? What are the limits of their use? Often, these questions seem to be obscured by over-specialised policies which bear little relation to people’s lives.

Experts and lay people must therefore join forces in an attempt to understand why drug abuse and drug trafficking are so prevalent in our supposedly democratic societies, which base their laws and institutions on universal rights. Why is it that the impressive political resources deployed to combat drug-related crime, drug trafficking and drug misuse in the last few decades have not done more to help those who are affected?

The likelihood is that our supposedly advanced, civilised and developed societies fail to provide proper civic education on the universal rights which underlie human ethics, or have not

1. See references on p. 27 for a list of the main European organisations engaged in combating drug misuse.

fully learnt how to share these ultimately harmful “assets” – these drugs which are generally available, and can treat, cure or kill.

People patently know too little about medicine and the law, both of which are vital, but are not dealt with in schools. How can children or adolescents grasp the significance of the human body, of nourishing it, of eating and drinking in order to grow up and live alongside others, if they never have reason to consider the scientific and political changes and upheavals rooted in the development of medical knowledge and practices? This specialised knowledge has a direct bearing on our lives, but rarely penetrates beyond the universities; professional practices are prescribed by powerful corporations, and the public at large is involved only in contributing blindly to the increased production, not to say overproduction, of new “biomedical” products.

How can children or young adolescents acquire a feeling for the licit and illicit, and grasp the meaning of offences and crimes, and of action to prevent violations of communal rules and laws, unless they are shown the meaning of their relationships with themselves, their friends and their families, and of the universal rights rooted in that “irreducible human element”<sup>2</sup> for which they – we – are responsible? Again, these rights are taught only in universities, and with such a strong national bias that the work of international organisations is scarcely touched upon.

These were the questions which prompted the Pompidou Group to organise the first seminar on ethics, professional standards and drug addiction:<sup>3</sup> the limits, difficulties and even failures of efforts to tackle drug misuse in a situation where a glaring lack of education encourages criminals – most of whom escape punishment – to engage in international trafficking based on powerful networks. How can these crimes be prevented, and potential victims protected? How can we relate to others in a way which makes sense of our humanity, options, limitations and errors, if our personal and social ties, and the environments in which we are born, live and die, do not equip us for the task?

2.

See the statement by the UN Secretary-General to the World Conference on Human Rights, Vienna, 1993; also Delmas-Marty, 1994; Gravier and Elchardus, 1996; Braibant, 2001; Ambroselli, 1998 and Ambroselli, 1990.

3.

Seminar organised at the Council of Europe, Strasbourg, 6-7 February 2003.

The fight against drug-related crime and drug abuse has now entered the classroom. Drug use among young children is surely an abuse in itself, reflecting a crisis of parental and teachers' authority, just as drug trafficking reflects a crisis of political and judicial authority. Here too, we need to dispel the political ambivalence which surrounds laissez-faire attitudes to the use of legal drugs (tobacco, alcohol) which – apart from the deaths they cause – are habit-forming and so lead on to unlawful drugs which are even harder to tackle.

This is why efforts to combat drug abuse and trafficking must be related to universal rights. This is what the Council of Europe is trying to do.<sup>4</sup>

### **Anti-drug measures in Europe – a geopolitical perspective**

The first step towards acknowledging universal rights is to review national anti-drug addiction policies and assess their effectiveness by collecting information and organising meetings. The recent enlargement of the Council of Europe and the European Union makes this particularly difficult. Anti-drug policies vary widely, reflecting the legal and institutional history of the countries concerned, and their positive, negative, ambiguous and sometimes harmful effects must be determined. Moreover, these policies do not all date from the same time: some countries have had them for over thirty years, others for less than ten. A geopolitical picture of anti-drug action in Europe will accordingly help us to pinpoint political priorities and, in particular, tackle the most glaring injustices and inequalities. European anti-drug policies are also a part of policies for social and cultural cohesion.

This geopolitical approach also makes it necessary to look at differences in the language used in individual countries and international institutions, so that we can understand what people are saying, and allow for cultural differences and the many different registers of personal, professional, administrative and legislative language. Studying conceptual and cultural differences will help us to take account of the various political systems which have weighed (or still weigh) on certain European peoples, and assess them critically. Drug misuse can be prop-

4. See the speech given by Maud de Boer-Buquicchio, Deputy Secretary General of the Council of Europe, to the 7th Conference of European Health Ministers entitled "Health, dignity and human rights", Oslo, 12-13 June 2003 ([www.coe.int/T/E/Com/Files/Ministerial-Conferences/2003-Health/](http://www.coe.int/T/E/Com/Files/Ministerial-Conferences/2003-Health/)).

erly addressed only by remaining receptive to people's concerns.

Finally, questions of ethics must be distinguished from questions of professional conduct, but must not be divorced from questions of fundamental rights. Rules of professional conduct evolved during the twentieth century and are now based on universal human rights, not vice versa. But Europeans, like people in other parts of the world, need to understand what these new fundamental rights are about. The Pompidou Group's work on the ethical problems of fighting drug addiction – which range from the deeply personal to the difficult problems created in international criminal law by efforts to dismantle networks – is vital in tackling the educational and political problems involved in teaching international rights.

### **Drug use and the human condition**

International efforts to combat drug abuse and trafficking must not deflect attention from the individual and collective efforts needed to put an end to this scourge. We may have no contact with the decision makers – the people who implement and evaluate anti-drug policies – let alone the criminals who operate worldwide, but we all have some contact with drug users.

Who are these people? They are still sometimes referred to as “drug addicts”, a term all too often associated with violence, terror, rejection or exclusion. The ones who talk to, and work with, these people, have a different vocabulary: they speak of patients, seriously ill people, clients, workers, employees, children, immigrants, outsiders, drop-outs or people with problems. How can we understand them unless we give them a say, particularly on policies which affect them? How can we assess those policies' effectiveness unless we work together in the right way?

This is why the professionals involved in anti-drug action must reach out to people affected by drugs, both physically and personally.

Three contributions at the seminar (see footnote 3, p.18) showed how difficult this is. One speaker told us that people could turn anything which gave pleasure or relieved tension into a drug. This came as a clear reminder that we need to think about ourselves as human beings even before we think about drugs, in order to understand where the dangers lie. It is not drugs that are dangerous, but the use we make of them. The negative effects of some drugs on patients may outweigh their medical usefulness: how can we prevent this?

The risk of dying from drug use masks another, perhaps greater, danger – loss of humanity. In fact, we seem to lack forms of treatment which address the human issues raised by those who abuse and misuse drugs in a – largely unsuccessful – bid to solve their problems, at a time when certain drugs are hugely important to international criminals, while others (e.g. tobacco and alcohol) are ambivalently viewed by the authorities, who speak of legal drugs that kill.

Another speaker usefully defined drug misuse as a common space shared by citizens with rights, and a potential basis for a new ethic. Drug addicts – male or female, young or old, born or unborn – are all citizens.

There are two main dangers in addressing the ethical aspects of anti-drug measures: the danger inherent in our basic human vulnerability, which drug abuse masks, and the danger inherent in professional anti-drug practices which obscure people's real problems. In fact, public health policies are more concerned with drug use than with the situation and real needs of drug abusers.

A third contribution, by a Council of Europe representative, showed that the problems of addiction have become problems of public health and medical research. Current policies highlight the importance of treatment, but they also provide useful pointers to the cultural and political significance of mass medicine in industrialised societies, which are not always able to devise policies to meet people's needs.

Focusing on the ethical implications of anti-drug action helps us to see why we need to shift our attention from health and medical aspects to human needs. Drugs threaten to create

between us that “sense of desolation” which isolates and dis-orients us when human beings become (or are already) “superfluous” – a condition analysed by Hannah Arendt in *The origins of totalitarianism*, when she says that solitude means being with oneself, being two-in-one, whereas desolation means being truly alone and abandoned by everyone else (Arendt, 1951).

### The ethical implications of medical thinking

The fight against addiction has marshalled a whole health army, which tries to recover lost ground by combating the wrong fears and clinging desperately, but firmly, to human misery – that “mute residue of politics”, which compels us, once we hear it, to stand up and make others hear it too, stand up and fight it, as Michel Foucault already did in Geneva, in 1981:

“Because they claim to serve the happiness of societies, governments arrogate to themselves the right to write off the human misery which their decisions cause, or their negligence permits, as just another item on the profit/loss account. But this international citizenship carries with it a duty to remind governments unceasingly of the human misery which it simply is not true that they do not cause. Human misery must never be a mute residue of politics. It gives us an absolute right to stand up in open protest against those who wield power.

Experience shows that we must reject the role of simply being angry which is assigned to us. Amnesty International, Terre des Hommes, Médecins du Monde are among the initiatives which have created this new right: the right of private individuals to play an effective part in shaping international policies and strategies. Individuals must impose their wishes on a reality which governments have sought to monopolise – and must wrest that monopoly from them, piece by piece and day by day.” [editorial translation]<sup>5</sup>

These words can guide us in framing ethical questions and deciding how best to answer them. To conclude these few remarks, and in anticipation of the difficulties we shall find ourselves facing, I should like to mention some earlier studies which may illuminate and support our own efforts. For exam-

5. Text read at the press conference for the launching of the international committee against piracy, set up to defend “boat people”; published in Spanish by *Liberación*.

ple, Hannah Arendt's work on the origins of totalitarianism, already referred to, should open our eyes – ten years after the collapse of the last of the twentieth century's totalitarian regimes – to the new forms of totalitarianism which threaten us politically today, precisely when we fail to play a part in framing policies which affect us. We should also bear in mind Georges Canguilhem's fundamental work on "the normal and the pathological" (1990). This was a recurrent theme at the Pompidou Group's seminar, and he throws light on the questions we should be asking: how can we deal with the medicinal and health issues which arise in our own daily lives? How has medicine developed in the West? How has medical thought affected western thought? What are our real capacities as mortal human beings? In a lecture given at the University of Strasbourg in 1988, Canguilhem reminded us what "being in good health" or "being well" mean: "I am well", he said, "when I feel able to accept responsibility for my actions, bring things into being, and create between things relationships which would not come about without me, but would not exist without them. And so, to change them, I must be able to find out what they are". How can we inculcate this knowledge and communicate this responsibility in European schooling and training?

But we also need to think about the meaning of death and human finitude in relation to our life-choices – a meaning we cannot dissociate from the history of medicine and law. Birth, life and health, sickness and death have today become the focus of new human relationships, and of new ethical and political problems, for which we still lack the forum and time we need to teach people about them. Our reference books, of course, are all recent. Why does Georges Canguilhem's work on the history of science centre on questions raised by medicine and biology, life and error? Why did Michel Foucault's philosophical and historical work start with the *History of insanity* and *The birth of the clinic*, and end with *Discipline and punish* and the *History of sexuality*? These works help us to understand that standardisation of medicine and health which we are now witnessing, so that we can resist the various types of personal and political enslavement it can engender. They help us to build on the benefits we can derive from an

approach to medicine which anchors medical procedures in human relations.

With a view to focusing, in this critique of standardised medicine in the West, on the ethical issues raised by the fight against drug addiction – and to initiating the critical work we need to do on this standardisation – I shall quote briefly from the conclusion of *The birth of the clinic*. In that book, Michel Foucault gives us an “archaeology of medical perception” and warns us of the dangers of ignoring, in the history of western thought and human relations, the fundamental changes which medicine underwent when a new type of clinical medicine developed in the late eighteenth century. Relying on the work of Bichat, but also Freud and Jackson, he studies the method used in clinical anatomy:

“that structure where space, language and death connect, and which has yet to be unravelled: we are barely starting to tease out one or two threads, which are still so unfamiliar that we blithely accept them as wonderfully new or utterly archaic, whereas they have actually been, for the last two centuries, the sombre yet sturdy web of our experience”. [editorial translation]

By locating that defining point in western thought where death was epistemologically incorporated into the medical experience, and by detaching death from metaphysics and making it comprehensible, Michel Foucault helps us to adopt a position in keeping with our status as living, mortal human beings, without being afraid of that condition, but tackling the historical and critical work needed to grasp its real implications. In this way, he also gives us pointers on the type of work we need to keep on doing:

“The decisive thing about our culture will certainly remain the fact that its first scientific discussion of the individual was obliged to accommodate this question of death. The fact is that western man could become, in his own eyes, an object of scientific enquiry, could apprehend himself within his language, and could assign himself a discursive existence in and through that language only with reference to his own destruction: from the experience of madness were born all the systems of psychology and the very possibility of psychology; from the incorporation of death into medical thought was born a form

of medicine which professes to be a science of the individual. And in a general sense, the experience of individuality in modern culture may possibly be linked with that of death: from Bichat's cadavers to Freudian man, a stubborn connection with death gives the universal an individual face, gives everyone's words an indefinite resonance; and this gives the individual a meaning which endures when he himself is no more". [editorial translation] (Foucault, 1993)

This critical and historical work, which we hope to see done in schools as well, will help us to make better sense of our own experience, personal and professional, civic and political. Positioning that experience correctly will help us to implement the right policies, whenever this is possible. The fragility of our efforts to combat drug addiction was frequently mentioned at the Pompidou Group's seminar – and seen as central to the ethical issues, since it is central to our human condition. Here again, we need the right guidance for our future action. I shall accordingly close with the following words from the end of Hannah Arendt's chapter on imperialism, which remind us how fragile our human condition becomes when we no longer know or recognise the world in which we live:

"The human being who has lost his place in a community, his political status in the struggle of his time, and the legal personality which makes his actions and part of his destiny a consistent whole, is left with those qualities which usually can become articulate only in the sphere of private life and must remain unqualified, mere existence in all matters of public concern. This mere existence, that is, all that which is mysteriously given us by birth and which includes the shape of our bodies and the talents of our minds, can be adequately dealt with only by the unpredictable hazards of friendship and sympathy, or by the great and incalculable grace of love, which says with Augustine *Volo ut sis*' (I want you to be) without being able to give any particular reason for such supreme and unsurpassable affirmation". (Arendt, 1951)

## Bibliography

Ambroselli, C., *L'éthique médicale*, Que sais-je?, No. 2422, PUF, Paris, 1988 (third edition 1998).

Ambroselli, C., *Le comité d'éthique*, Que sais-je?, No. 2544, PUF, Paris, 1990.

Arendt, H., "Totalitarianism", Part 3 of *The origins of totalitarianism*, Harcourt, New York, 1951.

Arendt, H., "The decline of the nation-state and the end of the rights of man", in "Imperialism", Part 2 of *The origins of totalitarianism*, Harcourt, New York, 1951.

Braibant, G., *La Charte des droits fondamentaux de l'Union européenne*, Points essais Inédit, No. 469, Seuil, Paris, 2001.

Canguilhem, G., "Essai sur quelques problèmes concernant le normal et le pathologique", doctoral thesis in medicine, published in 1943, re-published with other texts in *Le normal et le pathologique*, Quadrige, PUF, Paris, 1966, 1999.

Canguilhem, G., "La santé, concept vulgaire et question philosophique", paper delivered at the University of Strasbourg in 1988, Editions Sables, Toulouse, 1990, re-published in *Ecrits sur la médecine*, Seuil, Paris, 2002.

Delmas-Marty, M., *Pour un droit commun*, Seuil, Paris, 1994.

Foucault, M., *Naissance de la clinique, une archéologie du regard médical* ("The birth of the clinic: an archaeology of medical perception"), Quadrige, No. 100, PUF, Paris, 1963, 1993.

Colin, M. (ed.), *Le crime contre l'humanité*, papers compiled by Bruno Gravier and Jean-Marc Elchardus following the XXVith Congress of the French Criminology Association (*Association française de criminologie*) held in Lyon in 1990, Erès, Toulouse, 1996.

## References

Main European anti-drug bodies, with websites:

- Interdepartmental Mission for Drug Enforcement (Mission Interministérielle de lutte contre la drogue et la toxicomanie – MILDT) <http://www.drogues.gouv.fr/fr/index.html>
- Pompidou Group: Co-operation Group to Combat Drug Abuse and Illicit Trafficking in Drugs, Council of Europe [http://www.coe.int/T/E/Social\\_Cohesion/pompidou\\_group/](http://www.coe.int/T/E/Social_Cohesion/pompidou_group/)
- European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). The EMCDDA can be contacted via the web site <http://www.relis.lu>
- European Legal Database on Drugs (ELDD) <http://eldd.emcdda.eu.int/>

In addition to these bodies specialising in combating drug misuse, we should also mention the French National Consultative Committee of Ethics on Health and Life Sciences (CCNE), which published a report on drug misuse in 1994 (Opinion No. 43, 23 November 1994).



## Information processing and data confidentiality

by René Padieu

The “information society” is here to stay. The benefits to be gained from collecting and processing all sorts of data, and indeed the need for this – in public administration, private business or in the interests of scientific progress – are plain to see. To hold information, however, is to hold power, for better or for worse. To balance the benefits and the potential abuse of this power, moral and legal rules and practical instruments are needed.

Simple as this may sound, it is in fact an extremely complex matter, because of the number of people and institutions involved, the mass of information and the many uses to which it can be put. Authorising the use of specific information for a particular purpose may open the door to misuse of that information. Limits must therefore be placed on the authorisation. Similarly, however, placing restrictions on data communication in order to protect legitimate interests may have certain disadvantages. For example, maintaining law and order may involve collecting certain information about people, but the same information could then be used as a basis for discrimination, or for political ends. On the other hand, our efforts to avoid such discrimination, in the name of human rights and dignity, may hinder use of the data for legitimate purposes or in the public interest. Lawmakers and public and private decision makers who organise or prohibit the use of data for different purposes generally have excellent reasons for doing so, but they are not always aware that their decisions may also have adverse effects they neither mean nor have the authority to produce.

An ethical problem arises when different values clash: should one take precedence over the other? And if different people recommend different solutions, how do you reconcile them or decide who is right?

At the very foundation of our democratic society is the human being, whose life, safety, privacy, dignity and interests must be

protected. That is the purpose of the European Convention on Human Rights. Article 10 of the Convention establishes our freedom “to receive and impart information and ideas” (this freedom also includes the freedom not to receive or impart information). We shall see, however, that the enjoyment of other rights can lead in certain cases to an obligation to impart information, or to restrictions on the right to impart it.

Some information can violate people’s privacy or dignity, or make discrimination possible. To prevent such unauthorised use of information, one must often limit its communication. Members of some professions, however (doctors, for example, or holders of public office such as ministers, judges or inspectors), are obliged to collect information in order to do their jobs properly. This need to know entitles them to demand certain information, so the people who supply that information, the informers, must be under an obligation to inform.

Thus, in addition to the freedom to receive, or not to receive, information, there exists an obligation either to collect it or not to collect it. And in addition to the freedom to impart information or to refuse to do so, there exists an obligation to supply information or to refuse to supply it. There are thus two times four possibilities that can be paired off in various combinations, and although not all the possible combinations actually occur, some give rise to contradictions and require arbitration.

In view of the variety of possible information concerning people and the variety of information they, or institutions, may need, and in view of the professional or private relations between them, the resulting situations may be extremely complex. In the main, the course of action is determined by laws and customs, or by the ethics of certain professions. Numerous cases remain, however, where there are no rules or regulations. These cases are left to the individual conscience or resolved by discussion between the authorities or interest groups involved. Also, as society is constantly changing, even carefully drafted rules sometimes have to be reviewed and the various options considered.

I shall begin by clarifying various concepts, before going on to consider how certain obligations or restrictions come about, then examining how conflicting aims can be reconciled.

## The concepts of information and the right to information

Information can be broken down into several parts:

- *Content*: who or what is the subject of the information, and what does it say about this person or thing?
- *Holder*: who has the information and is able to impart it?
- *Addressee*: who is to be informed?
- *Purpose*: what may be done with the information received?

For example, the information may concern a child: which school he goes to and where his parents live. In principle this information is known to the child, his parents and the school. The Ministry of Education may wish to retrieve it in order to verify that the law on compulsory schooling is being respected, or to measure the activity of the school. Or a researcher may wish to conduct a survey of schooling.

Another example: the Ministry of Health has measured the spread of an epidemic: it is in possession of information about the state of health of the country's population. A journalist wants access to the information for a newspaper article.

Or a worker is an occasional heroin user. He knows it, of course, and so does his doctor. An employer wants access to the information, in order to decide whether to recruit the person, or whether he should assign him only to certain types of work.

These few examples show how varied the content, holder, addressee and purpose of information can be. They also give a glimpse of the relational problems that can arise.

Let us turn now to the right to information: which potential addressee(s) may receive the information, depending on its content and the purpose for which it is to be used? Here again, several factors must be taken into account when prescribing a right:

- The *object* or content of the right: what information does the right relate to, and when and how is it to be provided?
- The *subject* or holder of the right: who is to be informed?
- The *person liable to provide*: who is under an obligation to supply the information (as its holder, or after obtaining it from another holder)? Or is it a right with no particular person liable to provide, that is a *freedom*,<sup>1</sup> in which case nobody is obliged to supply the information, but the right holder may not be prevented from receiving it if someone is willing to give it to him?
- The basis of the right: what are the reasons for granting the subject this right, and why is it legitimate for him to receive the information: does this depend on who he is, the content of the information and what use is to be made of it?

Let us take the same examples as before. The Ministry of Education is officially required to ensure that children receive schooling and to supervise the work done by schools. It cannot be expected to do this if it does not have the right to obtain the necessary information. In this case the persons in possession of the information are required to disclose it. A researcher conducting a survey is carrying out recognised scientific research: he has the right to receive the information, but he does not necessarily have the right to demand it: he can do his work, but he must rely on the voluntary co-operation of his informers. If his research is acknowledged to be in the public interest, however, it is possible that the subjects thereof will be placed under an official obligation to provide the information he requests.

It is generally accepted in our societies that journalists, whose job it is to inform the public, should have access to the relevant information. Most of the time government departments and other bodies supply them with the information they hold. Article 10 of the European Convention on Human Rights entitles the journalist, but also the public, to receive and impart this information. In principle, however, nothing obliges a government department holding information about an epidemic to release it, or the journalist to report it. In this case, however, practice goes well beyond the requirements of the law. More

1.

When we refer to a right without a person liable to provide, we mean that nobody is under an obligation to fulfil it, that is to provide the information. In negative terms, however, everyone is under an obligation not to prevent it from being fulfilled. It is a right with *erga omnes* effect.

prescriptive laws may exist. In all countries, parliament or supervisory bodies may request most information in the possession of government departments, provided that the information is not classified as confidential, like certain information of a personal nature. A French law dating from 1978 grants all citizens the right to consult administrative information, with an exhaustive list of exceptions. In a different sphere, many countries' national statistical institutes are not only authorised to publish their findings, but obliged to do so. A relatively recent landmark Dutch law confirmed this trend by prohibiting the ministry concerned from opposing publication.

Nobody would deny an employer the right, or even the duty, to make sure that an employee's unsuitability for a job does not make him a danger to himself, his colleagues or the consumer. But it is not universally recognised that employers should be able to use this right to demand information about the employee's drug consumption habits: this is a moot point to which we shall return later. This example also illustrates a more general issue: in some cases the right to obtain information is granted for a well-defined purpose, in which case the information must not be used for any other purpose.

The above examples serve as an introduction to a number of problems which we shall now look at in a more systematic manner. The concepts introduced above (content, holder, addressee and purpose of information; object, subject, person liable to provide and basis of a right) will be helpful in the questions we need to ask and to consider solutions that best take into account the various interests present. While the same problems arise in virtually every field, they are particularly delicate where drugs are concerned, because of the combination of factors involved: law and order, economic interests, health and safety and fundamental values of human respect.

### **Information – freedom, obligation or prohibition?**

As we have seen, the right to information is sometimes more than just the power to receive or impart it; in some cases it may be an obligation, in others, prohibited. To begin with let us take

the relatively simple case where the use to be made of the information is well defined.

### ***What to do about the wish to know?***

Sometimes this wish is not considered legitimate and the authorities prohibit any communication of information. In order to curb drug use, for example, the law may ban information on where to find drugs and how to use them. Or to take another example, the fact that someone is a drug user, if publicised, may harm their reputation or lead to undue discrimination, so access to and communication of this information will be restricted to specific users and uses.

By contrast, that drug abusers or their families or friends should try to find out about the risks of drug use, the regulations, the availability of treatment centres or support and so on is considered not only acceptable but in the interest of public health. Rather than leaving the provision of information to chance, the authorities anticipate and organise information services.

The public authorities may even consider that prevention includes informing people who are not necessarily concerned. Article 10 of the Convention recognises this right of initiative. This nevertheless raises a technical and therefore an ethical question: there is no guarantee that information actually has a preventive effect. Some people take this for granted, without questioning whether the information provided really serves its intended purpose.

The difference between harmful and beneficial information has been well illustrated in recent years by the risk prevention policies developed in various countries. Prevention, repression and treatment have not eradicated drug abuse, while the Aids and hepatitis epidemics have brought a more pressing danger. A leaflet distributed by the French Government, under the title "Know more, risk less", is a good illustration: critics pointed out the contradiction between this sort of information and the legal ban on drug use: could this advice on how to avoid health risks not be construed as encouraging drug users to take precautions? This is not the place to settle that argument,

but it shows the crucial role information can play in the presence of conflicting aims and values.

### ***The duty to know and to make known?***

Public and private players provide various services (treatment, repression, etc.). They accordingly need to know about trafficking, addiction and so on. They also need to know what forces are at work. The very nature of their task makes it their duty, rather than an option, to keep informed. But if this is their duty, they must have the right to demand information. And once they have it, they are then duty-bound to disclose what they know, as opposed to merely authorised to do so if they so wish. Chains of rights and duties are forged in this way.

In these chains, obligations to release information, for certain specific purposes, sometimes clash with prohibitions designed for others. These contradictions are dealt with *infra*.

Now, do all those who are theoretically under an obligation to seek information actually do so? They may consider that they know enough already. They may seriously believe in the reality of a phenomenon, the efficacy of a method, the singleness of an aim, and not wish to question their own certainty. It makes life simpler. Not everybody is like the biologist Jean Rostand, who says: "I would rather contradict myself than others, it's more interesting!" This is a question of the ethics of action, which is not the subject here. But what should the potential supplier of information do? How does one communicate with someone who has decided not to listen? In the face of a player with political or professional legitimacy, is the expert sure of his knowledge and of his right to denounce the shortcomings of persons in authority?

In a truly democratic society, those invested with responsibilities are required to account for their actions. They often do so based on selected information that serves their purpose: less in a spirit of accountability than of self-justification. Anyone who is aware that these people are leaving out or concealing information therefore has a duty to inform the public, whatever the officials concerned might think, provided that he is sure of his facts and not just expressing personal convictions or an

institutional strategy. Which brings us back to the ethics of the expert and the journalist. Not forgetting the role played by organisations like the European Monitoring Centre for Drugs and Drug Addiction and its national counterparts, and the work of the Pompidou Group.

### ***The quality of information***

Whether information is provided to us on an optional or a compulsory basis, we are entitled to expect it to meet three standards:

- *It must be true:* does freedom to inform mean freedom to deceive? We believe, on the contrary, that the informer is under an obligation to pass on reliable information. And even that he has a duty to make sure it is accurate and not to rely solely on personal belief;
- *It must be to the point:* we have seen drug addicts ask for shelter, or schoolchildren ask to talk about drugs. Sometimes such requests conceal a different need altogether, cloaked in terms the petitioner believes will be perceived better. Is a direct answer what is really required? A teacher who invites an expert in to talk about drugs may be missing the point: an attempt by the pupils to establish dialogue with him, for example;
- *It must be intelligible:* information is not just a message that can be located in material terms. It is something that registers in the mind of the addressee, depending on what they already know or are capable of understanding. The vocabulary and wording used must, of course, be geared to the level of education of the addressee. It may also depend on his frame of mind at a given time, his emotional state, something he is subconsciously trying to hide, and so on. Somebody who calls a telephone information service does not necessarily want a technical explanation. A scientific report is no use to a politician. Or is scientific language being used merely to impress? The ethics of informing includes making oneself understood and getting the message across.

## Dealing with information according to its different purposes

The free circulation of information – or the freedom to refuse to pass it on – becomes an obligation or a prohibition depending on the information concerned and what uses can be made of it, and this in a network of people who – in a private or professional capacity – know, would like to know, should know, or should be prevented from knowing. The same information can be used by different addressees, each of whom may be able to use it in several ways. The information may be protected, that is inaccessible to certain people or for certain uses, while at the same time being accessible or even necessary for others. The solution – simple in theory but less so in practice – consists of separating the uses and therefore the transfers of information. Without attempting an exhaustive description, we shall look at three guiding principles and illustrate them with two examples.

What follows applies mainly to information concerning people, whereas the above applies also to information concerning products and their properties, therapies, the population in general and institutional activities.

### **Three guiding principles**

#### *The principle of purpose*

This principle was defined around 1980, when legislation governing the electronic processing of personal data was developed. Where Europe is concerned it is enshrined in a 1981 Council of Europe Convention,<sup>2</sup> and reaffirmed for EU member states in a directive dated 24 October 1995. Although drafted with automatic data processing in mind, its application seems to be much broader: while the power of modern-day computers means that violations of this principle have much greater effect and are therefore more dangerous, a similar risk exists when information is processed manually, or transmitted orally. On the other hand, the power of electronic data processing technology also provides us with means of protecting and restricting information that help to ensure that this principle is applied.

2. Convention for the Protection of Individuals with regard to Automatic Processing of Personal Data (ETS No. 108).

According to this principle, personal data may only be collected for a specified (and legitimate) purpose and may be used only for that purpose, which must not impair the rights or interests of the data subject, unless important public interests (security, public health, etc.) previously defined by law are at stake. It also prohibits the first addressee from passing on the information, except for reasons compatible with the initially stated purpose. Strictly speaking this principle also means that if the same information is to be used for different purposes, it should be collected as many times as there are purposes. In practice it is accepted that the data are only collected once, provided that the purposes for which it is to be used are well defined from the outset. The data may even be re-used for purposes not initially envisaged, provided that they are strictly compatible with the initial purpose(s) and known to the supervisory authority, or after renewed notification (and consent) of the data subjects.

A principle of fairness also applies here: people who are asked to supply information are informed of the identity of the requesting party, where the data will be stored and the purpose for which they are being collected and processed. The data subjects may agree or refuse to co-operate. If they are obliged to co-operate, they must be informed of the legal basis of the obligation. If the information is collected from a third party, the data subjects must be informed. They also have the right to know what information about them is being held and, where applicable, to have it rectified or even deleted if it was collected wrongfully. Finally, the national data protection authorities must have the requisite powers to be informed of processing operations and carry out inspections, in order to issue any authorisations that may be necessary or to impose penalties in the event of any infringement.

#### *Authorisation and functional separation*

When there is a possibility that information can be used for both authorised and unauthorised purposes, a formal authorisation procedure makes it possible to restrict access to authorised users only. Some data may be communicated only to doctors, for example, other data only to a judge, and so on. The

addressee undertakes, of course, not to pass on the information to any unauthorised third parties.

Sometimes, however, a single user may be in a position to use data for both an authorised and an unauthorised purpose, so would have to be very honest indeed not to take advantage of this situation, which is rather like that of a card player who has inadvertently seen his opponent's cards and, wanting to be fair, tries not to be influenced by what he has seen. The solution is then to organise into separate entities the persons or departments allowed or not allowed access to the information concerned.

### *Data protection tools*

Even when there are legal guarantees such as those offered by the above principle of "purpose", and a clear distinction is made between lawful and unlawful uses, information which is not supposed to be communicated may get through, as a result of negligence, the loss of documents, unintentional indiscretion or even manoeuvring by an unauthorised user. Practical safety devices exist to prevent this from happening: controlled access to premises and files, encryption or data storage in anonymous form, etc. Recently algorithms have been developed to encrypt identifiers and make it possible to transfer or cross-match data from different sources without the result of the operation being accessible to any of the sources.

These different tools make it possible to avoid unauthorised uses while making data available for authorised uses. They are a technical and ethical means of reconciling the various lawful uses of information with due respect for the data subjects.

### **Two examples of such reconciliation**

#### *Screening*

It is a legitimate concern of employers, as well as people in charge of public safety, not to assign drug users to certain tasks where they may be a danger to themselves, their colleagues or the public. The same information, however, may be used to take other decisions (recruitment, remuneration, etc.). It may also stigmatise the persons concerned in the eyes of colleagues

or clients. These effects are obviously unacceptable. So should employers be allowed to screen for drug use in order to prevent the undesirable risks thereof, which means accepting the contingent discrimination? Or should all screening be prohibited, to protect the employee's privacy and dignity, even if it means accepting an accident risk? The idea here is not to choose between these contradictory solutions, or even to propose a solution that reconciles them satisfactorily, but rather to point out that functional separation combined with data confidentiality may solve the problem. For example, a specially appointed person or body (occupational physician, approved laboratory) could be authorised to do the screening but to keep the results confidential and simply issue a positive or negative opinion on the subject's aptitude for a particular type of work, without having to give reasons.

However, in order to preserve this confidentiality of the test results, a broader category of employees should be subject to screening than simply those the employer suspects of being potential drug users, and the decision concerning aptitude should be based on other criteria too (physical or psychological), so that a negative decision cannot automatically be associated with drug use.

### *Research*

The Council of Europe's 1981 Convention and the European Union's 1995 Directive and the corresponding domestic legislation afford added protection to "sensitive" personal data (beliefs, ethnic group, health and criminal record). Except in a very small number of well-defined cases in the public interest, such data may be collected only with the express consent of the data subject.

As well as being used directly to treat or punish drug users, information on drug consumption can be useful in research on addiction and the spread of drug use. In addition to their personal rights, citizens have the right to be properly governed, based on sound appreciation of the various parameters, and therefore on reliable research. This scientific use of data has no direct effect on the data subject, as the aim is merely to produce general, anonymous results. There is evident public interest in

this type of work in the fight against drug abuse, as it provides professionals and politicians with a means of monitoring trends and taking the appropriate action. However, this public interest does not always override the need for the data subject's express consent. There is a contradiction, therefore, between the public interest and the need to protect the individual. Functional separation, between the police and therapists on the one hand and researchers on the other, is not enough: the law, or at least the way the authorities interpret it, forbids the processing of this information.<sup>3</sup> In practice the express consent condition does not really work here, for a combination of two reasons. First of all, the illegal nature of drug use makes users, and often those around them, wary: even if they are assured that the information will be communicated only to a researcher or statistician, they will not give their consent. And drug use can lead to personality disorders, making it difficult sometimes to obtain officially recorded consent: either it is withheld, and the research cannot go ahead, or it is obtained, but possibly without the person fully realising what he or she is consenting to, which could be considered unethical.

Now, this extra protection of sensitive data is fully justified when it helps individuals to protect themselves, but it becomes unnecessary when the data are to be used solely for scientific statistics. The statutory requirement for consent was meant to avoid the misuse of information, but did not allow for the recent development of new protection techniques, or for the illusory nature of a requirement for consent from drug abusers. The problem could be avoided, without causing any damage to anyone – and the rights and interests of this particular group possibly need special protection – if the statistician or researcher were specially accredited, in the framework of a clearly defined study, to collect the information without formal consent, subject to every guarantee of fairness, harmlessness and confidentiality, and to use of the practical and software tools mentioned earlier.

The question of the right to information is not as simple as it might seem from the European Convention on Human Rights,

3. The author is, of course, thinking primarily about the situation in France, where the law on "data processing and freedoms" has just been amended to transpose the 1995 EC Directive into domestic law. This particular problem may be less apparent in other countries, but the author nevertheless points to the type of problem that can arise and possible solutions.

for it involves complex interaction between people with different outlooks and agendas, and other rights and prerogatives are in play. The ability to receive or impart information sometimes turns into an obligation either to impart it or not to do so. But the multitude of uses to which the same information can often be put can give rise to clashes between forbidden disclosure and disclosure in a good cause. These conflicting values and aims call for thought and solutions which the law does not fully cover.

While this is by no means an exhaustive overview of the problems that can arise, what we have considered shows how values can clash and the need for solutions where powers come into conflict. These problems and their solutions have been clarified by covering some conceptual ground, but it is no use looking for a single, universally and fully satisfactory solution. It is more important to provide means of dealing with these ever-recurring problems. This more or less applies to all ethical issues, particularly those relating to information. Drug abuse is doubtless one of the fields where the choices to be made are most difficult.

# Drug prevention and education

by Richard Ives

In this chapter, the ethical issues in relation to drug prevention and education are briefly considered. The focus of this chapter is on “primary prevention” – that is, prevention aimed at stopping people from starting using drugs (or to delay onset of use), rather than on “secondary prevention” (helping people to stop using or use drugs less dangerously), or “tertiary prevention” (aiming to stop, or to reduce the consequences of, drug misuse). Therefore, prevention aimed at younger people is mainly considered here, since the young are the main targets for primary prevention.

## “Protection” and “rights”

There are two broad approaches to tackling the issue of reducing danger, and in particular in reducing danger to young people. One is the protection approach, the other the rights approach. Both have a sound ethical basis, but in recent years there has been a strong current of change away from a protection approach towards a rights-based approach. A significant milestone was the UN Convention on the Rights of the Child, adopted unanimously by the UN General Assembly in 1989.

Nevertheless, in the convention there remains the notion of “protection”. For example, Article 33 of the convention covers drugs issues:

“States Parties shall take all appropriate measures, including legislative, administrative, social and educational measures, to *protect* children from the illicit use of narcotic drugs and psychotropic substances as defined in the relevant international treaties, and to prevent the use of children in the illicit production and trafficking of such substances.”<sup>1</sup> [emphasis added]

From a “protection” perspective, it can be argued that it is ethical for society to attempt to protect children from the effects of drug misuse. Drugs are so widespread and readily available, and can have such harmful effects, that it is necessary for soci-

1. To view the text of the UN Convention on the Rights of the Child, and for more information about it, see [www.unicef.org/crc/crc.htm](http://www.unicef.org/crc/crc.htm)

ety to take special measures to protect citizens – and especially young people – against their dangers.

One justification for this argument is based on the particular and severe dangers of drugs. However, some people argue that the dangers of illegal and illicit drug use, in comparison with other dangerous activities that society tolerates, are not so extreme and that the proponents of “protection” are overstating their case. For example, alcohol consumption, and the use or misuse of prescription drugs, are connected with more deaths than illegal drugs are.

Nevertheless, there is a need for society to protect its citizens against the actions of others. If drug misuse leads to people acting in ways that could potentially harm other people, then there is an ethical basis for action in protecting others. Thus, for example, drug-testing in the workplace to prevent employees using drugs that might put their colleagues or the public at risk might be justified as a preventive strategy. But what about situations where the use of drugs in the workplace does not impact on job performance or safety; or where drugs may be detectable by drug testing but, having been consumed outside the workplace, do not have any psychoactive effect during the working period? These points are considered in a later chapter, on drug-screening in the workplace, but it is important to note here that the idea of protecting some people might be in conflict with a drug user’s “right” to take drugs – even if in doing so they are breaking the law this is arguably not directly of concern to the employer.

A particular danger of drugs is that some of them lead to dependence or “addiction”. This might provide a strong ethical basis for tackling drug issues from a “protection” perspective. Certainly, once someone is drug dependent, many countries implement compulsory treatment, sometimes with the justification that the “addict” is no longer competent to make choices in his or her own best interests. Later chapters take up the theme of compulsory treatment.

But as the ethical basis for prevention, the notion of “addiction” is problematic. Some experts question the existence of the medicalised version of this concept, and there is evidence that

people of different genetic make-up (or who have, together with a particular set of genes, had particular early experiences) may have different predispositions towards drug dependence.

There are also other kinds of behaviours, such as compulsive gambling, that bear a close resemblance to the behaviour of drug dependent people. Their existence indicates that the problem of “addiction” is not one entirely inherent in the chemical substances, but is also connected with the lifestyle choices of dependent people. This would mean that the focus of prevention efforts might be better placed on helping people to avoid certain behaviours rather than on preventing substances being used by means of protecting people from them; this might involve empowerment rather than protection.

Some people have likened drug prevention to inoculation – and that we need to treat drug abuse as analogous to an infectious disease, providing universal childhood protection against it. But argument by analogy is often weak, and drug abuse is not a disease in any meaningful sense. Furthermore, we do not have a “vaccine”.

Even if one accepts these points, there may be a particular case for the protection of children and young people from drug misuse. The ethical case for this would be based on their immaturity (physical, intellectual, emotional) and their inexperience and therefore their greater potential vulnerability to drug-related problems.

### **The effectiveness of drug prevention activities**

Given that there is an ethical case for drug prevention, how might it best be implemented?

It should first be pointed out that the evidence for the effectiveness of drug prevention activities is limited. The research base – particularly in Europe compared with North America – is weak. The UK Health Development Agency reviewed the evidence in 2003 and concluded that: “The impact of drug prevention programmes [...] has not been adequately reviewed.” (Canning et al., 2003)

Where there is evidence, it is not strongly in favour of effectiveness. For example, White and Pitts' systematic review of the effectiveness of prevention interventions found that the impact of evaluated interventions was small, with dissipation of programme gains over time. They also reported that interventions targeting hard-to-reach groups had not been evaluated adequately (White and Pitts, 1998).

Some commentators have suggested that prevention programmes are not an effective use of resources. For example, the authors of an international review of alcohol policy state that: "the impact of education and persuasion programmes tends to be small, at best. When positive effects are found they do not persist", and preventive education does not feature in their "top ten" policy options suggested for tackling alcohol abuse (Alcohol and Public Policy Group, 2003). Given this, it might be considered unethical to divert resources from arguably more effective interventions in young people's lives towards less effective drug prevention activities.

### **Licit and illicit drugs**

The reference to alcohol is a reminder that, while this book focuses on illegal and illicit drugs, a key consideration in discussing these issues must be the different legal and social status given to different psychoactive substances, and therefore the different preventive approaches being implemented.

For example, while certain kinds of psychoactive substance use – caffeine, for example – are tolerated or even encouraged, other sorts of substances are banned and their use is punished. There may be good grounds for the distinctions between different substances – for example, from science and medicine (some substances being more harmful than others); from history (some drugs, such as tobacco, would probably be banned if introduced nowadays, but their dangerousness was not apparent when they first became available); or from international agreements (the UN treaties on drugs defined the range of drugs included in the agreements).

However, these distinctions are not always apparent to the targets of prevention activities – particularly young people, many of whom do not like adults telling them what they should do. Young people are particularly attuned to what they see as “adult hypocrisy”, and are therefore keen to point out the “injustice” of “their drugs” (cannabis, ecstasy, etc.) being illegal, while “adults’ drugs” (alcohol and tobacco) are legal.

A practical implication of this is that an adult’s ostensibly “ethical” proposition that “drug misuse is wrong” is not likely to dissuade young people from using illegal drugs. Users of illegal drugs will be aware that the moral and ethical basis of current drug classification – and therefore much drug prevention activity – is questionable. Thus, drug prevention efforts that rely on moral exhortation are unlikely to be successful.

### **“Just say no” and other negative approaches to prevention**

This was partly why prevention campaigns that called on young people to “just say no” to drugs were ineffective. While those young people who were anyway inclined to say “no” to drugs might have been marginally empowered by these campaigns, they did not influence those many young people who were considering drug use as an option.

Prevention campaigns with a simple underlying “moral” message – such as: “don’t use drugs because it is wrong to do so” are not only ineffective, they are unethical. Young people are being asked to do something that – for some – is very difficult and which requires skills to achieve, and yet simple morally-based campaigns do not offer effective strategies. Such approaches ensure that some young people will fail to do what society is requiring of them.

Implicit in these approaches is the idea that what is “right” can be “handed down” from those in authority. But many young people are resistant to this idea – and perhaps those most likely to try drugs are some of the most resistant. As the 1995 UK central government advice to schools about drug prevention put it, young people should be: “encouraged to reject drugs because they believe that to be the right thing to do rather

than because they have been told to ‘say no’”. (Department for Education and Employment, 1995)

### **Informational and skills-based approaches to drug prevention**

More ethical – and possibly more effective – are skills-based approaches to drug prevention. These approaches attempt to provide young people with the skills necessary to avoid drug use. They arise from the idea that, while exhortation not to take drugs is ineffective, so, too, are purely informational approaches to drug prevention – approaches that rely on providing young people with knowledge about drugs and their effects and hoping that this knowledge, by itself, will be preventive.

Again, the evidence is that information alone is inadequate to change behaviour. That is not to say that information is not important, and indeed could be considered to be a right, in line with Article 17 of the UN Convention on the Rights of the Child, which includes the right of the child to have: “access to information and material from a diversity of national and international sources”.

But the development of skills such as how to say no to an offer of drugs, and skills that enable young people to live life more fully so that they no longer resort to drugs to achieve pleasure, may be more effective in reducing drug use.

### **The context of drug prevention**

But this raises the question of the purpose of primary drug prevention. It is generally seen as aiming to stop people from starting to use drugs, or at least to delay the onset of drug use until the young person is older and can make more considered choices. Much drug prevention takes place in schools within an educational context. But is it the job of education to prevent people from doing things?

A so-called “liberal education” is about introducing young people to human culture, and helping them to develop under-

standing and critical faculties; it is not about teaching them not to do certain things. Thus, some educators resist the role of drug prevention assigned to the education system, insisting that their job is to inform and assist their students to make a critical examination of the topic of drugs; and whether or not the students choose to try drugs is a matter for them, not a matter for the educational institution.

So for example, a UK government agency suggested the following aims for drug education for 14- to 16-year-olds:

- “explore the historical, cultural, political, social and economic factors relating to the production, distribution and use of drugs worldwide.
- understand that Britain is a drug-using society and recognise the different patterns of use and their effects, for example, transmission of HIV infection through shared needles and the detrimental effect on the foetus of all types of drug use.
- recognise that individuals are responsible for choices they make about drug use.
- be able to analyse safe levels of intake: for example, tobacco use is never safe, limited use of alcohol may be.
- discuss the role of the media in influencing attitudes towards drugs, particularly smoking and alcohol.
- be able to communicate effectively and confidently with those who administer medication.”

(National Curriculum Council, 1990)

These aims are clearly educational, rather than preventive, and therefore not open to the charge of being outside the scope of school-based education.

It is not just that the aims of drug prevention that have been attacked for being misguided and non-educational. The implementation of drug prevention has also been questioned. Some critics have described most drug prevention in schools as “propaganda, not education”. It has been argued that these approaches seek to:

“censor information, exaggerate dangers, limit discussion, perpetuate stereotypes and tell young people what to think. This

discourages the development of informed decision-making [and] increases the likelihood of young people feeling that drug education is irrelevant, that they are being patronised and that they are not being told the truth or given a balanced picture." (Cohen, 2002)

What these critics would like to see is drug education which develops, for example: "individuals' abilities to maintain their self-esteem when it's under threat [...] readiness to seek help [...] routine and skilled consideration of health issues whenever exciting but hazardous activities are being contemplated [...] communication skills leading to less conflict with parents." (King, 2002). Such approaches are more in line with the aims of a liberal education.

Drug education in schools as generally conceived is also vulnerable to the charge that it ignores young people's rights. As another critic puts it:

"the aim of drug education should not be to demand reduction at all – it should be part of a child's right to education, part of a comprehensive process of enabling them to learn about the world around them, and to analyse, understand and act within that world. Drug education, like all education, is a right, not an initiative." (Evans, 2002)

This, then, is the central disagreement – is it the role of professionals in education to deliver drug prevention, or to ensure, as they do with other subjects, that there is understanding of the topic? That is not to say that educators could abandon all responsibility for alerting young people to the dangers of drugs. After all, in other areas of the curriculum risks are addressed – it would be an irresponsible teacher of physical education who did not communicate to students the different risks associated with different sports.

What is suggested is that the results of drug education (not drug prevention) activities should be measured in the way that results for other school subjects are measured; the demand for schools to achieve reductions in drug use through drug education is as if: "we were to measure the success of teaching Shakespeare at school by a reduction in the sales of cheap love novels." (ibid.)

## The problem of targeting

While schools are still the primary location for drug prevention, there are other contexts where it is carried out.

There is much interest in targeting groups thought to be particularly vulnerable to drug misuse which may also be “hard to reach”. These include young people who miss a lot of schooling, young people involved in criminal activities, young people from disrupted families, or with parents who are themselves drug users, and so on.

These programmes have the potential for addressing problems early on and are potentially more efficient in directing resources to where they are most needed.

Their disadvantages include difficulties with screening and predicting which children will have future problems, as well as a danger in focusing on the individual and ignoring the social context in which their behaviour has been formed. It is also possible that the targeted young people will be labelled and stigmatised, raising empirical questions about “self-fulfilling prophecies” and ethical questions about, for example, the appropriateness of “treating” people who as yet show no signs of “disease”.

There is also the practical question of increasing resistance by young people to drug prevention messages. There is some evidence that among substantial proportions of young people, the use of illegal drugs has become “normalised”. This does not mean that “everyone takes drugs”, but it does imply that there is a considerable degree of tolerance by young people who don’t take drugs towards those who do. It also means that a large proportion of young people who have never taken drugs have nevertheless been exposed to drug use (in the sense of being with others who are taking them). Drugs are a familiar part of young people’s lives. As two researchers put it:

“drugs are part of young people’s lives regardless of whether or not they themselves are involved in drug use [...] drugs, whilst being an accepted part of life, are not an important central issue to the young people themselves. Drugs for the most part are either fairly insignificant or are treated as part of routine experience.” (Hirst and McCamley-Finney, 1994)

Targeting vulnerable young people means that they will be getting drug prevention messages from a range of professionals working with them, and there is some evidence that young people are becoming resistant to what they see as endlessly-repeated, irrelevant and inaccurate messages about drugs. From their point of view, the emphasis of drug prevention – in so far as it “crowds out” other interventions that they would be more likely to welcome is unhelpful. As many such young people experience multiple problems, it could be seen as unethical to concentrate on what they see as the least of their problems.

Furthermore, the theory underlying many such programmes, based on the notion of “inadequacy”, may be incorrect. As one research group put it:

“the underlying assumptions about how drug use happens are wrong. Most people who experiment with drugs do so for reasons that have nothing to do with psychological pathology or with an inability to resist peer pressure. [...] Drug education based on simplistic inadequacy theories is doomed to be ineffective.” (Coggans et al., 1994)

## **Drug prevention in the mass media**

If targeting has theoretical, practical and ethical problems, why not try to reach everyone? Governments have tried mass-media advertising, widely-available booklets, websites and other initiatives to try and spread the drug prevention message widely. Adults have been a key target. As the UK Government’s 1995 policy statement put it:

“schools alone cannot ‘solve’ the drugs problem. Young people are also influenced by their parents, carers, the media, other professionals and their peers. It is therefore important that all those involved with young people, both in formal and informal settings, should have accurate information about drugs and are helped to develop the confidence to deliver effective and consistent drug prevention messages.” (UK Government, 1995)

Many campaigns have targeted parents, because there is evidence that they can play a crucial role in drug prevention. But the mass media is most effective when delivering general

messages; not the nuanced and detailed information required to help parents address drug issues with their children.

Such campaigns can therefore have the unfortunate effect of increasing the anxiety of those parents who are worried about drugs while not providing them with adequate information or support to enable them to do anything useful about the problem.

It has also been argued that governments sometimes find it convenient to use the mass media to raise the public's anxiety about particular social problems, since this provides justification for anti-democratic measures – such as a crackdown on certain groups associated in some people's minds with drug problems, for example, some immigrant groups.

### **A wider perspective**

More radical social critics see drug misuse as a response to the problems of today's societies, be they the amount of stress that young people experience, or the lack of employment opportunities, or of fulfilling leisure activities. As Irvine Welsh puts it:

“The main issue for me is that so many people are using drugs negatively, to get as far away from the horror and dullness of straight, mainstream life as possible, rather than positively, as life enhancers. That's the real crime, the real issue: that so many people feel that straight life in this society has so little to offer them.”<sup>2</sup>

For such critics, the key ethical issue is to address the underlying causes of drug misuse, not to try to prevent it. If these were dealt with, it is argued, while experimental drug use would not decrease, problematic drug misuse would, since it is a response to difficult circumstances. Such an approach would protect the vulnerable minority while acknowledging the rights of the majority to try drugs.

To improve the situation of people who have terrible personal problems or who live in dreadful circumstances is an ethical imperative. However, there are various empirical reasons to suppose that such action would not necessarily be effective in reducing drug problems. Motivation to use drugs, and the

2.  
Scottish novelist Irvine Welsh, author of *Trainspotting*.

propensity to experience drug problems, are not simply related to social and personal circumstances. It is also known that there is a relationship between the size of the population experimenting with drugs and the numbers of those experiencing drug problems: the more experimenters, the more problematic users.

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It is clear that drug prevention is not a straightforward enterprise and that there are conflicting but genuinely-held views that lead to different approaches. While it is true that in all countries there is a broad consensus that the current approaches to drug prevention are appropriate, there is little empirical support for their effectiveness, and some opposition to the demands made by the “drugs agenda” on education and other young people’s provisions.

In the future, there will be new and complex ethical challenges. These include the possibility of actual, physical, inoculation against drugs – for example, by giving people a vaccine to make the body’s immune system recognise a cocaine molecule as “foreign”, covering it with antibodies and thereby making the drug too large to pass the blood-brain barrier – and thus preventing the cocaine “high”. Would it be ethical to give children this treatment – ensuring that they can never become cocaine dependent, but also that they can never experience a cocaine high? Another future possibility, if a genetic basis for drug dependence can be detailed, is gene therapy as prevention for drug dependence. Dealing with these future challenges will raise new and difficult ethical questions.

## Bibliography

Alcohol and Public Policy Group, "Alcohol: no ordinary commodity. A summary of the book", in *Addiction* 98, 2003, pp. 1343-1350.

Canning, U., Millward, L. and Raj, T., *Drug use prevention: a review of reviews* (evidence briefing summary), Health Development Agency, London, 2003.

Coggans, N. and McKellar, S., "Peer pressure: a convenient explanation", in *Druglink*, November/December 1994, pp. 16-18.

Cohen, J., "Just say – 'Oh no, not again'", in *Druglink* July/August 2002, pp. 13-14.

Department for Education and Employment, "Drug prevention and schools", in *Circular 5/95*, DfEE, London, 1995.

Evans, K., "Drug Education: teach or treat?", in *Druglink* July/August 2002, pp. 18-20.

Hirst, J. and McCamley-Finney, A., *The place and meaning of drugs in the lives of young people*, Health Institute Report No 7, Sheffield Hallam University, 1994.

King, A., "Measure for Measure", in *Druglink* July/August 2002, pp. 15-17.

National Curriculum Council, in *Curriculum guidance 5*, Health Education York, 1990.

UK Government, *Tackling drugs together* (White Paper), House of Commons, London, 1995.

White, D. and Pitts, M., "Educating young people about drugs: a systematic review", in *Addiction* 93, 10, 1998, pp. 1475-1487.



## Intensive care in countries with weak economies

by Oto Masar

According to the law, doctors must administer medical care commensurate with the most up-to-date advances in medicine. In other words, when diagnosing and treating complaints, they must use all the possibilities that medical progress makes available to them. However, application of this absolute rule of course depends on where the doctor practices, the equipment available, his or her own knowledge and experience, and any other particular circumstances of the situation in which the medical care is to be provided. Today, economic aspects also play a central role, but this does not exempt doctors from the obligation of providing the most appropriate treatment. This is not just an ethical consideration, it is also a legal one.

Doctors may therefore find themselves in a complex situation, having to address contradictory requirements:

- under the law, doctors are obliged to use all the possibilities available in the medical field to protect the patient's health; it allows for no exception to this obligation;
- their superiors may, by means of internal regulations, reduce this obligation, stipulating an alternative approach to the one the doctor might otherwise have wished to take. In countries where the pace of transformation is somewhat slow (it was not all that long ago that the Berlin Wall came down), where health system officials have all been trained under a totalitarian regime, there are also rules deriving from the concept of "chief specialist", which again may not tie in with the doctors' ideas, giving rise to a medical and ethical conflict. The "chief specialist" holds a "monopoly" on truth and alone decides whether or not to call in advisers. The role of the medical association in these countries is a problematic one as the totalitarian legacy ensures loyalty to the "team" in charge;
- a further factor influencing the care provided is the level of reimbursements to hospitals by insurance funds.

A situation such as this is far from satisfactory. Where a health system has been modified to the extent that decisions depend on the financial resources available, then it needs to be improved.

One of the legal/ethical solutions is to promote the idea among all medical staff that patients have a right to the treatment their state of health demands within the limits of the financial resources available at a given time. These limits in turn determine the other measures taken by the competent bodies. Paradoxically, these limits are neither ethical nor legislative. The economic point of view breaches the right of a patient to be treated in accordance with the latest medical knowledge and prevents doctors from practising their profession solely with the patient's interests in mind, in pursuance of the ethical obligation incumbent on all medical staff. One solution could be to adopt standards for medical care, striking a balance between the demands of insurance funds and those of medical representatives, and thus helping doctors decide on the care to be provided. From the legislative point of view, this would mean setting an absolute minimum level of care to be delivered to patients in concrete cases, but which should not be exceeded. However, no regulation could lay down an obligation to act in accordance with standard procedure and automatically consider any departure from such procedure as not being in the best interests of the patient. If this were so, even where in the patient's interests another approach was deemed necessary, the doctor would be obliged to follow standard procedure. However, nobody can alter the fact that a doctor must be able to choose freely the form of treatment he or she considers to be the most appropriate in the light of all the relevant circumstances.

This is perhaps easier when doctors work individually, but intensive care is a team activity and the individual doctor's ethical options come up against what it means to be part of a team.

Until the 1960s, the dominant principle was the Hippocratic oath, with professional ethics guided by the commitment to do patients good and avoid anything that could be harmful to

them. This approach ignored any prognosis for the patient's overall condition.

In the second half of the twentieth century, a number of factors brought about a change in medical, ethical and legal considerations:

- patient care became a team effort. Treatment options were no longer decided by one person;
- patients became free to accept or reject medical care, as informed consent and refusal are now part and parcel of the treatment process;
- the cost of medical care has been constantly rising and consequently, especially in the case of intensive and resuscitation care, treatment should be given only where it will be useful and within reasonable limits;
- treatment for patients in a critical condition, and their reintegration, require care to be administered at all stages – from intensive care to medical and social care. Economic aspects play a much greater role in intensive care medicine than in other disciplines, which are less expensive. The question of whether resources are distributed appropriately is assessed from an ethical point of view; effectiveness is viewed from the patient's angle.

A number of ethical questions are linked to these economic aspects:

- reasons for admission into intensive care (respiratory failure, loss of consciousness);
- evaluating the chances of survival in intensive care;
- stopping or not commencing treatment;
- validity of treatment "scoring systems" (where treatment is requested or refused);
- decision-making abilities of patients who are temporarily mentally incapable;
- quality of life during and after intensive care;
- unnecessary and excessive care, proportionality of the level of treatment, care unnecessarily requested or delivered;

- resources allocated to intensive care – cost, distribution and appropriate use.

Discussions of these issues illustrate the importance of team work in intensive care and it is not possible to define precisely the boundaries of responsibilities in complex problems. Accordingly, it is difficult to draw up standards and define good clinical practices and professional approaches in terms of standard procedure. It is equally difficult to define the approach to be adopted (once again in terms of standard procedure) applicable both to specialist associations and those working on the ground. Of fundamental importance is professional trust and constructive co-operation in order to solve any problems and limit as far as possible any conflicts between ethics and the law.

It is in the field of intensive care that standards are the clearest.

The prime objective of intensive care is to save the lives of those seriously ill or wounded, or patients at a very acute stage of chronic diseases. The measures taken are designed to keep stable a patient who is in a critical position, and help him along the road to recovery. In intensive care, the main aim is to save lives, whereas in other specialist fields, the aim is to improve the quality of life. It is difficult to compare the success criteria and cost-effectiveness of intensive care with other medical disciplines.

All medicines and forms of treatment, everything that gives the patient a chance and which it is possible to obtain or perform without additional cost and without creating other difficulties can be regarded as standards. However, anything which is impossible to implement without an enormous increase in cost and which offers no hope for the patient is inappropriate.

In practice, this means that doing good – that is, saving lives – is a moral obligation only in cases where achieving a specific objective does not necessitate the disproportionate use of resources.

The above definitions place intensive care staff in a dilemma in cases where the health condition of patients is due to in greater or lesser degree to their own lifestyle (for example, drug

addicts); illnesses directly caused by the patient's own actions (accidental or deliberate poisoning) raise the question of the appropriate and fair allocation of financial resources for the intensive care of serious illnesses. In central and eastern Europe, given the difficult economic situation, the resources available for medical treatment and intensive care are limited, and so too, therefore, are the treatment options. If intensive care is provided without there being any reasonable grounds to justify this, then there will be a shortage of resources to care for patients with other complaints.

### **Treating drug addicts**

Treating drug addicts invariably means having to be attentive to ethical and medico-legal considerations, in order to avoid being faced with serious practical situations, which are often distressing and acute.

At the beginning, the use of drugs leads to a chemical influence on the brain of a healthy human being. The brain then protects itself through a process of adaptation: at that point it ceases being organically "normal". It is not always easy to tell whether such changes are reversible. Generally speaking, a new balance is formed and to maintain this balance, the patient needs to continue taking the drug. More often than not, the patient attempts to ignore the serious dangers involved: the continued consumption of the drug increases the damage to the brain, leading to a slow deterioration of the intellect and to dementia. Ultimately, the use of psychotropic substances will, to varying levels, affect other organs (lungs, heart, kidneys) which makes it all the more difficult to wean the patient off the drug, as it is hard to isolate among the people undergoing treatment those in need of a multidisciplinary medical approach.

If the patient is simply deprived of the drug, the balance between the effects of the drug and the mechanisms of neuro-adaptation is generally upset. This is a result of the dominance of neuro-adaptation when the patient no longer receives the drug. This can lead to typical withdrawal symptoms and, on the psychological level, depression and anxiety.

An interaction of socio-psychological factors, which may be the cause of the addiction, can either contribute to or reduce the risk of the emergence of these symptoms. Stress related to social situation lowers the threshold for turning to drugs, and the choice is between opting for a behavioural pattern leading to happiness or reward through activity in the real world (work, for example) and the drug. Another major consequence of drug addiction is the greater likelihood of involvement in crime or violence in order to find the money to finance the habit.

Dealing with drug addicts is a two-stage process:

- treatment in intensive care (following accidental over-consumption or attempted suicide);
- treatment of the addiction (voluntary or forced).

In accordance with the recommendations of the European Society of Intensive Care Medicine, the following situations may justify admitting a patient to an intensive care unit:

- where the patient is unstable and vital functions are under threat;
- where there is considerable risk of serious complications and these could be prevented by intensive care treatment. It must be stressed that it is not possible to draw any legal conclusions because there is no legislation defining an “unacceptable quality of life”.

The treatment of patients with an addiction requires multidisciplinary care and it is essential to clearly define the aim, conditions and regime of such treatment.

In countries with weaker economies, medical staff are subjected to considerable pressure from both the ethical and legal point of view. The growing gap between concrete opportunities for the medical establishment to treat patients because of the present economic situation and the current state of scientific knowledge is a major stress factor. Taking account of these economic limits gives rise to a dilemma on the appropriate use of resources both globally and locally. Both specialist associations involved in care and the insurance companies that pay must

reach agreement on treatment for patients in a critical situation. This would put an end to the underfunding of care and at the same time bring a halt to the expensive care administered to patients with no hope of improvement. It is always very difficult to assess the importance of care because of the many dimensions involved and the attendant complications possible. This concept should open a discussion on the question of the cost-benefit ratio. Neither individuals nor the state can answer this question. It is therefore for the world community to define rules for best practices – the standard procedure to be followed – in this important area, with due regard for the economic aspect.

## Bibliography

Dobiáš, V., "Úvaha nad tradičnými postupmi v anestéziológii", in *Anesteziologie aneodkladná péče*, 3, 1992, No. 5, pp. 156-158.

Drábková, J., "Otravy, předávkování, antidota" ("Intoxication, overdose, antidotes"), selection of papers in *Anest. Resustitace* 1996, 43 (Supplement), pp. 2-3 (in Czech).

Drobná, H. and Huttová, M., "Novorodenec matky závislej na drogách – neonatálny abstinencný syndrom" ("Neonates of drug-addicted mothers – neonatal withdrawal"), *Praktická gynecológia*, 3, 1996, pp. 149-154 (in Slovak).

Drobná, H. and Huttová, M., "Matka závislá od drog a jej novorodenec" ("Drug-addicted mothers and their newborn children"), in *Alkohol Drog. Záv.* 31, 1996, pp. 183-191 (in Slovak).

Drobná, H., *Problematika drogovu závislých matiek a novorodencov* (The problem of drug-addicted mothers and newborn children), Zdravotne Soc. Fakulta České Budejovice, 2000 (in Slovak).

Hackovcová, H., *Lékařská etika*, Galén, Prague, 2003.

Masár, O. and Cizmárová, E., "Niektoré medicínske problémy spojené s narkomániou detí a mládeže" ("Medical problems related to drug addiction in children and adolescents"), in *Detský lekár*, 3, 1996, pp. 6-9 (in Slovak).

Stolínová, J. and Mach, J., *Právní odpovědnost v medicíne*, Galén, Prague, 1998.

Sevcík, P., *Akutní intoxikace* (Acute intoxication), Galén, Prague, 2000, pp. 240-262 (in Czech).

Sevcík, P., "Obecné aspekty péče o nemocné v prednemocnicní etape" ("General aspects of patient care in the pre-hospitalisation stage"), in *Anest. a neodkl. péče* 2, 1991, pp. 141-143 (in Czech).

Vinar, O., "Psychologie drogových závislostí" ("Psychology of drug addictions"), in *Forum medicinae*, 2, 1999, pp. 22-23 (in Czech).

## **Compulsory treatment: the Russian Federation's approach**

by Irina P. Anokhina, in co-operation with V.E. Pelipas and M.G. Tsetlin

The suggestion to present the Russian approach to ethical problems of compulsory treatment (CT) was certainly not made by chance. In Russia as perhaps in no other country, the idea of coercing patients suffering from alcohol and drug dependency to undergo treatment and the organisation and practice of CT have been implemented in the most consummate form.

### **A system based on compulsory treatment**

What is usually meant by CT of addiction profile patients, particularly drug addicts? Firstly, CT of patients in the health care system on the basis of civil commitment. Its equivalent has been widely used in Russia: compulsory treatment in so-called "labour and treatment profilactoria" (LTPs) under the umbrella of the Interior Ministry on the basis of a civil court decision. Secondly, transferring drug users who violate the law from the criminal justice system to the civil health care system (so-called alternative treatment). In Russia there is a long-standing practice of suspended sentences for drug users who violate the law, with a period of probation and the obligation to undergo drug dependency treatment, which can be considered equivalent to alternative treatment. Thirdly, CT of convicted drug users who violate the law in prison settings, or in the health care system if the punishment is not imprisonment. This procedure was used in Russia until very recently. Sometimes CT is rather inadequately and rather too broadly understood to incorporate all incentives to treatment, that is as a social process aimed at increasing addiction patients' motivation to receive treatment, which in this case becomes in a sense both voluntary and compulsory. In the recent past in Russia there also existed a whole system for compelling addiction patients to receive treatment. This system included patients' duty to undergo treatment, the system of patients' comprehensive

registration, employment restrictions for some occupations, discrimination in some areas of family, employment and housing legislation, systematic social pressure in the community and at work, compulsory placement in LTPs for those who refused voluntary treatment and other measures.

In Russia all known measures for compelling and coercing patients to receive treatment have thus been used to some extent, sometimes in the most cruel and repressive forms. And in 1993, in the same Russia, this system that had functioned for 30 years was radically and rapidly demolished, without having achieved any of its aims (to reduce alcohol and illicit drug consumption, the incidence of alcohol and drug addiction and related crime).

What experience, in ethical terms among others, was acquired during the period of this system's existence? How is this experience being used now? It is accepted that CT affords an opportunity to provide a large number of patients with therapy (or rather what we call therapy), in the hope that a proportion of them, even if it is a small one, will achieve a stable remission and that the majority will at least change their pattern of substance use for the better, while their families are given a "break".

However, comparative clinical and social studies published in Russian scientific journals show that the frequency and quality of remissions after CT were much poorer than those after voluntary treatment; adaptation among patients who underwent CT was much worse than among those who received treatment voluntarily or did not undergo in-patient treatment at all; being in CT inevitably resulted in additional social and psychological problems in the family, daily life and working life, and the massive practice of CT also generated strong social tensions among the population.

All in all, the system for compelling and coercing addiction patients to receive treatment which was implemented over a certain period in Russia proved to be very ineffective and costly.

At present in Russia there is no CT for either alcohol or drug-addicted patients. Not in any form, either for patients who vio-

late the law or for those who do not. And this is certainly related to a negative assessment of past experience. It can even be said that the unsatisfactory outcome of the social practice described above has to a large extent discredited the very idea of CT for addiction patients in Russia.

With the adoption of the Russian Federation's "Basic law on health care for citizens"<sup>1</sup> in 1993, non-voluntary medical acts were restricted to the spheres of quarantine infections, severe psychopathology and penitentiary practice. Soon afterwards, these measures were regulated in each sphere by appropriate federal laws.

Was the practice of total compulsion ethically wrong? And to what extent is the modern practice of refusal to exert any form of compulsion or even pressure on addiction patients to receive treatment, which is in itself a manifestation of society's and the state's ambivalence towards them, ethically correct? Unfortunately there is no discussion of this topic in society. Neither the authorities, nor professional associations, nor even human rights organisations are interested in ethical problems relating to addiction.

Yet we believe that the problem of CT and, generally speaking, any non-voluntary treatment of addictions is first of all an ethical problem with a number of extremely important aspects. Among these is the difficulty for a physician of establishing an ethically correct position towards a patient undergoing compulsory treatment. It is worth investigating the issue of ethical standards for compulsory treatment staff. It would be reasonable to discuss the range of possible ethical collisions during CT and plan ways to resolve them.

We would like to focus on the main issue – that of ethical justification for CT. The most important point is not whether there are legislative grounds for CT or not, or the limits of a physician's obligation to exercise his or her rights, or his or her responsibility for a refusal to exercise those rights. The important question is this:

- is it worth using CT from the ethical point of view? In all cases? Only in some strictly determined cases? Or only by way of exception?

1.  
See section 34.

Other obvious questions also arise:

- Can a guaranteed positive outcome justify compulsion (the use of force)?
- Can an uncertain or predictably negative outcome of intervention (treatment) justify compulsion (the use of force)?
- How great should the probability of a positive outcome be (what chance of a positive result should the patient have) in order to ethically justify the use of force?
- And lastly, what can be regarded as a positive result?

These are all very complex problems. Here we have more questions than answers. Nevertheless, putting a question means going halfway to answering it.

### **A paternalistic approach**

The system of CT for addiction patients described above was built on the paternalistic ethical paradigm. At first this was the variant that might be called optimistic paternalism: “we know what we are doing, do as you are told and everything will be fine”, that is paternalism with a belief in a positive outcome. At that time there was still residual optimism in society, and even addiction psychiatry was optimistic: the main thing is to begin, the rest is a matter of technique.

There was a whole system of arguments in support of the paternalistic approach:

- professional knowledge, methods and treatment approaches can lead to recovery, especially if they are strictly followed;
- there are patients whose critical abilities (as well as intellectual, emotional, volitional and personal qualities) are distorted or underdeveloped as a result of illness;
- those suffering from addiction must be treated, as long as they are socially significant;
- patients should take care of their health, in so far as it is a part of the nation’s social wealth;
- doctors should perform their duty – to treat patients;

- patients cannot help themselves, so they must follow the doctor's instructions;
- the doctor should not only decide on treatment (prescribe therapy), but also ensure that the patient goes in the right direction, which even means overcoming resistance;
- refusal to coerce a patient into receiving treatment means leaving him or her without care and not performing a doctor's duties; moreover, this can lead to a worsening of the patient's psychological state and social status;
- even if the success of CT with a certain patient is minimal, the treatment must be carried out, if only to ease the situation in the patient's family.

Noble aims? Commendable strivings? This looks ethically correct. Especially if we take account of the situation and circumstances out of which this sort of paternalism arose: a totalitarian society with a compulsion ideology, a concept of expediency and a belief in possessing the absolute truth in combination with a perfectly adjusted legislative base (socially significant diseases, obligation to undergo treatment, CT as an alternative, etc.).

Outside the paradigm described above, applying this type of paternalism to the majority of addiction patients seems irresponsible (as it does not answer for the consequences), ineffective (as it does not solve medical or social problems either for individuals or for the population at large), wasteful and costly (as it expends society's resources for nothing) and a violation of human rights (as it restricts freedom, the choice of an occupation, etc.); it also lowers the social status of the patient (as it brings him or her down to the level of an anti-social or even criminal element) and in some cases worsens the patient's somatic and psychological state (e.g. through the thoughtless prescription of *teturam*<sup>2</sup>). As for "giving the family a break", this has nothing to do with medical ethics. It is more likely to belong to the spheres of social care and legislative practice, but not to that of the health care system.

In general and in practice, when applied to addiction profile patients without grounds or differentiation, the paternalistic approach, despite ethically approved expectations, often leads

2.  
Drug used for weaning off alcohol.

to violation of one of the basic principles of medical ethics: *non nocere* (not to cause harm).

In our rapidly changing world medical ethics is also changing radically. We are witnessing a change of ethical paradigms: from paternalism to biomedical ethics (bioethics), which is known to be non-paternalistic medical ethics. In paternalistic ethics the patient was always considered ethically non-competent; in bioethics on the contrary he or she is ethically competent and personal moral autonomy is a priority. Responsibility for decision making is shared between the doctor and the patient. The system of values that determines the moral choice of a doctor and a patient is not really bound up with medical tradition, as it is first of all based on priority for the patient's rights, not the doctor's rights. There is no place for compulsion in this ethical system, which is based on a number of principles (personal autonomy, causing no harm, justice) and ethical standards (truthfulness, privacy, confidentiality, loyalty and competence) and on the standards arising from them in terms of the doctor's attitude.

General principles and standards of biomedical ethics no doubt apply to the professional activity of psychiatrists and addiction psychiatrists. However, some essential features of psychiatry and addiction psychiatry create specifics in medical practice. Related ethical problems often cannot be resolved by analogy with other branches of medicine and require a special approach.

Psychiatry (and addiction psychiatry) are to a very large extent socially oriented medical disciplines. A psychiatrist (or addiction psychiatrist) often deals with patients who demonstrate socially deformed, asocial and anti-social behaviour. At the same time patients vary a great deal in the extent and manifestations of their psychopathological symptoms, as well as in intellectual level, self-esteem, ability to control and understand the consequences of their actions and ability to express and defend their interests.

At one end of the spectrum are seriously ill patients with expressed psychopathological symptoms, who are absolutely incapable (in the broad sense of the term) and are not self-

dependent in their decisions and actions. At the other end are quite autonomous individuals with moderate psychological problems.

That is why psychiatrists (and addiction psychiatrists) will perhaps never give up paternalism in their relations with some of their patients; at the same time, they can widely use a non-paternalistic, partnership-based model in their work with the majority of their patients. Ultimately, these ethical models can replace each other depending on changes in the patient's psychological state. Thus psychiatrists and addiction psychiatrists, unlike other physicians, are probably condemned to exist in a dual-dimension ethical model – classical and biomedical – while trying to avoid the ethical pitfalls peculiar to each approach.

In the paternalistic model there is a danger of overestimating the extent of a patient's partial incapacity: the level of decrease in self-esteem, educational deficiency, personality immaturity, intellectual underdevelopment or retardation, etc. As a result, a psychiatrist's rights and obligations are easily transformed into the doctor's right to thrust treatment onto a patient and the patient's obligation to undergo treatment.

In bioethics there is a danger of overestimating individual autonomy to the detriment of the autonomy of others and the interests of society, justifying good intentions with the use of any means to fulfil them, or of inflating the idea of usefulness, which may lead to sacrificing the interests of society to the interests of the patient. It is worth remembering that bioethics qualifies overstating the interests of society as doing the patient an injustice.

To return to the questions outlined at the beginning of this paper, and in view of what has been said, CT is justified for an addiction patient only in cases where a doctor who plans medical or related interventions can guarantee the patient recovery, stable remission or at least a significant improvement in his or her condition, which would compensate for the patient's temporary loss of autonomy. If the doctor cannot guarantee this or shifts responsibility for the final outcome of

the treatment onto the patient, the right to apply CT looks ethically unconvincing.

CT to the detriment of a patient's interests is nonsense. Treatment must not be a punishment or a medical variety of punishment. CT should be applied only for the purposes of a patient's welfare. In any event, it should resolve the patient's problems and improve his or her condition and status, not create new difficulties for the patient and worsen his or her psychological state and social status.

Compulsion is a highly sensitive sphere, which is why the introduction of CT must be limited to those cases where it cannot be avoided and can be effective. In other words, CT can be ethically justified only for medical (psychiatric) reasons, which must be strictly determined by law.

The Russian Federation's "Law on psychiatric services and safeguards for citizens' rights in psychiatric service provision" (1993) allows involuntary measures to be taken in cases where serious psychiatric disorder or the patient's helpless state exposes the patient or his or her social environment to danger, as well as in cases where leaving a patient without psychiatric treatment would lead to a marked worsening of his or her condition. This formula for involuntary treatment can be applied to the population of addiction patients. At least, it is so applied in practice.

So-called "social indications" must not be a reason for assigning individuals who have committed no offence to CT. This is especially important now that drug addicts' interest in CT has been somewhat heightened by the spread of HIV/Aids. However, it is an illusion to hope that CT will be capable of halting the progress of the epidemic. It might only have a short-term effect. It is easy to predict a further decrease in demand for testing and treatment, dissimulation, self-treatment, an increase in complications, mortality, psychological aberrations among HIV-positive individuals associated with social dissent, accusatory tendencies and sexual aggression, and the subsequent uncontrolled growth of the epidemic. In some countries this danger has fortunately been perceived at the proper time,

and instead of confrontation with drug addicts, the tactics of compromise have been adopted.

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To conclude, a few words about prospects. We resolutely express the conviction that the future most probably does not lie in increasing measures of compulsion and CT, but in perfecting voluntary treatment. Its availability (low threshold) in various forms and under a variety of schemes, personalisation, differentiation and professional motivational work with patients, together with the involvement of highly qualified experts and reasonable social pressure, may make compulsory measures unnecessary. A highly qualified professional has opportunities to motivate a patient to enter the therapeutic process and does not need unnecessary compulsion.



# Compulsory treatment: the Swedish approach

by Elisabet Svedberg

Compulsory treatment of adult addicts has been regulated by Swedish law since 1913. The first piece of legislation on the treatment of alcoholics was based on disciplinary paternalism. Alcoholics caused so much social damage that they were separated from the rest of society by means of periods of internment. The primary intention was to protect society from alcoholics. Although there was a certain faith in the idea that hard work and healthy living would have a positive effect, the expectations of improvement in the ways of alcoholics were limited. In 1933 this law was replaced by the Act on Treatment of Alcoholics. This laid somewhat more emphasis on care of the individual alcoholic, while the justifications for compulsory care were extended.

The Temperance Care Act introduced in 1954 included both voluntary preventive measures and compulsory intervention through probation and, as a last resort, compulsory institutional care. Measures were to be applied according to the degree of addiction and included various stages running from voluntary to compulsory. The law was applied to “vagrant” alcoholics who, without honestly trying to support themselves, lived a nomadic life, were a danger to or caused serious disturbance for others, neglected their duties to their intimates or otherwise caused harm to society. The disciplinary character of the law, with its mandate to protect society and the environment from the addict, remained in place, though compulsory care now had an additional purpose: to return the addict to a temperate existence.

During a revision of Swedish social care legislation and the drafting of the Social Services Act (SoL),<sup>1</sup> an act was passed in 1982, called the Care of Abusers (Special Provisions) Act (LVM),<sup>2</sup> concerned with compulsory care for certain addiction cases as a complement to the voluntary care covered by SoL. This construction was preceded by extensive debate and several surveys. The surveys found that coercive aspects should

1. Social Services Act (SoL) 2000/01:80.

2. Care of Abusers (Special Provisions) Act (LVM) 1988:870.

be deleted from social legislation in regard to adult addicts, and that in future, social services activity should be based on respect for people's self-determination and the integrity of the individual. The possibility of coercing individuals would only be valid when required to prevent addicts from seriously damaging their own health or exposing themselves to danger, and such intervention would then take place within the confines of medical health care supervision. Despite this proposal, compulsory care continued to exist within social service provisions (Petttersson, 2003).

Protection for others besides the addict remained in place for intimates only. The protection of intimates was justified by the view that "the connection between addiction and violence is indisputable". Although illegal threats and physical abuse are now subject to public prosecution, LVM protection is still needed, primarily for female intimates, as a complement to criminal code legislation (SOU, 1987).

After a recent review of the implementation of LVM, it is suggested among other things that the roles and responsibilities of the players involved should be clarified, that the quality of the LVM treatment should be improved and that the legal rights of the individual should be reinforced (SOU, 2004).

This article examines the ethical arguments pertaining to the restriction of adult self-determination. Sweden has a long tradition of compulsory care of addicts. Is there an acceptable argument for committing adults to compulsory care? Is it important whether or not compulsory care has a positive outcome?

### **Care for whose benefit?**

The central question in regard to compulsory care has been the actual purpose of the care. For whose benefit does compulsory care exist? For how long can compulsory care reasonably be applied and what should the criteria be? In recent years the question of individual rights has grown in importance and research into the effects of care on the life situation of addicts has increasingly been called into question.

Attitudes towards compulsory care of adult addicts and regulation of this care have varied throughout history, and reflect the prevailing ethical attitudes at any given time. In the ethical critique against compulsory care, it is the denial of the right to self-determination and personal integrity that is central.

People's own responsibility for their social situation on the one hand and society's responsibility to provide citizens with social welfare on the other raise questions about what means are permissible and what means are ethically defensible. The social undertaking to change the client's lifestyle, with its exercise of authority, clashes with the undertaking to maintain respect for the client's self-determination. There are problems attached to coercing someone to do something, even if this takes place in their best interests. This gives a modern slant to the issue of paternalism, which is about how welfare and self-determination should be assessed and how the relationship between the state and the behaviour of the individual should be understood (Petterson, 2003).

### **Social services work must be based on free will and self-determination**

One of the most important premises in the Swedish social services is that their efforts in individual cases must uphold free will and self-determination. LVM regulates the conditions under which deviations from the basic free will principle contained in SoL are permissible.

The following passage from the SoL portal provides the basis for social services activities and expresses the ethical values and norms that are to be used for guidance:

“Public social services shall, on the basis of democracy and solidarity, promote people's

- economic and social security
- equality in living conditions and
- active participation in social life

With due consideration for the responsibility of the individual for his own social situation and that of others, social services

shall be aimed at liberating and developing the innate resources of individuals and groups.

Activities shall be based on respect for people's self-determination and privacy."

The possibility of compulsory care for addicts is regulated by Swedish social legislation. This enables care to be provided without the consent of the individual once certain criteria have been met. LVM states that the objectives described in the above passage shall apply to all care aimed at helping individuals free themselves from addiction to alcohol, drugs or liquid solvents. Care shall be based on respect for the individual's self-determination and integrity and shall, as far as possible, be designed and applied in co-operation with the individual. The present situation, in which social services can coerce addicts into compulsory care, while SoL maintains that efforts shall be based on free will and respect for the individual's integrity and self-determination, is self-contradictory and can result in ethical difficulties.

### **When is compulsory care applicable?**

Compulsory care can apply when addicts require care to free themselves of their addiction, but are unable to achieve this through their own free will, and when this state of addiction leads to individuals:

- exposing their own physical or mental health to serious danger;
- running an obvious risk of destroying their own lives;
- being considered at risk of seriously injuring themselves or an intimate.

Once it has come to their knowledge that compulsory institutional care might be called for, the social services start an investigation. Should the social services find that there is cause to initiate compulsory care, they apply for approval from the county administrative court. If the court decides in favour of compulsory care, the social services provide the addict with compulsory care in a purpose-designed institution. As soon as

its purpose has been attained, and after a maximum period of six months (care time), compulsory care ceases.

### **Exposing oneself or others to danger – two reasons for compulsory care**

As described in the previous paragraph, according to LVM, it is possible to initiate compulsory care of an addict on the basis of two different principles: that the client, because of his or her addiction, is exposed to danger, or that the client's intimates are exposed to danger. In the first case, care of the addict, consideration of what is best for the addict forms the basis for compulsory care intervention. In the second case, where the addict could expose others to danger, the reason is to protect others.

When persons put themselves at grave risk owing to their addiction, or it is thought that they might injure themselves, society can, in certain circumstances, take compulsory measures against the will of the individual. Many regard this principle as being defensible when the need for intervention is acute owing to an obvious risk of mortal danger. The basic question is whether the individual has the right to injure himself or herself, for example through addiction to alcohol or drugs. According to LVM the individual does not hold this right. This is the point at which society sets a limit on individual integrity and self-determination, addiction being a state that society refuses to accept. To legitimise compulsory care, and set individual integrity and self-determination aside, addicts are in some cases regarded as not being responsible for their actions; they are not to be penalised but provided with care for their addiction (Bergmark and Oscarsson, 2000).

The other basis for intervention, that people in the vicinity of the addict are in danger, raises certain ethical (and legal) problems. In Sweden such action is normally regulated by the criminal code. An exception to this principle would be if the individual at the time of the act or offence suffered from mental illness or disturbance and thus qualified for psychiatric care. Because LVM includes danger to others as a criterion for implementing compulsory care, this entails a departure from the

principle that individuals shall either be sentenced or declared not responsible owing to (mental) illness or a similar condition. A decision to apply LVM care means that the addict can, against his or her will, be forced to spend up to six months in institutional care without having committed an offence under the criminal code (Bergmark and Oscarsson, 2000).

The argument in the preparatory work preceding LVM, in favour of retaining the requirement for the compulsory care of addicts who by their addiction are at risk of seriously injuring their intimates, is aimed at avoiding the deterioration of protection for the addict's family, this protection being more comprehensive than is possible under the criminal code. It has been pointed out that the existence of a compulsory care law is contrary to this, but removing any risk to intimates comes first. On the other hand, widening the human circle to include the addict's social environment would "entail a much more serious infringement of the principle of LVM as a social welfare law" (SOU, 1987).

### **What does compulsory care comprise?**

The number of heavy drug addicts (injection addiction or other daily/more-or-less daily use) in Sweden in 1992 was estimated at 19 000. By 1998 this number had risen to about 26 000.

The National Board of Institutional Care (SiS) is a government authority assigned to care for young people aged 12 to 21 with serious psychosocial problems and for adult addicts. Activities are run in close co-operation with the municipal social services. SiS operates 49 institutions around the country, with 14 institutions and 330 beds for adult addicts. As of 26 April 2004, 250 addicts were housed in LVM institutions. The institutions have a very high number of staff and many different professions co-operate in providing care.

A spell at an LVM institution runs for a maximum of six months and is turned into outpatient care as soon as possible. The sojourn frequently starts with detoxication and an assessment of the addict's problems and needs. This assessment

phase might include talks with a psychologist, ability tests and a social and psychiatric examination, and lead to an individual treatment plan. Treatment and motivation methods vary between different LVM institutions and are based on the needs of the individual client. Motivation interviews, twelve-stage treatment, social competence training and ego-strengthening therapy are some of the therapeutic forms used. Personal support and group talks are other important features, as is participation in daily institutional activities. LVM institutions are oriented towards different target groups, for example addicts with psychiatric diagnoses, violently inclined addicts, pregnant addicts or addicts with special care needs.

In recent years institutional care of addicts has undergone major structural change. The number of beds at LVM institutions has been greatly reduced as a direct result of the drop in demand for social services.<sup>3</sup>

This reduction in institutional addict care is connected with municipalities striving to find treatment forms on the home front, often in co-operation with intimates and other significant partners. The restructuring of care can be seen as a consequence of institutional care failing to provide the expected results and being expensive. A brief stay at an LVM institution can rarely break a long period of addiction. Cutbacks in addict care might lead to a situation where it becomes impossible to accommodate addicts who are aware of their own inability to cure themselves and are asking to be taken into compulsory care.

### **Duration of care – a debatable point**

Duration of care is a controversial question connected to the actual purpose of care. When the act was introduced, care time could last four months (2 x 2 months). During the revision of the act in 1988, care time was extended to six months to ensure that “the client shall be motivated to undergo treatment aimed at making changes to their life situation”. It was found that durable changes to life situations could not be achieved unless clients themselves took a stand and participated actively in care. The idea was that during the care period

3.  
See [www.stat-inst.se](http://www.stat-inst.se)

addicts would be helped to diagnose their own needs for care and thus exercise their own free will in effecting their own cure. Simultaneously, knowledge of the effects of compulsory care, and of whether this treatment had other effects besides that of saving lives, was found to be lacking. The argument in favour of compulsory care that does more than save lives is that the result of care should be seen in relation to how severe the addiction is. Furthermore, heavy addiction is interpreted as a “cry for help” that has to be answered; it needs access to compulsory care in order to be put right. A passive offer of help means that we “leave these people to their fate, because many of them will never seek help, no matter how desperately in need of it they might be” (SOU, 1987).

### **Who are those in compulsory care and how do they experience care?**

Ekendahl (2001) summarised research in the LVM area from the 1990s until 2001. He found that addicts given LVM care were usually very socially vulnerable and had a far-reaching addiction problem and the worst prognoses of all those cared for in institutions. Ekendahl interviewed fifty-four addicts in compulsory care at five LVM institutions. He found that initially the compulsory aspect – the actual LVM sentence, locking-up, searches and denial of parole – was experienced as negative and insulting. However this attitude could change with time to a more positive attitude. The interviews revealed that motivation to change lifestyle grows out of a personal process and that LVM had no positive influence on this process barring exceptional cases. On the contrary, several interviewees subjected to an extended period of compulsory care said it had appeared to them that LVM care worked to discourage their motivation. Ekendahl maintains this indicates that in some cases compulsory care can have the opposite effect to that intended.

### **Care results**

Research conducted into the results of compulsory care for addiction problems does not suggest that LVM institutions suc-

ceed in ridding clients of their addictions to any great extent. Ekendahl (2001) refers to four studies where 60% to 70% of clients were classed as showing no improvement, a classification the author interprets as a relapse into addiction. He says that so far Swedish research into the results of LVM institutional care has not been able to substantiate that compulsory care has an effect on treatment results.

There is a great deal of international research dealing with treatment of addicts. The Swedish Council on Technology Assessment in Health Care (SBU) has compiled an evidence-based knowledge base on the treatment of alcohol and drug problems (2001). However, this knowledge base does not include research results on the compulsory care of addicts.

### **Principles of ethical analysis**

Decision making about ethical problems must draw upon the facts and a number of basic ethical principles. Ethical problems are made up of contradictions between principles and the assessment of available facts. By agreeing in general over the ethical principles to be used as a foundation for ethical analysis, we can clarify the values and norms relevant to each case. Hermerén (2000) addresses the works of Beauchamp and Childress (1994) and Gillon (1985) in which the authors discuss the principles of self-determination, beneficence, non-maleficence and justice, in no particular order of importance.

#### ***The principle of self-determination***

According to the self-determination principle people should decide on their own lives, unless this puts the self-determination of others in jeopardy.

What does it mean to choose and decide independently? Is it to decide which one of two alternatives one prefers? Hermerén (2000) says the process presupposes possessing the correct information about the consequences of these alternatives for the decision maker and for others. He asks if this requires not only being satisfied with choosing between alternatives that have been presented, but also independently trying to find

other alternatives to choose from in a particular situation. The individual's right to decide over his or her own life, or to act according to his or her own plan, includes the right to decide (in certain matters) whether to retain this right or pass it over to another party.

### ***The principle of beneficence***

According to this principle we should do good to others and prevent or eliminate that which is injurious to others. Although the principle of beneficence is about maximising beneficence, it does not maintain that the individual has to be beneficent.

The requirement that people should act beneficently and not maleficently can be interpreted in several ways. If interpreted as a demand for solidarity with the most needy members of society, it implies that the needs of clients shall be paramount and the needs of those in most difficulty or suffering shall be given priority. In other words, vulnerable individuals and groups in society should be given preferential treatment. The requirement to act beneficently and not maleficently often functions in practice as a platform for attempts to weigh up anticipated benefits – for example, the usefulness of an investment made in care or rehabilitation – against foreseeable risks.

### ***The principle of non-maleficence***

According to this principle we have a duty to avoid causing suffering to others or causing damage. The principle of non-maleficence is about minimising suffering.

### ***The principle of justice***

According to the principle of justice, identical cases (persons, actions, motives, etc.) should be treated or judged equally. This principle emphasises that it would be unethical to give certain groups special treatment unless there are relevant ethical differences between them: for example, to refrain from intervention (e.g. with coercive measures) in certain groups unless the same measure is taken with other groups possessing equally relevant aspects. Hermerén (2000) provides an example, and

writes that if, in similar situations, intervention takes place with B, but not with A, this might be because the prognoses for A and B are different and thus provide a reason to apply special treatment. But why should we take prognoses into consideration? Determining ethically relevant differences can cause controversies in which norms and values are set against each other.

### **Ethical criticism of compulsory institutional care**

The situation where an addict can be coerced into care when we “fear” that he or she will seriously injure himself or herself or an intimate has awakened criticism. Imponderables, always present when trying to anticipate human behaviour, have to be included in the assessment. Intervention based on the need to protect society must appear legitimate and just, even if pervaded by a certain degree of uncertainty.

Two Swedish researchers, Bergmark and Oscarsson (2000), describe work with addicts in the social services as follows: “applying respect for the integrity and self-determination of the addict in a personal relationship and in circumstances of shared responsibility between the social services and the client, via assistance and care, while, by using the resources of society and the addict, creating the conditions required to support the client with the purpose of permanently freeing the client from addiction”. They mean that those ethical principles expressed by this wording are the principle of self-determination (the addict is responsible for himself or herself) and the principle of beneficence (society has a responsibility and must use its resources to support the addict). They add that in regard to compulsory institutional care, the question of reducing suffering will also be brought into focus.

Bergmark and Oscarsson make an ethical assessment of compulsory care and conclude that respect for the self-determination principle can only be given a subordinate position if the beneficence principle is maximised and the non-maleficence principle is minimised. So far, research in the compulsory care area does not support the thesis that compulsory care has beneficial consequences or minimises the suffering of the addict.

This makes it ethically indefensible to take the self-determination principle out of play.

Additionally, Bergmark and Oscarsson ask if it is ethically defensible to coerce an addict, who exposes others to danger only through his or her actions. Further, they ask if it is ethically defensible that an addict who is “feared” may cause injury to others can be coerced into up to six months of institutional care when an alcoholic who drives a car when inebriated and puts both himself or herself and others in mortal danger generally risks only two months imprisonment at most. The authors provide a possible explanation as to why society takes a different view of the legal rights of the individual as regards the application of LVM from that taken as regards the application of the criminal code, and as to why the “consequence” is compulsory care instead of a punitive sentence: addicts are regarded as not being responsible for their actions and must therefore be given care. Basically, legislation exists for the addict’s own good.

### **Paternalism versus self-determination**

When discussing compulsory care it is natural to arrive at the question of paternalism. Collste (1996) positions paternalism as the opposite of autonomy and differentiates between strong and weak paternalism. According to him, strong paternalism means that someone decides on a measure said to be in the client’s best interests, irrespective of what the client wants and thinks. Weak paternalism on the other hand means that someone decides on an action on behalf of a client who is assessed as lacking the ability to decide what is best for him or her. Tännsjö (1998) maintains that we should assume a cautious attitude towards paternalism and only approve of it when the stakes for the client are very high.

Pettersson (2003) says that in the compulsory care of an addict, society takes over responsibility in order to administer the care requirement of the client, with the long-term objective of changing the client’s lifestyle. At a certain stage, and after a process intended to ensure that the client gains insight into his or her plight, the right of self-determination is restored. The

temporary withdrawal of self-determination and accompanying infringement of integrity are necessary actions intended to restore the client's understanding of his or her own situation and provide the client with the tools to take responsibility and change his or her lifestyle permanently.

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When it is decided to take an addict into compulsory care, society takes over responsibility for this individual's life for a defined period. The individual's right to autonomy is subordinated to paternalism, using the argument that coercion is necessary so that the individual, who does not know what is good for him or her, shall by these means cease his or her addiction. Because society considers that addiction leads to suffering for the individual, and when the individual fails to do anything to emerge from this addiction, compulsory measures must be resorted to in order to reduce suffering. Therefore, a reduction in suffering is a basic motivation for compulsory care.

In order to make it ethically acceptable for the addict's own responsibility and autonomy to be placed in a subordinate position, compulsory care should actually result in a reduction in the suffering of the addict. It can perhaps be said that when the government resorts to compulsory measures (based on the principle of beneficence), the suffering of the addict is reduced over the period of care itself. This can be a point in favour of putting the self-determination principle in a subordinate position. But should not "suffering" be reduced in a long-term perspective too, if compulsory care is to be justifiable? Because it is a fact that the results of modern compulsory care fall short of this requirement.

Compulsory care of addicts is criticised because the results fail to meet the expectations of clients, their intimates and society at large. Furthermore, it is difficult to foresee what care will actually result in; will the addict cease his or her addiction entirely or is it enough for its intensity to be reduced and if so to what level? Will the addict cease the addiction for the remainder of his or her life or for a short period only? Should the addict change over to a drug considered to be less dangerous?

A debate is now in progress over whether social services activities should be more scientifically based. In effect, this means social service personnel should use methods that have been proven to produce the desired results. The same demands must be made of compulsory care. If compulsory care is to be awarded legitimacy in society, then it must provide the desired result to a greater extent than is now the case. Methods applied should be based on scientific knowledge and tried and tested experience, so that individuals who are to be helped by compulsory care can be sure that they really will be helped. This would provide compulsory care with ethical legitimacy. However, up until now compulsory care results have been modest. Some would go so far as to maintain that compulsory care does more harm than good to the individual.

## Bibliography

Beauchamp, T.L. and Childress, J.F., *Principles of Biomedical Ethics*, (fourth edition) Oxford University Press, New York, 1994. Quoted in Herméren (2000).

Bergmark, A. and Oscarsson, L., "Vad får det kosta att bota missbrukare?" in Pettersson, U., (red.), *Etik och socialtjänst*, Gothia, Stockholm, 2000.

Collste, G., *Inledning till etiken*, Student literature, Lund, 1996.

Ekdahl, M., *Tvingad till vård – missbrukares syn på LVM, motivation och egna möjligheter*. (Akademisk avhandling), Stockholms universitet, Institutionen för socialt arbete, 2001.

Gillon, R., *Philosophical Medical Ethics*, Wiley, New York, 1985. Quoted in Herméren (2000).

Herméren, G., "Utgångspunkter för etisk analys i socialt arbete", in Pettersson, U., (red.), *Etik och socialtjänsten*, Gothia, Stockholm, 2000.

Kommittédirektiv, *Översyn av tillämpningen av lagen (1988:870) om vård av missbrukare i vissa fall*, Dir. 2002:10.

Pettersson, I.-M., *Etik i tvångsvård. Att göra gott för andra med hjälp av tvångsvård*, Magisteruppsats, Ersta Sköndal Högskola, Stockholm, 2003.

SOU (1987:22), *Missbrukaren, socialtjänsten och tvånget. Betänkande av Socialberedningen*, Statens Offentliga Utredningar, Ministry for Social Affairs, Stockholm, 1987.

SOU (2002:3), *Psykisk störning, brott och ansvar. Betänkande av Psykiatriansvarskommittén*, Statens Offentliga Utredningar, Ministry of Justice, Stockholm, 2002.

SOU (2004:3), *Tvång och förändring. Rättssäkerhet, vårdens innehåll och eftervård*, Betänkande av LVM-utredningen, Statens Offentliga Utredningar, Ministry for Social Affairs, Stockholm, 2004.

Swedish Council on Technology Assessment in Health Care (SBU), *Behandling av alkohol- och narkotikaproblem. En evi-*

*densbaserad kunskapssammanställning*, Reports No 156/I and 156/II, Stockholm, 2001.

Tännsjö, T., *Vårdetik*, (third revised edition) Thales, Stockholm, 1998.

# Compulsory admission to care: the obligation to undergo treatment as an alternative to imprisonment

by A. Lourenço Martins

The global community has consistently sought to deter drug-traffickers by making them liable to severe penalties. Strangely, this pro-punishment stance has also applied to drug users brought before the courts, and their status as victims has frequently been overlooked.

## A change of attitude

A change of attitude towards drug addicts prosecuted for drug offences, in particular “use”, or for other offences that are directly or indirectly drug-related can none the less be noted in both legislation and judicial practice within the European Union, although this is still a slow process.

We are at last finding the right role for the justice system: once the focus of the support provided to drug users has shifted to health and social solidarity, that system will in spite of everything be able to play a major role in their rehabilitation. In countries where the use, purchase or possession for one’s own use of prohibited plants, substances or preparations is a criminal offence,<sup>1</sup> this change of attitude entails the adoption of measures constituting alternatives to the penalties traditionally imposed for this category of offence, encompassing “trafficking/use” These alternative measures include official warnings, fines, community work and suspension of prison sentences or administrative penalties subject to conditions, in particular the requirement that the offender undergo treatment for his or her drug problem.

The main question arising at present is to what extent the following situations can be regarded as ethically legitimate:

- a court sentences or threatens to sentence a defendant to prison for a drug or drug-related offence, but suspends

1. Some countries (Spain, Italy and Portugal, for instance) have ceased to impose criminal penalties for drug use and/or possession, and the perpetrators of such offences incur administrative penalties.

2.  
The situation is the same where an administrative authority applies a sanction, which is suspended also on condition that the person concerned participates in a programme of treatment.

3.  
Here, the application of the measure by an administrative authority (without guarantees as to the impartiality and lawfulness of the procedure) is not even envisaged.

4.  
See the European Legal Database on Drugs – <http://eldd.emcdda.eu.int/>

5.  
In Portugal drug users sentenced to not more than three years in prison may be given a suspended sentence provided they are willing to accept the obligation of treatment. The proceedings themselves may be suspended by decision of the court with the defendant's agreement. A suspension may also be ordered at the stages of police or judicial investigation. Non-pecuniary administrative penalties incurred for drug use or possession are preferably suspended where the person concerned is undergoing treatment.

6.  
Fernando Savater, *Ética para amador*, English translation published by Henry Holt and Co., 1994.

either the proceedings themselves or the sentence on condition that the drug user agrees to undergo treatment;<sup>2</sup>

- a court<sup>3</sup> orders the compulsory treatment of a drug addict, without convicting the person concerned of a criminal offence and regardless of his or her willingness to undergo treatment.

In the first case, should the defendant fail to follow the programme of treatment, the proceedings are resumed and the sentence is enforced; in the second, the person has no choice, in other words the compulsory treatment measure is enforced over the period laid down by the court.

The first situation exists, in a variety of forms, in most western countries,<sup>4</sup> such as Austria, Belgium, Spain (where the conditions are fairly strict), France (where the public prosecutor can issue a treatment order (*injonction thérapeutique*) in liaison with the health authorities or conclude an agreement (*composition pénale*) to waive prosecution), Germany (where the watchword is “treatment instead of punishment”), Ireland, Italy, the Netherlands and Portugal.<sup>5</sup> As a general rule, the drug user's consent to undergo treatment as an alternative to imprisonment is required.

## Ethical framework

Before discussing this issue, it appears desirable to give some general idea of the ethical framework as conceived here.

Whereas morals determine conduct and rules which many (or some) people hold to be valid in all circumstances and which guarantee a common frame of reference, ethics “examines the rational justification for moral judgments”, asks why we consider them valid and compares them with other people's moral principles. Ethics must hence be left to individual discretion, whereas morals are universal.

However, ethics focuses more on debate than on rules, not so much with a view to discovering theories or seeking a model “way of life” but with the rational aim of ascertaining how we can tangibly improve our lives.<sup>6</sup>

Borrowing from a Brazilian author,<sup>7</sup> and with all due reservations as to the risks of over-simplification, we shall distinguish three main philosophical schools of thought concerning human behaviour.

The first – the Aristotelian school – starts from the premise that humans are political animals, gifted with language and acting in a logical manner, evolving within a given society at a given time, in the context of tangible forms of “governance of the city”, with happiness as their objective. Aristotle understands virtue as strength and excellence in both the practical and the theoretical values of existence. Ethical behaviour will not only encompass specifically “moral” considerations, but will also entail, in the context of a given concept of human nature, a degree of wisdom and prudence in dealing with the world at large. The virtues are the goal which everyone can and must aspire to and are very different from mere reactions of hedonism or fear.

The second ethical movement, utilitarianism, which has Anglo-Saxon roots and proponents less inclined to theorising, regards the greatest good for the greatest number, including the agent performing the action, as the ethical principle to be pursued in life (after John Stuart Mill). For example, if, in a situation where financial resources are scarce, a choice had to be made between allocating more resources to saving children’s lives or to treating Aids sufferers in the terminal stage of the disease, the ethically right decision would be in favour of the children, since they have a greater life expectancy and more chance of happiness. In practice, the problem none the less arises in determining what constitutes the final good for human beings, since utility is a relative concept.

The third school has its origin in Kantian philosophy and focuses on the concept of duty, as expressed in the well-known categorical imperative that people should act only according to maxims that they might wish to see become a general law. For Kant, what counts in an action is the will of the agent and acting according to one’s duty. Freedom is not rejection of any external determination, it is awareness of one’s independence in the face of constraints and circumstances. The only limit on

7.  
V. Alvaro L. M. Valls,  
*Ética na Contemporaneidade*, Dep.  
Filosofia – UFRGS, see  
<http://www.bioetica.ufrgs.br/eticacon.htm>

an individual's freedom of action is others endowed with the same power/duty. The second formulation of the categorical imperative – that we should act in such a way as to treat humanity (ourselves and others) as an end in itself and not a means – enshrines the ethic of respect for individual human beings and humanity in general. This theory is described as modern in that it places trust in human beings, and in their reason and freedom. It is divorced from consumerist capitalism since it accords little value to the enjoyment of pleasures and emphasises the importance of duties. It holds that happiness lies in awareness of having done one's duty, in the tranquillity that comes from a calm conscience.

However, some thinkers (for example, Merleau-Ponty) have objected that freedom is not to be found beyond one's being but rather in things. It is an exchange and a reunion between the internal and the external, since human beings are free in the world and with others. Neither determinism nor absolute choice exist. We are not only in the world, we are the world.

Without coming out in favour of one of these theories, it is worth drawing attention to certain matters that are assuming a growing importance. It is said that the only world in which it is possible to live well is one where people treat others as human beings (Fernando Savater). To achieve this in practice, everyone must try to put themselves in others' shoes, which does not mean systematically siding with them. Recognising someone as a fellow human being entails understanding them from the inside out; espousing their point of view, if only momentarily; taking account of their rights, or failing that, their reasons.

This in fact brings us close to the concept of respect for human dignity in all circumstances, although some people<sup>8</sup> add that account must be taken of individual "merit".

At the same time, all the major moral theories include the principle of impartiality, which does not just entail impartial consideration of individuals' interests but also prohibits treating them in an arbitrary manner.

The Portuguese neurologist António Damasio<sup>9</sup> asserts that there is no moral centre (or centres) in the human brain. Good

8. James Rachels, *The Elements of Moral Philosophy*, fourth edition, New York, McGraw-Hill, 2002.

9. António Damasio, *Looking for Spinoza*, San Diego, Harcourt, 2003.

and evil are not revealed, they are discovered. Ethical behaviour is the outcome of a number of synergies: biological regulation, memory, decision-making, inventiveness. Acknowledging that Spinoza was right, he says: "The biological reality of self-preservation leads to virtue because in our inalienable need to maintain ourselves we must, of necessity, help preserve other selves." We cannot preserve ourselves without society.

Good actions are those which, while doing good to individuals through their appetites and natural emotions, do no harm to other individuals. We derive our well-being from friendship and the benefits we bring to others. The natural tendency to seek social harmony has been incorporated in our brains, through the evolutionary process, in the form of co-operative behaviours.

### **Respect for human beings**

In modern European societies which have their roots in the ethical principles set out above – while bearing in mind that these values are not set in stone for all time – solidarity-based respect for human beings and their dignity, in particular those whose suffering is greatest or who are the most deprived of material or spiritual wealth, can be seen to constitute a paradigmatic framework for a discussion of this kind. The significance of responsibility for one's own decisions (responsibility ethics) follows from the protean concept of freedom, which cannot be absolute since that would make relations within society unviable; balancing individual freedom against the interests of society (the ethical imperative) must not result in encroachment on, nor unnecessary interference with, individual privacy.

Debate over values must take place in accordance with the principles of tolerance and pluralism – but without making equality of subordinate importance and without unnecessarily detracting from individual autonomy – in an atmosphere of impartial reasoning. Many major international instruments, ranging from the Universal Declaration of Human Rights and various international conventions to the European Convention

on Human Rights, not forgetting national constitutions, enshrine ethical principles. However, here too an ethical debate is necessary owing to the very fact that they may be showing signs of wear with the passage of time.<sup>10</sup>

10.

See Article 5, paragraph e), of the European Convention on Human Rights itself, which provides for an exception from the right to liberty in the following case: "the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants". The author believes that the stigmatisation resulting from such situations goes too far and may violate the dignity of the persons concerned.

11.

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, ETS No. 164. This convention was opened for signature by Council of Europe member states in Oviedo on 4 April 1997; it has been in force since 1 December 1999; it has been ratified by 18 Council of Europe member states (1 October 2004) – see <http://conventions.coe.int/>

## An alternative to imprisonment

Where a treatment measure is applied to a drug user as an alternative to imprisonment, the salient point, in ethical terms, is the validity of the consent given. A parallel must be drawn between this consent and the withholding of consent, or refusal of the measure.

It is only where there is freedom of choice that a decision can be regarded as freely taken and entailing liability for the consequences, be they good or bad. Aristotle maintained that an act done under compulsion or in ignorance could not be voluntary. Persons who are not in control of their own destinies may wish to do something, but cannot act out of free choice. Being able to act according to one's duties presupposes that one can act according to one's wishes.

Safeguarding individual autonomy is linked to freedom from manipulation, to the right to freedom from interference by the state or one's fellow citizens. Effective, relevant information makes it possible to choose what is best. Let us draw examples from a recent international instrument in a neighbouring field, the Convention on Human Rights and Biomedicine.<sup>11</sup>

"An intervention in the health field may only be carried out after the person concerned has given free and informed consent to it.

This person shall beforehand be given appropriate information as to the purpose and nature of the intervention as well as on its consequences and risks.

The person concerned may freely withdraw consent at any time."

(Article 5)

Where a person is unable to consent, the intervention may only be carried out for his or her direct benefit:

"[...]an intervention may only be carried out on a person who does not have the capacity to consent, for his or her direct benefit."

(Article 6)

Similar rules apply where an adult does not have the capacity to consent to an intervention because of a mental disability, a disease or for similar reasons:

"Where, according to law, an adult does not have the capacity to consent to an intervention carried out with the authorisation of his or her representative or an authority or a person or body provided for by law."

(Article 6.3)

Additionally:

"Subject to protective conditions prescribed by law, including supervisory, control and appeal procedures, a person who has a mental disorder of a serious nature may be subjected, without his or her consent, to an intervention aimed at treating his or her mental disorder only where, without such treatment, serious harm is likely to result to his or her health."

(Article 7)

In the case of an emergency:

"When because of an emergency situation the appropriate consent cannot be obtained, any medically necessary intervention may be carried out immediately for the benefit of the health of the individual concerned"

(Article 8)

Where research is conducted on human guinea pigs, not only must their consent be free and informed, but it must be given expressly and specifically and be documented; such consent may be freely withdrawn at any time:

"Research on a person may only be undertaken if all the following conditions are met: [...]the persons undergoing research have been informed of their rights and the safeguards prescribed by law for their protection."

(Article 16.*iv*)

Stronger guarantees apply to protect persons not able to consent to research.

The author believes that, in cases of treatment as an alternative to imprisonment, although their acceptance is described as voluntary, drug addicts are unquestionably placed under some psychological pressure by the courts. These offenders have to weigh the suffering and foreseeable disadvantages of imprisonment, including probable deprivation of drugs and uncertainty as to the availability of appropriate medical care, against subjection to a programme of treatment, possibly also a cause of suffering, and to other conditioning, especially where they are not new to such an experience. Whether they agree to or refuse treatment, they must enjoy at least a modicum of freedom of decision.

From an ethical standpoint, questions must be asked about the validity of acceptance or refusal of treatment in the case of someone whose free will and ability to comprehend the situation are undermined, someone who may not even have any form of medical assistance and who may experience “cold-turkey” symptoms (withdrawal syndrome) or mental problems.

This means that the ethical approach consistent with respect for drug users’ dignity and individual autonomy is to refrain from compelling them to take a decision if they are not in control of themselves and are incapable of making an informed, free choice.

Where that is the case – and to diagnose it a psychiatric examination is necessary – can/must the state, acting through an independent body, order the preliminary treatment of the person concerned (detoxification) until that person fairly rapidly attains the necessary level of capacity?

The author believes that the state must first engender the necessary conditions and only then can it legitimately proceed. This means that it is only after hearing the psychiatric expert, and possibly after a period of treatment – the compulsory nature of which cannot be ruled out, that the court may or may not pronounce the conditional judgment.

## **A compulsory admission**

In the second of the situations described above the measure is applied regardless of the wishes of the drug addict, who is subject to a compulsory admission order with a view to undergoing obligatory treatment.

From an ethical standpoint, what is at stake here is not so much consent and individual autonomy – although beforehand the same problem arises as to whether the defendant's refusal of treatment was a free, informed choice – as values such as the right to moral and physical integrity and protection of privacy or non-interference by the state with the private lives of citizens addicted to drugs.

This situation can be considered from two angles:

- the situation of drug addicts who have committed fairly serious offences;
- that of persons who have merely committed offences of use or possession for their own use, which the law treats as minor criminal offences or mere administrative offences.

In the first case it is argued that compulsory treatment is justified on public interest grounds, in the same way as most countries make education compulsory until a given age or require the compulsory isolation in hospitals of persons suffering from serious contagious diseases. It is also contended that the person concerned is incapable of ending his or her drug addiction and the link between drugs and crime represents a risk for society.<sup>12</sup>

However, this obligation is considered justifiable only where the person concerned has been identified under a fair procedure as the perpetrator of an offence in which his or her drug addiction played a significant role. Furthermore, there must be a guarantee that the treatment will be effective for the majority of those concerned.

In the second case, where there has been no formal judicial procedure, it is not possible to defend the idea of compulsory treatment, but merely that of encouragement to undergo treatment.<sup>13</sup>

12. Andreas Kapardis, "Compulsory treatment and compulsory admission to care", paper presented at the seminar on "Ethics, professional standards and drug addiction", Strasbourg, Council of Europe, 6 and 7 February 2003.

13. The situation of pregnant drug addicts, where the issue is the right not only to life but also to a healthy life, poses a different problem.

A comparison can be drawn between the compulsory treatment of patients suffering from mental disorders and that of drug users. In both cases the same degree of prudence is called for.

The Portuguese Constitution provides for the possibility of “admission of persons suffering from a psychiatric disorder to an appropriate therapeutic establishment, ordered or confirmed by a competent judicial authority”.<sup>14</sup>

Persons suffering from serious psychiatric disorders who jeopardise personal or pecuniary legal assets of significant value, whether belonging to themselves or to others, and who refuse to undergo the necessary medical treatment may be placed in an appropriate establishment. Persons suffering from serious psychiatric disorders who lack the capacity to appreciate the meaning and scope of their consent may also be placed in an establishment where lack of treatment would considerably worsen their state of health.<sup>15</sup>

These arrangements are none the less surrounded by many safeguards so as to prevent arbitrary decisions: a consensus is sought between the doctors and the judges concerned, habeas corpus is applicable in cases where the decision process was excessively slow, the decision was taken by a body lacking due authority or the circumstances did not correspond to those laid down by law; the court reviews the situation on request and, obligatorily, every two months.

The author believes, *de jure condendo*, that these rules could also be applicable to drug addicts, with the necessary adaptations, if the competent medical authority confirms that the essential precondition of the existence of a serious psychiatric disorder is fulfilled.

In many countries the degree of co-operation between the justice and health systems is far from satisfactory, although people are beginning to acknowledge that it is essential that they work in partnership in criminal proceedings concerning drug addicts.

14.  
Article 27, 3, (h).

15.  
Section 12 of Law  
No. 36/98 of 24 July.

Studies and scientific research show that outside pressure, by the drug addict's family or the court, is increasingly important as a factor determining the success of treatment.<sup>16</sup> In the Netherlands, the most problematic drug addicts may be obliged to submit to a prison-based treatment programme lasting two years at most, and the participants themselves have given a positive verdict on this approach.

The more widespread compulsory treatment of drug addicts becomes, the more essential will be the need for observance of ethical principles before, during and after treatment.

Just as it seems unjustifiable, in terms of respect for human dignity, to force a drug addict to undergo treatment as an alternative to imprisonment without his or her free, informed consent, no compulsory treatment must be ordered for a lengthy period without guarantees as to the beneficial outcome, nor must drug addicts be required to undergo detoxification without this being followed by an appropriate therapeutic strategy aimed at prolonging the effects of the treatment.

16.  
See [http://www.projectcork.org/bibliographies/data/Bibliography\\_Compulsory\\_Treatment.htm](http://www.projectcork.org/bibliographies/data/Bibliography_Compulsory_Treatment.htm)



## Drug testing in the workplace

by Tom Mellish

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

## **What is the scope of the 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 work canteen.

The policy must set out clearly who has overall responsibility for its implementation. 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 the 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. At least one million people are at any one time using prescribed tranquilisers – many for reasons that 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 the employer that he or she is taking prescribed medication and how that may effect the way he or she is able to carry out 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 diagnosis 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 he or she is responsible.

The policy must also guarantee a no-blame, non-judgmental 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 he or she continues 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 must also 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 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; and also for all 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 colleague to seek assistance. Training for staff and their commitment to the policy is essential. Training and education must also be ongoing and under regular review to ensure 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. In the UK, for instance, there are over one million people at any one time using prescribed tranquilisers to maintain the 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 widespread use of drugs for a range of short-term and ongoing illnesses that, 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, for example:

- *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 cannot be given if an employee is under duress, for example from the loss of employment 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;*
- *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 that most people would consider a highly developed system. Testing regimes are in themselves no guarantee that the workplace will 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 it 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 workforce. 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 this only indicates whether 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.

There is also a risk that testing may be 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. Discussion of the legal position on drug testing also raises broader moral questions.

### **Private life, public life**

A distinction between the public sphere and private sphere has been fundamental for liberal societies like the UK and much of Europe. For a society that is committed to the values of tolerance and autonomy, the mere fact that an action is disapproved of – or is harmful to the individual involved – does not, in itself, provide a compelling justification for interference with personal choice and private life. The fact that it may harm an individual does not give carte blanche for the state to interfere in that person’s right to continue with that practice.

Perhaps the best-known statement of this principle is found in J.S. Mill:<sup>1</sup>

“the only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is

<sup>1</sup>.  
*Essay on Liberty*,  
1859.

to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant.”

It can be argued that the state is sometimes justified in acting, paternalistically, to protect individuals from the harmful consequences of their own actions. Nonetheless, there is, in general, a strong presumption against interfering with individual freedom, which can usually be overridden only by demonstrating that this is necessary to protect others from harm. The philosopher Grayling<sup>2</sup> argues that liberal societies accord a special moral weight to the rights and freedoms of individuals, but that these freedoms can be limited where third parties are affected or harmed. There is surely widespread agreement that drug use by people whose work affects the well-being, and even lives, of others must be a matter of special interest. Passengers would not welcome an airline pilot who was drunk or higher than the plane he was flying.

It could be argued therefore that employers are justified in requiring their employees not to turn up for work in a condition where their intoxication, while not a threat to safety, is an embarrassment or a nuisance. Unions would for the most part concur with this. But this is testing with cause; random testing must be unethical as it would undermine the principles of a liberal society where an individual is doing no harm to others.

## **Liberty and the law**

If an employee or prospective employee takes cannabis or cocaine, then that is a criminal offence. Surely, this is a case for drug testing at work.

Employers do have a legitimate interest in knowing whether the people who work for them have broken the law but this is significantly different from allowing employers to actively investigate employees and potential employees, which testing would represent. Would it then be legitimate for the employer to go further and have the power to search the houses of job applicants, or to monitor the bank transactions of their staff, or even to acquire stop and search powers? Does society expect employers to be its policemen?

2. Grayling, A.C., MA, DPhil, is Professor of Philosophy at Birkbeck College, University of London.

Employers do interest themselves in the activities of staff and how it may impact on their work, but this does not give them the right to impose strictures on their leisure time simply to increase productivity at work. Random testing which uncovers a person's private activities introduces a questionable grey area. It raises questions about the degree to which, in the absence of express agreement and definition, an employer can exercise influence over employees' private lives. Only the most careful mutually agreed arrangements between individuals and those who employ them in safety-critical situations can be regarded as ethically sound.

Evidence presented to the Independent Inquiry into Drug Testing at Work in the UK in 2004 underlined an acceptance that drug testing at work did constitute an invasion of privacy and that there needs to be a compelling reason for overriding this right.

### **Purposes and outcomes**

Rather than looking at what might motivate employers perhaps it would be more profitable to look at the outcomes of drug-testing regimes. If drug tests do not improve safety or enhance performance, then the case for testing is weakened significantly.

Even where there are good arguments for drug testing at work, there will also be ethical questions about the *type* of testing that is used. As a general principle, there is a clear case for saying that employers should adopt the least invasive drug-testing regime that is consistent with realising their ends. While drug testing will rarely – if ever – constitute “degrading” treatment in the sense required to invoke Article 3 of the Convention of Human Rights and Fundamental Freedoms,<sup>3</sup> it may be humiliating, uncomfortable or embarrassing for many.

3.

ETS No. 5, Article 3: Prohibition of torture: “No one shall be subjected to torture or to inhuman or degrading treatment or punishment”.

### **Fairness**

In order to ensure that testing is not discriminatory no employee should ever be “selected” for testing without good reason. This effectively means that workplace drug testing – if

it is not voluntary – should either be “for cause”, “post-accident” or random, and within a transparent and agreed policy. It is also important that any disciplinary action taken against workers who test positive is fair and proportionate.

If the employer is simply testing for use of an illicit substance, discipline such as suspension or dismissal might be seen to constitute an arrogation of a law-enforcement role by the employer. The employer imposes a “sentence” and therefore could be seen to be acting in a quasi-judicial capacity.

This would imply that any disciplinary action should be focused on the consequences of impairment for performance at work rather than the consumption of a drug as such. But nor should the responsibilities of employees be neglected. Society takes a dim view of people who drive under the influence of alcohol. It is also wrong for people to turn up at work in a state of intoxication that makes them unfit for their work and might put their colleagues or members of the public at risk.

## **Welfare**

Employers are becoming more and more involved in staff welfare and health issues, providing health care services and health insurance as well as gym facilities. Employers would be thought to be “good” employers as well as have ethical obligations, alongside any legal responsibilities, to deal in a sensitive and appropriate way with staff who, for example, develop significant health or mental health problems. In part, this is because depriving employees of work is likely to exacerbate problems as people become increasingly reliant on workplace relationships for support and structure in their lives. Similar considerations could apply to staff with drug and alcohol dependency problems. It is also arguable that employers have an ethical responsibility to ensure that the pressures of work are not so excessive as to increase significantly the chances that staff will turn to damaging forms of alcohol or drug use, for example, by ensuring workloads do not become unmanageable and by taking firm action to tackle bullying at work. Hence the significant interest at the European level in ways to

combat stress as reflected in the Social Partners Agreement signed in late 2004.

### **Social problems and social responsibilities**

Work provides a structured life and social support and friendship networks. This means that the way that employers approach drug testing at work has wide repercussions for society as a whole. There are obvious and strict limits to the extent that society can reasonably expect employers to shoulder responsibility for social problems. But it is important that these wider issues are not ignored in the debate about drug testing at work.

People do not develop alcohol and drug problems independently of everything else that is happening. An awareness of the wider causes and contexts of problematic substance use is needed. There is a growing body of anecdotal evidence that the demands of work are greater than ever before, and that some people turn to alcohol and drugs as a way of dealing with these pressures.

It is evident that employment policies, both at national and workplace level, need to address the causes of problematic drug and alcohol use in particular by recognising the need for a sensible work/life balance.

Employers, like the rest of us, are ordinary members of our community who find themselves in a position of responsibility and with some authority for which many have received no training and have limited experience to draw on. Like the rest of us they are concerned at the alarmist headlines of the red-top newspapers and see drug-related crime all around them and respond accordingly. Those companies which accept the need for corporate social responsibility have the resources and access to expertise to assist them in this delicate area. But many other employers do not. They see drug testing as a way of protecting the firm and see it purely as a cost and benefit issue. Unfortunately, the costs of an inappropriate approach to

drugs at work materialise only when their policy, if they have one, fails.

The ethical and legal quagmire of drug testing can only be avoided if employers first consider whether they really do have a problem and they can find that out by talking to and fully involving their workforce. In order to gain the confidence of their staff, employers must respect their workforce and that takes investment, both of time and patience. If employers respect their workers the need for drug testing starts to become irrelevant.



# Access to treatment for young users of psychoactive substances

by Olivier Simon, Renaud Stachel and Bruno Gravier

In the majority of European countries the social and health-care facilities available for minors and young adults who use psychoactive substances are once again the subject of hot debate.

Issues surrounding compulsory drug screening in schools or the workplace, heavier penalties for minors, new forms of treatment and, in the absence of specialist facilities, placement in adult psychiatric units have come to the fore and illustrate the emotional focus of the debate.

Access to care, a key indicator of the effectiveness and fairness of a health-care system, is directly linked to the way such problems are addressed in our societies. The ethical dimension takes on vital significance, especially when measuring the gap between many people's unrealistic expectations of the total eradication of consumption and the day-to-day reality in which consumption of alcohol or cannabis, if not widespread among adolescents, is at least relatively commonplace.

The aim of this chapter is to take a look at the ethical issues surrounding the accessibility of assistance and treatment for young substance abusers. We shall first of all define some of the key terms used and then look at the relationship between clinicians and patients, and the way in which such care or treatment is organised.

## Harmful use or use comprising a risk

**Case example No. 1** – A 13-year-old boy, claiming to have no previous history of substance abuse, was brought by two friends to a hospital accident and emergency unit, in a delusional state, after eating a cake containing cannabis. The three refused to give their names, fearing that their parents would be informed. One of the boys had been arrested a short time previously in possession of cannabis for his own personal use and charges were being brought against him as he was suspected of dealing.

With regard to psychoactive substance-induced health problems, the international classification of diseases mainly relates to adults (1, 2)<sup>1</sup>. There are two main categories – (i) chronic dependence, whether physical or psychological, and (ii) “harmful use” or “abuse”. The latter presupposes consumption patterns with proven negative effects on a given subject, although the stage of dependence strictly speaking has not yet been reached. In addition to these “diseases” there is a wide range of usage patterns which do not necessarily entail health problems; these include isolated instances of use, controlled recreational use generally in some form of social context, and use comprising a risk, the nature of which varies according to the type, dose and method of administration of the substances in question (3).

This classification is not always appropriate for adolescents (4). Dependence or addiction, far from being invariably chronic, may be sub-acute or acute. The inherent risk factor itself may provide the main “kick”, without the user reaching the stage of “harmful use”. The risk may therefore be a psycho-pathological one, as in the above situation, it may foreshadow the initial stages of addiction, or quite simply it may relate to the social repercussions that could ensue.

Epidemiological surveys showing a clear increase in substance abuse among the young are somewhat vague about the level of consumption which specifically causes health problems.<sup>2</sup> While the old escalation theory whereby a “joint” would inevitably lead to intravenous heroin use has now clearly been discredited, observations of animals nonetheless suggest that early exposure to substances increases the neuro-biological vulnerability to subsequent addictions (5).

However, such observations might lead us to overlook the fact that the risks involved in the use of a given substance are not limited to its effects on the mind and body. The reactions from family, friends and society may be more dangerous than the substance itself if they lead to stigmatisation and exclusion (6).

1. These figures refer to the bibliography.

2. See the summary of the 2003 European School Survey on Alcohol and Other Drugs (ESPAD) <http://www.espad.org/diagrambilder/summary.pdf>

See also the Swiss Institute for the Prevention of Alcoholism and other drug addictions (ISPA), *Chiffres et données sur l'alcool et les autres drogues 2004*, Lausanne, 2004.

## **The nature and accessibility of treatment**

In order to define “access to treatment” we need to consider the concept of “treatment” itself. Is it imperative that it be provided in response to an explicit request? When dealing with consumers who might be classified as being “at risk”, before any “disease” develops, are we talking about treatment, assistance or prevention? And if the latter, what form of prevention exactly?

Is it primary prevention (before disease develops) or secondary prevention (identification of what is termed a “sub-clinical” form, before symptoms appear)? Are we thinking of selective prevention (targeting the whole of a subset deemed to be at risk) or indicated prevention (and in that case, based on what criteria)? Are we talking about offering personal assistance or simply providing information?

Lastly, should all this be governed by the rules of the medical or other professions (teachers, social workers, police), all having their own code of ethics? In what follows, we shall be considering “treatment” in the broad sense, rather than in its strictly medical interpretation.

In the field of addiction, the concept of accessibility of treatment facilities depends on a variety of criteria, some of which are now being well documented (7-11). Key factors are the provision of a welcoming physical and relational environment, conveying a message of respect for the person and confidence in his or her ability to attain self-fulfilment, guarantees of confidentiality, the possibility of free care, and even anonymity. It is also important that the treatment facility is close by, that it can offer an appointment quickly, provides a variety of treatments, is flexible and able to satisfy all sorts of assistance needs, accepting patients as they are, not as some would like them to be.

## Ethical questions concerning the professional attitude of operators

**Case example No. 2** – A 15-year-old girl arranged to see the nurse at her school on the advice of her friend who had said that she could rest assured her mother would not be informed. She had had unprotected sex during a night out with friends, after taking something she said was GHB or ecstasy. She did not remember exactly what had happened. Two weeks later, the nurse was called by the mother who insisted on being told why her daughter had gone to see her. Although the nurse complied to the letter with her duty of confidentiality, the young girl felt under threat and refused all offers of assistance. Some time later, the girl's mother was rushed into hospital following an attempted overdose.

Ideally a treatment relationship should be truthful, open, professional, collaborative and participatory. From a specifically ethical point of view we can add that it should offer confidentiality, respect for the patients' privacy and honesty (12). In addiction therapy, clinical research has shown that where the patients' friends or family can be involved, the prognosis is much better (13). But what about cases where such involvement, far from being voluntary, is mandatory because the patient is under age or because it is insisted upon by the parent or person acting *in loco parentis*? What is the right approach when faced with the conflict between the duty to comply with legal obligations and the imperative need to avoid heightening the risk that the patient will fail to attend treatment or simply stop it before it has run its full course?

### Legal competence and capacity for discernment

The concept of "competence" to consent to treatment is a matter for the courts to decide but varies considerably from one country to another (and even within a country such as Switzerland, from one canton to another). It defines the extent to which parents are able to have a say in the decision in accordance with predetermined criteria, but allows for some excep-

tions to be made for reasons of public health, such as pregnancy, sexually transmitted diseases or substance abuse (14).

In contrast, a person's "capacity for discernment" is a matter for the clinician to decide, on a case-by-case basis. There are two aspects to it: the first is cognitive (the capacity to understand) and the second, volitional (capacity to decide in line with that understanding) (15). Under law, there are only two possible answers – either a person has the capacity or does not. In subjects who have reached what is usually termed the "age of reason", any difficulties in assessing this capacity will be related most often to the volitional level. It must be borne in mind that any assessment of capacity relates exclusively to one particular form of treatment: it is perfectly possible for a person to be deemed capable of discernment for one decision but incapable for another. Assessing this capacity for discernment is an essential part of the clinician's role.

While children and adolescents may be capable of perceiving a major risk, in practice they may, at emotional or behavioural level, deny its existence. Underestimating the capacity for discernment can give the wrong message, possibly resulting in a counterproductive passive approach to the various forms of assistance on offer. Conversely, overestimating this capacity could substantiate mistaken ideas about a perceived "unwillingness" and reinforce feelings of incomprehension and exclusion.

### Confidentiality and respect for privacy

**Case example No. 3** – A 21-year-old man was dismissed following a urine test ordered by the garage where he was an apprentice. His parents, shocked by this turn of events, threatened to end their financial support. He swore that he had never taken any opiates other than the codeine-based cough medicine prescribed for him by his GP. He said that he had occasionally taken cocaine, but claimed to have always ensured that this was well before any tests carried out at work.

In the case of minors, two international treaties reinforce the rights of children and adolescents with regard to medical confidentiality. The United Nations Convention on the Rights of the Child<sup>3</sup> (16), now in force in all European countries, and the Council of Europe's Convention on the Exercise of Children's Rights<sup>4</sup> which came into force on 1 July 2000. In theory, if a minor is deemed capable of discernment, he or she alone decides on matters of personal medical confidentiality and is the only one who can authorise a doctor to break that confidentiality.

There is a considerable body of literature (17-20) attesting to the importance of confidentiality as an incentive for adolescents to seek treatment. A further incentive is the ability to receive treatment or information anonymously (e.g. blood tests, information via the Internet).

In practice, it is neither productive nor helpful to give parents the impression that they are being sidelined because of the need to maintain confidentiality. Parents are by far the ones most likely to make the initial call for help. Excluding them could be harmful not only for the youngster involved, but also for the parents themselves, whose distress very often conceals their own neglected health problems (for example, chronic depression with suicidal tendencies) (13).

At another level, contractual policies such as those in the above case example, obliging an adolescent to undergo screening tests, can severely encroach upon a person's privacy and jeopardise the adolescent's relationships and working life.

Depending on the constraints laid down by domestic legislation, situations in which confidentiality may or should be broken should be made clear at the outset, in order to clarify and lend credibility to the treatment proposed (21, 22). However, surveys have shown that primary care providers are in need of training on how to convey this idea of "conditional" confidentiality (23).

3.  
Adopted on 20 November 1989, in force in Switzerland in 1997.

4.  
ETS No. 160; see also <http://conventions.coe.int/Treaty/EN/v3MenuTraites.asp>

## **The right to consent to treatment and the right to refuse**

In order to be legally valid, consent presupposes a capacity for discernment, a lack of pressure and the provision of all relevant information (the idea of “free and informed” consent) (12).

In the case of adolescents, this idea raises serious ethical questions in terms of autonomy, since the right to consent to treatment is not dealt with on the same level as the right to refuse. Under the international treaties cited above, children and adolescents are certainly able to give their consent, even against the wishes of their parents, but that does not guarantee them the right to refuse: in the majority of cases, parents or any of the authorities acting with parental responsibility are likely to override any such refusal in the higher interests of the minor (14, 24).

It is quite easy therefore to appreciate the risk of a clinician crossing the line between a collaborative and a hierarchical approach, which is somewhat incompatible with the role of a treatment provider (25). Before availing oneself of this margin of appreciation available to adults, one must first of all weigh up the respective pros and cons of avoiding the risk in question (which should be clearly identifiable, with short-term effects) and the longer-term risk of making the adolescent wary of all forms of treatment relationships as a consequence of his or her first, unfortunate, experience.

Clinically speaking, where a person in authority has taken advantage of this margin of appreciation in the past, he or she is more likely to do so again. In point of fact, it occurs very frequently in cases concerning patients with a serious addiction problem.

## **The right to information**

There are also frequent ethical questions regarding the quality of the information provided. For some, particularly those in the policy field, only the simplest possible message can be taken on board. But there is a risk that this message will become a simplistic one: as all drugs can be dangerous depending on how they are used, all drugs should be

forbidden to minors and the only effective way of dealing with the problem is the unambiguous promotion of abstinence; any other approach being contradictory or indeed incomprehensible (26).

Regardless of the fact that such an approach could be seen as being a crude attempt at persuasion, simplifications of this sort violate the ethics of care provision. It is an obligation to provide accurate and truthful information. Simplifications are also an insult to the capacity for understanding of an adolescent, on the threshold of becoming a fully-fledged citizen. Some people fear that qualified information might “encourage” consumption. The public at large and politicians regularly express their concern about the allegedly negative impact on young people of harm-reduction prevention measures targeted at adults (such as needle replacement, substitution treatment). In fact, surveys of young people show that such measures tend to have a neutral or preventive effect. It is other factors that tend to be more influential in encouraging consumption, such as peer or parent drug use (27).

### **Constraint**

Although it is preferable for requests for assistance to be made voluntarily, and leaving aside cases where action is urgently needed for psychiatric reasons in the strict sense, there are nonetheless cases where treatment is ordered by a civil-law or criminal-law authority. Who then should be tasked with administering this treatment?

Logic would suggest that when one ethical principle (in this case, beneficence or non-maleficence) takes precedence over another (autonomy), solutions need to be found to limit the consequences of this precedence to a minimum (12). It is essential to maintain the freedom of choice as to where such treatment is to be administered and the nature of the treatment to be provided. The relevant authority should make do with general progress reports, indicating whether the treatment ordered is taking place or not. Ethical questions come to the fore if a court demands to see the medical file, and in particular the results of urine tests.

There are other ethical issues involved where the treatment order is given not by an authority but by a school or place of apprenticeship, with a threat of exclusion as in case example 3: is the entity concerned entitled to ask for something other than a medical certificate of fitness? If it is planned to liaise with an establishment of this type, it needs to be made clear who is best placed to do this: the employer's medical service, a school psychologist or the social services?

### Issues relating to the provision of treatment

**Case example No. 4** – A 16-year-old girl was admitted to hospital to treat an abscess in her groin. It became clear that she was an intravenous heroin user. The surgical ward was at a loss what to do because of her ongoing consumption while in hospital and the difficulty in obtaining an appointment with the local psycho-social centre, which was mandatory if she was to be given psychiatric care. In order to continue the physical treatment for the groin problem, and after the girl had run away twice from hospital, it was decided to opt for short-term morphine substitution treatment. However, any attempt to lower the morphine dose was immediately followed by a return to heroin consumption. The family was opposed to an application for exceptional authorisation from the health authority for methadone to be prescribed. To date attempts at both hospitalisation and out-patient treatment have been unsuccessful.

### “Low threshold” services and getting across the message of abstinence

Given the public service trend towards creating single access points as a means of rationalising treatment facilities, consideration of the obstacles to accessibility has tended at times to be neglected. Above and beyond matters of a technical nature, the key issue is whether the fundamental role of public establishments should be to promote an unequivocal ideal of abstinence as the ultimate aim of any treatment approach,

regardless of whether the person being addressed is a user “at risk” or a young person addicted to a wide range of drugs (28).

In support of the promotion of abstinence as the only message, some people stress that public institutions have an obligation to uphold legislation forbidding the use by minors of the vast majority of substances. Some play the health card; yet others claim that it is technically impossible to offer certain forms of treatment to active abusers. The need to protect other people undergoing treatment is also argued. It is only rarely that any mention is made of the risks of not undergoing treatment or the consequences of this for public health. It would appear that the arguments put forward are more a means of promoting abstinence as a value system.

Opinions within the community differ considerably with regard to abstinence. Some people appear to be in favour of a general prohibition and emphasise abstinence as an ideal to be attained, despite the high level of mortality that such a policy might entail. Others believe a distinction should be made between legal and illegal substances for a given age-group, between “hard” and “soft” drugs. Others would like to liberalise all drugs, claiming that their negative effects are due to the fact that they are illegal. Lastly, there are those (the majority according to a referendum held in Switzerland) who, while accepting the international treaties governing the prohibition of certain substances, favour a pluralist prevention policy, encouraging both help with abstinence and measures to increase users’ chances of survival, under a harm-reduction policy.<sup>5</sup>

One might therefore legitimately wonder whether in order to foster fair access to assistance, a public establishment should first of all cater for all these different viewpoints and distance itself from the arguments for or against the ideal of abstinence.

Interestingly, services providing treatment for addicts which advertise both abstinence-based and controlled consumption treatment find that it is the second option which attracts most patients. Subsequently, following an individualised approach, many patients, including the younger ones, tend to choose strict abstinence rather than controlled consumption (29). It should also be noted that research on spontaneous remissions

5. Federal Office of Public Health “Swiss drug policy”, 2001; available at: <http://www.suchtundaids.bag.admin.ch/imperia/md/content/drogen/11.pdf>

shows that the controlled consumption option is not as unrealistic as might have been thought in the past (30).

### **Non-discrimination and continuity of treatment**

From an ethical point of view, refusing to treat a young patient because of drug abuse in a health-care establishment is unacceptable. Such refusal is, moreover, in theory prohibited by provisions in the international treaties cited above dealing with non-discrimination in respect of access to health-care (16). As the case examples show, such refusals sometimes result in the young patients concerned being transferred to adult addiction treatment centres or psychiatric units, and it is reasonable to ask whether these are the right places to treat adolescents. In order for treatment to continue in the original setting, there need to be liaison services providing the primary clinician with effective advice and assistance in such delicate situations (31, 32).

In situations where the relationship between patient and clinician appears to have reached deadlock (for example, where there is illegal sale of drugs in the health-care establishment, or physical violence), recourse to the police poses a number of ethical confidentiality-related problems for other patients in the establishment. One solution in order to ensure continuity of care is temporary transfer rather than interruption of treatment (28).

### **Substitution treatment for adolescents**

**Case example No. 5** – A 14-year-old girl living in care occasionally resorted to prostitution and in the space of six months had become addicted to heroin administered intravenously. The child and juvenile psychiatric service referred her to the withdrawal unit of the adult psychiatric service, since the counselling she was being given was complicated by the fact that she was injecting herself before every appointment. In the end, she stopped her hospital treatment. Two years later she was diagnosed as having hepatitis C. Exceptional authorisation was given by the health authority for methadone substitution treatment.

With young or very young patients, generally speaking the consumption pattern has begun relatively recently. Quite apart from the restrictions which apply in this field, naturally enough opiates are much less frequently prescribed than in the case of adults. Such treatment cannot be considered a means of attracting or retaining patients. As we shall see below, these aims are best achieved by ensuring co-operation between the various services and the provision of networked support.

On the legal level, however, questions could be asked about the discriminatory nature of the rules limiting access to this type of treatment for minors. In practice, it is possible in most cases to get round these restrictions, but it is not unreasonable to wonder whether excessively cumbersome procedures for obtaining special authorisation could lead to a significantly increased risk of overdoses (33).

Despite a considerable body of very revealing clinical research, the risks inherent in prescribing opiates have been somewhat distorted. Because of the history and symbolism attached to this class of analgesics, a number of health-care professionals are unaware that prolonged methadone use has no harmful effects, even though this has been documented by several decades of pharmacovigilance. Conversely, the risks of dying from an overdose following a poorly conceived course of withdrawal treatment are still too often underestimated, or worse denied, as too are the risks of infection as illustrated in the above case example.

### **Equivalence of care**

**Case example No. 6** – A 17-year-old had been taking cocaine at weekends for just under a year and smoking cannabis on an almost daily basis. He was placed in an adult psychiatric unit for depression but discharged for bringing joints into the unit. A few days later he was taken into custody for trafficking in his workplace and released without seeing a medical officer. He was once again admitted to hospital shortly afterwards and referred to a clinician under a new liaison programme. While still in hospital, he could be regularly monitored.

The number of minors held in custody is rising and as a result the prisons sector has to look long and hard at how minors with an addiction are handled. The equivalence of care principle should apply to them in the same way as to anyone deprived of their liberty (34). The tensions everywhere between the role of prisons and the requirements of public health are heightened in the case of adolescents suffering from severe anxiety problems resulting in violent behaviour. It is essential to review the lack of appropriate services for adolescents held in adult prisons, a situation that may occur in many European countries.

### **Quality assurance and programme evaluation**

Evaluation is one of the key concerns of those responsible for financial and policy matters, and it is also central to the ethical dimension of addiction treatment facilities (28). Where such evaluation takes on a clinical research dimension, it must also be subject to ethical provisions governing biomedical research, which are even more stringent in the case of minors (35). However, in contrast to these quality of care objectives, we have a situation in which, with regard to addiction in general and adolescents in particular, the scientific literature has constantly revealed an under-diagnosis of substance abuse. In Switzerland, a survey carried out in 1993 showed that when adolescents were being given primary care, in 50% of cases no questions were asked about any substance abuse (23).

### **Treatment and the “network”**

While interdisciplinarity and networking have become two essential keywords, their fundamental importance with regard to the commencement and continuation of treatment might at times be overlooked. There is hardly anything more damaging as far as requesting assistance is concerned than encountering professionals constantly in conflict, concerned only about their own area of responsibility, replicating perhaps what young people might themselves have experienced in their personal life. The lack of literature, for methodological and institutional

reasons, on this problem does not diminish the ethical issue at stake.

In the reciprocal apportioning of responsibility, schools are often severely criticised for not placing sufficient emphasis on health education and an understanding of law in general, which are fundamental to preparation for citizenship. As schools are in the front line, having young substance abusers in their midst and having to deal with the pressure exerted by parents worried about the possibility of the problem spreading and affecting their own children, much thought is being given to the school's role in prevention and as a referral point for treatment. The ethical difficulties derive from the multitude of operators and the different codes of conduct governing their respective professions (teacher, school psychologist, social worker, voluntary assistant, nurse, etc.) (36).

As in the case of hospitals, it is generally accepted that state schools should show respect for different opinions and beliefs, both religious and moral, with flexible attitudes to abstinence being one example. From this point of view, it is difficult, though essential, to maintain a clear distinction between respect for citizens' different opinions in this field and the application of school regulations banning smoking, drinking and use of other substances on the premises.

Children or adolescents who show signs of possible intoxication during lessons should be referred as soon as possible to the appropriate services, since even if these signs prove to be unconnected with any substance abuse, they must nonetheless be taken very seriously as they may reveal some psychological problem (for example, depression, latent suicidal tendency, chronic fatigue linked to a difficult social background).

The screening and denunciation policies pursued by certain private schools raise a number of questions. Some medical organisations, like the Geneva Medical Association, have criticised such practices as being medically inappropriate.<sup>6</sup> Nonetheless such practices continue in certain private schools because of a legal vacuum concerning the availability of urine tests, which can be obtained over the counter. A recent survey by the European Monitoring Centre for Drugs and Drug Addic-

6. Geneva Medical Association "Dépistage non volontaire des drogues" (Non-voluntary drug screening), Association Charter, 1999.

tion reveals that such practices are carried out in at least ten European Union countries, and sometimes in state schools.<sup>7</sup>

## Two current programmes in Switzerland

Given the many ethical and clinical questions concerning adolescent substance abuse, it is essential to have the right programmes and facilities to deal with the problem. The following two examples show possible approaches.

### The Supra-f programme

Supra-f is a prevention research programme set up by the Federal Office of Public Health focusing on secondary prevention of addiction and health promotion among young people at risk. The project was prompted by the fact that there were no real prevention facilities for the 15-20 age group, (which includes the period following the end of compulsory schooling and before starting work). The programme set out to avoid the pitfalls of an excessively medicine-based approach and premature referral to traditional addiction treatment centres, which were seen as potentially unattractive or indeed threatening in the eyes of the age group in question.

The programme began in 1999 and is being run in 12 centres throughout Switzerland. The centres are located in towns and offer various facilities ranging from leisure activities and group meals to individual or group psychological counselling; they also provide help with schoolwork. Each centre can provide equal care to some 15 to 20 young people, most of whom have been referred there by schools, some by juvenile courts and others by specialist services. Attendance is conditional on consent given by both the adolescents and their parents.

The interim assessment of the programme carried out in February 2003 looked at over 400 young people who had been attending, of whom only one fifth had left the programme before completion. It would appear that young people at the greatest risk benefited the most as regards their performance at school and their behaviour (petty crime, suicidal tendencies), although there was no direct correlation

7. EMCDDA, "Drug testing in schools in European countries", information note for use by the ethical section of the Pompidou Group, 2004.

between this improvement and a reduction in substance consumption (37).

**DEPART Programme (screening, assessment, support for adolescents at risk of developing an addiction problem)**

The aim of this project being run in Lausanne over the period 2004-2006 is to back up existing institutions with a manageable arrangement focusing on ongoing and interdisciplinary monitoring of adolescent substance abusers and on sensitising and training professionals dealing with the problem (32). The central ethical challenge of the approach relates to the difficulties of fostering collaboration between operators in the social and educational spheres and those in the medical and psychiatric field, compounded by the cross-referrals from one facility to another, resulting in a very high dropout rate.

DEPART was devised jointly by a number of hospital, university and social facilities dealing with substance abuse and providing medical, psychiatric or social assistance. It is addressed to both adolescents aged between 12 and 20 who have begun experimenting with substances and for whom early action could halt the development towards addiction, and those already addicted for whom specialist assistance could help the front-line operators. Treatment is free of charge.

The initial results show that the project is meeting a real need, and the number of applications has far exceeded the level anticipated: in the first nine months over a hundred applications had been processed, one third coming from institutions and two thirds from young people themselves or those around them (primarily their parents).

While the effectiveness of information campaigns is often questioned, it might be worthwhile looking at the type of health education given at school. Proper use of the services available should not be based simply on knowledge of the properties of psychoactive substances but also on a greater awareness of the processes involved in relationships and emotions.

In another register, moving on from a definition of health based on quality of life to the definition given in the Ottawa Charter, firmly based on human rights,<sup>8</sup> it might be preferable to give greater weight to the early acquisition of a legal understanding of the treaties setting out those rights. A basic ethical principle holds that a subject's autonomy cannot be limited by the law except insofar as this affords greater protection.<sup>9</sup> With regard to access to treatment, it would seem that decriminalisation is essential.

From an academic point of view, where the relevant literature gradually clarifies the question of the dangers involved, we need to move on from moral standpoints and look at the clinical arguments and the public health prospects involved, ensuring that any action taken is based on meticulous research.

Lastly, in the light of the complexity of medical law relating to minors, the relationship between clinician and patient has to be a credible one if we are to overcome differences of opinion on the unconditional nature of confidentiality or the relative nature of abstinence. The problems experienced by adolescents challenge the firm beliefs and values held by the adults with whom they are in contact. In this respect, approaching matters from an ethical point of view can overcome the inevitable conflicts which come to the fore and make it possible to work out an approach which a troubled adolescent can subscribe to.

8. Ottawa Charter for Health Promotion, "First International Conference on Health Promotion Ottawa", WHO, 1986; to be downloaded from WHO's site: [www.who.int/hpr/NPH/docs/ottawa\\_charter\\_hp.pdf](http://www.who.int/hpr/NPH/docs/ottawa_charter_hp.pdf).

9. Malherbe, J.F., "The Contribution of Ethics in Defining Guiding Principles for a Public Drug Policy", Expert Report to the Special Committee on Illegal Drugs of the Senate of Canada, 2002. See <http://www.parl.gc.ca/37/1/parlbus/commbus/senate/Com-e/ille-e/library-e/malherbe-e.htm>

## Bibliography

- (1) American Psychiatric Association, *Diagnostic and statistical manual of mental disorders*, DSM-IV, Washington, 1994.
- (2) World Health Organization, *The ICD-10 Classification of mental and behavioural disorders*, Geneva, 1993.
- (3) Rocques, B., *La dangerosité des drogues*, Rapport au Secrétariat d'Etat à la santé à l'attention du ministre de la Santé, Odile Jacob, Paris, 1999.
- (4) Chinet, L., Plancherel, B., Bolognini, M., Holzer and L., Halfon, O., "Adolescent substance-use assessment: Methodological issues in the use of the ADAD (Adolescent Drug Abuse Diagnosis)", in *Substance use and misuse*, 40, pp. 1-21, 2005.
- (5) Volkow, N.D., "Exploring the whys of adolescent drug abuse", in *Nida Notes*, Vol. 19, No. 3, p. 3, 2004.
- (6) Pentz, M.-A., "Prevention", in *The American Psychiatric Press Textbook of Substance Abuse Treatment*, 2nd edition, edited by Marc Gallanter, The Guilford Press, New York, 2000.
- (7) Michaud, P.-A., "Les adolescents et leur santé: quelles réponses de la part des professionnels?" in *Dépendances*, co-edited by SFA/ISPA and GREAT, No. 19, pp 23-27, April 2003.
- (8) Klein, J.D. et al., "Access to medical care for adolescents: results from the 1997 Commonwealth Fund Survey of the Health of Adolescent Girls", in *Journal of Adolescent Health*, 25, pp. 120-130, 1999.
- (9) Klein, J.D., Slap, G.B., Elster, A.B. et al., "Access to health care for adolescents", in *Journal of Adolescent Health*, 13, pp. 162-170, 1992.
- (10) Ensign, J. and Panke, A., "Barriers and bridges to care: voices of homeless female adolescent youth in Seattle, Washington, USA", in *Journal of Advanced Nursing*, 37 (2), pp. 166-172, 2002.
- (11) Meade, M.A. and Slesnick, N., "Ethical consideration for research and treatment with runaway and homeless adolescents" in *J Psychol.*, 136(4), pp. 449-463, 2002.

- (12) Beauchamp, T.L. and Childress, J.F., *Principles of biomedical ethics*, 5th edition, Oxford University Press, Oxford, 2001.
- (13) Simon, O., Zullino, D. and Sanchez-Mazas, P., "Impliquer les proches dans le traitement des addictions: aspects transver-saux", in *Médecine et Hygiène*; 62, pp. 1794-1799, 2004.
- (14) Shaw, M., "Competence and consent to treatment in chil-dren and adolescents", in *Advances in Psychiatric Treatment*, Vol. 7, pp. 150-159, 2001.
- (15) Mauron, A., "Les fondements éthiques du droit médical", in *Médecin et droit médical – Présentation et résolution de situa-tions médico-légales*, under the direction of Bertrand, D., Harding, T.W., La Harpe, R. and Ummel, M., Editions Médecine et Hygiène, Chêne-Bourg, 2003.
- (16) Babel, F., "Les implications des droits de l'enfant sur la pra-tique médicale" in *Médecin et droit médical – Présentation et résolution de situations médico-légales*, under the direction of Bertrand, D., Harding T.W., La Harpe, R. and Ummel, M., Editions Médecine et Hygiène, Chêne-Bourg, 2003.
- (17) Sankar, P., Jones, N.L. et al., "Patient perspectives on med-ical confidentiality: a review of the literature", in *J Gen. Intern. Med.*, 18, pp. 659-669, 2003.
- (18) Ford, C.A., Halpern-Felsher, B.L. and Irwin, C.E., "Influence of physician confidentiality assurances on adolescents' willing-ness to disclose information and seek future health care. A ran-domised controlled trial", in *JAMA*, 278, p. 12, 1997.
- (19) Cheng, T.L., Savageau, J.A., Sattler, L. and DeWitt, T.G., "Confidentiality in health care. A survey of knowledge, percep-tions, and attitudes among high school students", in *JAMA*, 269, p. 11, 1993.
- (20) Akinbami, L.J., Gandhi, H. and Cheng, T.L., "Availability of adolescent health services and confidentiality in primary care practices", in *Pediatrics*, 111(2), pp. 394-400, 2003.
- (21) Ford, C.A. and Millstein, S.G., "Delivery of confidentiality assurances to adolescents by primary care physicians", in *Arch. Pediatr. Adolesc. Med.*, 151(5), pp. 505-509, 1997.

- (22) Rutishauser, C., Esslinger, A., Bond, L. and Sennhauser, F.H., "Consultations with adolescents: the gap between their expectations and their experiences", in *Acta Paediatr.*, 92, pp. 1322-1326, 2003.
- (23) Konings, E., Dubois-Arber, F., Narring, F. and Michaud, P.A., "Identifying adolescent drug users: results of a national survey on adolescent health in Switzerland", in *Journal of Adolescent Health*, 16, pp. 240-247, 1995.
- (24) Harrison, C., Kenny, N.P., Sidarous, M. and Rowell, M., "Bioethics for clinicians: involving children in medical decisions", in *Can. Med. Assoc. J.*, 156(6), pp. 825-828, 1997.
- (25) Koocher, G.P., "Ethical issues in psychotherapy with adolescents", in *J Clin. Psychol. Nov.*, 59(11), pp. 1247-1256, 2003.
- (26) Monti, P.M., Colby, S.M. and O'Leary, T.A., *Adolescents, alcohol, and substance abuse: reaching teens through brief interventions*, Guilford Press, New York, 2001.
- (27) Marx, M.A., Brahmabhatt, H., Beilenson, P. and Vlahov, D., "Impact of needle exchange programs on adolescent perceptions about illicit drug use", in *AIDS and Behavior*, 5,4, pp. 379-86, 2001.
- (28) Guggenbühl, L., Uchtenhagen, A. and Fabian, C., "Adequacy in drug abuse treatment and care in Europe (ADAT)"; Part I: Ethical Aspects in the Treatment and Care of Drug Addicts; available on [www.isf.unizh.ch/english/projects.html](http://www.isf.unizh.ch/english/projects.html), Research Report from the Addiction Research Institute, Zurich, 2000.
- (29) Miller, W. and Rollnick, S., *Motivational interviewing: preparing people for change*, Guilford Press, New York, 2002.
- (30) Klingemann, H., Sobell, L., Tucker, J. et al., *Promoting self-change from problem substance use: practical implications for policy, prevention and treatment*, Kluwer Academic Publishers, Leiden, 2001.
- (31) Chinet, L., Bolognini, M., Plancherel, B., Rossier, V., Stephan, P., Laget, J. and Halfon, O., "L'adolescent consommateur de substances face au réseau de soins", in *Revue médicale de la Suisse romande*, 123, pp. 591-593, 2003.

- (32) Chinet, L., "Adolescents consommateurs: quelles réponses du réseau de soins ?", in *Revue THS* (toxicomanie-hépatite-sida), pp. 1259-1260, December 2004.
- (33) Savoy, J., Laget, J., Charpentier, P., Sanchez-Mazas, P., Besson, J. and Halfon, O., "Prise en charge des adolescents dépendants des opiacés dans le canton de Vaud. Réflexions sur l'indication d'un traitement par la méthadone", in *Revue médicale de la Suisse romande*, 119, pp. 943-950, 1999.
- (34) Letters, P. and Stathis, S., "A mental health and substance abuse service for a youth detention centre", in *Psychiatric services*, 12, 2, pp. 126-129, 2004.
- (35) Brody, J.L. and Waldron, H.B., "Ethical issues in research on the treatment of adolescent substance abuse disorders", in *Addictive behaviors*, 25, 2, pp. 217-228, 2000.
- (36) Weist, M.D., Axelrod Lowie J., Flaherty, L.T. and Pruitt, D., "Collaboration among the education mental health, and public health systems to promote youth mental health", in *Psychiatric Services*, 52,10, pp. 1348-1351, 2001.
- (37) Fahrenkrug, B., "Au terme de trois ans, un modèle de prévention secondaire en bonne voie: de Supra-f à Superia Forte", in *Bulletin Supra-f* (published by the OFSP) No. 9, March 2003.



## Caring for pregnant women or mothers using drugs

by Paolo Stocco

The last century was characterised by the ongoing process of the emancipation of women, a consequence of their fight for freedom and the extension of their social and civil rights. This democratic progress emerged and was consolidated in many sectors of public life and in the private sphere, resulting in far-reaching social changes regarding woman's role in society, in the family and in interpersonal relationships. Age-old habits were therefore transformed and a new awareness emerged; for several decades, the question of equal opportunities has been highlighted in public policy programmes, with clear benefits for all groups seeking to promote gender equality.

In post-industrial societies, from the 1970s up to the present, these changes in habits have resulted in radical changes in lifestyle, in particular amongst the younger generations. The earliest protest movements of the young went hand in hand with a search for new forms of social participation and new cultural parameters. In this context of great social upheaval, there was also a radical change in the relationships between men and women, helping to bring the two sexes closer in terms of equality, and this played a significant role in their culture, social relations, lifestyles and behavioural models. In parallel to these major victories, a number of damaging phenomena also emerged, affecting the younger generations in particular. The use of drugs for pleasure and new experiences led to widespread consumption amongst young people of both sexes, with serious social, health and financial consequences that we are all familiar with and that are still felt today.

Nevertheless, today the spread of recreational practices, lifestyles, habits and types of behaviour among young people of both sexes has meant that females are adopting the same dangerous behavioural patterns as their male peers.

## **Women and drug addiction**

The statistics of the European Monitoring Centre on Drug and Drug Addiction (EMCDDA) show, none the less, that in all EU countries, all age groups of women show a lower probability of experimenting with illegal substances than is the case among males. However, the occasional and non-problematic use of drugs such as hashish and cannabis in particular is very frequent in both sexes. The respective prevalence of drug use between males and females depends on a series of factors such as age, drug type, level of schooling and geographical location. For example, the figures from EMCDDA, confirmed by other national research projects, show that under the age of eighteen, girls tend to experiment with the use of hashish to the same extent as their male peers while the difference gradually becomes more pronounced in later years where there is a clear predominance amongst males. The same applies to the problematic use of drugs and alcohol, where females represent a clear minority. Unfortunately, because this was seen as a minority situation, the problem of drug consumption by females was largely neglected.

The first articles that sought to analyse the phenomenon of female drug addiction began to appear at the end of the 1970s and dealt with epidemiological and sociological aspects, linked to prostitution and female crime (Rosenbaum, 1997). In the 1980s the studies concentrated much more on the spread of HIV infection, but female drug addiction was merely considered as an extension of male drug addiction with no particular emphasis on specifically female theoretical or clinical characteristics. It was not until the 1990s that an attempt was made to link gender identity-related considerations to the problematic use of drugs, leading to a debate within the scientific community and the involvement of European institutions, especially the Council of Europe's Pompidou Group. In contrast, a study of the literature on subjects dealing with the ethical aspects of the treatment of drug addiction reveals a complete lack of interest in gender-related issues.

All the same, various research projects stress that female drug addicts suffer from greater social stigmatisation than males;

they find it more difficult and more embarrassing to turn to treatment centres, and are consequently more reluctant to do so. These women, therefore, have specific needs and this raises a number of ethical questions on which greater attention needs to be focused. For example, because the emphasis has been placed on the incidence of drug addiction across-the-board rather than on gender-related characteristics, it has proved difficult not only fully to comprehend individual cases, but also to identify the most appropriate form of treatment.

Some of the research projects carried out by IREFREA<sup>1</sup> (Stocco and Llopis, 2000; 2002) have repeatedly confirmed that female drug addiction follows a specific path of development which, at the level of prevention, treatment and rehabilitation requires greater attention to be focused on gender-related differences (such as vulnerability and the need for protection). These research projects have also revealed that female drug addicts have to cope not only with managing their addiction, but also the feeling of not corresponding to the usual model and social expectations of a woman. These expectations, consolidated by cultural models, family traditions and social codes, mean that society tends to reject and criticise females engaging in deviant behaviour; in addition, these negative reactions may have serious consequences considerably undermining the foundations of the female identity and giving rise to the feeling of being a failure as a woman.

Many of the gender-related questions remain unanswered, one example being the link with violence. The relevant literature shows that women drug addicts are three times more likely to be victims of their partner's violence than the general population, and some 50% to 80% have experienced sexual abuse or ill-treatment during childhood or adolescence. Life on the streets for these women differs greatly to that of the men – physical and sexual aggression is a common occurrence from their long-term or occasional partners and at the hands of drug dealers and criminals. These aspects of gender violence are often underestimated by the treatment services precisely because of the prevalence of the drug addiction symptom and the predominance of male users towards whom treatment approaches are generally geared.

1. IREFREA is an institute of research created in Lyon (France) in 1988. Today it is a European network of seven permanent offices and various research partners originating from thirteen European countries. It develops professional partnerships with European experts in the field of the difficulties of youth, the prevention of drug addiction and the reduction in the use of drugs.

## Drug addiction and pregnancy

Pregnancy and motherhood raise particularly delicate ethical issues for health professionals when the mother or mother-to-be is a drug user.

First of all, very few treatment services offer pregnancy tests and very often treatment (such as substitution medication) is begun without the possibility of pregnancy being taken into consideration. Pregnancy is frequently discovered at a more advanced stage and in most cases is unintentional (Stocco et al., 2002). This delay in recognising pregnancy is easily explained: most female drug addicts suffer from amenorrhoea caused by the use of opiates and wrongly believe they are not fertile, thus neglecting any form of contraception. As a result, most of the pregnancies of drug-addicted women are discovered late, are unexpected, and especially in the initial stages of pregnancy, unwanted. Furthermore, in a considerable number of cases pregnancy is discovered in the second three months, when an abortion is no longer possible. The first problem is therefore the fact that only very rarely do treatment centres provide information on the risks of pregnancy.

### Addiction and pregnancy

*Sample of 284 women from six European countries; one group in substitution treatment and one group in drug-free treatment.*

Of the sample, 68% were not administered a pregnancy test before starting treatment (there was no significant difference between groups). Only a third of the sample stated that they had taken a test.

Comparing the results offered by the survey of professionals, we find substantially different percentages and an observation that may explain these differences: 55% of the professionals only performed a pregnancy test when they considered there were grounds to suspect pregnancy.

As regards the impact of addiction on pregnancy, no major differences were observed between the groups. The most

frequent consequence is a difficult birth and voluntary interruption of pregnancy. There was only a minimal percentage of miscarriages. However, in relation to this latter finding, it should be borne in mind that addicts are often unaware that they are pregnant and may mistake a spontaneous abortion for the return of the menstrual cycle.

The origin of last pregnancy was “accidental” in 78% of cases, with no significant difference between groups. More than half (53%) of the women stated that the pregnancy was “unplanned but wanted”, although 25% of the sample stated it to be “unwanted”, a fact which could have a considerable impact on the future of the mother-child relationship.

As regards detection of pregnancy, we find that 70% of the sample discovered they were pregnant during the first three months, 23% in the second three months, and 7% in the last three months.

The need to find money for drugs frequently leads to prostitution or sex in exchange for drugs, and very often pregnancy is a result; furthermore, there is a high risk of contracting a sexually transmitted disease.

The issue of pregnancy and motherhood raises a whole series of ethical questions in that it results in contact between health service professionals and the legal system – not so much because of any specific interest in the adult patient but more in terms of protecting the health and psychological and physical well-being of the unborn child.

From the viewpoint of medical treatment, the underlying issue is that one is faced with making a choice that may impact on the health of two people, and that the mother’s behaviour may pose a serious risk to the life and health of the unborn child, which, at least partially, may depend on the type of pharmacological treatment and the psychological and social support the mother receives. For example, as G. Nicoletti<sup>2</sup> observes:

“succeeding in reconciling the mother’s needs for pharmacological treatment with the foetus’s health is a difficult problem to deal with. First of all, there should be a detailed toxicologi-

2. Personal communication.

cal and psycho-social evaluation to obtain data regarding the actual risk of a relapse. Very often this evaluation is not carried out since the doctor believes it safer to opt for a standard treatment procedure rather than allowing margins of uncertainty by trusting the declarations of the future mother's intention to abstain from the use of drugs."

Since I am not a doctor, I am unable to go in more detail into the subject of the adequacy of substitution treatment during pregnancy and the possible risks of biological damage to the embryo or foetus. What is true, however, is that in some countries certain medical protocols are adopted that are rigidly geared towards the exclusive use of methadone with the intention of saving the pregnant woman from the risks of a relapse in the use of heroin and from the correlated problems such as becoming seriously infected through IV-administration. However, this does not mean that the pregnant woman no longer exposes herself to the further use of illegal substances, alcohol or psycho-pharmaceutical substances. In fact, clinical experience has shown that in the overwhelming majority of cases, the problematic consumers of substances, both male and female, are addicted to more than one type of substance (poly-consumption).

Accordingly, while rigidly administering substitution treatment may absolve the doctor from any legal medical liability on the basis of inexperience or imprudence, such treatment is no guarantee that the patient will not continue to use other substances. These include alcohol, a substance that is legal and socially acceptable and is therefore often regarded by the drug addict as a less harmful alternative, while it is in reality one of the most damaging substances and can cause the foetus serious biological harm.

Llopis (2003), for example, observes that in a sample of 284 mothers, pregnancy had a positive effect and led to a reduction in drug consumption in 31% of cases, and in 10% of cases the women said they had stopped taking drugs completely. Unfortunately, in 22% of cases pregnancy had absolutely no effect on drug consumption and in 7% of cases it actually increased. This shows that not only is constant toxicological monitoring of the women necessary during pregnancy, but that they also

require intensive assistance. Indeed, it is well known that women feel the need for emotional, relational and sometimes practical support in the final stages of pregnancy, during labour and after giving birth. In the case of the female drug addict these needs are unable to be met by the partner and the frequently conflictual family environment. Consequently, it is the ethical task of the health professionals in contact with the patient to make sure that they give reassuring answers and offer adequate psychological assistance throughout the pregnancy, at the birth itself and during the initial phases of the child's life. We know, however, that very often pregnant women avoid treatment services. A European study carried out by IREFREA (Stocco et al., 2002) shows that a significant percentage of pregnant drug addicts avoided contact with the treatment services and gynaecological surgeries for fear that they would be reported to the legal authorities and would therefore lose custody of their baby. Such fears are not unfounded.

The patient's frequent manipulatory tendencies and strong ambivalence vis-à-vis social workers must also be taken into consideration. This type of behaviour is very frequent and common in a clinical setting with drug addicts but is amplified when the social worker has the dual role of one offering assistance and help, and also of controlling their behaviour.

This raises a fundamental ethical question: is the social worker able to keep his or her own emotional reactions under control when faced with manipulatory attempts, diffidence or aggression? Will his or her judgment remain dispassionate and detached when he or she is required to make an assessment that might have a dramatic influence not just on the way the treatment develops, but also on the legal outcome, when asked to pass judgment on the woman's ability to protect her baby? In short, these questions raise the issue of who evaluates the evaluators.

In this regard, in certain historical and social contexts, strong influences have been brought to bear, leading to drastic choices, prompted more by a repressive ideology than ethical and professional considerations. In the 1990s in various states

of the USA, the War against Drugs sought to indict women who used drugs during pregnancy for presumed biological damage to the foetus. In the event of a miscarriage, attempts were made to charge them with infanticide. Paltrow also observes that: “at least 200 women in more than 30 States have been arrested and criminally charged for their alleged drug use or other actions during pregnancy”.

Above and beyond these strongly repressive social policies which – it is to be hoped – have now been abandoned once and for all, the question still remains as to how to assess maternal competence or, better still, how to provide treatment programmes that ensure that the mother acquires the degree of competence needed to respond adequately to the child’s needs. One answer, one that does not claim to be exhaustive but is nevertheless important, is that of interdisciplinary teamwork and supervision. When the viewpoints of a professional with considerable evaluation responsibilities are discussed as part of a supervised team, it is possible to acquire diverse opinions that can be used to consolidate one’s own. Supervision, understood in the broadest sense of the external evaluation by a professional, of the team and treatment services, represents an ethical requirement that is fundamental in ensuring that professionals use “best practice” tools and in improving the protection afforded to patients in terms of the transparency and validity of the evaluations to which they are subjected.

The attention paid to the mother-child relationship must be such that both the mother and the child are protected and have the opportunity for reciprocal growth and development. When it is planned to administer psychological or rehabilitation treatment in a protected facility (residential models have been developed in many European countries, accommodating both the drug-addicted mother and her child/children), it is important to keep in mind that from an ethical point of view, the child must not be considered as part of the treatment to help overcome the mother’s addiction, but rather as a subject with his or her own inalienable needs that the treatment facility must guarantee to meet adequately.

## **Maternal competence and drug addiction**

Operators may find themselves in the middle of ethical conflicts and diverging evaluations from colleagues from other services. The health operator is often asked by the legal system to express judgment on the mother's behaviour in relation to drugs and her psychological and relational problems, in order to assess whether or not custody of the patient's child or children should be withdrawn. A court's request for an opinion on the patient places the operator in a dilemma that is not easy to resolve since his or her assessment will be compared with those of colleagues in other services whose focus may be exclusively on protecting the interests of the child. As a consequence, the individual opinions may be divergent – sometimes considerably. Legal regulations and codes of conduct of the various professional orders require compliance with the principle of professional confidentiality in respect of those outside the treatment programme. These technical assessments will affect not only the treatment programme adopted for the mother but also the future of the mother-child relationship. In such cases, what priorities should be protected? It is clear that the child's interest is predominant, but how can this interest be evaluated over time? For example, separation, even where temporary, can leave deeply damaging emotional traces that cannot be erased from the child's psyche. Furthermore, in law the case of proven mistreatment or neglect is not always easy to determine (as in the case of manifest abuse or violence) and leaves room for arbitrary subjective interpretation by the court.

One question suffices: do the staff of addiction treatment services have the appropriate evaluation tools to assess the quality of the mother-child relationship? Here, we return to the aforementioned fundamental question – to what extent can the evaluator's judgment be affected by purely subjective criteria and his or her conjectures regarding the adequacy of the woman's maternal behaviour?

There is another aspect that should be kept in mind regarding the fluctuation of the legal stance, which may be influenced by general considerations and by public opinion. Certain sensa-

tional news reports of cases of methadone poisoning in Italy, whether accidental (where the child drank methadone from a bottle, possibly imitating his or her parents' behaviour), or intentional (where the parents themselves gave the newborn baby methadone to stop it crying), may have a negative influence on the court, which could well make a negative assessment of the mother's capacity to look after her child, and order certain legal steps, resulting in the temporary or permanent withdrawal of custody. In such cases, less attention may automatically be given to the health operator's assessment, even if it supports the mother's retaining custody.

In reality, little is known about the effects, on both the mother and child, of separating the two since it is not possible to carry out general legal case studies; the court therefore finds that it has no firm basis on which to take its decision. The Italian legal system, for the protection of the family and minors, stipulates that in cases of proven incapacity to look after a child, ill-treatment or neglect, or in cases in which the mother, because of her behaviour, might not be able to guarantee an environment offering sufficient protection for the child's development and physical, psychological and relational well-being, there may be a temporary removal (fostering), whereby, generally, the court will appoint a member of the close family, and in the majority of cases the maternal or paternal grandparents, as the child's guardians. The evaluation of the grandparents' ability to look after the child very often includes a whole range of criteria – socio-economic conditions, living conditions, whether at least one of the grandparents has sufficient time to look after the grandchild, the absence of any physical or recognised psychiatric disorder, absence of drug abuse, etc.

But very often this evaluation takes no account of the inter-generational dysfunctional family dynamics that often occur in these circumstances. While there is no doubt that as a rule it is certainly in the child's best interests to be in close contact with his or her family, clinical experience has shown that where the child is entrusted to the grandparents without their being given adequate psychological support, the child often finds himself or herself in living surroundings that are inevitably marked by conflict and tension between the grandparents and

the mother, with constant negations of the maternal figure (confirmed by legal measures).

In such cases, which are far from infrequent, the child may grow up in surroundings that pose a risk to his or her development, in which the grandparents may seek to prove to themselves and society that they can bring up the child more appropriately than their daughter. These conditions of competitiveness and conflict give rise to considerable negative repercussions in the mother-child relationship. For the child it results in confusion in finding figures to identify with and in a feeling of insecurity. A mother's separation from her child can often lead to behavioural and psychological consequences that are contrary to the ones anticipated – a deterioration of the addiction, an increase in anti-social behaviour, more frequent use of prostitution, a further loss of self-esteem and self-belief, lack of perspective, or less frequent participation in treatment programmes.

Finally, I would like to address the aspect of discrimination – including in the health field – experienced by drug-addicted mothers. The reactions of health personnel when dealing with a pregnant drug addict are often characterised – sometimes explicitly – by blame, reproach and barely concealed rudeness. Such discrimination is occasionally insidious and, on the surface, imperceptible. One example is of a young mother who was in a public hospital to give birth. The hospital had been informed of her addiction and the health-care staff had been told of the methadone treatment so that they would take the necessary precautions in the event of withdrawal distress in the newborn child. Prior to the birth, the mother-to-be had been able to witness two births from the monitoring room and was able to see the newborn baby immediately being placed on the mother's stomach and at her breast so that it would feel the warmth and the heartbeat and experience the smell and touch of the mother: clearly a reward for the mother after giving birth. In the case in question, the staff did not want to place the baby on the mother's stomach and it was only after she insisted that they did so, but not until they had placed a protective sheet over the mother to avoid any direct contact. Obviously there were no medical instructions to justify such a

measure. Many years later the mother still remembers this because it marked her as being different and “impure”. Social and health professionals must be aware of discriminatory actions, no matter how trivial or imperceptible they might appear, because they can have a dramatic effect on the treatment programme, and can increase the feelings of distrust vis-à-vis the treatment professionals.

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In conclusion, it is to be hoped that professionals in the treatment services will pay greater attention to the ethical problems underlying their acts, in particular as regards pregnant women and mothers. Particular attention should be paid to the drawing up of pharmacological and psychosocial treatment plans. Personalised treatment projects should be tailored to the specific characteristics of the woman, thus avoiding treatment that is based exclusively on emphasising the addiction symptoms. Furthermore, there should be a greater dissemination of information on sexuality and greater emphasis on an awareness of responsible motherhood since pregnancy and motherhood represent an extraordinary opportunity to change one's lifestyle.

## Bibliography

Covri, C., "Etica e deontologia degli operatori ee dei servizi per le dipendenze patologiche", in *Il sistema dei servizi per le dipendenze patologiche. Programmazione, qualità e valutazione*, FrancoAngeli, Milan, 2004.

EMCCDA (European Monitoring Center for Drugs and Drug Addiction), *Annual Report*, Luxembourg, 2003.

ERIT (Federation of European Professional Associations working in the field of drug abuse), "Linee-guida per il comportamento deontologicamente fondato dei professionisti delle tossicodipendenze", available on [www.erit.org](http://www.erit.org)

Facy, F., Villez, M., Delile, J.M. and Dally, S., *Addiction au féminin*, Ed. EDK, Paris, 2004.

Facy, F., Rabaud, M. and Andry, M., "Embarazo y tratamiento con metadona", *Addiciones*, Volume 15, No. 3, 2003.

Fava Vizziello, G., Simonelli, A. and Petenà, I., "Qualità delle rappresentazioni materne e trasmissione intergenerazionale di fattori di rischio e protezione in bambini figli di madri tossicodipendenti", available on ERIT's website, [www.erit.org](http://www.erit.org)

Klein, H., Jackson, M. and Lewis, S., *Drug misuse and motherhood*, Routledge, London, 2002.

Llopis, J.J. et al., "Study into the outlook for improvements in health-care for drug addicted women with children at European level: implications and consequences", in *Les Cahiers T3E*, communication made at the European Conference of Beauvais (France) 9-11 April 2003, "Conduites à risques et toxicomanies", available on [www.t3e-eu.org](http://www.t3e-eu.org)

Nizzoli, U. and Vaccari, C., *I tossicodipendenti e i loro figli*, Verso l'Utopia, Ravenna, 1999.

Rosenbaum, M., "Research and Policy", in Joyce H. Lowinson, *Especial Populations*, third edition, Williams and Wilkins, Baltimore, MD, 1997, pp. 654-665.

Sirvent, C., *La mujer drogodependiente: características, tratamiento y estudio de evaluación*, Fundación Instituto Spiral, Madrid, 1995.

Stocco, P., Llopis, J.J. et al., "Women and drug abuse in Europe: gender identity", Irefrea Publication, 2000, available on Irefrea's website, [www.irefrea.org](http://www.irefrea.org)

Stocco, P. et al., "Etica e deontologia degli operatori delle tossicodipendenze", in *Personalità e dipendenze*, fasc.2, 2002, pp. 213-224.

Stocco, P., Llopis, J. J. et al., "Women and opiate addiction: a European perspective", Irefrea Publication, 2002, available on Irefrea's website, [www.irefrea.org](http://www.irefrea.org)

# The Council of Europe and drug addiction

by Angel Ruiz de Valbuena

The co-operation group to combat drug abuse and illicit trafficking in drugs, better known as the Pompidou Group, is an intergovernmental body set up in 1971 at the initiative of former French President Georges Pompidou.

## Some background

Initially this informal group comprised seven European countries – France, Belgium, Germany, Italy, Luxembourg, the Netherlands and the United Kingdom – willing to pool their experiences in the fight against drug abuse and illicit trafficking in drugs. Other countries subsequently joined them, and today thirty-four<sup>1</sup> of the Council of Europe's member states take part in the group's work.

In 1980 the Pompidou Group was incorporated into the Council of Europe, where it is now part of the Directorate General of Social Cohesion.

Since 1990, technical co-operation has been extended to include countries of central and eastern Europe which are not members of the Pompidou Group. Various non-European countries, such as Canada and the United States, have also been invited to participate in certain activities.

Today, thirty-four countries work together in the Pompidou Group through their permanent correspondents, who meet twice a year to review the work in hand. A large network of experts contributes to its studies and discussions.

The group's approach is a distinctly multidisciplinary one: it includes improving data collection to monitor consumption modes and trends, co-operation between airports to combat trafficking, prevention handbooks for professionals and field workers, training programmes on care and treatment and a series of studies on penal systems, individual and public health issues and the social impact of drug use.

1. Austria, Azerbaijan, Belgium, Bulgaria, Croatia, Cyprus, the Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Liechtenstein, Lithuania, Luxembourg, Malta, the Netherlands, Norway, Poland, Portugal, the Russian Federation, San Marino, the Slovak Republic, Slovenia, Spain, Sweden, Switzerland, Turkey and the United Kingdom.

Every three years a conference of European ministers responsible for combating drug abuse in their respective countries lays down guidelines and sets a work programme that combines epidemiological research, work on prevention and training and the study of therapeutic responses and the social treatment of drug addicts, as well as the legal and penal aspects of the problem.

In the 1980s, soon after its incorporation into the Council of Europe, the Pompidou Group started work on one of its key activities: collecting and harmonising information with a view to closely monitoring trends in drug abuse. Investigating forms of drug use, keeping track of new substances as they come on the market, studying their effects on users, in terms of both public health and social impact: these are some of the lines of research now being pursued on a co-operative basis by epidemiologists all over Europe. Forty-two European towns and cities representing twenty-four countries are now working together in a network unique in Europe, which was joined in 1994 by nine cities of central and eastern Europe.

At the same time, in response to rising drug use among young people, the Pompidou Group helps to gather accurate and reliable information on drug and alcohol consumption among schoolchildren. Two surveys have already been carried out, in 1995 and 1999, covering thirty-odd countries.

### **The Pompidou Group today**

The Pompidou Group's main task is to help the member states to combat drug abuse through effective and innovative multidisciplinary policies based on verified facts.

The dynamic, ever-changing nature of the drug phenomenon means that the Pompidou Group must constantly adapt its role to face new problems as they emerge. This requires flexibility and innovation.

In an international context where numerous European and international agencies are involved in the same battle, the Pompidou Group is a multidisciplinary forum on the wider European scale where policy makers, professionals and experts

can exchange ideas and information. Accordingly, its approach is comprehensive and multidisciplinary, and its working methods varied.

The Pompidou Group also plays a “bridging” role, liaising between EU member and non-member states, as well as with neighbouring countries in the Mediterranean region.

After thirty years of shared analysis, exchange of information and study of the policies practised in its thirty-four member states, the Pompidou Group is now extending its field of interest beyond prohibited drugs to study the effects of other psychotropic substances, as well as multiple drug use, and limit the damage to the individuals concerned and the societies they live in. At the same time it will continue its work with the countries of central and eastern Europe, which are feeling the full effects of the increase in drug trafficking and abuse.

At present the main subjects on the work programme include co-operation between drug control services in Europe’s airports, activities in the criminal law field, new forms of consumption and new treatment strategies, risk reduction, regulations concerning substitution treatments, participation of young people in programmes to prevent drug abuse, and road safety problems related to drug use.

Because of its ties to the Council of Europe, the Pompidou Group also makes sure that general policy recommendations are compatible with the broad lines the Organisation follows in its other fields of activity, such as public health, social cohesion and justice, with particular emphasis on the *ethical* issues involved.

### **The Pompidou Group’s work on ethical problems**

Like human rights, ethical issues have always been a central concern for the Council of Europe, particularly in its work on health policy in its member states. It is only natural, therefore, that ethical considerations should inform all the Pompidou Group’s activities.

Drug control policies not only target drug abuse and trafficking but also involve preventive and therapeutic strategies, ensuring that drug users have access to proper information, in addition to their universal right to treatment. Drug abuse must be viewed as an illness and, as with any other illness, those who suffer from it must have the right to receive treatment, in the broadest sense of the word.

In addition to medical treatment, “harm reduction” strategies are needed to minimise the damage to the patient and to society. Both the treatment dispensed and the risk reduction measures taken must be of the highest quality; this means setting targets and maintaining high professional standards.

Drug control policies, not only in the specific field of treatment of drug users but also in such fields as research, prevention and legal and penal measures, cannot be implemented without taking a series of complex ethical factors into consideration, including:

- the accuracy and efficacy of information on unlawful drugs;
- the right to treatment and access to the relevant services;
- care for specific user groups (young people, pregnant women, etc.) and new consumption trends;
- ethical issues related to the economic aspects (cost of treatment, etc.) and the shortage of financial resources;
- screening, particularly at the workplace and in schools;
- the diversity of regulations on mandatory treatment;
- compulsory placement and the choice between imprisonment and the obligation to undergo treatment;
- the protection of data collected in epidemiological and other research.

The Pompidou Group organised a seminar in February 2003 on “Ethics, professional standards and drug addiction”, which focused mainly on the subjects mentioned above. To guarantee the quality and diversity of the discussions, each of the Council of Europe’s member states sent participants with one or more of the following professional profiles: ethics specialist; health professional; lawyer; prison staff; police officer; epidemiologist; and journalist.<sup>2</sup>

2. A summary of the proceedings and the conclusions of the seminar were published in a document entitled “Ethics and drug abuse: seminar on the ethical and deontological issues”.

The conclusions of the seminar made it clear that 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 should 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.

With this in view an expert committee has been set up under the Pompidou Group's 2004-2006 work programme to analyse the ethical problems involved in combating drug abuse. Its purpose is to draft consensus documents and/or codes of conduct that might ultimately serve as a basis for national regulations on these issues. This work is of course being carried out in accordance with the Pompidou Group's distinctive methodology, combining policy, practice and science to implement policies based on scientific and practical evidence. It is also guided by the principles of the European Convention for the Protection of Human Rights and Fundamental Freedoms in order to ensure that ethical considerations and human rights are taken into account in policies to combat drug abuse.



# **Appendices**



## Appendix I – Some key concepts

“Addiction” – derived from an ancient legal term in English, meaning “bound or devoted to someone” – means dependency on a substance (drug, tobacco, alcohol, medicinal product), a habit (gambling, sport) or a situation (love relationship) that more or less alienates an individual and is accepted to varying degrees or sometimes not at all by those around them. “Dependence” is the term most commonly used in clinical circles.

In the context of this publication, dependence refers to an individual’s state of reliance on the consumption of a drug; interrupting that process causes mental or physical distress, pushing the individual to consume on a continual basis.

Drug addicts are perceived, on the one hand, as victims of their own weakness and, on the other hand, as someone perpetuating drug abuse. We should step back from that rather mixed canvas and instead view drug addicts as people suffering from an illness who must have access to the best possible care.

The professionals treating drug addicts often have to adopt approaches and lines of action dictated by clearly defined rules and procedures. Yet they may be torn between the requirements of their work and codes of good conduct, covering both professional and personal aspects, including ethical or moral considerations, for example. They may also face issues of confidentiality and the like.



## **Appendix II – A selection of useful websites**

### **Pompidou Group**

[http://www.coe.int/T/dgIII/pompidou/default\\_en.asp](http://www.coe.int/T/dgIII/pompidou/default_en.asp)

### ***Related organisations***

EMCDDA – European Monitoring Centre for Drugs and Drug Addiction

<http://www.emcdda.eu.int/>

UNAIDS – The Joint United Nations Programme on HIV/AIDS

<http://www.unaids.org/en/default.asp>

UNODC – United Nations Office on Drugs and Crime

<http://www.unodc.org/unodc/index.html>

WHO – World Health Organization

<http://www.who.int/en/>

WHO Regional Office for Europe

<http://www.euro.who.int/>

European Commission – Drug policy coordination

[http://europa.eu.int/comm/justice\\_home/fsj/drugs/fsj\\_drugs\\_intro\\_en.htm](http://europa.eu.int/comm/justice_home/fsj/drugs/fsj_drugs_intro_en.htm)

Interpol – Drug control

<http://www.interpol.com/Public/Drugs/default.asp>

ILO – International Labour Organization

ILO Database on Substance Abuse and Tobacco in the Workplace

<http://www.ccsa.ca/ilo/ilotop.htm>

INCB – International Narcotics Control Board

<http://www.incb.org/e/index.htm?>

CICAD – Inter-American Drug Abuse Control Commission

<http://www.cicad.oas.org/EN/Default.asp>



## Appendix III

### **Resolution (80) 02 of the Council of Europe Committee of Ministers on setting up a co-operation group to combat drug abuse and illicit trafficking in drugs (Pompidou Group)**

*(adopted by the Committee of Ministers on 27 March 1980 at the 317th meeting of the Ministers' Deputies)*

The Representatives of Belgium, Denmark, France, the Federal Republic of Germany, Ireland, Italy, Luxembourg, the Netherlands, Sweden, Turkey and the United Kingdom, sitting on the Committee of Ministers of the Council of Europe,

Having regard to the decision taken in Stockholm on 13 November 1979 by the 5th Ministerial Conference of the Pompidou Group;

Having regard to Committee of Ministers Resolution (51) 62 concerning partial agreements;

Having regard to the decision taken by the Committee of Ministers at Deputy level at their 317th meeting, on continuing the work of the Pompidou Group within the Council of Europe on the basis of a partial agreement;

Recognising the need to enable the Pompidou Group to carry on its activities as efficiently as possible,

Resolve to set up a co-operation group to combat drug abuse and illicit trafficking in drugs (Pompidou Group).

I. The aim of the Pompidou Group shall be to make a multidisciplinary study of the problems of drug abuse and illicit trafficking in drugs.

II. The working methods employed hitherto by the Group shall be maintained under this Partial Agreement.

These methods are as follows:

1. Meetings, in private at ministerial level, are held, as a general rule every two years, but circumstances and urgency may

justify special meetings of the Group in addition to these two-yearly meetings;

2. Each state is represented at meetings either by the minister(s) concerned with the subject being dealt with, or by the minister instructed by his government to co-ordinate the action of ministries concerned with drug problems. A permanent correspondent appointed for each state is responsible for preparing the Group's ministerial meetings in personal liaison with the minister(s) attending them; he may be assisted by experts;

3. The permanent correspondents and their experts meet twice during the interval between ministerial meetings to follow the application of the guidelines adopted and to prepare the ministers' future meetings in accordance with a given mandate. Their duties in this connection include:

- arranging the agenda and subjects of the coming ministerial meeting;
- collecting material for the preparation of basic documents;
- making arrangements for the practical preparation of ministerial meetings;
- exchanging information on the latest developments in the participating countries concerning the subjects dealt with by the ministers at previous meetings;

4. The Group decides on the publication of documents drawn up by the permanent correspondents as well as resolutions adopted by it;

5. The languages used at meetings are Dutch, English, French, German, Italian, Swedish and Turkish;

6. The meeting papers are reproduced in English and French.

III. States not members of the Council of Europe may join the Group with the unanimous agreement of the member states of the group.

IV. The Secretariat of the Council of Europe shall provide the Group with the following secretarial services:

1. Preparation and distribution of papers for the Group's meetings at both ministerial and permanent correspondent level;
2. Convening of meetings;
3. Practical organisation of the Group's ministerial meetings, to be held every two years at the Council of Europe's Strasbourg headquarters and in one of the participating states alternately;
4. Practical organisation of the Group's meetings at permanent correspondent level, to be held at the Council of Europe's Strasbourg headquarters at the rate of two in each interval between ministerial meetings;
5. Translation of the Group's papers into English or French;
6. Provision of the staff required by the Group for its functioning;
7. Preparation and circulation of the conclusions of the Group's meetings.

V. The Group's operational expenditure under the Partial Agreement shall be apportioned as follows:

1. The travel and subsistence expenses of persons attending the Group's meetings (ministers, permanent correspondents and experts) shall be paid by the member state concerned;
2. Expenditure relating to the practical organisation of ministerial meetings held elsewhere than at the Council of Europe shall be borne by the host country;
3. Common Secretariat expenditure (papers, staff, translation, interpretation and all other operational expenditure) shall be covered by a Partial Agreement budget funded by the Group's member states and governed by the same financial rules as foreseen for the other budgets of the Council of Europe.



## Appendix IV

### **Resolution (80) 15 of the Council of Europe Committee of Ministers amending Resolution (80) 02 on setting up a co-operation group to combat drug abuse and illicit trafficking in drugs (Pompidou Group)**

*(adopted by the Committee of Ministers on 17 September 1980 at the 322th meeting of the Ministers' Deputies)*

The Representatives on the Committee of Ministers of the states members of the Co-operation Group to Combat Drug Abuse and Illicit Trafficking in Drugs (Pompidou Group)<sup>1</sup>,

Having regard to Resolution (80) 02 setting up the aforesaid Co-operation Group;

Having regard to the Budget Committee's report of 12 May 1980 (Doc. CM (80) 132);

Having regard to their decision taken at the 321st meeting of the Ministers' Deputies that the budget of the Partial Agreement on the Co-operation Group shall cover the cost of interpretation between English and French at meetings of the Group, the cost of interpretation from any other language into English or French being borne by the delegation(s) requiring it;

Whereas as a result of that decision Part II of Resolution (80) 02 needs to be amended,

Resolve as follows:

*Single Article* – Part II of Resolution (80) 02 shall be amended as follows:

“The working methods employed hitherto by the Group shall be maintained under this Partial Agreement, subject to the arrangements laid down in Article 11.5 below.

The working methods are as follows:

1. (unchanged);
2. (unchanged);
3. (unchanged);

1. Belgium, Denmark, France, Federal Republic of Germany, Ireland, Italy, Luxembourg, the Netherlands, Sweden, Turkey and the United Kingdom.

4. (unchanged);

5. The Partial Agreement budget referred to in Article V.3 below covers the cost of interpretation between English and French at meetings of the Group, the cost of interpretation from any other language into English or French being borne by the delegation(s) requiring it;

6. (unchanged).”

## Appendix V – List of Pompidou Group’s publications

All ISBN publications are published by Council of Europe Publishing. For further details see **publishing@coe.int** or consult the website: **<http://book.coe.int>**

*Drugs and drug dependence: linking research, policy and practice*, Lessons learned, challenges ahead – background paper by Richard Hartnoll, strategic conference, Strasbourg, 6-7 April 2004.

ISBN 92-871-5490-2

*Connecting research, policy and practice*, Lessons learned, challenges ahead – Proceedings, strategic conference, Strasbourg, 6-7 April 2004.

ISBN 92-871-5535-6

“Follow-up project on treatment demand: tracking long-term trends”. Final report by Michael Stauffacher et al.

P-PG/Epid (2003)37

*Road traffic and psychoactive substances*, Proceedings, Seminar, Strasbourg, 18-20 June 2003

ISBN 92-871-5503-8

“Ethics and drug use”, Seminar on ethics, professional standards and drug addiction, Strasbourg, 6-7 February 2003.

P-PG/Ethics (2003) 4

“International drug court developments: models and effectiveness”, by Prof. Paul Moyle. P-PG/DrugCourts (2003) 3

“Outreach work with young people, young drug users and young people at risk – emphasis on secondary prevention”, by Njål Petter Svensson. P-PG/Prev (2003) 6

“The general potential of police prevention in the area of illicit drugs”, by Prof. Dr. Lorenz Böllinger. P-PG/Prev (2003) 2

“The impact of the ESPAD project – the opinion of ESPAD researchers”, by Björn Hibell and Barbro Andersson.

P-PG/Epid (2003)31

"Mediterranean network: Mediterranean school survey project on alcohol and other drugs (MedSPAD)", Pilot Survey 1 – Morocco, by Richard Muscat. P-PG/Med(2003)12

"Estimating the social cost of illicit drugs in Poland". P-PG/Cost (2003) 2

"Targeted drug prevention – how to reach young people in the community?", Report of the Conference in Helsinki, November 2002.

"Pompidou Group multi-city study update report 1999-2000" by Ruud Bless, co-ordinator, May 2002. P-PG/Epid (2002)11

*Risk reduction linked to substances other than by injection*, Proceedings, Seminar, Strasbourg, February 2002. ISBN 92-871-5329-9

*Prisons, Drugs and Society*, Proceedings, Seminar, Bern (Switzerland), September 2001. ISBN 92-871-5090-7

"Prisons, drugs and society: a consensus statement on principles, policies and practices", published by WHO (Regional Office for Europe) in partnership with the Pompidou Group, September 2002.

"Benzodiazepine use: a report of a survey of benzodiazepine consumption in the member countries of the Pompidou Group", by Gary Stillwell and Jane Fountain, February 2002. P-PG/Benzo (2002) 1

*Development and improvement of substitution programmes*, Proceedings, Seminar, Strasbourg, October 2001. ISBN 92-871-4807-4

*Calculating the social cost of illicit drugs: methods and tools for estimating the social cost of the use of psychotropic substances*, by Pierre Kopp, November 2001. Available in Russian. ISBN 92-871-4734-5

*Contribution to the sensible use of benzodiazepines*, Proceedings, Seminar, Strasbourg, January 2001. ISBN 92-871- 4751-5

“Missing pieces: developing drug information systems in central and eastern Europe / Technical reports”, by Michael Stauffacher, co-ordinator (joint PG / UNDCP project: extension of the multi-city network to central and eastern Europe), September 2001.

*3rd multi-city study: drug use trends in European cities in the 1990s*, by Ruud Bless, co-ordinator, December 2000.

ISBN 92-871-4459-1

*The 1999 ESPAD report: alcohol and other drug use among students in 30 European countries, 2000*, joint publication Pompidou Group / CAN

ISBN 91-7278-080-0

[Order from CAN – The Swedish Council for Information on Alcohol and other Drugs, fax: +46 8 10 46 41 or e-mail: barbro.andersson@can.se]

“Joint Pompidou Group – EMCDDA scientific report 2000 – treatment demand indicator: standard protocol 2.0 and technical annex”.

Two parts available for download at: <http://www.emcdda.org>.

*Drug use in prison*, project of the group of experts in epidemiology of drug problems. Final report by Richard Muscat, co-ordinator, December 2000.

ISBN 92-871-4521-0

*Development and testing of an exit from treatment form for clients in drug abuse treatment*, project of the group of experts in epidemiology of drug problems. Final report by Anna Kokkevi, co-ordinator, December 2000.

ISBN 92-871- 4523-7

*Pregnancy and drug misuse: Update 2000*, Proceedings, Seminar, Strasbourg, May 2000.

ISBN 92-871-4503-2

*Vocational rehabilitation for drug users in Europe*, Proceedings, Seminar, Bratislava, January 2000.

ISBN 92-871- 4406-0

“Vocational rehabilitation of drug users and drug dependent persons (EUREHA Project) – report on the state of the art and

on the results of a survey in all member states of the Pompidou Group", by Ambros Uchtenhagen, Susanne Schaaf and Christa Berger (Addiction Research Institute at Zurich University). P-PG/ Rehab (2000)1

"Problem drug use by women – focus on community-based interventions", by Dagmar Hedrich. P-PG/Treatment (2000)3

*Attention deficit/hyperkinetic disorders: diagnosis and treatment with stimulants*, Proceedings, Seminar, Strasbourg, December 1999.

ISBN 92-871-4240-8

*Drug-misusing offenders in prison and after release*, Proceedings, Seminar, Strasbourg, October 1999.

ISBN 92-871- 4242-4

*Road traffic and drugs*, Proceedings, Seminar, Strasbourg, April 1999.

ISBN 92-871-4145-2

*Treated drug users in 23 European cities – Data 1997 – Trends 1996-97*, Pompidou Group Project on Treatment Demand. Final report by Michael Stauffacher, co-ordinator, November 1999.

ISBN 92-871-4007-3

European Handbook on Prevention: Alcohol, Drugs and Tobacco (1998)

*Drug-misusing offenders and the criminal justice system: the period from the first contact with the police to and including sentencing*, Proceedings, Seminar, Strasbourg, October 1998.

ISBN 91-871-3790-0

"Working group on 'Minorities and drug misuse'", Final report by G.F. van de Wijngaart and F. leenders, 1998.

P-PG/Minorities(98)1

*Multi-city Network Eastern Europe – Joint Pompidou Group / UNDCP project: extension of the multi-city network to Central and Eastern Europe*. First city reports from: Bratislava, Budapest, Gdansk, Ljubljana, Prague, Sofia, Szeged, Varna, Warsaw, 1997.

ISBN 92-871-3509-6

*Pregnancy and drug misuse*, Proceedings, Symposium, Strasbourg, March 1997.

ISBN 92-871-3784-6

*Special needs of children of drug misusers*, Final report by Beate Leopold and Elfriede Steffan, 1997.

ISBN 92-871-3489-8

*Volatile substance abuse among young people in Poland*, Final report by Richard Ives, 1996.

ISBN 92-871-3184-8

*Outreach work with drug users: principles and practice*, Final report by Tim Rhodes, 1996.

ISBN 92-871-3110-4

*Women and drugs/Focus on prevention*, Proceedings, Symposium, Bonn, October 1995.

ISBN 92-871-3508-8

*Multi-city study: drug misuse trends in thirteen European cities*, 1994.

ISBN 92-871-2392-6

*Volatile substance abuse*, Proceedings, Seminar, Bratislava, November 1993.

ISBN 92-871-2570-8

*Women and drugs*, Proceedings, Symposium, Prague, November 1993.

ISBN 92-871-2838-3

*Outreach*, Proceedings, Symposium, Bergen, February 1993.

ISBN 92-871-2601-1



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