Adequacy in Drug Abuse Treatment and Care in Europe (ADAT)

Part I: Ethical Aspects in the Treatment and Care of Drug Addicts

Country Reports and Ethical Guidelines

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Content

1. Introduction

It is a particular characteristic of human service organisations that they are oriented towards humanistic ideals and their underlying values. Such values determine both the institutions' objectives as well as the understanding of quality and adequacy of services. An integral part of assessing the adequacy of drug abuse treatment and care must therefore involve the disclosure of implicit moral codes.

Since modern societies take a pluralistic view of values, it has become difficult to define ethically correct behaviour in a general way that can be applied particularly to the way society deals with illegal drugs and drug addicts.

Admittedly, a high degree of consensus exists within Europe concerning general basic values. However, viewpoints can differ when it concerns putting values into concrete terms within a specific context, when values conflict with one another, when priorities must be set, or when it concerns the question of which approach justifies which methods. Such differences can occur both between and within individual European regions.

A democratic process of negotiation between the various viewpoints of the problem and the approaches made to solve it is therefore in itself a requirement for an ethical approach (Uchtenhagen, 1998). Therefore, if the appropriateness of the treatment and care system of a region is to be assessed, the evaluation must be based on regionally accepted ethical principles.

Within the framework of the ADAT project, two objectives were pursued:

- First of all, using country reports, an insight is gained into both the ethical aspects in the treatment of drug addicts that are currently being discussed in various European countries as well as the current state of the codification of ethical principles.
- In addition, ADAT provides a manual of the most important ethical aspects (see 4) which forms the basis for dealing professionally with drug addicts. The manual is based on a multitude of documents of international, national, regional, or profession-specific relevance such as codes of ethics used in treatment domains, by funding authorities, or by professional organisations, most of them referring specifically to the treatment or care of drug addicts. The manual is intended to provide interested users with a basis for the formulation or further development of individual ethical guidelines.

2. Country Reports

The following country reports are based on contributions provided by the ADAT Principal Investigators. They had been asked to report on the current national debates on ethical aspects involved in the treatment and care of drug addicts as well as on theoretical and empirical studies on ethical aspects of drug abuse treatment and care. Furthermore, they made available official documents on ethical aspects used in treatment domains, by funding authorities, or by professional organisations.

The reports provide an insight into the ethical questions that are currently being discussed in Europe in connection with the treatment and care of drug addicts. In addition, they highlight the ways in which the ethical postulates are respectively codified. This can occur both in the form of national laws as well as in establishment-specific guidelines. Concrete ethical postulates in the participating countries will not be gone into here. These form, however, the basis for the formulation of the ethical principles in Chapter 4. In addition, documents of particular interest can be found in the annex.

2.1. The Czech Republic[1]

The National Drug Strategy for 1998 - 2000, which has been adopted by the Czech Government, identifies key priorities in all drug-related areas and sets specific tasks to relevant ministries responsible for the treatment and care of drug addicts. The main outcome of the National Drug Strategy is, together with a national debate of service providers, the initiation of a definition process of ***Minimal Treatment Standards***, which has not been concluded yet.

The Treatment Standards defined by the World Health Organization (WHO 1993) have served as a basis for the national discussion. These standards have been sent to all service providers by the Ministry of Health in order to collect their opinions and recommendations. Subsequently, the standards are to be modified according to the providers' suggestions and the specific Czech conditions. Before finalising the standards, the modified version is again sent out to the service providers in order for them to add their recommendations. The Minimal Standards shall include all kinds of services for drug addicts, e.g. general services, outreach and harm reduction programmes, low-threshold centres, detoxification programmes, out- and in-patient treatment services, or after-care services. All funding authorities for treatment and care services for drug addicts (Ministry of Health, Ministry of Social Affairs, National Drug Commission) as well as the professional organisations in the relevant field (Medical Expert Association for Ad-

1 Based on text prepared by Josef Radimecky, Executive Secretary of the National Drug Commission, Prague, The Czech Republic, 1999.

dict Illnesses, Association of Non-governmental Organisations) are taking part in the definition process of Minimal Treatment Standards.

In relation to these standards the Ministry of Health and Social Affairs is preparing an ***accreditation/licence system*** for treatment and care services, which enables the quality evaluation of the programmes quality. In addition, the Ministry is defining a ***Minimal Treatment Network***, i.e. a definition of the kind of services required for drug abusers and a specification of their range.

Another discussed issue is the ***Methadone Maintenance Treatment Programme*** (MMT) expanding in Prague and in other regions of the Czech Republic[2]. The Ministry of Health started MMT in 1996 as a pilot study, and the approach has not changed much since that time. In 1999 a Methadone Commission was nominated by the Board of the Ministry of Health in order to define ***guidelines for MMT*** programmes and to support its expansion to other regions, together with the training of new providers.

The third very important and nationally discussed question is the ***cost of treatment and care[3]***. This issue shall be treated within special provider groups (e.g. low-threshold centres, outreach programmes, therapeutic communities), organised in co-operation with the National Drug Commission and the Association of NGOs. Each group is preparing the budgets for different kinds of services that will serve as a basis for the funding of these institutions in the future.

Another important goal of the work of the above mentioned groups is the development of an ***Ethical Codex*** for the work with clients as well as the ***Bill of Clients' Rights***. Up to now, no ethical guidelines or similar documents have been used by treatment and care facilities, funding authorities, or by professional organisations. Such documents are currently being prepared.

2.2. Denmark[4]

The corpus of Danish documents dealing with ethical aspects of drug abuse treatment and care forms part of the ***statements of policy***, either on an official, national or county-related basis or from various semi-official sources or from institutions[5].

The public drug treatment system does not possess any written ethical guidelines for the staff. The normal vow of silence for anyone employed in the public sector and codified in the Penal Code and in the Act on Patients' Rights is

2 In 1999 there were 150 places in Prague and 150 places in other regions.

3 Futhermore, a project of New Legislation Consequences (PAD) planned for 1999 - 2001 is in preparation. Part of this project will be a Cost and Benefit Analysis of the Czech drug policy.

4 Based on text prepared by Karen Ellen Spannow and Jørgen Jepsen, Centre for Alcohol and Drug Research, University of Aarhus, Denmark, 1999.

5 E.g. Statement by the Danish Physicians` Association on Past, Present and Future Danish Drug Policy, including a section on treatment (January 1994); Governmental paper on (Principles of) future Danish Drug Policy from the Ministry of Health, the Ministry of Social Affairs and the Ministry of Justice (March 16, 1994); Statements by the National Narcotics Committee (Advisory Body to the Parliament and the Ministries of Health, Social Affairs and Justice) on: "What is good treatment?".

applied, and it is expected that ethical aspects should be observed as a natural part of professionalism. ***Professional ethical codes*** do exist, e.g. for doctors, psychologists and social workers, but they do not deal specifically with treatment of drug abusers, as they are of a general nature.

Some of the ***private drug treatment institutions*** have written down ethical guidelines which staff are obliged to stick to as a protection measure for clients[6]. The most elaborate rules come from an institution working according to the principles of therapeutic communities and stem from the ***World Federation of Therapeutic Communities' code of ethics*** (see annex III). Besides standards for residential treatment service that forms a staff code of ethics, it includes a bill of rights for members and clients plus standards and goals for therapeutic communities. Other treatment institutions have a shorter version of ethical guidelines. Not all private drug treatment institutions have a listed code of ethics for staff, but all of them demand that staff maintain a vow of silence with regard to their clients.

From the ethical codes for staff working in drug treatment institutions it can be easily seen that the privately owned treatment milieu in Denmark is rather narrow and that codes for different institutions have many similarities. Adjustments are made in accordance with differences in the treatment policies, principles and terms for those receiving treatment.

Not all the rules listed by the treatment institutions can be called ”ethical”; some of them can be categorised more as codes of conduct related to the specific treatment programme. Some codes of conduct, which are closely related to classic human rights, are mentioned by everyone. Thus, the obligation of staff to serve clients independently of their race, gender, age, religion, nationality and political affiliation is widely applied. The same goes for rules in relation to intimate relations with clients or patients. Everywhere there is a ban on sexual contacts between clients and staff and a warning of exploiting presumed vulnerable clients in any way.

2.3. Germany

From Germany there is no country report. However, on the basis of numerous press releases and reports from the German Federal Government Drug Representative (in particularly the Drug and Addiction Report 1999), as well as documents from the Academy for Ethics in Medicine, Göttingen, the following current ***subjects of discussion*** concerning the treatment and care of addicts of illegal drugs can be established:

6 Selected Codes of Ethics from Danish treatment and care facilities: Codes of Ethics for staff at Projekt Menneske (”Project Man”, a drug treatment institution in Copenhagen, modelled on the Italian Projetto Uoumo, or Ce.I.S.); Codes of Ethics of Egeborg, a drug treatment institution; Codes of Ethics of ”Kongens Ø”, a private drug treatment institution based upon the Minnesota- or 12 step-model; Ethical Code for employees at Kråsiglund, a public (county) drug treatment facility.

- Implementation of the basic principle ***"addiction is illness"***
- Legal protection of ***drug consumption rooms***
- ***Improvement of substitution treatment*** (register; qualified doctors, guidelines)
- Discussion of a pilot scheme for ***"heroin-assisted treatment"***: The Federal Government is supporting several cities and federal states with the development of a pilot scheme for heroin-assisted treatment. This concerns a multicentric clinical study of outpatient heroin-assisted treatment for opiate addicts who are long-term addicts, have had several unsuccessful attempts with abstinence-oriented therapy, and could also not be stabilised using substitution methods. The intention is to examine whether these persons, through heroin-assisted treatment, can be stabilised in health and social terms, be firmly integrated into the care system, kept within the care system, and motivated to undergo further therapy.
  The *Bundesärtzekammer* (German Federal Medical Council) demands the following prerequisites for the medical provision of heroin to chronically addicted persons: "long-term, chronicled opiate addiction, abandonment of several therapy attempts; severe danger of harm to health or social impoverishment, continual evaluation to assess the course of the therapy and its success; measures to prevent parallel use of addictive drugs if the objectives of the therapy could be endangered by the parallel use." (Press release by the *Bundesärtzekammer* from 6th March 1998). Furthermore, they are also demanding a comprehensive interdisciplinary treatment approach and psychosocial care appropriate to the needs of the patients.
- ***Use of cannabis as a medicine***: A resolution by the Federal Constitutional Court affirmed the use of cannabis as a medicine. The problem in making cannabis available as a medicine, however, lies in the provisions of the *Arzneimittelgesetz*, the act relating to the manufacture and distribution of medicine. The Federal Ministry of Health supports the exhausting of all possibilities of the act.

Objectives of addiction and drug policies: The Federal Government has made the basic principle "Drug addicts are ill" their central theme in drug addiction care. "The declared aim is to help addicted people using the available medical, therapeutic and social resources while seeking new additional ways. The addiction and drug policies place the health and social aspects to the fore (...)" (Drug and Addiction Report, 1999, p.18).

Ethical guidelines: From Germany, the "Ethical Principles in Professional Addiction Care" of the *Deutsche Hauptstelle gegen die Suchtgefahren* (German Federation of Associations Fighting Against Drug Addiction) from 9th February 1999 have been included in the ADAT guidelines (see Annex IV). The *Deutsche Hauptstelle gegen die Suchtgefahren* (DHS) is an amalgamation of non-profit public organisations who are active across Germany in addiction care. Their purpose is to co-ordinate and represent the interest of their members, take up themes concerning the problems of addiction, stimulate expert discussion, pub-

lish statements and develop guidelines, as well as contribute to the exchange of experience and shape public opinion. (www.dhs.de).

2.4. Greece[7]

The development of treatment facilities that deal with the problem of substance abuse and addiction in Greece started in the early 1980s. The majority of the existing treatment services, however, have been established in the last decade. In particular, the services offering treatment with substitutes have developed over the last four years.

The ***1987 law*** foresaw drug abuse and addiction as a complex problem with social, psychological and medical aspects. That legislative normative changed the image of drug addicts as criminals into that of people suffering from a specific illness, i.e. the condition of dependency on an illicit substance. This law also established the first Treatment Centre for Addicted Individuals (KETHEA). Despite the ideological and philosophical change in attitude for dealing with drug dependence, the legislation was still severe in terms of the penal penalties against drug addicts, supporting a repressive policy.

In 1993 the law was partially modified to take account of the demand reduction and harm reduction views. A central governmental organ was created (OKANA) for co-ordinating programmes in the field of drug addiction at national level. OKANA acted from the beginning into two directions: the reduction of demand through the creation of centres for the promotion of health and the prevention of drug abuse, and harm reduction through the creation of the first substitution pilot programmes in Athens and In Thessalonika. In fact, the 1993 law permitted the use of methadone in drug addiction therapy for the first time in Greece. The therapeutic use of methadone was restricted to two pilot centres, which started their work in 1996 for a restricted number of addicts who display specific characteristics of chronicity. The addicts' access to the programmes was regulated by specific procedures. Currently, three more centres for substitutive treatment are in operation.

Compulsory treatment is not allowed for drug and alcohol addicts. The law for compulsory admission of psychiatric patients when major psychiatric disorders are assessed does not include addicts, except in cases of double diagnosis. The therapeutic facilities in Greece accept clients who voluntary ask for therapy. Although the 1987 law regulating drug use and abuse clearly refers to the possibility of treatment under judicial pressure as an alternative to imprisonment, in practice very little use is made of this possibility. To deal with this lack of provision, a specific law was introduced in 1999 by the Minister of Justice that establishes the operation of special treatment centres for addicted prisoners.

[7] Based on text prepared by Valeria Pomini, Athens University Medical School, Department of Psychiatry, "Eginition" Hospital, Greece, 1999.

In 1998 a Commission composed of members of the Greek Parliament was created with the aim of testing and ***evaluating national policy*** and to elaborate proposals. The harm reduction approach, together with a less severe approach by the penal system towards drug addicts and the creation of alternatives to imprisonment, are the trends in the current drug policy adopted by the country.

During the last three years, three ***national laws have dealt with ethical issues in the field of health care***. The law 2519/97 "Rights of Citizens in Health Care Facilities" adopted the principles of "The Rights of Patients in European Member States," elaborated by the WHO Regional Office for Europe, and established a National Commission for Bio-ethics and Ethical Codes. The national law 2619/98 adopted the Charter for Human Rights and Bio-medicine of the Council of Europe, signed by the European Countries at Oviedo in 1997. Finally, the law 2716/99 established a Special Commission for the Protection of Rights of Mental Health Patients. Nevertheless, the above laws do not specifically mention issues regarding drug addicted individuals in any of their articles.

The majority of the professionals working in the field of drug abuse treatment and care belong to professional categories such as physicians, psychiatrists, psychologists, social workers, sociologists, etc. Each of these ***professional categories*** has a ***specific code of ethics*** at national level and each professional is expected to respect it, independently from the specific field of health and or social care in which he/she is working.

Specific documents on ***ethical guidelines in the field of drug abuse treatment are lacking*** at national level. One of the reasons for this lack is the recent development of treatment services, as reported above. Nevertheless, the professionals' concern about ethical issues is increasing. The overload of work with which the treatment services are faced on a daily basis often does not give professionals and administrators any time to reflect and elaborate on such a critical issue.

Few documents have been produced within specific networks of treatment services. KETHEA, a non-governmental, non-profit organisation, and the largest network of therapeutic communities, is the only network which has adopted a specific code of ethics, the ***World Federation of Therapeutic Communities' Code of Ethics*** (see Annex III). One section is dedicated to the professionals working in the network and to their behaviour towards the members of the T.C[8].

A limited number of treatment agencies belonging to the public sector employ graduate as well as ***non-graduate professionals (i.e. ex-users)***. The Drug and Alcohol Dependence Unit of the State Psychiatric Hospital of Attica is one of these agencies. Although there is not a specific code of ethics, this issue has been addressed by K. Matsa, the Scientific Director of the Unit[9].

Finally, the code of ethics is one of the concerns of OKANA, the central governmental organisation which co-ordinates the programmes in the field of drug

[8] The 1998 Annual Report of KETHEA, p.61.

[9] Matsa, K., 1996. The Dialectics of Dependence and Freedom: Moral Issues. In 2nd European Conference on Rehabilitation and Drug Policy: Europe in transition, T.C. in transition. Thessaloniki, 28th May – 2nd June, 1995, Proceedings, pp. 41-45, KETHEA, Athens.

abuse treatment and prevention, and manages the services responsible for the treatment with substitutes. OKANA is currently still developing its internal regulation, including specific guidelines on ethical aspects.

2.5. Italy[10]

In Italy, a ***discussion about ethical questions*** in the treatment and care of drug addicts has only just begun. The discussions in the last 20 years were, in terms of content, shaped by a moral debate concerned with the pros and cons of providing substitution substances. Whereas some made efforts to have it legalised, others described methadone as a drug of the state and condemned it as such. The professions, however, hardly participated in this debate - expert arguments did not stand to the fore in the dispute. In 1989 an ethical debate was sparked off as a result of a draft bill for a law which rejected a positioning of the use and abuse of psycho-active substances within the field of pathology. As an alternative to the legal and administrative sanctioning of illegal consumption, however, the law foresaw the use of treatment.

In 1997 the introduction of the ***'harm reduction'*** approach was heavily debated. In particular, it was questioned as to whether the approach was defensible if, parallel to it, abstinence was not made a precondition.

Up to now there has been no scientific work in Italy concerning ethical aspects of addiction treatment and care. However, the following two documents, which have just been recently published, can be referred to:

The ***"Ethical Declaration Against Drugs"*** (Dichiarazione etica contro le droghe) was published in 1999 by the Department of Social Policies for the Veneto region (Assessorato alle Politiche Sociali della Regione Veneto). This is more of a propaganda pamphlet against the legalisation of psycho-active substances and the consumption of all forms of drugs, however, than a reflection on ethical implications in the treatment of drug addicts.

On the other hand the ***"Ethical Guidelines For Professional Operators in the Field of Drug Addiction"***, published by the Co-ordinating Body between Associations and Scientific Societies of Drug Abuse Treatment Professionals[11], is of great interest (Clerici and Tempesta 1999). These guidelines (see Annex V) aim to provide "operators and other professionals working in the field of drug use and abuse with a tool that could prove to be useful in outlining an 'ethical code of practice' which envisages the different problems connected with addiction-related therapeutic activities". These are aimed at all persons in Italy involved in the treatment of drug addicts and are to be recommended. The implementation is voluntary since it concerns an auto-regulation instrument. The guidelines contain the following three sections: I. General guidelines; II. Ethical guidelines for public

[10] Based on text by Maurizio Coletti, Centre for Addiction Research (Centro per la Ricerca dei Comportamenti Additivi), Rome, Italy, 1999.

[11] Consulta delle Associazioni e delle Società Scientifiche degli Operatori Professionali delle Tossicodipendenze.

services operators (out-patient facilities, hospitals and services within the general framework of medical treatment); III. Ethical guidelines for therapeutic communities (residential treatment). These are very concrete guidelines that are concerned with rules of conduct for professional operators towards clients and other employees, professional competence and professional conduct in general, as well as the safeguarding of human rights.

2.6. The Netherlands[12]

2.6.1. The Dutch approach to the drug problem

Background

The Dutch approach to the drug problem can best be understood in terms of some of the Netherlands' characteristics. First, it is densely populated with almost 16 million inhabitants on around 42,000 sq. km. Second, it has a history of commerce and has one of the world's largest seaports which functions as a gateway to Europe. Third, the freedom of the individual is of great importance to the people. The government favours open discussion on moral issues and leans towards a consensus regarding these. And fourth, the extensive social security system and accessibility of health care illustrate the importance given to the protection of social welfare.

Legal basis of drug policy

In the Netherlands the laws applying to mental health incorporate the treatment and care of addicts. The following excerpts from the drug and health care laws indicate the close relationship between the laws and the drug policy:

- ***The Opium Act*** 1919[13] regulates the production, distribution and consumption of "psycho-active" substances. Drug possession, trafficking and production are illegal and punishable by law except for medical, scientific and instructional purposes, but only if a licence is provided. The use of drugs is not punishable by law. Since 1976 the Opium Act distinguishes between hard drugs (such as heroin, cocaine, LSD and XTC) and soft drugs (cannabis products). Penal provisions for hard drug offences are considerably more serious than those for soft drug transgressions. In 1996 the public Prosecutor established regulations for the investigation and prosecution of Opium Act offences. Investigation and prosecution of the import and export of hard drugs have the highest priority. (NIMHA 98,10).

12 Based on text prepared by Monique Nieuwenhuijs and Wim van den Brink, The Amsterdam Institute for Addiction Research, The Netherlands, 2000.

13 The Opium Act was amended in 1928 and 1976.

- ***International Treaties*:** The main international drug treaty ratified by the Netherlands is the United Nations Single Convention on Narcotic Drugs of 1961 (amended 1972). The primary aim is to achieve world-wide co-operation in the fight against drug abuse and the drug trade other than for medical and scientific purposes. In 1993 the Netherlands also ratified the 1971 United Nations Convention on Psychotropic Substances and the 1988 United Nations Convention on Illicit Traffic in Narcotic Drugs and Psychotropic Substances. The Schengen Treaty of 1985 aimed at opening the borders of all European Union member states. The agreement was implemented on the 26th of March 1995. It includes agreements on better co-operation in the fight against crime and the harmonisation of drug legislation. (NIMHA 97,7)
- ***The Professions Individual Health Care Act*[14]**: This act provides the general framework for improving the quality of professional practice and for protecting patients against incompetence and negligence. It covers all care activities by health care providers. (Walburg 97, GGZ)
- ***The Medical Contract Act*[15]**: This law defines the relationship between the patient and the health care provider, standardised under a civil-law contract. It covers the patient's position and rights. (Engberts 97)
- ***The Care Institutions Quality Act*[16]**: This law came into effect in 1996. It obliges institutions to guarantee quality of care, which means care that is in any event provided in an effective, efficient and client-oriented manner. This is to be achieved by systematically monitoring, controlling and improving the quality of services. Directors, management and professionals are held responsible. The law set in motion a process of care innovation, which has received a significant impetus from the Government's anti-nuisance policy. (NIMHA 96,4; NIMHA 98,10)
- ***The Special Admission Psychiatric Hospitals Act*[17]:** The Act creates the possibility for compulsory admission of psychiatric patients to a psychiatric hospital under specific conditions and regulates the legal position of these patients. Compulsory admission can only be realised with court intervention (GGZ)
- ***The Right of Complaint Act*[18]**: The act applies to all complaints of those patients either voluntary admitted or under coercion, who are not covered by the Special Admission Psychiatric Hospitals Act. (GGZ)
- ***The Exceptional Medical Expenses Act*[19]**: Based on this law, costs of medical risks not covered by the (compulsory) health insurance, can be compensated for. Those without health insurance (homeless, illegal immigrants) pay for costs of medical care. Only in those cases, when abstained medical care would either lead to a life threatening situation of the individual or en-

14 Wet op de Beroepen in de Individuele Gezondheidszorg, BIG.

15 Wet Geneeskundige Behandelingsovereenkomst, WGBO.

16 Kwaliteitswet Zorginstellingen.

17 Wet Bijzondere Opnemingen in Psychiatrische Ziekenhuizen, BOPZ.

18 Wet Klachtrecht Clienten, WKCZ.

19 Algemene Wet Bijzondere Zieketekosten, AWBZ.

danger public health, are costs covered (Z&W 97). With the municipal funds under the terms of the Welfare Act (gemeentelijke doeluitkeringen), the AWBZ is the most important source of funding of addiction care (RVZ/RMO 99).

Drug policy

The main aim of the Dutch drug policy is to minimise the risks of using psychotropic substances to the users themselves, to their environment and to society as a whole. (NIMHA 96, 4). Reducing public nuisance is central to and the starting point of the Dutch policy. After proving that a small proportion of hard drug addicts were responsible for the majority of the nuisance problems, a national policy of fighting hard drug nuisance was introduced in 1993. (NIMHA 97, 6) Three ministries share the responsibility for drug policy: the Ministry of Health, Welfare and Sports (HWS 97) carries the main responsibility for the drug prevention and treatment policy, with the exception of administrative prevention, which is the responsibility of the Ministry of Internal Affairs. The Ministry of Justice is responsible for the enforcement of the Opium Act. The Minister of HWS is responsible for the co-ordination of the Government's drug policy. (NIMHA 96, 4; NIMHA 97, 6) The nuisance associated with drug use is tackled in two ways. One approach involves passing administrative measures designed to promote public law and order (the coffee shop policy, safety on the streets). The other approach is based on innovating and improving the quality of the care offered to (hard) drug addicts. (NIMHA 98, 8).

Care policy

A unique aspect of the organisation of addiction care services in the Netherlands is that it deals with all addiction problems, i.e. alcohol, drugs, smoking and gambling[20]. The Exceptional Medical Expenses Act means that access to any addiction care facility in the Netherlands is free of charge. Both specialist (addiction-orientated) and general care facilities (hospitals, psychiatric centres, general practitioners and social services) provide care to addicts. The specialist facilities for addiction care are responsible for promoting prevention and offering consultation and assistance to all addicts, including the rehabilitation of addicts who have come into contact with the police and the judicial system (NIMHA 98, 8).

The aim of the addiction care services is to reach as many addicts as possible and to assist them in efforts to rehabilitate or limit the risks caused by their drug habit, i.e. the principle of harm reduction. Social rehabilitation is an essential element (HWS 97). The ultimate goal in addiction care is to (re)integrate the addict into society. Therefore 'integrated care' focuses on 1) offering appropriate help at the earliest possible stage, 2) providing care that not only aims for abstinence but also aims to achieve less ambitious care objectives such as stabilisation, improving the addict's living situation, limiting the damage to health and ending criminal behaviour, and 3) all problem areas with which the client is faced, and his or her ability to improve them. (NIMHA 98, 8)

[20] Approximately half of the expenditure of the Netherlands on facilities for addicts is spent on the drug problem (HWS 97).

In 1996 the Care Institutions Quality Act became effective. Reaching the addicts causing nuisance was emphasised by setting up facilities to improve the effectiveness of the addiction care system (quality) and to make better use of available capacity (costs). Within the framework of quality of care more importance has recently been given to the active contribution of the client, research on the effectiveness of treatment and care, and the rehabilitation of clients.

The accessibility of the programmes of specialised addiction services means that 75% of opiate addicts have benefited from these services. Owing to an increase in poly-drug use and infectious disease complications, the ageing of the population and the combination of addiction and psychiatric problems, the Dutch treatment and assistance system in the field of addiction has a great diversity of care resources for drug addicts (NIMHA 98, 10).

Goals in treatment programmes include the suppression of acute intoxication, stabilisation of use, stabilisation of abstinence, and treatment of psychiatric and somatic co-morbidity. Treatment and care activities include methadone supply, high dose methadone experiments, experiments with medically prescribed heroin, a hepatitis B vaccination programme, syringe exchange programmes, social rehabilitation programmes, user rooms, street corner work or outreach work, youth information and prevention programmes and ethnic minorities programmes (NIMHA 98, 10, HWS 99).

2.6.2. Ethical Issues

In connection with drug treatment and care, the main ethical issues under discussion are:

- ***Compulsory treatment***: In treatment under judicial pressure, a criminal drug user is offered a choice, for instance between continuation of the punishment and prosecution on the one hand and a treatment programme on the other. In compulsory treatment there is no choice. Compulsory admission in hospital has its legal grounds defined in the criminal code intended for placing mentally ill offenders in special clinics (The Act of Special Admission Psychiatric Hospitals, BOPZ). Legislation for The Penal Detention of Addicts (SOV) has been provided for in the criminal code. Issues of discussion are the individual's basic rights, the effectiveness and duration of treatment. More specifically, since the measure is not directly related to the offence but geared towards the offender, the question is whether the measure will reduce the caused trouble. (Rigter 98, Dute 98, HWS 99, de Vrijer 98).
- ***Legal supply of opiates***: Methadone distribution to drug addicts is legal in the Netherlands. In 1998 the Ministry of HWS agreed to a trial of high dose methadone (>85 mg/day), based on positive results of high doses of methadone in the U.S. (Bureau Driessen). Attention is also directed towards the supply of heroin to heroin addicts. In 1997 a trial treatment of heroin addicts with heroin was approved. The goal of the study is to determine whether severely addicted heroin users who respond insufficiently to the pharmacologi-

cal interventions which are currently available can be stabilised by means of the prescription of heroin. It shall be verified as to whether their bio-psychosocial well-being can be improved, whether additional use can be reduced and whether they can perhaps be encouraged to bring their addiction to an end. Clients who qualify for the trial have to be chronically addicted to heroin and should have repeatedly but unsuccessfully participated in treatment programmes. And they must be in a bad physical, mental or social health state. The ethical discussion concerns the legal medical prescription and supply for treatment, which may lead to legal heroin supply on medical prescription. (Health Council of the Netherlands 95; HWS, 99)

- ***Testing drugs***: Since 1992 it is possible to test synthetic drugs through the Drugs Information and Monitoring System (DIMS). The DIMS project has been set up to obtain information about trends in drug use and the quality of drugs. The main aim is to protect public health by means of preventive and educational activities. For these purposes the testing of illegal substances is no longer an illegal act. The ethical dilemma is that users and dealers profit from the opportunity to have the composition of pills evaluated. Nevertheless, programmes whose motive is prevention and harm reduction have gained support. (NIMHA 96, 3).
- ***Heroin detoxification under anaesthesia***: Medical ethical issues form the determining factors in the treatment and set the defining requirements for the method (indication). On account of high expectations of the effectiveness, there have been no strong ethical objections until now. After a few successful small-scale experiments, a trial on detoxification with naltrexon under anaesthesia has just started (HWS 99).
- ***Methadone treatment in prison***: The moral issue here is whether people do have a right to continuation of maintenance treatment. Legal test cases favoured the patients. The court judged in several cases that the State should enable drug-addicted prisoners to choose a general practitioner that is prepared to prescribe methadone as maintenance treatment. The Ministry of Justice is currently working on solutions for methadone treatment in prisons. (Ministry of Justice 97; Dute 97).
- ***Drug testing in prison***: To create a legal basis for urine checks, the Ministry of Justice laid down regulations in June 1999. The moral issue here is to respect the individuals' physical integrity. (Ministry of Justice 99, Constitution Art. 10).
- ***Workplace and driver drug testing***: Ethical discussions concern the privacy and safeguarding of physical integrity according to the principles laid down in the Constitution, Art. 10 and 11. The constitutional provisions have a considerable effect on the civil law considerations that apply to the employer-employee relationship. As no consensus has been reached yet, judges make their own decisions in individual cases (NVAB 95). There are clearly defined criteria and laws concerning driving after alcohol use, which is not the case with regard to drug use.

- ***User rooms*:** User rooms are meant for street users of hard drugs. Instead of using drugs on the street they are permitted by law to use drugs inside the user room. The aim is to reduce street use. Ethical aspects under discussion are the attraction of dealing in the vicinity of the user rooms, and thus nuisance at the location. User room trials in various cities in the Netherlands have been set up to evaluate the problems. (Regioplan, 99).

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Dute JCJ (1997) Methadon in de gevangenis. Tijdschrift voor Alcohol and Drugs, 22 (3)164-171. (Methadone Treatment in Prison)

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2.6.3. Official guidelines and recommendations

The following official guidelines and recommendations have been issued on the above mentioned ethical topics:

- ***Compulsory drug treatment*** (Vrijer P de, 1998)
- ***Prescription of heroin to heroin addicts*** (Health Council of the Netherlands, 1995); the experiment on the medical co-prescription of heroin to chronic, treatment-resistant methadone patients is currently running.
- ***Methadone treatment in prison*** (Ministry of Justice, 1997); Advice to doctors on the prison staff on the prescription of methadone.
- ***Drug testing in prison*** (Health Council of the Netherlands, 1998) Advice and guidelines for urine checks on use of drugs; (Ministry of Justice, 1999) Binding regulations of the Minister of Justice on urine checks in prisons.

- ***Drug testing in the workplace:*** The Dutch Association of Industrial Medicine (NVAB, 1995) defines its attitude regarding the role of the company doctor in respect to the alcohol and drug policy of companies.

2.6.4. Ethical Guidelines

The professional associations of social workers and psychologists report that there are no specified guidelines for drug treatment and care. An important document comes from the medical doctors:

The Royal Netherlands Medical Association organised a drugs project between 1998 to 1999 that resulted in a policy document on ***duties, roles and responsibilities of medical doctors working with drug users*** (The Royal Dutch Medical Association 1999). The aim of the project was to clarify the medical role in assistance, prevention and care as well as to reach agreement on the question as to the ways in which physicians can combat drug-related problems. In order to reach medical unanimity on the tasks, roles and responsibilities of physicians in drug-related problems, as a first step a survey was conducted of the attitudes that existed in relation to this subject within the profession. The findings showed that physicians' views appeared to be hardly based on medically informed insights and were highly coloured by their personal opinions of the social aspects of the problem (ibid., p.2). As a result of this situation it was decided, within the framework of a conference with numerous physicians from different working fields, to take a closer look at the profession. The findings of the conference were summarised in a report and made available for more detailed discussion. At a second conference with the same participants the comments about the report were discussed in order to arrive finally at a joint view of the tasks, roles and responsibilities of physicians in drug-related problems. These findings shall now be discussed with the relevant social groups (within and outside the care professions) as well as with the responsible regional and national authorities. The comprehensive document contains a precise description of 22 tasks, roles and responsibilities of physicians in drug-related problems.

Ethical guidelines from the institutions for drug treatment and care: In general, institutions are formulating more and more rules of conduct, mission statements, protocols for interviews and treatment as a result of the use of the ISO-PLUS+ quality standard (also see Dutch report on professional standards).

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2.7. Poland[21]

2.7.1. Ethical Issues

Public debate on drugs in Poland has had a quite large coverage in media and involved medical practitioners, drug professionals as well as NGOs, drug addicts and their families. Penalisation of drug possession and other issues related to criminal policy dominated in the media. Ethical aspects of treatment were less paramount but included a number of important questions:

- **Involuntary treatment:** Contrary to the opinions of several NGOs (especially those of parents of addicts) Polish legislation promotes voluntary treatment. The exceptions to this rule (e.g. under-age addicts) are well defined. The courts control the procedure for involuntary treatment. Punishment for some crimes and offences may be either suspended or replaced by treatment.
- **Harm reduction - *substitution programmes:*** For decades, drug-free treatment dominated in Poland. The first methadone maintenance programme was launched by the Institute of Psychiatry and Neurology in 1992. It had experimental status with a research grant to study the possibility of applying methadone maintenance to patients dependent on so-called "Polish heroine". A high-threshold approach was adopted for "hopeless" clients aged 21+ who had failed at least five times in traditional drug-free treatment. Only one six-month programme got approval with detoxification from methadone during the last month. The clients, the majority of whom did not wish to give up methadone, effectively forced the continuation of the programme. In the institute it was regarded to be unethical to let patients go back to illegal consumption. Later on two more programmes started in Warsaw. These were targeted at HIV seropositive persons; their existence did not create any particular controversy. The legal basis for substitution programmes has only recently been established in a new law for counteracting drug addiction. The parliamentary debate was proceeded by an intense discussion among drug professionals. A special seminar was organised for medical practitioners and health-policy makers. Those who resisted substitution programmes stressed, that medical professions should treat patients rather than maintain their dependence or replace one addiction with another. Some people were worried that substitution programmes would reduce funds for drug-free treatment. On the other hand, economic benefits were expected. The popular press tended to emphasise the technical aspects of methadone programmes: fewer infections, less crime, the stabilisation or improvement of the health status. In the Catholic press, however, methadone was presented as a "dangerous experiment" which failed in western countries[22]. Legal provisions

[21] Based on text prepared by Katarzyna Przymuszewska, Boguslaw Habrat and Jacek Moskalewicz, Institute of Psychiatry and Neurology, Warsaw, Poland, 1999.

[22] "Return to the lost illusions" - Catholic Daily, No 57, 21 March 1995.

for substitution programmes, better information and communication, co-operation between methadone programmes and drug-free programmes led to the gradual change in attitudes. Additionally, the spread of HIV and other infectious diseases among addicts reinforced support. Decentralisation of public health management increased interest in local communities. There are currently eight methadone programmes in Poland. A number of new programmes are being prepared. Detailed regulations have not been issued yet, but consecutive drafts are becoming more and more liberal. Permission to instigate the programme, which originally had to be given by the Minister of Health, can currently be received from regional authorities after consultation with the Institute of Psychiatry and Neurology.

- **Harm reduction - *needle exchange programmes*:** The idea of introducing needle exchange programmes was discussed among professionals and the public health authorities in 1986 and 1987, when instances of HIV epidemics among IV drug users in Edinburgh and other large cities started to be discussed. The introduction of needle exchange programmes was not approved owing to the shortage of dispensable injecting equipment that was suffered in the country (even in maternity hospitals, as it was argued). As soon as the first HIV infections were recorded among addicts at the end of the 1980s, needle and syringes started to be distributed and exchanged, first by the NGO "Monar" and soon afterwards by the drug treatment out-patient units of the public health system. Since the beginning of the 1990s, needle exchange programmes have been carried out in about 40 out of 49 administrative regions. Annually, approximately two to three million needles have been distributed. There is some evidence to suggest that their introduction has prevented the rapid growth of HIV (Kulka & Moskalewicz, 1998).
- **Harm reduction - *provision of condoms***: In general, the Catholic Church condemns the use of preservatives and safer sex education as "propagating irresponsibility for the health, life and dignity of another person". A few years ago, some voluntary community programmes were organised, usually supported by local priests. Today, condoms are easily available and their use is on the rise. The distribution of preservatives in drug counselling and treatment centres dates back to the late 1980s when it was introduced to reduce the risk of HIV and other sexually transmitted infections. The Government Bureau for Drug Addiction makes condoms available to treatment centres. In addition, foreign NGOs constitute another source, especially in several border areas between Poland and Germany. Despite the availability of condoms, safer sex education is not an important part of treatment. It is argued that the majority of patients are reluctant since "condoms reduce sexual excitement".
- **Attitudes towards HIV seropositive persons**: The beginning of the 1990s witnessed a series of conflicts between local communities and rehabilitation centres where it was believed that seropositive IV drug users lived. Rehabilitation facilities were attacked and their occupants were forced to leave (Moskalewicz, 1992). Thanks to a public campaign supported by a number of respected public figures, these kind of conflicts are now very

seldom indeed. Support from local authorities and the public are sought when considering new rehabilitation establishments.

- **Funding drug treatment**: According to Polish legislation, treatment and rehabilitation of drug addiction is free. Treatment of associated medical complications is to be covered by the insurance system. Since a high proportion of addicts have no insurance, however, their access to the medical care is limited. Another problem is the efficiency of the addiction treatment, which is considered to be rather low. The popular media has frequently posed the question: "Is it worthwhile to treat addicts if only one out of thousand has a chance to recover?"[23]. Limited resources for health services may also lead to a reduction in the public expenditure on the treatment of addiction for which an addict is deemed responsible, and shift scarce resources to other diseases.

Within the framework of a study which dealt with the moral and ethical attitudes of professional workers in the field of addiction treatment and care in Poland, it was possible to establish that the vast majority of professionals hold a liberal attitude. They prefer voluntary treatment and reject a teleological approach where the means justifies the purpose (Zamecka & Kwasniewski, 1998).

2.7.2. Official documents of ethical relevance

Mental Health Act (1995):

Regulation of involuntary treatment: This Parliamentary law stipulates rules for psychiatric treatment without the patient's consent and introduces court control over this procedure: Psychiatric examination is voluntary. Deviations from this rule are permitted with regard to *"a person whose behaviour indicates that, owing to mental illness, that person may pose an imminent danger to his own life or life or health of others, or a person incapable of satisfying his basic vital needs self-sufficiently"* (Art. 21). Hospital treatment is voluntary and has to be confirmed in writing by a patient. *"A mentally ill person may be admitted to the psychiatric hospital without consent only when that person's behaviour indicates that, owing to the illness, that person may pose an imminent danger to his own life or the life or health of others"* (Art. 23). The Guardianship Court has to be notified about involuntary admission within 72 hours. The Court may confirm or terminate the decision about involuntary admission. In case of serious doubts as to the capacity of the mentally ill person to give his informed consent, the Guardianship Court has also to be informed (Art. 22). Admission to the psychiatric hospital without consent of the mentally ill person is possible if non-admission to the hospital could cause considerable deterioration of that person mental health. Also in the case if a mentally ill person is incapable of self-sufficiently satisfying his basic vital needs and whose treatment in a psychiatric hospital may be justifiably expected

[23] Dziennik Polski, 13 May 1996.

to improve that person's state of health. In such cases the decision of treatment without consent is taken by the Guardianship Court (Art.29).

The Act guarantees the ***patients' fundamental rights***. When choosing the type and methods of treatment, not only health objectives but also the interests and other personal values of the mentally ill person are taken into consideration. Care is taken to achieve improvement of health with the least possible discomfort for that person (Art. 12). Article 13 guarantees the right to unrestricted communication with the family and other people. Rehabilitation activities in psychiatric hospitals and nursing homes shall not serve economic goals (Art. 15). Mentally disordered persons may be submitted to physical restraint only when such persons make an attempt against their own life or health, or the life or health of another person or public safety is at risk, or when such persons violently destroy or damage surrounding objects (Art 18).

The Mental Health Act provides for the improvement of ***accessibility of psychiatric treatment***. The local authorities (voivodes) shall establish and run mental health facilities within the target network of such facilities (Art. 6). Health care services provided to mentally ill or mentally retarded persons shall be free of charge (Art.10). The Act obligates the Cabinet to promote mental health (Art.4).

Law on Counteracting Drug Addiction (1997):

This Parliamentary Law obliges the central administration and local governments to implement tasks in the field of mental health promotion and drug education (Art. 3). The law states that treatment of addiction in public health establishments is free of charge (Art.14), provides the possibility of substitution treatment (Art. 15), introduces the principle of voluntary treatment (Art.13) and involuntary treatment of under-aged persons. *"Upon a motion filed by a statutory representative, relatives in direct line, siblings or actual or official custodian, family court may order an addicted person under 18 years of age to submit to compulsive treatment and rehabilitation"* (Art. 17). The duration of treatment may not be longer than two years. The law also introduces rules with regard to the penal responsibility of drug dependent persons: *"Shall an addicted person, accused of perpetrating an offence liable to imprisonment for a term not exceeding 5 years, submit him/herself to withdrawal treatment in a relevant health care institution, the procurator may suspend the proceedings"* (Art. 57). The sentence of imprisonment of an addicted person for an offence perpetrated in relation to the abuse of drugs can be suspended for up to 2 years if that person starts the medical treatment, rehabilitation or re-adaptation, and the results of the treatment would be positive (Art. 56).

Polish Association of Therapeutic Communities:

The Code of Ethics of the World Federation of Therapeutic Communities (see Annex III) has been adopted by the Polish Association of Therapeutic Communities, which is an association of several hundred persons working in the field of treatment.

Code of Ethics of the MONAR association:

”Monar” is the oldest Polish NGO in the field of drugs established in 1979. Its Ethical Code includes aspects on the behaviour and conduct of its employees and on the employees' ethical responsibility with regard to clients, peers, the profession and employer.

Code of Ethics of specialists in the therapy of dependence:

This document is currently being drafted by a certification team of the State Agency for Solving Alcohol Problems and is apparently based on the ethical principles of psychotherapy of the Polish Psychological Association. It regulates the relationships between the therapist and patient and between the therapist and the team.

Regulations and bye-laws of individual treatment and rehabilitation centres:

According to the law, each treatment and rehabilitation unit should have its own regulations or bye-laws displayed for patients. In addition, a patient should be given free access to enquire about his rights and obligations as described by the relevant law. A review of several local regulations reveals that most of them tend to limit the legal rights of patients. This policy is justified by the specificity of drug treatment. Detoxification units restrict the number and frequency of visits, limit the number of letters, and inspect parcels and gifts received by patients. In rehabilitation units the regime is less restrictive but a number of rights can be suspended as a penalty. In addition to drug use, drinking and sex are also not permitted. In one rehabilitation centre part of the wages of a working patient can be deducted to cover the costs of his/her stay. Usually, restrictions on civil rights are introduced to protect such values as a drug-free life and the well being of a patient or other patients.

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2.8. Spain[25]

Spain, like most Mediterranean countries in the south of Europe, has been displaying for decades high levels of production and consumption of alcoholic beverages as well as high levels of alcohol-related problems. As a result of this situation, by the late 1960s different professional teams started offering specialised ***treatment for alcohol abuse and dependence***. The therapeutic approaches of these teams were usually founded on some commonly accepted principles:

- Alcohol dependence is a disease (with biological, psychological and social components), not a "moral disorder". Therefore, alcoholics are patients and have the right to receive appropriate treatment.
- Medical, psychological and social problems shown by alcoholic patients are the result of alcohol abuse, which is not under their control. Alcohol treatment seeks to solve alcohol dependence and to cease alcohol use, not only treating complications.

25 Based on text prepared by Josep M. Suelves, Departament de Sanitat i Seguretat Social (Department of Health and Social Security), Barcelona, Spain, 1999.

- Treatment of alcoholics requires motivation from patients: they have to accept that a problem exists and that a treatment is necessary. During the treatment process patients must accept other basic considerations, such as the fact that they cannot use alcohol anymore.

By the late 1970s, the first cases involving the ***intravenous use of heroin*** had been detected in Spain. This use of heroin continued growing until the mid-1980s, creating important social and health problems. The fact that many heroin users were involved in illicit activities to obtain money to acquire drugs also contributed to generating a strong social concern about the use of illicit drugs.

Following General Franco's death in 1975, Spanish political organisations have undergone very significant transformations, which have made it difficult, however, to find answers for new and rapidly growing problems such as those associated with heroin use. The demand for care from heroin users is usually satisfied by mental health teams and/or social services, sometimes well experienced in the treatment of alcohol dependence but without any previous experience in the treatment of illicit drug use. As a result, since the early 1980s treatment of illicit drug abuse (mainly heroin) has been provided by teams whose composition and experience is very heterogeneous, with abstinence as the main (or only) target, and some widely shared basic principles:

- ***User's 'motivation'*** is a necessary condition for treatment success. As the treatment of non-motivated drug users seems ineffective, it may be considered appropriate by some treatment services not to offer specific treatment components (such as medication, admission to hospital detoxification units or therapeutic communities, etc.) before the patient has clearly shown high adherence to treatment (e.g. attending several interviews with the team) or a high acceptability to some difficulties associated with detoxification and rehabilitation (e.g. reducing - or even suppressing – the daily use of heroin without pharmacological support).
- Occasionally professionals have recommended ***moving from the community of origin***, although only for a very short time, systematically advising the remission to therapeutic communities or moving to rural areas.

In 1985 the Spanish Government approved the ***"National Plan on Drugs"*** and created an interdepartmental co-ordination body in the Ministry of Health. In the same year a first Law was approved by a regional parliament including guidelines for prevention, treatment and social rehabilitation in the field of drug abuse. Although these texts still showed the tendency to consider ***abstinence as a necessary condition for social rehabilitation*** of drug users, they included "new" concepts such as the consideration of drug dependence as a common disease and the right of drug dependent people to access social and health care.

Also in 1985, the ***treatment of drug users with opiates*** became strictly regulated. These regulations try to prevent bad medical practice, but they cause significant difficulties for the inclusion of heroin users in maintenance programmes with methadone and other opiates. Despite evidence about the negative impact of intravenous heroin use was having by increasing AIDS in Spain,

the provision of methadone maintenance or ***needle exchange programmes*** tended to be very limited until the 1990s. In 1990, the number of methadone maintenance programme (MMP) users is estimated to have been 3,043; in 1998 there were 63,030 clients in Spain.

Some of the laws and other norms on the treatment of drug use that have been approved by regional parliaments within the last five years do include some of the ***basic ethical principles*** that are intended to act as a guide in the health and social care of drug users. Among these ethical principles (which are intended to complement ethical principles for the general population) some should be highlighted:

- The right to have enough information about different available treatment facilities
- The right to confidentiality
- The right to choose between different available treatments
- The right for users to choose when to start and when to stop treatment, except when legal dispositions make it compulsory
- The right to be treated so that the user's dignity is respected
- The right of access to care provided by the public health system, having the same rights as those afforded to other patients
- Treatment goals include detoxification and rehabilitation but also risk and harm reduction.

Only one regional law also includes the right to free treatment provided that users meet certain obligation, including providing the necessary information for diagnosis and treatment, undergoing urine testing, and treating professionals with respect.

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2.9. Sweden[26]

2.9.1. Ethical Issues

During the last two or three decades the dominating ethical issue in connection with drug treatment is without doubt the ***existence, scope and content of coercive treatment***. The legal basis for coercive treatment of drug users is contained in two laws; the Care of Alcoholics and Drug Abuser Act, and the Act on Child Care. The latter, although designed for the general protection of children, provides for the coercive treatment of young drug abusers (under 20 years of age). Particularly during the 1970s and '80s the question of coercive treatment formed the heart of both the discourse on drug treatment as well as the general discourse on social policy. The main justification for coercive treatment has been that drug abusers will die if they are not provided with treatment and that coercive treatment will possibly motivate the drug abuser to voluntarily seek treatment (the latter objective is also the one that is officially stated, i.e. in the Care for Alcoholics and Drug abuser Act). The main reasons in favour of abolishing the legislation for coercive treatment has been that the law functions as a "class law" (in the sense that almost only individuals from the lower classes have been given coercive treatment) and that it is impossible to achieve a profound change in a person without the co-operation of that person.

It is noteworthy that it is very rare that a plead for the rejection of the legislation for coercive treatment takes its point of departure in the fact that the individual's autonomy is restricted, even if there are no indications of criminal behaviour or mental disease.

More recently there has been a discussion as to whether or not the person with drug problems should have the ***right to choose the type of treatment*** that is offered by the social service system. This used to be the case, but has changed as a result of a modification of the Social Services Act. Connected with this discussion is the restriction on treatment availability caused by the relative lack of financial resources for drug treatment, and it is argued by social workers that drug users, for economic reasons, are denied the type of treatment they are demanding.

26 Based on text prepared by Anders Bergmark, University of Stockholm, Department of Social Work, Sweden, 1999.

There are very few Swedish studies on these ethical issues, a fact that is somewhat surprising when one considers, for example, the presence of a rather unique form of coercive treatment for alcohol and drug abusers:

Bergmark and Oscarsson (1990) set out to analyse coercive treatment for alcohol and drug abusers within a framework of ethical principles that can be considered to be uncontroversial and fundamental with respect to ethical analysis within modern, western societies. The principles in question are:

- The principle of individual autonomy.
- The principle of harm minimisation (i.e. that one generally should avoid inflicting harm or at least minimise it).
- The principle of maximisation of wellness (i.e. that one should strive to act in such a manner that brings about a maximum of wellness).
- The principle of justice (i.e. that one should avoid differentiating between different groups if there are no differences that can ethically motivate a special handling).

Tännsjö (1995)[27] applies a basic utilitarian perspective and adds two additional maxims, autonomy and impartiality, as the foundation for the analysis of the practice areas. On the basis of the results he also makes recommendations for the circumstances under which coercion can be regarded as ethically acceptable. ***Paternalistic coercion*** (i.e. coercion that is justified by the claim that it promotes the well being of the individual) is not acceptable. He suggests that ***Homeric coercion*** (i.e. coercion which is initiated by the individual at time t1 because he realises that he otherwise will act in a manner that he does not want now at time t2) could be acceptable for drug abusers.

2.9.2. Ethical guidelines

Ethical guidelines referring specifically to the treatment or care of drug addicts could not be located. Twelve different organisations with connections to the treatment field have been scanned for documents with some ethical relevance, but only in two cases could guidelines be found:

- **Guidelines from the Swedish Social Worker's Association:** The Swedish Association for Drug Treatment (SNF), which is an interest group for personnel in the drug treatment field, does not have any guidelines of their own, but claims to use the guidelines provided by the Swedish Social Worker's Association (SSR): A total of 15 items are organised under the rubrics "Profession and Personality", "The Client", "Colleagues and Place of Work" and "Society". The guidelines are of a general character, covering questions of human rights, confidentiality, etc. Since the guidelines are not

[27] Tännsjö (1995) is Professor of Practical Philosophy at Gothenburg University and one of the leading Swedish scholars in the field of ethical analysis of medical and social problems. The indicated book is intended as a basic guide for students within such areas as medicine, nursing and social work. It covers several practice areas, among them the coercive treatment of drug abusers.

specifically directed towards drug treatment personnel, the target group includes all Swedish social workers. The guidelines were accepted by the SSR's board in January 1997.

- **Guidelines from the Swedish Association for Helping Drug Users:** The Swedish Association for Helping Drug Users (RFHL) does not have any guidelines of their own. Instead, they refer to the guidelines provided by the National Committee for Family Care (RFF), an interest group for family care units within the social welfare sector in Sweden. To a rather large extent the clients in these units are alcohol or drug abusers. The "guidelines and ethical rules of the RFF" (RFF: s riktlinjer och etiska regler) have been published in 1997. The items are organised under the rubrics of different target groups and their specific goals and networks for interaction. The guidelines are kept brief and, on the one hand, feature very general rules ("maintain a high level of service"), and on the other concrete instructions ("visit the family homes regularly").

References:

Bergmark, A. & Oscarsson, L. (1990). Till frågan om Tvångsvårdens etik (On the question of the ethics of coercive care), Nordiskt socialt arbete[28] (Nordic Social Work), 90; 3: 59-70.

Tännsjö, T. (1995). Tvång i vården (Coercion in Care). Stockholm, Thales.

2.10. Switzerland[29]

2.10.1. The Swiss approach to the drug problem

Legislative basis of the drugs policy

The Swiss Narcotics Act (BetmG) forbids the cultivation, production, trafficking, distribution, possession and consumption of opiates, coca products and cannabis. (Pure) consumption as a contravention of the law became punishable in 1975, with the possibility of being able to refrain from pressing charges under certain conditions. At present a further revision of the Narcotics Act is being prepared. The main changes which are being striven for are, amongst others, the widening of the law to permit the use of addictive drugs (instead of narcotic substances) for prevention, therapy and harm reduction, the definitive legal embodiment of heroin-assisted treatment (Cf. 2.10.2), new determination of punishments, as well as an increase in the role of government.

[28] The journal is a scientific journal for social work issues and research in the Nordic countries, also including Iceland. Articles are subject to judgement by referees.

[29] Based on text prepared by Ulrich Simmel, Schweizerische Koordinationsstelle für stationäre Therapieangebote im Drogenbereich (KOSTE), Bern, Switzerland, 2000.

The basis of international co-operation in the fight against drugs is provided by the UN Single Convention on Narcotic Drugs of 1961, the Additional Protocol of 1972, the UN Convention on Psychotropic Substances of 1971 as well as the UN Convention on Illicit Traffic in Narcotic Drugs and Psychotopic Substances of 1988, which was signed by Switzerland in 1989 but has not yet been ratified.

Prevalence

According to current estimates, around 30,000 of the 7 million inhabitants (i.e., 0.43 % of the urban population) are considered to be addicted to illegal narcotic substances. The problem consumption mainly concerns the intravenous consumption of heroin and cocaine. A further 500,000 to 600,000 people can be described as regular consumers of cannabis. The consumption of harder drugs has remained relatively stable in recent years. The number of mortalities in connection with the consumption of drugs has clearly reduced. Whereby in 1992, 419 drug-related deaths were recorded, in 1999 it was only 181 (Federal Office for Police, 2000). The consumption of Ecstasy / MDMA / Speed and other so-called party and designer drugs appears, after temporary increasing, to have stabilised.

Political system: Distribution of responsibility between the Federal Government and the cantons[30]

The Swiss drug policy needs to be considered against the background of the federal system of states, ranging from its 26 cantons with extensive sovereign jurisdiction to their municipalities. The implementation of the Narcotics Act lies mainly with the cantons. They are responsible for criminal prosecution (police, jurisdiction, prisons), prevention, and the care and treatment of drug abusers. The competence of the government is limited to support and co-ordinating functions. In particular, its responsibilities include the promotion of research and evaluation, providing support for the cantons and independent bodies in implementing the laws, the provision of suitable documentation, information and co-ordination instruments, as well as the promotion of training for professional drug workers[31].

As a consequence of the federal system of states, political measures need to be co-ordinated with one another. There is therefore a series of committees responsible for drug policy that are co-ordinated by the Federal Office of Public Health. To achieve this, it has established a co-ordination and service platform with the task of securing the flow of information between the participating authorities and providing operative support for the committees in their work (Bundesamt für Gesundheit BAG, Koordinations- und dienstleistungsplattform Drogen Schweiz KDS, 1999). In particular, the following committees at federal and national level should be mentioned:

30 The report presented here concentrates on the national level, whereby the drug policy approach at federal level is supported by practically all cantons.

31 In addition the Federal Government is responsible for defining narcotic substances to be placed under state control, regulating the legal production, distribution, purchase and use of these substances, as well as assigning responsibilities and duties to cantons, private providers and official authorities.

- The ***National Drug Committee*** (Nationale Drogenausschuss (NDA)) consists of representatives from municipal, canton and government authorities, and has the task of developing strategies and co-ordinating them with one another.
- ***The Conference of Canton Representatives for Addiction Issues*** (Konferenz der Kantonalen Beauftrafgten für Suchtfragen (KKBS)) deals with specialist and political themes and publishes statements on select issues (with the aim among other things of advising its own government).
- 15 cities[32] are represented in the ***Conference of Municipal Authority Representatives for Addiction Issues*** (Konferenz der Städtischen Beauftragten für Suchtfragen (SKBS).
- The ***Drug Platform of the Swiss Association*** **of Municipal Authorities** (Drogenplattform des Schweizerischen Städteverbandes (DSSV)) fulfils the task of providing expert advice for the Swiss Association of Municipal Authorities, represents the addiction- and drug-specific positions of the municipalities at federal level, and provides an annual overview of development in the municipalities[33].

The Federal Council policy to reduce the problem of drugs

Faced with an escalating drug problem in the 1980s, the Federal Council decided in 1991 to dramatically increase its commitment to drug issues. The decision was based - and this is fundamental to understanding the Swiss drug policy - on the judgement that the postulate of an addiction-free society can only be neared but never achieved. The government set itself the target of reducing the number of drug users and addicts, increasing the number of those who manage to withdraw from drugs, reducing harm to health and social exclusion, protecting society from the damaging effects of the drug problem, as well as intensifying the battle against organised crime. The measures which have since been taken are being scientifically analysed within the framework of an overall evaluation (Gervasconi et al., 1996). The main aim is the development and optimisation of a joint strategy for the government, cantons and local authorities to reduce the drug problem. The executive authority is the Federal Office of Public Health (Bundesamt für Gesundheit (BAG)). To achieve these aims, the Federal Council's drug policy consists of four strategic elements[34]:

- The central element is ***prevention***. This includes primary prevention, in particular for young people, as well as secondary prevention for casual users. Certain target groups and "settings" receive special attention. In addition, the specialist competence of the local authorities and occupational groups in the field of prevention is being promoted.

32 As of 8/97; to some extent top specialists from heterogeneous fields of work including welfare, social services and police.

33 In addition there is the Interdepartmental Drug Working Group (*Interdepartmentale Arbeitsgruppe Drogen*) . This plans and co-ordinates those measures which fall within the jurisdiction of the Federal Government. The Swiss Commission for Drug Issues (*Eidgenössische Kommission für Drogenfragen)* is an expert committee providing advice for the Federal Council, departments and Federal Offices in drug matters.

34 The approach is also described in Switzerland as the "4 pillars policy".

- Today, Switzerland has a diverse and well developed range of ***services for treatment and therapy*.** This is considered as imperative, both by the health authorities and amongst wider sections of the professional community, in order to be able to respond to and appropriately treat and care as many people as possible in their respective situations. The spectrum extends from out-patient counselling to methadone treatments[35], from the medical prescribing of heroin with integrated social and psychological care services to classic withdrawal- and abstinence-oriented in-patient therapy[36], as well as evaluated out-patient therapy within the setting of a penal or correctional institution. At the moment there are around 100 specialist institutions in Switzerland for inpatient care which provide around 1,600 slots[37]. The overriding aim of all these intervention approaches is to lead and accompany the persons concerned out of drug addiction, to support them in restoring or improving their physical and psychological state of health, and to integrate them into society again as far as it is possible.
- A further important element in the overall strategy is ***harm reduction/aid for survival***. For most of those concerned drug addiction is a phase in life from which they grow out of after several years. Those affected are to be evaluated and receive care at an early stage in order that the addiction phase can be shortened as much as possible, enabling them to live through this phase in a good state of health and socially integrated, whereby the chances of them being able to withdraw from drugs later are also increased. Therefore, for the last 15 years the government has been supporting a range of medical services for harm reduction (injection rooms, needle exchange programmes, needle dispensers, medical out-patient departments, HIV and hepatitis prevention in prisons, etc.) as well as social welfare services (outreach social work, low-threshold drop-in centres, street kitchens, emergency overnight shelters, day centres, leisure activities, structured occupational programmes, etc.).
- The fourth pillar is represented by ***repression/control***. Unauthorised production, trafficking and consumption of substances prohibited by law are subject to prosecution[38]. Recent government measures include a federal law imposing sanctions as part of legislation concerning foreigners, increasing the number of personnel in the Central Office for Combating Narcotics (Zentralstelle für Betäubungsmittelbekämpfung), as well as the development of new sentencing norms for money laundering and organised crime.

35 Around15,000 drug addicts are currently participating in a methadone programme, around half them with a family doctor, the rest in specialist treatment centres. Substitution treatments with methadone have a long tradition in Switzerland and represent by a long way the most used service in addiction treatment.

36 These are usually based on a social-, psycho- or milieu therapeutic/educational approach and emphasise professional training and reintegration..

37 Particular attention has been given recently to services for persons who suffer both from drug dependency as well as from psychological problems – a diagnosis which has been made with increasing frequency in the last five years.

38 Looking back over several years, approx. 80% of the prosecutions have been for consumption, around 10 % for consumption and trafficking, and just less than 10 % for trafficking and smuggling.

Various plebiscites[39] in recent years have revealed that there is a large consensus of support for the national drug policy. The success achieved in the past years has been acknowledged by the population and the policy recognised as an approach capable of achieving consensus.[40].

2.10.2. Ethical Issues

- The ***medical prescription of heroin to heroin addicts*** has been the most controversial and, publicly, the most discussed drug policy theme in the last few years. The referendum in June 1999, in which a majority voted for the government decision to prescribe heroin, showed, however, that today the advantages of this form of treatment are recognised by a large section of the population. The starting point for the clinical trials that lasted from 1994 to 1996 was the recognition that a group of chronically addicted persons, despite the diverse range of treatment services available, could not be sufficiently supported. It was particularly concerned with addicts over thirty who had already tried all types of in-patient and out-patient treatment but, against all efforts, constantly relapsed back into addiction. In terms of public health this group is particularly significant because of the high risk of HIV- and hepatitis infection, the risk of overdosing, as well as the wide-spread use of prostitution to provide an income. Furthermore, the resulting criminal activities represent a considerable burden on the public. The findings[41] show that heroin-assisted treatment, combined with a comprehensive programme of health care, therapy and support in all social fields, can be implemented with sufficient safety and has proved sensible for the target group described. Improvements in terms of the health and social situation are significant and still remain after completion of the treatment. Especially noticeable is the sharp decline in criminal activity and consumption of illegal drugs. Today, the prescribing of heroin is on the right way to establishing itself as a standard treatment complementing the existing ones. If there is to be a definite introduction, however, a change in the law will be necessary which is currently being prepared.
- ***Free choice of therapy:*** The diverse selection of treatment and care services led to controversial discussions concerning the freedom of choice that a drug addict has in selecting a certain treatment programme. The earlier so-called ”chain model” (with an effectively regulated sequence of interventions and corresponding admission requirements) has been replaced by a ”net model” (with a variety of possibilities for changing between the various pro-

39 In 1997 the initiative "Youths Without Drugs”, which demanded a much more repressive drug policy, was rejected by a clear majority (71%). In the following year, the legalisation initiative "Droleg” was also rejected with a high proportion of no-votes (73%). In 1999, almost 55% of those voting confirmed the federal resolution for the medical prescribing of heroin, but only after resorting to a referendum.

40 This is also occasionally described as the ”third way” (between extreme positions).

41 The evaluation of the trial is based on the data of 1,146 patients admitted into treatment programmes between 1994 and 1996. 16 treatment facilities were authorised, one of them was in a prison, the others were out-patient facilities.

grammes). This led to fears being raised that, if there is too much freedom of choice for the clientele, the professionally sound indication for a certain form of intervention loses importance, while at the same time parallel and multiple treatments become increasingly problematic the easier the access to treatment services. Furthermore, at the moment there is the justified worry that, in view of the currently uncertain financial basis in some sectors, grounds for a specific treatment have less to do with professional considerations than with financial ones.

- In Switzerland, ***short-term withdrawal under anaesthetic*** and deep sedation (ultra-rapid opiate detoxification) has been implemented for some time now. Up to now the discussion has concentrated first and foremost on specialist questions such as contraindications, location and competence of the indication authority, and the question as to whether consent is required. The initial high expectations have given way to a certain sense of realism. The recognition that drug dependency cannot be overcome if only the physical withdrawal has taken place, and that additional social-educational and psychological care measures are indispensable for successful treatment, has once again been confirmed. The fact that it has not been possible to create everywhere the necessary intensive medical evaluation, including suitable structural frameworks, has proved to be problematic.
- Today it can be assumed that there is a sufficient range of ***low-threshold services***. The field itself is currently undergoing a consolidation phase in which the following controversial themes are being discussed in particular: If initially a critical attitude towards the ”official” addiction treatment system prevailed, today the facilities consider themselves to be more and more a part of this system, which is also correspondingly less critically examined. The anti-prohibitive ideological position is losing dominance as attitudes supporting prohibition become increasingly established with the introduction of educationally-oriented intervention ideas. The initial concentration on the clients have given way to a ”focusing on institutions” - institutional interests are increasingly given more weight than the individual interests of the clients. Thus, there is now a shift in orientation from public health as a priority to public order.
- Today, there are 14 official ***injection rooms*** throughout Switzerland which are predominantly situated in the city centres and in German-speaking Switzerland. In some cities in Francophone Switzerland a discussion about the establishment of fixer rooms is currently going on. A self-help group that has just been founded has committed itself to this aim. Likewise, it is also being considered as to how these services could be established in rural regions. This also applies to the provision of clean needles.
- ***Harm Reduction and substitution in penal and correctional institutions:*** Clean needles are available in the larger Swiss prisons. A continuation of methadone programmes is possible in practically all prisons, whereas new admissions for methadone treatment are only possible in the larger prison establishments. In addition, drug-free areas or sections are offered within prisons (with voluntary access for the inmates).

- ***Drug testing in the workplace:*** The practice of several far-right employers of carrying out drug testing, particularly on trainees, has provoked a controversial discussion. If found positive, there is the threat of the apprenticeship being withdrawn. Until now it has not come to a judicial decision; it can only be assumed that those concerned have not protested against these measures - at least not using judicial means.
- ***Immunity from prosecution for consumption:*** In connection with the revision of the Narcotics Act (Betmg), the question as to whether consumption of soft drugs or even all drugs should be immune from prosecution is becoming the subject of intensive political debate. Depending upon the outcome of the discussion, the individual intervention fields will see themselves faced with fundamentally new challenges.

2.10.3. Ethical Guidelines

In Swiss addiction care the written formulation of ethical principles occurred comparatively early. This can be attributed to two developments. On the one hand, the increased commitment of qualified experts in addiction care led to an increase in professionalism. On the other hand, it should be understood as a reaction against intolerable occurrences, namely in the field of in-patient therapy. An important role here was played by the ”le Patriarche” establishments. Because of the low costs relative to Swiss standards, for many care workers placements here were seen as advantageous. Bit by bit, however, restrictions and violations of civil or even human rights in these establishments became known. However, the necessary basis to monitor and, where necessary, prevent such placements was lacking. As a consequence basic requirements for in-patient therapy were formulated by the Swiss Association of Professional Drug Workers (Verein schweizer Drogenfachleute (VSD 1994)) which, with slight modifications, were also adopted by the Canton Representatives for Addiction Issues (KKBS, 1997).

Today, various guidelines exist for the treatment and care of drug addicts that have either been published by professional organisations or produced within the public sector. Also of importance are the general guidelines used in the professional fields active in addiction care (especially the medical and nursing professions):

- ***VSD Ethical Guidelines, association rules and regulations for dealing with complaints*** (German-Swiss Association of Professional Addiction and Drug Workers (Verband Sucht- und Drogenfachleute Deutschschweiz) VSD, Olten, 1998): This deals with ethical guidelines for the work of the association members in the fields of prevention, addiction and drug work. The guidelines cover the following points: 1. Basic attitude: respecting the dignity and personality of the clients; prohibition of discrimination. 2. Contact and dealings with clients; professional relationships: duty to provide information about concept of work and professional qualifications, prohibition of sexual assaults as well as the abuse of trust and misuse of

power. 3 Development of specialist and personal competence, correspondence of competence and services offered, transparency of the relationship between employees. 4. Right to complain: an Ethics Committee which has yet to be appointed will oversee the observance of the guidelines. At the moment a regulation concerning the application of the guidelines as well as the responsibilities of the **Ethics Commission** is being drawn up. This is responsible for advising clients and VSD members[42] on ethical matters and problems, for mediation in conflicts between VSD members, as well as for judging breeches of ethical guidelines by VSD members. The rule regulates the procedure in cases of violations. Warnings and expulsion from the VSD are provided for as sanctions. It reserves the right to use information from professional organisations and other authorities as well as to take legal action.

- ***Charter of GREAT***[43] (1995): This is a declaration of the shared values of the GREAT members as well as their common attitude in terms of drug policy orientation.
- ***Requirements and criteria for inpatient establishments in the field of therapy for addiction*** (Association of Christian Specialists in the field of Rehabilitation and Drugs (Verein christliche Fachleute im Rehabilitations- und Drogenbereich) VCRD, 1996, Zurich): The document contains information on (1) basic attitude, ethics, (2) structure, organisation, (3) expertise (4) therapy, as well as (5) rights and duties.
- ***Outline requirements for in-patient establishments in the field of addiction treatment*** (Konferenz der kantonalen Beauftragten für Suchtfragen, KKBS, Bern, 1997): The document is aimed at authorities at all levels and is intended to be used in the assessment of addiction treatment facilities and as a basis for decisions in connection with expense reimbursements and authorisation procedures. It covers the following areas: 1. Structural Framework (legal form and organisation; finances, reports; services); 2. Professional Framework (concepts, professional competence, gender-specific addiction work, admission of children, medical provision); 3. Right and Duties (general information, admission, discharge, abandonment).

In addition, the following ***general professional codes of conduct*** are of importance:

- Code of conduct of the Swiss professional association ***Soziale Arbeit*** (***Social Work)*** (Structure: general behaviour; conduct towards clients; conduct towards professional colleagues and other specialists; conduct towards the employer; conduct towards society; professional conduct; application of the professional code of conduct).
- Professional Regulations of the Federation of Swiss ***Psychologists*** (*Föderation der schweizer Psychologinnen und Psychologen* (FSP, 1998, Bern)): The document includes a chapter on professional ethical principles that refer to the following themes: responsibility, professional competence,

[42] The VSD has more than 162 private members and 56 corporate members, which corresponds to around 300 people (as of March 2000).

[43] GREAT, Groupement romand d'études sur l'alcoolisme et les toxicomanies.

duty of confidentiality and data protection, developing professional relationships, publicising services; sharing responsibility of the professional ethics of the FSP and its members.

- Professional Regulations of the ***Swiss Medical Association*** (*Vereinigung der Schweizer Ärztinnen und Ärzte*), (FMH, Bern, 1996): This includes, amongst others, general principles, guidelines for conduct towards patients, conduct towards colleagues and funding providers, as well as the application and implementation of the professional regulations.
- Ethical Principles for Nursing. Swiss Professional Association of ***Nurses*** (*Schweizerischer Berufsverband der Krankenschwestern und Krankenpfleger*), 1990.

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2.11. United Kingdom[44]

Ethical issues concerning the treatment and management of drug misuse problems in the UK tend to be covered by a range of statements, policies and standards of practice. These are contained in many different documents and are issued by many different sources. For this reason, an understanding of the ethical issues surrounding drug misuse treatment requires a discussion of a much broader context than that of drug misuse:

The most general statement of the rights of patients is set out in ***The Patient's Charter***, first published October 1991. This national document was prepared to improve the quality of health service delivery to all patients treated in the National Health Service (NHS)[45]. The Charter sets out patients' rights and the standards

[44] Based on text prepared by Michael Gossop, National Addiction Centre, The Maudsley Hospital, London, United Kingdom, 1999.

[45] A revised Charter was issued in 1995, which drew together the rights and standards set out in the original Charter together with improvements made since 1991. Dental, optical and community pharmaceutical servi-

of service they can expect to receive in areas addressing, among others, waiting times, information about services and treatment; and privacy and dignity of the patient.

In addition to the national Patients Charter, local treatment providers also provide statements of standards of practice. Not surprisingly, these tend, to a considerable extent, to reflect the national charter. For example, The Maudsley Hospital provides a ***User's Charter***. This sets out the areas in which the patient has a right to expect standards of fair treatment, a safe environment, information about treatment, involvement in the programme of care, patient choice, confidentiality, and complaints. The majority of health trusts in the UK now provide some statement of this sort.

In many instances, the appropriate ethical guidelines are provided by ***professional organisations***. This is most clearly seen with regard to the ethical duties of doctors. Many treatment services for drug misusers are provided by medical practitioners. Many of the specialist British treatment services for drug misusers are run by psychiatrists. General practitioners are also increasingly involved in the treatment of drug misusers.

In the case of medical practitioners, there are a range of ethical guidelines for doctors which apply to all patients. The ***General Medical Council*** (GMC) licenses doctors to practise medicine in the UK[46]. By law, the GMC has four functions: keeping registers of qualified doctors; fostering good medical practice; promoting high standards of medical education; dealing firmly and fairly with doctors whose fitness to practice is in doubt. The GMC has strong and effective legal powers designed to maintain the standards that the public has the right to expect from doctors. "We are not here to protect the medical profession .... our job is to protect patients" (GMC policy statement, website 1999). Where doctors are found to be in breach of their professional standards of behaviour, the GMC can (and does) remove their licence to practice. The GMC guidelines[47] set out the duties of a doctor and cover what are seen as the essential elements - professional competence, good relationships with patients, and observance of professional ethical obligations.

The GMC also publishes statements which address ***issues of specific relevance to drug misuse***. For example, during the 1980s when national policy regarding HIV infection and AIDS was being formulated and clarified, the GMC stated that *"It is .... unethical for a doctor to withhold treatment from any patient on the basis of a moral judgement that the patient's activities or lifestyle might have contributed to the condition for which treatment was being sought. Unethical behaviour of this kind may raise the question of serious professional misconduct"* (GMC, 1988). The firm and early statement of this position made an extremely important and influential contribution to the development of a national strategy to tackle HIV infection, and had a significant impact upon the development of effec-

ces were also covered for the first time in the revised Charter. Due to administrative arrangements within the UK, separate charters have been drawn up for Northern Ireland, Scotland and Wales.

46 At the time of preparation of this report (1999), the GMC medical register contains about 189,000 names.

47 The GMC has published four booklets that provide advice on the standards of practice and care that patients have a right to expect of doctors.

tive harm reduction interventions for injecting drug users in the UK. A further statement of the above principle was made by a Medical Working Group of the Department of Health. This stated that: *"Drug misusers have the same entitlement as other patients to the services provided by the National Health Service. It is the responsibility of all doctors to provide care for both general health needs and drug-related problems, whether or not the patient is ready to withdraw from drugs"* (HMSO, 1991).

Other professional groups also operate codes of conduct for their members. The ***Code of Conduct for the British Psychological Society*** sets out certain minimum standards for conduct with which chartered psychologists are required to comply. The Code is also supplemented by several other guidelines and statements on matters of ethics and conduct published by the Society and its sub-systems. The Code covers issues such as competence, obtaining consent, confidentiality and personal conduct.

Similar guidelines and expectations are set out for other groups. ***The Royal College of Nursing***, for instance, promotes the interests of nurses and patients on a wide range of issues including standards of care, through working with government, other unions, professional bodies, and voluntary organisations.

This ***interlocking network of codes of conduct***, guidelines and regulations provides a framework regarding the ethical standards for treatment providers. It operates most clearly with regard to professional groups (such as doctors) and to those who work in structured government-funded services (such as NHS hospitals). In such cases, there is usually a clear and explicit statement of what can be expected by the patient, and the sanctions for failing to meet the standards can be serious.

For ***non-professional treatment workers*** and for voluntary or ***non-governmental organisations*** which operate outside the NHS, the impact of such guidelines is, at best, indirect. Some of the best non-governmental organisations set their own internal standards and provide explicit statements for their staff and their clients. Often they do not. In such cases, where there is variation in the provision of treatment services or in the implementation of ethical standards, the precise nature of the policies and guidelines for practice are much less clearly defined. Under such circumstances, the nature of any procedures for redress of any complaint by the patient will also be less clearly defined, and may be unspecified.

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3. Summary and Discussion

In the following sections the different forms of codification, the aims of drug policies, the ethical content of discussions and, finally, the central ethical principles in society's dealings with drugs and drug addiction will be briefly summarised.

3.1. Forms of codification

Ethical principles are often embodied in a wide variety of documents of different character; these include government documents which are highly compulsory in nature such as laws, political statements and recommendations, but also in guidelines which professional and specialist organisations or individual institutions have imposed upon themselves.

Particularly in the Netherlands, but also in Poland, numerous ethical principles are regulated at legislative level, including matters concerning the safeguarding of quality (NL). Most principles, however, relate to the entire health and social services, not specifically to the treatment and care of drug addicts. The laws are, however, supplemented with numerous recommendations and ***guidelines from the ministries*** concerning specific aspects of drug addiction treatment and care. In the Netherlands on the other hand, with the exception of the medical professions there are no addiction-specific ethical guidelines from professional or specialist organisations.

In all countries the ***compliance with ethical principles is considered an integral part of professionalism***. Presumably, there are also overall guidelines for the most important professional groups involved with the treatment and care of drug addicts. Doctors, social workers and psychologists have at national level their own professional codes of conduct whose observance is expected from all professional, qualified employees. In Great Britain it can be pointed to the increasing importance of such guidelines, particularly in the medical field, which are combined with corresponding possibilities for sanctions (withdrawal of licence to practise). Moreover, professional groups in various countries have ***specific guidelines for drug addiction treatment and care***, such as the doctors in Holland and the psychologists in Poland.

Patients' Charters are of growing importance in the UK with the aim ***of improving national health care services in general*** (not specifically in the field of drug addiction treatment and care). Patients' Charters include patients' rights as well as standards of service which can be expected by the patients. In addition, some institutions have their own users' charters. The patients' charters

form, together with the guidelines of the professional organisations, the ethical framework for the treatment providers[48].

Various degrees of importance are attached to specific ethical guidelines in written form. ***Specific guidelines from umbrella associations*** or similar organisations exist in Germany, Switzerland, Italy and Poland[49]. In Switzerland such guidelines have come into being relatively early within the framework of increasing professionalism in addiction care as well as a result of shortcomings in in-patient therapeutic establishments. In addition, specific ethical guidelines are either being planned or developed in the Czech Republic and Greece. In the Czech Republic, the process is occurring in close conjunction with the prescribing of minimum standards of treatment. On the other hand, there are no specific guidelines in Denmark, Sweden, Holland and Great Britain. An example of ***ethical guidelines from a single institution*** which can be named are the comprehensive guidelines from MONAR in Poland. Considered of particular importance among the specific guidelines are the ***Ethical Guidelines of the World Federation of Therapeutic Communities*** (WFTC): in Poland this was adopted by the Polish Association of Therapeutic Communities; in Greece the largest NGO has oriented itself to it, and in Denmark a large institution has adopted the WFTC guidelines.

If the same general regulations valid for all patients of the health and care services are equally valid for drug addicts, then this is to be welcomed as far as equality of treatment is concerned. In addition, however, specific aspects need to be considered in the treatment and care of drug addicts. For instance, on the basis of their addiction drug addicts are often denied the ability to make their own decisions concerning themselves. In addition, they require special protection from discrimination, not least because of the illegality of the drug consumption. Ethical guidelines must also deal precisely with such aspects because the answering of ethical questions is largely dependent upon the context. Therefore, the aim of ADAT is the formulation of *specific ethical guidelines* for the treatment and care of drug addicts. This means that general guidelines, such as those formulated by the Patients' Charter or professional codes of conduct, are included in it, but are specified for the treatment and care of drug addicts.

The ADAT guidelines are intended in this respect, however, to be of a *general* nature as they are neither directed to just one professional group nor refer to definite settings for treatment and care. This is of importance because in practice it is mostly different professional groups who work together, people without any relevant training are employed in treatment and care, and the guidelines are similar for the various professional groups. Guidelines which embrace all fields of work are of significance because numerous questions cannot be answered at the level of individual institutions and treatment procedures. The right of the patients and professionals must also be protected at a higher level.

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48 The system functions well for the members of these professional groups as well as for state-funded institutions. For non-professional treatment workers and NGOs , however, these guidelines have at most an indirect effect.

49 Adoption of the WFTC guidelines.

3.2. Drug policy aims

In several of the country reports ethical aspects were placed within the context of drug policy aims, while others refrained from making this connection. This therefore raises the question as to what sort of relationship exists between drug policy aims and ethical aspects and principles. First of all, policy aims can represent in concrete terms ethical principles for the way in which society deals with drug addicts. They can also represent, however, a political compromise between different values. Finally, ethical principles can be used to legitimise policy aims. In every case, however, the policy aims reflect the ethical principles. In particular, the following drug policy aims are mentioned in the country reports:

1. General reduction of availability and demand for psycho-active substances (through enforcing the prohibition of production, trafficking and consumption as well as through prevention and treatment).
2. Minimisation of the drug-induced risk of damage to health and social exclusion of the users through medical services (needle exchange programmes, medical out-patient departments, infection prophylactics in prisons, etc.) and social care services (low-threshold drop-in centres, street kitchens, emergency overnight shelters, structured day programmes, etc.).
3. (Re)integration of drug addicts into society as ultimate goal in addiction care (by reaching as many addicts as possible, by offering appropriate help at the earliest possible stage, by providing care with the aim of not only achieving abstinence but less ambitious care objectives such as stabilisation, by improving the living situation, by limiting the damage to health and ending criminal behaviour, and by focusing on all problem areas with which the client is faced and his or her ability to improve them).
4. Minimisation of the health and social risks for those associated with the drug users as well as for society as a whole (e.g. HIV and hepatitis infection risks, but also family care too).
5. Reducing public nuisance (e.g. through drug-related crime).

In particular, the aims mentioned under 2 and 3 have become established in the ethical guidelines from ADAT because it deals with guidelines for the *treatment and care* of drug addicts. However, the other aims have also been taken into account.

3.3. Ethical debate in Europe

The following aspects concerning how professionals and society deal with drug addicts are currently being discussed or were the subject of ethical debates in recent years:

- ***Addiction as an illness or criminal behaviour*:** Because of the illegality of substances and consumption, the way society deals with drug addicts shifts in all countries between the two poles. Fundamentally, however, it is demanded that there is a consequent orientation of the treatment and care to the illness paradigm. As a starting point, drug abusers should be placed outside the prison system since criminal drug abusers must be offered social-pedagogical/psychological treatment. The discussion in Switzerland which has recently started concerning immunity from prosecution for consumption of soft drugs or, alternatively, all drugs should also be understood in this context.
- ***Treatment under judicial pressure and compulsory treatment*:** Whereas in the first case drug addicts can choose when being sentenced between therapy or being punished, in the second case (compulsory treatment) they have no choice. In particular, the modalities for compulsory treatment are currently being discussed in Sweden, Poland, Denmark and the Netherlands. In Sweden compulsory treatment has shaped the ethical debate for years. Holland is also moving in new directions at the moment. The intention is to use compulsory treatment to reach both long-term drug addicts and those serious offenders who do not voluntarily take advantage of the treatment services. The central arguments in this debate are concerned with the safeguarding of the rights of those affected, the appropriateness of the aims being followed, and the measures which are therefore applied.
- ***Legal supply of opiates*:** The provision of *methadone* enjoys generally increasing acceptance. In many places an increase in the number of vacancies for treatment is being registered (Cf. Developments in the Czech Republic, Poland, Spain and Italy). Existing reservations are particularly concerned with the abandonment of abstinence as a goal[50]. Less widespread is the discussion on the right to continue *methadone treatment in prisons*. In Switzerland, the Netherlands, Germany, and in Denmark the *prescribing of heroin* is currently being tested or is being discussed.
- ***Harm reduction*:** Besides the provision of methadone, other forms of harm reduction are also being intensely discussed (e.g., provision of needles and condoms, needle exchanges, user rooms, drug testing). There is also increasing acceptance here, and in the centre of the debate stands once again the question as to what extent harm reduction and the goal of abstinence run counter to each other, i.e., whether risk reduction measures reduce the motivation of the drug addicts to withdraw from drugs. One aspect of the discus-

[50] Correspondingly, substitution treatment is described in some countries as a harm reduction measure (e.g. Poland), in others, on the other hand, as a form of therapy (e.g. Switzerland).

sion concerning the use of *user rooms* is the attraction of dealing in the vicinity of the user rooms and thus causing a nuisance at the location. The ethical dilemma of *drug testing* is whether users and dealers just profit from the opportunity of having the composition of pills evaluated or if the testing of drugs is useful at all as a prevention and harm reduction strategy. In Switzerland, in the field of low-threshold services a shift in orientation can be observed from public health as a priority towards public order. In addition, it is being discussed as to which range of treatments should be available in the field of *harm reduction and substitution in prisons,* and whether the right should be given to continue the substitution treatment in prison.

- ***Clients' rights*:** Increasingly, the rights of the clients are being discussed. The discussion began in general health care and is being led under the term ”patients' rights”. These rights form a central basis for the following guidelines.
- ***Free choice of treatment*:** Besides the rights within the establishments, the right of the client to have a free choice of treatment is under discussion. As a result of the change from the ”treatment chain” to the ”network model” (with a large variety of possibilities for changing between the range of programmes), reservations are being expressed that, if the client has too much free choice, the professionally sound indication for a certain form of intervention loses any meaning. In addition, the problem of parallel and multiple treatments has also been pointed out (CH).
- ***Quality and costs of services*:** To this belongs the question of the quality which can be expected by the clients and must be guaranteed by the providers, the importance given to the active participation of the clients for the treatment to be effective, the question as to how much the treatment and care may cost, whether the treatment is fundamentally worth it / must be worth it (high costs, little success), and by whom should the treatment be financed / whether access to treatment should be free for the client. In this context, the danger has also been pointed out that the grounds for a specific treatment could have less to do with professional considerations than with financial ones.
- ***Employment of ex-users*:** In Greece the question is under discussion as to whether ex-users should be employed in addiction treatment and care, and if so under which conditions. The Danish Association of Social Workers welcomes ex-addicts as co-operation partners in treatment. The rule is being discussed as to whether ex-users must prove themselves during a one- to two-year period outside a therapeutic establishment before they may be taken on as employees.
- ***Prison, workplace and driver drug testing (urine tests)*:** Ethical discussions in the Netherlands and in Switzerland (workplace) concern privacy and safeguarding of physical integrity.

The summary shows that the questions and arguments discussed in the various countries are similar. The ethical principles are the same. There are differences, however, in how much weight is given to the arguments, and, as a result, in the priorities which are established for drug policies. The postulates were able,

therefore, to be adopted in the following guidelines. Many of them have already been put into concrete terms in the regional guidelines.

3.4. Ethical principles in the treatment and care of drug addicts

Because the way in which professionals deal with drug addicts generally always occurs within the context of the way society as a whole deals with drug consumption, in the following section, on the basis of the country reports and specialist literature, several central ethical principles for the way society deals with drug users will be listed and briefly documented (for the principles, see in particular Bergmark and Oscarsson, 1990, Tannsjo, 1995, as well as Uchtenhagen, 1998):

1. The principle of maximisation of wellness
2. The principle of harm minimisation
3. The principle of individual autonomy
4. The principle of justice
5. The principle of usefulness
6. The principle of appropriateness
7. The principle of the democratic negotiation process

The principle of maximisation of wellness

The basis of the principle is that one should strive to act in such a manner that brings about a maximum of goodness (Bergmark & Oscarsson, 1990).

(Ringeling 1992) describes the promotion of the *people's health* as the wealth which must be maximised. The aim of drug policies must be to protect, as much as it is possible, all members of the community from hardship through prevention, therapy and legitimate public security. Closely associated with this is the second principle:

The principle of harm minimisation

The significance of this principle is that one generally should avoid inflicting harm or at least minimise it (Bergmark & Oscarsson, 1990).

On the basis of these principles it can be debated as to the conditions under which either harm minimisation for drug addicts, i.e., the safeguarding of their health, should stand to the fore, or public order and the safeguarding of the health of the entire population (e.g., through the generally preventative effect of a general prohibition on consumption).

The principle of individual autonomy

The central point of citizens' civil rights in democracies is that the individual can freely choose his lifestyle and goals in life within the limits of the given legal norms. This is also valid when his choices - apparent or actual - are hardly beneficial to his interests or even disadvantageous (Uchtenhagen 1998).

Included in the principle of individual autonomy is also the much discussed principle of consent by the client, especially within the context of medical treatment and care.

In this sense, according to (Herwig-Lempp 1994, 120 f.), it must be fundamentally assumed that drug users are in the position to decide for themselves on all relevant questions. Their behaviour should be understood as an expression of autonomous decisions and as a result of a specific intent.

According to (Wolf 1991, 44), "philanthropists and professional carers (...) tend to underestimate the paternalistic aspects of care and therapy. In the centre of their attention are the lives and well-being of the patients, not their autonomy." Therefore, an important aspect of the principle of individual autonomy is also the client's consent to all matters concerning the determination of their treatment and care on the basis of suitable information.

Tännsjö's (1995) reason for the admissibility of homeric coercion is also based on the principle of individual autonomy: Homeric coercion can be regarded as ethically acceptable (i.e., coercion which is initiated by the individual at time t1 because he realises that he will otherwise act in a manner that he does not want now at time t2), whereas coercion that is justified by the claim that it promotes the well-being of the individual (paternalistic coercion) is not acceptable.

The principle of justice

The basis of this principle is that one should avoid differentiating between different groups if there are no differences that can ethically motivate a special handling (Bergmark & Oscarsson, 1990).

The principle of usefulness

Usefulness means that measures in the sense of utilitarian ethics are then justifiable when they are appropriate for achieving the desired goal. The evaluation of measures for reducing addiction phenomena must therefore be orientated to the *principles of preventative or curative usefulness* (Uchtenhagen, 1988). For this it is important that there is a readiness to check, impartially and using empirical research, the effects of existing regulations and their application, and to draw all the necessary conclusions from them.

The principle of appropriateness

The principle is used, above all, when it concerns the restriction of civil rights. Appropriateness means that defensive measures should not cause more harm than the disorder itself (Uchtenhagen, 1998).

Individuals‘ civil rights (Cf. third principle) reach their limits when the interests of others are affected, when third parties are exposed to unreasonable risks and dangers, or when there is a considerable risk of danger to themselves. The mere fear of transgressing these limits is insufficient, however, for restricting civil rights, and the loss of autonomy associated with addiction cannot already be considered as endangering one’s self. It is difficult to judge what should be considered as a public nuisance and a disturbance of public order (ibid.).

The principle of the democratic negotiation process

Since modern societies take a pluralistic view of values, it has become difficult to define ethically correct behaviour in a general way which applies particularly to the way society deals with illegal drugs and drug addicts. A democratic process of negotiation between the various viewpoints of the problem and the approaches made to solve it is therefore in itself a requirement for an ethical approach (Uchtenhagen, 1998)[51].

These principles can be drawn on when evaluating the way in which society deals with the consumption of illegal and legal psycho-active substances and with the users. As such they form the basis for the following guidelines.

References:

Bergmark, A. & Oscarsson, L. (1990). Till frågan om Tvångsvårdens etik (To the question of the ethics of coercive care), Nordiskt socialt arbete (Nordic social work), 90; 3: 59-70.

Herwig-Lempp, Johannes (1994). Von der Sucht zur Selbstbestimmung. Drogenkonsumenten als Subjekte. Dortmund: Borgmann.

Ringeling, Hermann (1992). Die Suche nach dem rechten Mass. Ethische Erwägungen. In: Böker, Wolfgang & Nelles, Joachim (Hg.): Drogenpolitik wohin? Sachverhalte, Entwicklungen, Handlungsvorschläge. Bern: Hauptt Verlag, 65-72.

Tännsjö, T. (1995). Tvång i vården (Coercion in Care). Stockholm, Thales.

Uchtenhagen, Ambros (1998). Sucht und Umgang mit Sucht: Ethische Implikationen. In: Festschrift Horst Eberhard Richter. Giessen: Psychosozial Verlag.

Wolf, Jean-Claude (1991). Paternalismus, Moralismus und Überkriminalisierung. In: Gözinger, Gerd (Hg.). Recht auf Sucht? Drogen, Markt, Gesetze. Berlin: Rotbuch Verlag, 38-65.

[51] From the country reports, the participative negotiation of minimal treatment standards in the Czech Republic as well as the clarification of the medical role in the treatment of drug addicts in the Netherlands can be mentioned as examples.

4. Ethical Guidelines

4.1. Purpose and Subject Matter of the Guidelines

Aim and intent

The following manual contains the most important ethical aspects concerning the treatment and care of drug addicts which are currently being debated. It can serve as a basis for interested experts, institutions, umbrella organisations and national authorities, either for the formulation or process-oriented further development of their own ethical guidelines.

When evaluating the adequacy of a drug treatment system in a given region, the values which are highly valued there need to be revealed and their placing in concrete terms and in order of importance within a democratic negotiation process determined. For a code of ethics to be fully beneficial to all parties concerned it is fundamental that it is based on the widest possible participation and sharing by the different cultural and scientific areas involved, as well as on the support of the various professionals working in the field (Clerici and Tempesta 1999).

As it has been stated in the introduction (1), ethical conflicts particularly occur where concrete problems emerge and where different values conflict with one another. The following guidelines contain no recipes on how to proceed in such situations. Instead, the ADAT guidelines are intended to facilitate the identification of ethical aspects involved in conflict situations and make visible the violation of ethical principles. The significance of the guidelines must be discussed and substantiated for conflicts occurring between different values. Deviations from the guidelines must be declared and justified. In case of disagreement, a neutral figure must be available to be contacted. Various examples of conflicts and suggestions for their solution are illustrated in the country reports (see summary in Ch. 3.3).

Subject Area

First of all it deals with guidelines for the professional treatment and care of drug addicts. It also mentions briefly, however, other aspects which concern the general way in which society deals with users of legal and illegal drugs, including political, police, legal and primary preventative interventions and research, provided that they are connected with treatment and care (see 3.2).

Why specific guidelines for the treatment and care of drug abusers? All human, civil and patients' rights, as well as ethical principles for the treatment of mental and physical illnesses, also apply to drug abusers. However, particularly be-

cause of the linking of illness and criminality in the way society regards drug abusers, this is not always self-evident. The country reports show that the professional treatment and care of drug abusers raises a variety of specific ethical questions. Therefore, the guidelines refer especially to treatment in the field of illegal drugs. Ethical questions which concern the entire health and care system, i.e., which do not specifically concern the treatment and care of drug addicts, are either not considered or only briefly. It is a fundamental principle, however, that drug addicts in general health care have the same rights as any other patients, and that the professional role with regard to drug addicts is the same as regards other patients (also see 3.1).

The guidelines refer to *all treatment and care procedures* and are aimed at *all professional groups* who are employed in this field. Guidelines which embrace several fields are important because numerous questions cannot be answered at the level of individual institutions and treatment procedures (for reason see also.3.1).

Because an ethical approach is an inherent part of professionalism, *ethical principles and professional standards* cannot always be clearly differentiated. Within the framework of the ADAT project, general demands stand to the fore with the ethical guidelines that are a direct expression of a fundamental position. In contrast, professional standards refer primarily to specialist principles which have been derived from scientific knowledge and practical experience.

Basis for the guidelines

The manual has been produced on the basis of a study of the existing literature on ethical issues, as well as the ethical guidelines of participating countries and international organisations, such as professional codes of conduct, professional association regulations, patients' rights and human rights in general. Thus, the ADAT ethical guidelines are based upon the current state of discussion in the participating countries.

The material on which it is based differs considerably. Some guidelines are aimed only at certain professional groups or fields of work, others are more comprehensive in character (see 3.1). The spectrum ranges from general ethical principles to obligatory instructions for treatment for specific fields of work. The following material should be mentioned in particular:

- Universal Declaration of Human Rights (General Assembly of the United Nations 1948) (annex I)
- European Convention on Human Rights (ECHR 1950)
- European Social Charter (Council of Europe 1996)
- The International Code of Medical Ethics (The World Medical Association 1994)
- Declaration of Helsinki (The World Medical Association 1975)
- Convention on Human Rights and Biomedicine (Council of Europe 1997)
- The Patients' Rights of the World Health Organization (WHO 1997) (annex II)

- The World Federation of Therapeutic Communities Code of Ethics (WFTC o.J.) (annex III)
- Ethical principles in addiction treatment, (Deutsche Hauptstelle gegen die Suchtgefahren 1999) (annex IV)
- Ethical Guidelines For Professional Operators in the Field of Drug Addiction, Italy (Clerici and Tempesta 1999) (annex V)
- Code of Ethics of Workers of the Monar Association, Poland (MONAR o.J.)
- Tasks, roles and responsibilities of physicians in drug-related problems (The Royal Dutch Medical Association 1999)
- Ethical Guidelines (Switzerland VSD 1998)
- Requirements for stationary institutions in addiction, Switzerland (KKBS and Suchtfragen 1997)

Drawing up the guidelines

The fundamental principle when drawing up the ADAT guidelines was the accumulation and summarising of the existing guidelines. Very specific aspects that, for example, referred to a specific therapeutic approach were left out along with individual guidelines whose significance would only be clear in a more comprehensive context. Frequently, the same aspects are treated from different perspectives. In such cases the formulation was adopted which was most neutral or appeared most appropriate for the purpose being pursued here. At times the levels of the guidelines had to be adapted and gaps closed concerning content. No actual contradictions in terms of content occurred.

The structuring of the guidelines caused certain difficulties. In accordance with the material on which it was based, the guidelines are directed at different addresses. This leads inevitably to a certain amount of repetition. For example, the duties of professionals are often the rights of clients, or the postulate that there should be easy access to institutions can be formulated as a right at system and institutional level, but is also put into concrete terms in the interaction between the specialist and the client. Precisely because it concerns rights and duties at different levels, such repetition must be accepted.

A format was chosen where *general values*, *guidelines for the entire system* as well as *for individual establishments* are named at the beginning. This is followed by the *guidelines aimed at specialists*, differentiated according to general professional competencies, professional behaviour towards clients, as well as towards professional colleagues. Finally, this is followed by a list of the *rights of clients*, regardless of the type of institution. In conclusion, several *guidelines concerning matters of procedure* and the further development of the guidelines are named.

Finally, it must be pointed out that there is no correlation between the order of the guidelines and their importance. The ADAT guidelines do not attempt to establish a hierarchy for the ethical principles.

Explanation of terms

By *clients* we mean current or former drug users who, as a result of problems in connection with their drug consumption, voluntarily, or as a result of legal or administrative measures, receive professional treatment and care or take advantage of specific social services. This does not include relatives and close friends. These will be explicitly named as such.

The term *professionals* is used to describe all people who, as part of their occupation, provide clients with a service, regardless of their training.

4.2. ADAT Ethical Guidelines

Basic values and human rights

1. **Health as a human right:** Everyone has the right to such protection of health as is afforded by appropriate measures for disease prevention and health care, and to be given the opportunity to try to reach his or her own highest attainable level of health. This applies to addiction, which shall be recognised as an illness as with every other impairment of physical, psychological and social well-being. Each drug misuser has a right to receive professional treatment and care according to currently accepted quality standards. Services should be made available according to the financial, human and material resources which can be made available in a given society.
2. **Solidarity in action and participation:** Every society does what it can for the health of its people. It facilitates and supports the participation of individuals, groups, institutions and associations for the continuous development of health.
3. **Respect of all human rights:** People who misuse drugs or are dependent upon them are citizens with equal entitlements, having all rights and duties regardless of whether they are undergoing professional treatment as a result. They have, above all, a right for civil rights, self-determination, choice of lifestyle, personal fulfilment, privacy, dignity, and that their own moral and cultural values and religious and philosophical convictions are respected. Every restriction of these rights must be revealed, justified and clearly regulated.
4. **Equity in health**: The enjoyment of all rights set forth in these guidelines shall be secured without discrimination on any ground such as race, colour, sex, age, language, religion, political affiliation, national extraction, social standing, financial situation, bio-psychosocial health, criminal record, sexual preference, association with a national minority, birth or other status. Drug abusing prisoners have the same right for the protection and promotion of their health as drug abusers outside penal establishments.

5. **Goals of treatment and care:** The overall aim of the treatment and care of drug addicts should always be their (re)integration into society as well as the minimisation of risks for the drug addicts themselves, for their social milieu, and society as a whole. Abstinence cannot always be the only aim of treatment for all drug addicts. Intermediate goals and alternative objectives, such as the stabilisation of the living situation, the reduction of health risks or the reduction of criminal behaviour, should be recognised and supported. All treatment and care procedures must be suitable in terms of influencing the bio-psychological, social well-being of the clients, and this with the least possible discomfort for the clients themselves and their environment.
6. **Limits of responsibility:** Drug use that does no damage to the health of the user, his environment or society is not a medical matter and therefore does not belong in the sphere of responsibility of health and social care professionals.

Organisation of the treatment and care systems

7. **Low-threshold services:** The care system must be so organised that it can reach as many drug addicts as possible at an early a stage as possible. Drug addicts and their relatives must be able to receive quick, unbureaucratic access to professional help. This applies particularly to medical emergency cases.
8. **Accessibility of services without discrimination:** All public health and social services should be available to all, equitably and without discrimination. No one should be excluded from treatment and care owing to certain characteristics such as age, gender, religion, ethnic, political or geographic affiliation, physical or psychological state, prognosis or substance used. For seriously ill clients with a long lasting, permanent addiction to heroin and a short life expectancy, palliative treatment with heroin, methadone or other substitutes should be facilitated.
9. **Voluntary access:** Voluntary access to and permanency in any treatment and care programme should be available at all times. The motivation to claim help should be facilitated and supported.
10. **Information for potential clients:** Information about the availability and location of treatment and care services is to be made available to all potential users of the services.
11. **Financing:** It must be possible to organise the financing of desired or suitable treatment within a useful period and this should not represent a long-term burden for potential clients and their relatives. Each client has the right to receive health care on the basis of his/her clinical need, not his/her ability to pay. Financial considerations must not supersede expert criteria in the selection of a certain treatment.
12. **Scope of Services:** Adequate support should be available for all problem areas with which clients are faced.

13. **Diversity of services:** Since both the individual needs of clients and their problem situation can vary a great deal, a variety of modalities of treatment and care should be offered. The unification of services must be avoided. The specific needs of different target groups should be taken into account with a suitable range of services.

14. **Choice:** The person seeking help should be able to choose between various services in order to achieve their personal goals in an optimal way and in a preferred manner. The choice should not run counter, however, to professionally sound indications.

15. **Compulsory treatment:** The reason for compulsory treatment must be disclosed. Its implementation must be clearly regulated in legal terms and its effectiveness evaluated. Compulsory treatment must be orientated towards the principle of facilitating the drug abuser's self-determination and towards the goal of social (re)integration. Voluntary treatment must always be attempted first. The individual rights must be respected in every case. The same principles apply for compulsory treatment both in and outside the prison system.

16. **Treatment in prison:** The access to addiction-specific treatment within penal establishments should be just as guaranteed as outside, under consideration, however, of the specific security requirements of the respective prisons.

17. **Evidence-based treatment and care:** Treatment and care establishments must work in accordance with recognised and empirically established principles, and their effectiveness should be monitored through evaluation. The practical experimenting with new approaches must be facilitated where the adequacy of the present services can be improved. However, there is an increased need for evaluation of new treatment approaches.

18. **Institutional and professional networking:** The co-operation between treatment and care establishments should facilitate an appropriate and continual care of drug addicts. The expertise which professions acquire on drug-related problems, as well as on the treatment and care of drug addicts, should be made available to other professionals in a systematic form.

Responsibility of treatment and care facilities

19. **Information to the public:** Treatment and care facilities should disclose and disseminate to the public the necessary information on the methodologies and basic principles on which their action rests, as well as on how the programmes are organised, and what the main aspects are concerning psychological, educational and social activities.

20. **Internal transparency of rights and obligations:** Each treatment and care facility should have its own instructions displayed for clients and staff. Their responsibilities and rights should be defined clearly and be easily accessible.

21. **Rights of staff:** Each facility shall ensure that contact between the staff and between the staff and clients is respectful and that there are appropriate working conditions. The facility shall provide access to adequate training, support and supervision for its staff.

22. **Continuity of treatment and care:** Each establishment must ensure that clients, after completion or interruption of the treatment, are referred to suitable support services corresponding to their needs, unless the client refuses or it concerns a low-threshold facility without any actual entitlement to provide treatment. If drug abusers cannot be treated in the establishments they have turned to, the respective establishment must ensure that there are adequate referral procedures. Clients from substitution programmes should be able to remain in the programme until they begin an abstinence-oriented therapy, or no longer wish to continue the substitution, so as not to be forced into illegal consumption.

23. **Adequate infrastructure:** Each treatment and care facility is responsible for creating and maintaining an infrastructure which enables compliance with the guidelines as well as a professional method of working.

24. **Quality assurance and improvement:** Each institution is obliged to guarantee quality of care, which means that care is always provided in an effective, efficient and client-oriented manner. It applies measures, in accordance with its possibilities as well as appropriate to its field of work, which safeguard and continuously improve quality.

25. **Vicinity of treatment and care facilities:** Treatment and care facilities must make arrangements for preventing nuisance and risks to the surrounding neighbourhood which could occur as a result of the establishment.

26. **Facilitating professionalism:** Treatment and care facilities are responsible for the creation of suitable conditions which enable the professional employees to execute the professional duties described under 0.0.0.242007256 and 33.

Professional competence and behaviour in general

27. **Compliance with professional standards:** The regionally valid professional standards for addiction treatment and care will be just as equally complied with by all members of the staff as with the legal regulations and internal guidelines of the establishment.

28. **Quality of service:** Professionals are obliged to ensure the quality of their services to clients. In order to achieve this goal they must have both the maturity and the ability to handle the responsibility entrusted to them. They should endeavour to create confidence for the treatment and care of drug misusers and for their professional competence among the citizens, and be open-minded to critical examination of their professional practice.

29. **Confidentiality:** All information about a clients' health status, medical condition, diagnosis, prognosis and treatment and all other information of a per-

sonal kind must be kept confidential and protected in a suitable manner. All national regulations on data protection are to be respected. Confidential information can only be disclosed if the client gives explicit consent. Where disclosure is to other health care providers involved in the clients' treatment and care consent may be presumed.

30. **Participation in research projects:** Confidentiality and the informed consent of the client are the main prerequisites for client participation in scientific research. In addition, relevant national and international guidelines must be considered (e.g. Declaration of Helsinki on Ethical Principles for Medical Research Involving Human Subjects[52]).

31. **Professional exchange:** Professionals shall share professional knowledge and individual practical experience with colleagues within and outside of their own establishments, and therefore contribute to the development of specialist knowledge. They shall provide support for the training of the next professional generation and for regular vocational training.

32. **Interdisciplinary conduct:** Specialists from different professional backgrounds shall treat other professions' understanding of problems and their approach to solving them with respect and openness, and foster the exchange of knowledge and experience, including beyond professional boundaries. It is important for all professional groups involved in addiction treatment and care to know what the different professions have to offer in the field of drug-related problems. Each professional group should therefore clearly state what can and may be expected of them in a specific situation.

33. **Mutual recognition and support:** Professionals shall respect different opinions and methodologies which are based on specialist standards, and express recognition and criticism in an appropriate form. Each professional shall co-operate with his/her colleagues for the sake of the clients' interests and the resolution of professional problems. Each employee shall have the possibility to receive advice and support from other staff members concerning the treatment and care of clients.

34. **Readiness for reflection:** Professionals shall be ready to resolve conflicts openly and strive for constructive solutions. They are responsible for creating within the team a climate of mutual trust and readiness for critical reflection. Problems of individual clients, between the clients, between employees and clients, as well as amongst employees, should be addressed and reflected upon. It must be possible to express and discuss feelings of love, sexual desires, aggression, impotence, omnipotence and guilt by employees.

[52] http://www.wma.net/e/policy/17-c_e.html.

35. **Misconduct:** Professionals shall draw the attention of their colleagues to conduct which is not in accordance with the guidelines. If they are not willing to change their behaviour, or in the case of severe misconduct, then professionals shall bring allegations of misconduct by a professional colleague to the attention of those charged with the responsibility of investigating them. This also applies to violations caused by the organisation's way of working or the behaviour of clients. This obligation overrules other demands of loyalty.

Professional behaviour towards clients

36. **Respecting clients' rights:** Each professional shall respect the rights of clients. They shall point out to the clients their rights, explain to them their meaning and support them in exercising their rights.

37. **Transparency:** The professional must make it clear to the individual client what he/she can expect of the professional. The professional relationship should be based on collaboration and mutual understanding.

38. **Orientation towards the individual's needs:** Each professional should plan the care process together with the client and, within the framework of the institutional possibilities and on the basis of generally accepted professional principles, orient it towards the individual goals, needs and resources of the person seeking help.

39. **Acting against the will of the client:** A professional must work to minimise provisions for the legal enforcement of compulsory treatment, as clients should have power over their problems and the solutions to them. A professional shall only intervene against the will of clients when, as a result of their behaviour, they threaten to endanger themselves or other persons. In doing so, they shall carefully weigh up the risks and interests of the persons involved before intervening. Clients suffering from mental disorders may only be physically restrained when such persons make an attempt on their own life, endanger the life or health of another person, or are a danger to public safety. A professional must be aware of and counteract situations in which clients are subjected to invisible compulsion and indirect exercise of power (e.g. when clients are deprived of their liberty if they do not follow a prescribed course of treatment).

40. **Prohibition of the misuse of power:** Social institutions, in particular therapeutic ones, exercise a certain amount of power over their clients. This should be used for the benefit of the client. How this power is used must be permanently reflected upon. Every form of physical, psychological and sexual exploitation or violence is forbidden.

41. **Prohibition of exploitation:** A professional shall neither attempt to secure nor accept any significant financial or material benefit from those receiving their service beyond that which has been contractually agreed, nor secure directly from them any such benefit for services which are already rewarded by salary.

42. **Prohibition of sexual relationships:** A sexual relationship of any kind with any client under any circumstance during treatment and care is forbidden. Feelings of love and sexual desire can occur in the care process on both sides. It is the particular responsibility of the professional to prevent any form of sexual contact. For this the individual feelings must be perceived and not kept secret, played down or denied. It must be possible to discuss these feelings with the team or with supervisors.

43. **Personal responsibility as an aim:** Any professional care must be oriented to the goal of greater personal responsibility in life. Clients should be given the necessary support to become responsible for their own actions and to further develop their own abilities. In a therapeutic process, if a client lacks the ability to cope with the responsibilities of life, the employees or the therapy group can temporarily assume responsibility on the client‘s behalf. This taking over must be limited and transparent, and have the goal of creating greater self-sufficiency in life. Clients must not be left dependent upon a professional or an institution. They should not be supported for any longer than is required by the treatment or care for them to attain their goals.

44. **Awareness of limits of professional competence:** A professional must use his/her position in a responsible way and be aware of the limits of his/her competence. He/she should be able to understand whether referring the client to another service or professional would be in the individual’s best interest and consequently should not hesitate to do so.

Bill of rights for clients

45. **Respect for human rights:** Clients have the absolute right to dignity, confidentiality, respect, health and safety at all times. They have a right to protection from real or threatened corporal punishment, from physical, emotional and sexual abuse and from involuntary physical confinement.

46. **Fulfilment of basic needs in residential care:** Clients in in-patient services have a right to be provided with nutritious food, safe and adequate lodging, physical exercise and adequate personal hygiene facilities. They have a right to adequate medical care and to gain access to legal advice or representation when required.

47. **Medical care:** Drug addicts have a right to medical care from qualified practitioners, wherever they may be or whatever their condition, even if abstinence from drugs is not possible or aimed for. Such treatment must not disrupt the continuity of the treatment of their drug-related problems. Continuity of medical treatment must be ensured despite sanctions that may result from a client‘s breaking of the institution’s house rules. Clients also have the right to refuse the medical care offered.

48. **Right of choice:** Clients have the right to choose between different available treatments, as long as their choice does not contradict an important expert indication. It should be possible to change the contact person within an establishment if there are sufficient reasons for doing so.

49. **Duration of treatment:** Clients have the right to discharge themselves from the programme at any time, except when legal requirements make it compulsory. They have the right to continue any treatment begun, provided that this was planned and introduced on the basis of suitable information and the prerequisites for treatment still remain.

50. **Right of co-determination:** Clients are entitled to be involved in the planning of their treatment and care. Their personal goals and preferences should be considered.

51. **External communication:** Personal communication with relatives or friends about their whereabouts on admission and thereafter needs to be ensured according to the rules of the programme, except when prohibited as a documented part of the treatment plan. Contact between the clients and the referral authorities or the funding providers must always be guaranteed

52. **Right of assistance at discharge:** When leaving the programme for any reason, clients have the right to be given guidance and assistance about other health care and assessment services, sources of financial aid and places of residence.

53. **Information on the programme:** Clients have a right to be provided with accurate information concerning their rights and all current rules, regulations and methods of the programme, its risks and limitations, as well as sanctions, disciplinary measures and all fees and costs to be charged. They also have a right to be adequately informed on how to assert their claims.

54. **Information about their personal health status and treatment:** Clients have the right to be informed about their state of health as well as about the treatment and care which they are receiving in a way that they can understand.[53]

55. **Right of access to files:** Clients have a right of access to their files and records pertaining to their diagnosis, treatment and care and a right to receive a copy of their own files and records. They also have a right to demand correction or clarification.

56. **Freedom of worship:** Clients have a right to freedom of worship. Professionals shall refrain from imposing any direct or indirect religious practices which are not shared by their clients.

57. **Freedom not to be exploited:** Clients and their relatives have the absolute right of freedom not to be exploited for the benefit of the agency or its staff.

58. **Access to grievance procedures:** Clients have a right of access to a board-approved grievance procedure to register complaints about the administration of all rules and regulations, sanctions, disciplinary measures and modification of rights set forth in these guidelines.

[53] However, care should be taken that the clients are not made to feel insecure or frightened (WHO 1997, 115).

59. **Obligation to co-operate:** Clients are asked to contribute to a successful treatment process by providing the staff with the necessary information for diagnosis and treatment, by their active participation in the treatment programme, and by contributing to a good working relationship with staff.

60. **Obligation to behave adequate adequately:** Clients must treat other clients and professionals with due respect and refrain from violent behaviour of every description.

Procedure in case of infringement of ethical guidelines

61. **Internal advisory office for clients:** Clients whose rights have been violated, who do not feel respected, who are victims of sexual assaults, or have the impression that they are not receiving correct care, must be able to approach someone within the establishment designated by the providers with their concerns and without fear of discrimination. Each establishment must take the necessary precautions to ensure that such complains are pursued with care and impartiality.

62. **External advisory office for clients:** In addition, clients must have the possibility to approach an external office with a complaint. This can either be the providers or an independent supervisory board or ombudsman.

63. **Internal clarification of reports from professionals (staff):** If assaults of any kind become known, or a professional suspects that a colleague is playing down or denying feelings in dealing with patients, or that the patient could be harmed, he is obliged to inform the management or providers. Each institution must define a set of procedures which enables these themes to be addressed without any possibility of individuals being unjustly accused.

64. **External advisory office for professionals (staff):** If internal clarification is not possible or insufficient, or if it is suspected that an institution is disregarding ethical principles, professionals who have knowledge of this must immediately approach an independent ombudsman designated for this purpose.

65. **Clarification of complaints and taking measures:** The authority to which there has been recourse shall clarify the accusations comprehensively and impartially. When necessary, it shall make contact with the responsible organs, the employees involved, and any possible victims. It shall work together with other responsible organs and decide upon suitable measures. These can be, depending upon the severity, a warning, the informing of professional organisations, political authorities or the public, and the taking of legal action or any other suitable measures, whereby the dignity and protection of the affected persons is to be ensured. The right of assault victims to maintain silence about the incident in question or to take legal measures themselves is to be respected.

Further development of the ethical principles

66. **National ethics committee:** Every country should have a committee which is concerned with ethical questions in theory and practice, and is responsible for the continual examination and further development of ethical guidelines. Such a committee should be comprised of representatives from various professional groups and be embedded in existing organisational and national structures.

67. **International discussion:** In view of the high social mobility, it is recommended that national ethics committees (66) participate in cross-border discussions on ethical questions concerning professional dealings with drug addicts.

4.3. Checklist for the Development of Regional Guidelines

The central task of ethics is to find the best possible compromise between various values/ideal concepts of morality and real-life situations. In a modern society, however, this cannot just be a matter of a universally applicable and long-term catalogue of rules that, in terms of content, are fixed. Rather, these must be repeatedly re-negotiated from new in a constantly occurring process. (Uchtenhagen 1998).

For a code of ethics to be fully beneficial to all parties concerned, it is fundamental that it based on the widest possible participation and sharing by the different cultural and scientific areas involved, as well as on the support of the various professionals working in the field (Clerici and Tempesta 1999).

The ADAT Ethical Guidelines can be drawn upon for the further development of regional[54] guidelines. In doing so the following aspects need to be explained and considered:

Clarification of the scope and compulsory nature of the guidelines

- *Who decides upon the content and validity of the guidelines?*

  Umbrella organisations for institutions, professional associations, national authorities? The aim of guidelines is that they are accepted as valid and complied with by as many people as possible, and that in the case of non-compliance suitable measures can be taken. It is therefore recommended that there is as broad a consensus as possible at the highest possible levels.

54 The term region refers to the geographic area in which the appropriateness of the drug treatment system is to be assessed. These can be entire countries, individual parts of the countries or supranational regions.

- *For whom should the guidelines apply?*

  For which geographical region, type of establishment, professional groups and clients should the guidelines apply? Should all or certain guidelines also apply to voluntary workers?

- *How compulsory should the guidelines be?*

  Should the individual guidelines be categorised in accordance with different degrees of obligation (e.g., imperative, strongly recommended, to be recommended)?

- *To which authority should there be recourse if there is an infringement of the guidelines?*

  When clients‘ rights are violated? When professional responsibilities are neglected? When there are deficiencies at the level of the entire care system.

Procedure in the case of the further development of regional guidelines

- *Who should be included in the further development?*

  This depends upon the question named above concerning the geographical and professional scope of the guidelines. As well as the professionals responsible for the treatment and care, it would be desirable to include interested groups of clients and their relatives, as well as representatives from national authorities.

- *How should further development proceed in terms of organisation?*

  It makes sense to lead as broad a debate as possible (Cf. the definition of minimal treatment standards in the Czech Republic under 2.1, or the clarification of the medical role in the treatment of drug addicts in the Netherlands under 2.6.2). In doing so, the ADAT Ethical Guidelines presented here could serve, together with the guidelines already used in the regions, as a basis for discussion. Ideally, the discussion should take place in several stages and sub-groups. The Delphi process can also serve as a source of information.

- *How can it be developed in terms of content?*

  For every individual guideline the following questions can be asked: Is the guideline deemed correct? Is it important? It is clear enough? Is it apposite or does it have to be weakened or strengthened? How shall its degree of obligation be categorised? In addition, it should be examined to see which guidelines considered important regionally are not included in the ADAT guidelines.

  When further developing the guidelines it should NOT be asked whether the guidelines are complied with. If a region considers an individual guideline important, but does not currently observe it, it does not have to be deleted. Ethical guidelines record how something should be.

- *Are the responsibilities and time periods for the continual further development of the guidelines defined?*

  In order that the ethical guidelines remain practice-relevant, the discourse must be continued further. The guidelines must be adapted to meet new developments. In order that this can occur, responsibilities and methods of proceeding must be regulated and appropriate resources made available.

Publication and use of the guidelines

- *How can the observance and use of the guidelines be enforced?*

  For this to happen it must be clarified as to which authority there is recourse when respective guidelines are infringed (in case of violation of clients' rights, professional negligence, or deficiencies at the level of the entire care system).

- *How can the guidelines be applied as a means to improve quality?*

  The guidelines can be used to improve quality and to localise the need for action, both at the level of individual establishments and at the level of the entire care system, by asking, and if necessary clarifying, the extent to which the relevant guidelines correspond to or can correspond to those in practice. This requires on the one hand that people working in practice are informed about the guidelines. Possible means are, for example, the organisation of conferences for specialists or publishing the guidelines within the framework of specialist training and further training. On the other hand, the relevant people in public administration as well as persons employed in evaluation and research must also be informed about the guidelines.

  For a *systematic survey*, however, corresponding instruments are provided in the other ADAT modules that are based on these ethical guidelines.

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Annex: Selected Codes of Ethics

Annex I: Universal Declaration of Human Rights[55]

Preamble

Whereas recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world,

Whereas disregard and contempt for human rights have resulted in barbarous acts which have outraged the conscience of mankind, and the advent of a world in which human beings shall enjoy freedom of speech and belief and freedom from fear and want has been proclaimed as the highest aspiration of the common people,

Whereas it is essential, if man is not to be compelled to have recourse, as a last resort, to rebellion against tyranny and oppression, that human rights should be protected by the rule of law,

Whereas it is essential to promote the development of friendly relations between nations,

Whereas the peoples of the United Nations have in the Charter reaffirmed their faith in fundamental human rights, in the dignity and worth of the human person and in the equal rights of men and women and have determined to promote social progress and better standards of life in larger freedom,

Whereas Member States have pledged themselves to achieve, in cooperation with the United Nations, the promotion of universal respect for and observance of human rights and fundamental freedoms,

Whereas a common understanding of these rights and freedoms is of the greatest importance for the full realization of this pledge,

Now, therefore,

The General Assembly,

Proclaims this Universal Declaration of Human Rights as a common standard of achievement for all peoples and all nations, to the end that every individual and every organ of society, keeping this Declaration constantly in mind, shall strive by teaching and education to promote respect for these rights and freedoms and by progressive measures, national and international, to secure their universal and

55 Souce: http://www.unhchr.ch/udhr/lang/eng.htm. The Universal Declaration of Human Rights was adopted and proclaimed by General Assembly resolution 217 A (III) of 10 December 1948.

effective recognition and observance, both among the peoples of Member States themselves and among the peoples of territories under their jurisdiction.

Article I

All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.

Article 2

Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

Furthermore, no distinction shall be made on the basis of the political, jurisdictional or international status of the country or territory to which a person belongs, whether it be independent, trust, non-self-governing or under any other limitation of sovereignty.

Article 3

Everyone has the right to life, liberty and security of person.

Article 4

No one shall be held in slavery or servitude; slavery and the slave trade shall be prohibited in all their forms.

Article 5

No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.

Article 6

Everyone has the right to recognition everywhere as a person before the law.

Article 7

All are equal before the law and are entitled without any discrimination to equal protection of the law. All are entitled to equal protection against any discrimination in violation of this Declaration and against any incitement to such discrimination.

Article 8

Everyone has the right to an effective remedy by the competent national tribunals for acts violating the fundamental rights granted him by the constitution or by law.

Article 9

No one shall be subjected to arbitrary arrest, detention or exile.

Article 10

Everyone is entitled in full equality to a fair and public hearing by an independent and impartial tribunal, in the determination of his rights and obligations and of any criminal charge against him.

Article 11

Everyone charged with a penal offence has the right to be presumed innocent until proved guilty according to law in a public trial at which he has had all the guarantees necessary for his defence.

No one shall be held guilty of any penal offence on account of any act or omission which did not constitute a penal offence, under national or international law, at the time when it was committed. Nor shall a heavier penalty be imposed than the one that was applicable at the time the penal offence was committed.

Article 12

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

Article 13

Everyone has the right to freedom of movement and residence within the borders of each State.

Everyone has the right to leave any country, including his own, and to return to his country.

Article 14

Everyone has the right to seek and to enjoy in other countries asylum from persecution.

This right may not be invoked in the case of prosecutions genuinely arising from non-political crimes or from acts contrary to the purposes and principles of the United Nations.

Article 15

Everyone has the right to a nationality.

No one shall be arbitrarily deprived of his nationality nor denied the right to change his nationality.

Article 16

Men and women of full age, without any limitation due to race, nationality or religion, have the right to marry and to found a family. They are entitled to equal rights as to marriage, during marriage and at its dissolution.

Marriage shall be entered into only with the free and full consent of the intending spouses.

The family is the natural and fundamental group unit of society and is entitled to protection by society and the State.

Article 17

Everyone has the right to own property alone as well as in association with others.

No one shall be arbitrarily deprived of his property.

Article 18

Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief, and freedom, either alone or in community with others and in public or private, to manifest his religion or belief in teaching, practice, worship and observance.

Article 19

Everyone has the right to freedom of opinion and expression; this right includes freedom to hold opinions without interference and to seek, receive and impart information and ideas through any media and regardless of frontiers.

Article 20

Everyone has the right to freedom of peaceful assembly and association.

No one may be compelled to belong to an association.

Article 21

Everyone has the right to take part in the government of his country, directly or through freely chosen representatives.

Everyone has the right to equal access to public service in his country.

The will of the people shall be the basis of the authority of government; this will shall be expressed in periodic and genuine elections which shall be by universal and equal suffrage and shall be held by secret vote or by equivalent free voting procedures.

Article 22

Everyone, as a member of society, has the right to social security and is entitled to realization, through national effort and international co-operation and in accordance with the organization and resources of each State, of the economic, social and cultural rights indispensable for his dignity and the free development of his personality.

Article 23

Everyone has the right to work, to free choice of employment, to just and favourable conditions of work and to protection against unemployment.

Everyone, without any discrimination, has the right to equal pay for equal work.

Everyone who works has the right to just and favourable remuneration ensuring for himself and his family an existence worthy of human dignity, and supplemented, if necessary, by other means of social protection.

Everyone has the right to form and to join trade unions for the protection of his interests.

Article 24

Everyone has the right to rest and leisure, including reasonable limitation of working hours and periodic holidays with pay.

Article 25

Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.

Article 26

Everyone has the right to education. Education shall be free, at least in the elementary and fundamental stages. Elementary education shall be compulsory. Technical and professional education shall be made generally available and higher education shall be equally accessible to all on the basis of merit.

Education shall be directed to the full development of the human personality and to the strengthening of respect for human rights and fundamental freedoms. It shall promote understanding, tolerance and friendship among all nations, racial or religious groups, and shall further the activities of the United Nations for the maintenance of peace.

Parents have a prior right to choose the kind of education that shall be given to their children.

Article 27

Everyone has the right freely to participate in the cultural life of the community, to enjoy the arts and to share in scientific advancement and its benefits.

Everyone has the right to the protection of the moral and material interests resulting from any scientific, literary or artistic production of which he is the author.

Article 28

Everyone is entitled to a social and international order in which the rights and freedoms set forth in this Declaration can be fully realized.

Article 29

Everyone has duties to the community in which alone the free and full development of his personality is possible.

In the exercise of his rights and freedoms, everyone shall be subject only to such limitations as are determined by law solely for the purpose of securing due recognition and respect for the rights and freedoms of others and of meeting the just requirements of morality, public order and the general welfare in a democratic society.

These rights and freedoms may in no case be exercised contrary to the purposes and principles of the United Nations.

Article 30

Nothing in this Declaration may be interpreted as implying for any State, group or person any right to engage in any activity or to perform any act aimed at the destruction of any of the rights and freedoms set forth herein.

Annex II: The Rights of Patients in WHO's European Member States[56]

1. Human rights and values in health care

The instruments cited in the Introduction should be understood as applying also specifically in the health care setting, and it should therefore be noted that the human values expressed in thee instruments shall be reflected in the health care system. It should also be noted that where exceptional limitations are imposed on the rights of patients, these must be in accordance with human rights instruments and have a legal base in the law of the country. It may be further observed that the rights specified below carry a matching responsibility to act with due concern for the health of others and for their same rights.

1.1 Everyone has the right to respect of his or her person as a human being.

1.2 Everyone has the right to self-determination.

1.3 Everyone has the right to physical and mental integrity and to the security of his or her person.

1.4 Everyone has the right to respect for his or her privacy.

1.5 Everyone has the right to have his or her moral and cultural values and religious and philosophical convictions respected.

1.6 Everyone has the right to such protection of health as is afforded by appropriate measures for disease prevention and health care, and to the opportunity to pursue his or her own highest attainable level of health.

2. Information

2.1. Information about health services and how best to use them is to be made available to the public in order to benefit all those concerned.

2.2. Patients have the right to be fully informed about their health status, including the medical facts about their condition; about the proposed medical procedures, together with the potential risks and benefits of each procedure; about alternatives to the proposed procedures, including the effect of non-treatment; and about the diagnosis, t prognosis and progress of treatment.

2.3. Information may only be withheld from patients exceptionally when there is good reason for believe that this information would without any expectation of obvious positive effects cause them serious harm.

2.4. Information must be communicated to the patient in a way appropriate to the latter's capacity for understanding, minimizing the use of unfamiliar techni-

[56] World Health Organization, Regional Office for Europe (1997). European Health Care Reforms. Citizens' Choice and Patients' Rights. Copenhagen: WHO, pp. 54-58.

cal terminology. If the patient does not speak the common language, some form of interpreting should be available.

2.5. Patients have the right no to be informed, at their explicit request.

2.6. Patients have the right to choose who, if any one, should be informed on their behalf.

2.7. Patients should have the possibility of obtaining a second opinion.

2.8. When admitted to a health care establishment, patients should be informed of the identity and professional status of the health care providers taking care of them and of any rules and routines which would bear on their stay and care.

2.9. Patients should be able to request and be given a written summary of their diagnosis, treatment and care on discharge from a health care establishment.

3. Consent

3.1 The informed consent of the patient is a prerequisite for any medical intervention.

3.2 A patient has the right to refuse or to halt a medical intervention. The implications of refusing or halting such an intervention must be carefully explained to the patient.

3.3 When a patient is unable to express his or her will and a medical intervention is urgently needed, the consent of the patient may be presumed, unless it is obvious from a previous declared expression of will that consent would be refused in the situation.

3.4 When the consent of a legal representative is required and the proposed intervention is urgently needed, that intervention may be made if it is not possible to obtain, in time, the representative's consent.

3.5 When the consent of a legal representative is required, patients (whether minor or adult) must nevertheless be involved in the decision-making process to the fullest extent which their capacity allows.

3.6 If a legal representative refuses to give consent and the physician or other provider is of the opinion that the intervention is in the interest of the patient, then the decision must be referred to a court or some form or arbitration.

3.7 In all other situations where the patient is unable to give informed consent and where there is no legal representative or representative designated by the patient for this purpose, appropriate measures should be taken to provide for a substitute decision making process, taking into account what is known and, to the greatest extent possible, what may be presumed about the wishes of the patient.

3.8 The consent of the patient is required for the preservation and use of all substances of the human body. Consent may be presumed when the sub-

stances are to be used in the current course of diagnosis, treatment and care of that patient.

3.9 The informed consent of the patient is needed for participation in clinical teaching.

3.10 The informed consent of the patient is a prerequisite for participation in scientific research. All protocols must be submitted to proper ethical review procedures. Such research should not be carried out on those who are unable to express their will, unless the consent of a legal representative has been obtained and the research would likely be in the interest of the patient.

As an exception to the requirement of involvement being in the interest of the patient, an incapacitated person may be involved in observational research which is not of direct benefit to his or her health provided that the person offers no objection, that the risk and/or burden is minimal, that the research is of significant value and that no alternative methods and other research subjects are available.

4. Confidentiality and Privacy

4.1 All information about a patient's health status, medical condition, diagnosis, prognosis and treatment and all other information of a personal kind must be keep confidential, even after death.

4.2 Confidential information can only be disclosed if the patient gives explicit consent or if the law expressly provides for this. Consent may be presumed where disclosure is to other health care providers involved in that patient's treatment.

4.3 All identifiable patient data must be protected. The protection of the data must be appropriate to the manner of their storage. Human substances from which identifiable data can be derived must be likewise protected.

4.4 Patients have the right to access to their medical files and technical records and to any other files and records pertaining to their diagnosis, treatment and care and to receive a copy of their own files and records or parts thereof. Such access excludes data concerning third parties.

4.5 Patients have the right to require the correction, completion, deletion, clarification and/or updating of personal and medical data concerning them which are inaccurate, incomplete, ambiguous or outdated, or which are not relevant to the purposes of diagnosis, treatment and care.

4.6 There can be no intrusion into a patient's private and family life unless and only if, in addition to the patient consenting to it, it can be justified as necessary to the patient's diagnosis, treatment and care.

4.7 Medical interventions may only be carried out when there is proper respect shown for the privacy of the individual. This Means that a given intervention may be carried out only in the presence of those persons who are necessary for the intervention unless the patient consents or requests otherwise.

4.8 Patients admitted to health care establishments have the right to expect physical facilities which ensure privacy, particularly when health care pro-

viders are offering them personal care of carrying out examinations and treatment.

5. Care and Treatment

5.1 Everyone has the right to receive such health care as is appropriate to his or her health needs, including preventive care and activities aimed at health promotion. Services should be continuously available and accessible to all equitably, without discrimination and according to the financial, human and material resources which can be made available in a given society.

5.2 Patients have a collective right to some form of representation at each level of the health care system in matters pertaining to the planning and evaluation of services, including the range, quality and functioning of the care provided.

5.3 Patients have the right to a quality of care which is marked both by high technical standards and by a humane relationship between the patient and health care providers.

5.4 Patients have the right to continuity of care, including cooperation between all health care providers and/or establishments which may be involved in their diagnosis, treatment and care.

5.5 In circumstances where a choice must be made by providers between potential patients for a particular treatment which is in limited supply, all such patients are entitled to a fair selection procedure for that treatment. That choice must be based on medical criteria and made without discrimination.

5.6 Patients have the right to choose and change their own physician or other health care provider and health care establishment, provided that it is compatible with the functioning of the health care system.

5.7 Patients for whom there are no longer medical grounds for continued stay in a health care establishment are entitled to a full explanation before they can be transferred to another establishment or sent home. Transfer can only take place after another health care establishment has agreed to accept the patient. Where the patient is discharged to home and when his or her condition so requires, community and domiciliary services should be available.

5.8 Patients have the right to be treated with dignity in relation to their diagnosis, treatment and care, which should be rendered with respect for their culture and values.

5.9 Patients have the right to enjoy support from family, relatives and friends during the course of care and treatment and to receive spiritual support and guidance at all times.

5.10 Patients have the right to relief of their suffering according to the current state of knowledge.

5.11 Patients have the right to humane terminal care and to die in dignity.

6. Application

6.1 The exercise of the rights set forth in this document implies that appropriate means are established for this purpose.

6.2 The enjoyment of these rights shall be secured without discrimination.

6.3 In the exercise of these rights, patients shall be subjected only to such limitations as are compatible with human rights instruments and in accordance with a procedure prescribed by law.

6.4 If patients cannot avail themselves of the rights set forth in this document, these rights should be exercised by their legal representative or by a person designated by the patient for that purpose; where neither a legal representative nor a personal surrogate has been appointed, other measures for representation of those patients should be taken.

6.5 Patients must have access to such information and advice as will enable them to exercise the rights set forth in this document. Where patients feel that their rights have not been respected they should be enabled to lodge a complaint. In addition to recourse to the courts, there should be independent mechanisms at institutional and other levels to facilitate the processes of lodging,- mediating and adjudicating complaints. These mechanisms would, inter alia, ensure that information relating to complaints procedures was available to patients and that an independent person was available and accessible to them for consultation regarding the most appropriate course of action to take. These mechanisms should further ensure that, where necessary, assistance and advocacy on behalf of the patient would be made available. Patients have the right to have their complaints examined and dealt with in a thorough, just, effective and prompt way and to be informed about their outcome.

7. Definitions

In these Principles of the Rights of Patients in Europe, the following terms have been used with the meanings given:

Patient (s): User(s) of health care services, whether healthy or sick.

Discrimination: Distinction between persons in similar cases on the basis of race, sex, religion, political opinions, national or social origin, associations with a national minority or personal antipathy.

Health care: Medical, nursing or allied services dispensed by health care providers and health care establishments.

Health care providers: Physicians, nurses, dentists or other health professionals.

Medical intervention: Any examination, treatment or other act having preventive, diagnostic, therapeutic or rehabilitative aims and which is carried out by a physician or. other health care provider.

Health care establishment: Any health care facility such as a hospital, nursing home or establishment for disabled persons.

Terminal care: Care given to a patient when it is no longer possible to improve the fatal prognosis of his or her illness/condition with available treatment methods; as well as care at the approach of death.

Annex III: The World Federation of Therapeutic Communities Code of Ethics

Standards for residential treatment service - Staff Code of Ethics

The primary obligation of all staff is to ensure the quality of services to clients in treatment. The relationship between the staff and the client is a special one and it is essential that staff have both the maturity and the ability to handle the responsibility entrusted to them.

All staff must be aware that they are part of a profession which must carefully watch over its own activities and those of its clients. This Code of Ethics relates to staff at all times, both at and away from their work.

Behaviour towards clients

Staff members must:

1. Conduct themselves as mature and positive role models
2. Maintain all client information in the strictest confidence with regard to all applicable laws and agency rules.
3. Provide all clients with a copy of the ”Client Bill of Rights” and ensure that all aspects are understood and implemented by both the staff and the clients.
4. Respect all clients by maintaining a non-possessive, non-punitive and professional relationship with them.
5. Provide service regardless of gender, race, creed, religion, national origin, sexual preference, age disability, political affiliation, previous criminal record or financial status, respecting the position of staff in the case of special circumstances.
6. Recognise that the best interest of the client may be served by referring or releasing that person to another agency or professional.
7. Prohibit any sexual relationship of any kind with any client
8. Compensate adequately a client for any work performed personally for a staff member
9. Prevent the exploitation of a client for personal gain

Bill of rights for members and clients

All members and clients of residential treatment programmes have the absolute right to the following:

1. A supportive drug-free environment

2. Treatment without regard to gender, race, creed, religion, national origin, sexual preference, age disability, political affiliation, previous criminal record or public assistance status
3. Dignity, respect, health and safety at all times.
4. Knowledge of the programme philosophy and methods.
5. Information given accurately of all current rules and regulations of the programme as well as sanctions, disciplinary measures and any modifications of rights.
6. Access to a Board approved grievance procedure to register complaints about the administration of all rules and regulations, sanctions, disciplinary measures and modification of rights,
7. Definition of all fees and costs to be charged, the methods and schedules of payment and the availability of money and personal property during the programme and on leaving.
8. Confidentiality of information regarding participation in the programme and of all treatment records in accordance with the laws of the land.
9. Examination of personal records with Board approved guidelines and the insertion of a counter statement of clarification to rebut recorded information.
10. Discharge themselves from the programme at any time without physical and psychological harassment.
11. Personal communication with relatives or friends of whereabouts on admission and thereafter according to the rules of the programme except when prohibited as a documented part of the treatment plan.
12. Protection from real or threatened corporal punishment, from physical, emotional and sexual abuse and from involuntary physical confinement.
13. Provision of nutritious food, safe and adequate lodging, physical exercise and adequate personal hygiene needs.
14. Medical care from qualified practitioners and the right to refuse the medical care offered.
15. Access to legal advice or representation when required.
16. Regular contact with any child accompanying the member into the programme.
17. Clear definition of responsibilities when working in the position of a staff member together with adequate training, adequate staff support and supervision (including evaluation and feedback), with no exploitation and the right to decline the position without any recrimination.
18. Guidance and assistance when leaving the programme for any reason, about other health -care and assessment services, sources of financial aid and places of residence.
19. Freedom from exploitation (including parents and family) for the benefit of the agency or its staff.

Standards and goals for therapeutic communities

1. Therapeutic communities represent a design of treatment which is directed primarily to wards recovery from substance abuse through a personal growth and which requires abstinence from mood-altering substances, (with the sole exception of those appropriately prescribed by physicians to produce a specific medical result.)
2. The members of the World Federation of Therapeutic Communities are required to:
   A. Recognise the human and civil rights of all persons associated with their therapeutic community and clearly state the rights, privileges and responsibilities of clients and staff.
   B. Vest in each individual within the therapeutic community the right to be free from the threat of the negative use of power by any individual or group
   C. Develop a statement on the philosophy and the goals of the programme.
   D. Adopt regulations for their therapeutic community which afford protection from apparent or actual abrogation of local or national laws.
   E. Function with environments which provide maximum opportunity for the physical, spiritual, emotional and aestethic development and which will ensure the safety of everyone.
   F. Facilitate the structure of a society/community based on the optimal use of the integrity, good will and humanity of all its members in which the dignity of persons is a priority value.
   G. Train and provide adequate supervision for staff.
   H. Be accountable to an external Executive or Community Board which meets at predetermined, regular intervals during the year for the purpose of maintaining supervision and responsibility for the activities of the programme and each facility.
   I. Produce an annual audited financial report, authorised by the members of Executive or Community Board.
3. The Board of the World Federation of Therapeutic Communities will require adherence to the Standards and Goals when considering applications and renewals of membership and will also require active compliance with the criteria established by the European Federation's By-laws.

Annex IV: Ethical Principles in Professional Addiction Care in Germany[57]

The "German Head Office Against the Dangers of Addiction" (*Deutsche Hauptstelle gegen die Suchtgefahren e. V.* (DHS)) adopted the resolution "Ethical principles in professional addiction care" on 9.2.99. These principles are intended to serve as guiding principles for employees in this field of work. (Hamm, March 1999).

Introduction

Professional addiction care is confronted with questions of ethics in its work with drug users at risk, drug addicts and their relatives. Apart from the professional dealing with health and psychosocial problem situations, the contact between professionals and those seeking treatment demands a confrontation with the values and purpose of human existence. Ethical reflection and communication are fundamental elements of the professionalism and the quality of this work.

In this paper the DHS presents ethical principles for the work of professionals in the various fields of addiction treatment and care. Regardless of the models of individual providers, this paper can be considered as a professional standard for professional addiction care.

It has the purpose of providing professionals working in one of the most demanding and difficult occupational fields with principles for forming the concrete treatment process for and with the individuals seeking treatment. It provides clarification as to whom they should be most loyal in the professional relationship, how they should behave within this relationship, and finally, serves to clarify their professional conception of themselves.

Professional addiction care acts on behalf of the public and must therefore act in a transparent and legitimate way. Thus, these principles provide the individual professions with a set of guidelines for their conduct and actions towards those seeking help, professional colleagues, the employer and the general public.

In this paper those central guiding principles for ethical behaviour are mentioned first of all which are themselves concerned with the responsibility and basis of professional work (I and II). Next, the conception of humans is described which forms the fundamental basis for the provision of care for drug users at risk, drug addicts and their relatives (III). This is followed by principles and standards for dealing with those seeking treatment in a respectful, responsible and transparent way (IV). The following sections contain observations concerning behaviour towards professional colleagues and the employer as central requirements for the provision of the treatment process (V and VI).

At this point it will be pointed out as a matter of principle that conditions must be created by the facility and service providers which facilitate professional and ethically-based services in the establishments. Essential are good working con-

57 Source: http://www.dhs.de/reihe/ethisch.htm; Deutsche Hauptstelle gegen die Suchtgefahren (1999). Ethische Prinzipien in der professionellen Suchtkrankenhilfe. Sucht 45 (2), p.131-134.

ditions, respectful treatment of employees and a transparent leadership style which allows for recognition and criticism. This quality is linked with the professional work of the employees which flows directly into the relationship- and problem-solving work with those being treated.

The DHS recommends that this paper, as a professional basis for procedures in professional drug treatment, should be included as an attachment in employment contracts with employees, and that it should be discussed thematically at regular intervals in team meetings.

I. Addiction and human dignity

1. People who misuse addictive drugs or are addicted to them are citizens with equal entitlements, having all rights and duties.
2. They shall be treated with dignity and respect, regardless of their race, nationality, gender, age, beliefs, political-, social- and economic position, social position, sexual orientation and their health and psychosocial state.
3. Consumption of addictive drugs is a form of lifestyle, but also a way of coping with life and crises, which must always be seen within the social context. It can lead to dependence. Dependence causes suffering and leads to mental, psychological, physical and social difficulties which constitute the illness of addiction. Addiction is an illness which needs to be accepted, alleviated, improved and healed. The basis of any care is the conviction that positive changes are possible.

II. Guiding principles for ethical behaviour

1. Drug addicts are ill. For them the same regulations apply as for any other chronic illness.
2. Professional workers in addiction treatment have the duty to constructively apply their entire professional knowledge and skills in the treatment process, to reflect upon their work and to further develop their respective profession abilities.
3. The duty to maintain confidentiality, the right to remain silent and data protection are legally regulated. The passing on of information about clients fundamentally requires their consent.
4. Professionals have the duty to constantly improve their qualifications. All relevant knowledge and skills should be extensively exhausted. Methods to ensure quality should be applied.
5. The extent and possible causes of psychosocial and health emergencies must be recognised. They should be clarified in terms of the individuals concerned, public welfare, national and international concerns, and with regard to the respective profession.
6. Multidisciplinary professional knowledge shall be optimally applied to further develop realistic strategies for improving the quality of life of individuals and the public.

III. Access to treatment and its provision

1. Drug users at risk, drug addicts and their relatives must be able to gain rapid access to professional treatment. They must be guaranteed the best possible development opportunities to overcome their individual plights.
2. The basic approach of all those employed in addiction care towards drug users at risk, drug addicts and their relatives, both in the treatment concepts and in the treatment process, must be oriented to encouraging those concerned to lead a self-sufficient life. They must not be left dependent upon a professional, an institution or an addictive drug.
3. Psychosocial, medical, and other care must be actually available in order to ensure optimal assistance and integration.
4. In order to prevent further harm, early diagnosis must lead to relevant and appropriate intervention.
5. Professionals must be equipped with appropriate expertise in line with the latest developments in practical knowledge, human science and medical research. Interdisciplinary co-operation between all those involved in the treatment process provides an essential part of all care.
6. Institutions or individual professionals who discriminate against drug addicts, or derive an emotional or material profit from the weakness of dependent people and the fears of relatives, must be called to account.
7. Service providers are responsible for providing funding for appropriate treatment. Institution providers and organisations must provide appropriate professional care. The institution providers must comply with their legal requirements to exercise proper supervision in the sense of social and ethical principles. The possibility for the establishment of an independent ethics commission is being examined.
8. Those patients who do not feel respected, are victims of sexual assaults. or have the impression that they are receiving incorrect treatment must have the possibility of notifying the establishment management or providers.

IV. Behaviour towards patients

1. In every situation the dignity of those seeking treatment should be respected. The reason for their behaviour is also to be respected as are their individual ways for coping with problems and life.
2. Joint planning between the patient and the professional forms the basis of every treatment process.
3. In doing so, the right of the person seeking treatment to a relationship based on mutual trust, to be considered as an individual, and to absolute confidentiality regarding the information received must be guaranteed.
4. Resources, personal goals, readiness to take on responsibility and the independence of the person seeking treatment must be recognised, respected and supported. Within the framework of possibilities of the facility and the so-

cial environment, they should be provided with the necessary support to assume responsibility for their own actions and to further develop their own abilities as far as is possible.

5. The professionals shall inform the person seeking treatment about the type and extent of treatment available, as well as about rights, duties, possibilities and risks.
6. In crisis situations, for example, in suicidal cases, the limitations of individual professional action must be recognised and support taken advantage of both internally as well as externally. Measures shall be agreed with the person seeking treatment. In emergency cases remedial measures should, however, be immediately applied. It is necessary, as a prophylactic for those seeking treatment, to make clear to them the professional's own position and responsibility (e.g., failure to give assistance), to inform them about possible measures for behaviour in crisis situations, and to agree upon these as far is possible.
7. The professional shall not used their relationship with the patient for their advantage and under no circumstances shall they begin a sexual relationship.
8. The position of dependence of the persons seeking treatment means that there is a particular obligation and responsibility to deal with them in a clear and transparent manner. Professionals have a particular responsibility for greater self-awareness and to reflect upon their professional actions.
9. Feelings of love and sexual desire can occur during the treatment process. Professionals have a particular responsibility to recognise their own feelings, and not try to trivialise them, cover them up, play them down or to deny them. It must be possible to discuss them, e.g., in the team or with supervisors.
10. Professionals who are not in the position to observe the ethical boundaries described here with regard to the patient are obliged to end the treatment process immediately and to secure the continuation of the treatment through other professionals.

V. Behaviour towards professional colleagues

1. Respect and recognition for the training and work achieved by colleagues and other professionals are, in the interest of co-operation and an effective service, indispensable.
2. Differences of opinions and methodologies based on professional standards shall be respected. Recognition and criticism must be expressed in an appropriate form.
3. As part of the professional qualification, possibilities must be used for exchanging experience and knowledge with other professionals and voluntary assistants.
4. Within the multidisciplinary team it is up to everyone to create a climate in which there is continuous awareness, and patients‘ problems can be discussed and reflected upon in a discriminating manner. These can be feelings

of love, sexual desires, aggression, impotence and omnipotence, and feelings of guilt.

5. If someone suspects that a colleague is playing down or denying feelings in dealing with a patient, and it is suspected that the patient could be harmed, then they are obliged to notify the head of management or the institution providers.
6. If someone finds out about patients being mishandled by professionals, they should immediately inform the management or the institution provider.

VI. Behaviour towards the employer

1. Professionals are accountable to their employers, taking into consideration the legal requirements for the protection of patients. This applies to fulfilling both the professional results-oriented responsibilities as well as the economic ones.
2. Professionals shall work together on the further development of the objectives, methods and the entire establishment in order to optimise treatment processes.
3. In the case of conflicts which cannot be solved within the establishment, or when professional boundaries are exceeded, professionals are to immediately approach their employers.

Annex V: Ethical Guidelines for Professional Operators in the Field of Drug Addiction, Italy[58]

Introduction

This document is meant to provide operators and other professionals working in the field of drug use and abuse with a tool that could prove to be useful in the outlining of an "***ethical code of practice",*** envisaging the different problems connected with addiction-related therapeutic activities. It is a most pressing objective, as proven by the constant and fast-paced changes characterising drug use and abuse phenomena, and consequently by the impact they have in terms of health and psychosocial and cultural consequences, as well as by the need to devise diverse intervention patterns to face the various drug-related disorders.

The extreme complexity and the wide range of issues operators in the field of drug-addiction have to confront today is best exemplified by the emergence of new areas, which will have to be kept under close scrutiny, especially in the years to come and namely:

1) Abuse behaviours, both with regard to traditional and 'new' substances, evolve at such a pace that the improvement and optimisation of the supply of new and diversified treatment and care patterns for the user has became a high priority.
2) The epidemiological monitoring of drug-use-related issues peculiar to the adolescent age bracket, which finds it more difficult to gain access to the Services, at least as they stand nowadays.
3) The devising of ad-hoc strategies and the setting up of facilities targeted to handle drug abuse and addiction phenomena ensuing from non-EU emigrants, especially in the largest cities with a high multi-racial population.
4) The need to gain a better understanding of the very concept of abuse and pathological addiction in their widest sense and forms.

For an ethical 'code of practice' to be fully beneficial to all parties concerned, it is fundamental that it rests on the widest possible participation of and sharing by the different cultural and scientific areas involved, as well as on the support of the various professionals working in the field.

The document is organised into three areas: *General Guideline, Ethical Guidelines for operators and Ethical Guidelines for therapeutic communities.*

58 These guidelines are an outcome of the "Consulta delle Associazioni degli Operatori Professionali delle Tossicodipendenze", which is a co-ordinating body of the main Professionl Associations in Italy. The main authors of the text are Massimo Clerici and Enrico Tempesta.

GENERAL GUIDELINES

An operator working in either public or private authorised facilities - independently of his/her professional qualifications, should:

a) be aware that use- and abuse-related pathologies are the expression and/or the simultaneous cause of the individual's serious bio-psychosocial malaise, besides being the direct consequences of abuse and addiction .

b) be able to acquire and apply operational methodologies which can single out, within a specifically drug-abuse and addiction-oriente approach, the characteristics and needs peculiar to each individual. Consequently the operator must make the effort to promote treatments that are tailor-made to the user's specificity and not vice-versa, that is adjusting the user to the treatment;

c) continue to upgrade one's own methodology so as to keep up with the different opportunities provided by the available treatment models and with the constant advances of international science;

d) pay attention to the quality of life of the individual who uses abused substances.

It follows that, while exercising his/her profession, the operator should:

- prevent the selected approach model from becoming a dogmatic structure;
- put the complexity of the individual's life and his/her human rights at the centre of the problem and maintain this same focus throughout the different stages of treatment;
- support and implement all scientific, theoretical, practical and cultural presuppositions which are expedients in guiding the operator across the diverse dimensions of drug addiction.

ETHICAL GUIDELINES FOR PUBLIC SERVICES OPERATORS

The following are regarded as priority elements:

1) An individual showing abuse and addiction problems should be dealt with like any other citizen, asking for health-related, psychological or social services. He/she should in no way be discriminated on the basis of ideologies, religions, moral judgements and any other form of discrimination. Every assistance should be guaranteed independently from race, sex, nationality, age, sexual behaviour, handicap, political affiliation, religion, previous criminal charges and economic condition.

2) The profound interconnections between the malaise of a drug addict and his/her bio-psychosocial sphere should be taken into consideration at all times. The 'interpersonal nature' of the relationship between the user and the operator should be the focus on which to build any action, be it pharmacological, rehabilitative, psycho-educational, pedagogical or any other, while keeping constant the level of one's own professionality and respecting the user's socio-cultural background.

3) The user should be provided with every and all pieces of information and methods expedient in reducing psychical and physical risks for his/her health, which are imbedded in abuse and addictive behaviours. Moreover the operator should take the necessary actions to ensure and increase the life quality of the patient throughout every treatment stage, independently of the attainment of a state of complete abstaining from the use of substances, while at the same time supplying the information necessary to prevent the onset of problems within the individual's family because of his/her conditions.

4) An operator should be able to understand whether referring the client to another service or professional would be in the individual's best interest and consequently should not hesitate to do so.

5) The individual's inclinations should be taken into account when deciding on a treatment. Moreover the various interventions within the treatment program should be defined and shared with the individual concerned, so as to avoid any imposition theoretically or ideologically based on stereotyped technical considerations.

6) The client suffering from use- and abuse-related pathologies should be informed of his/her right to an informed consensus, which is to be matched by the operator's obligation to obtain it.

7) The operator should do his/her best to obtain from the client an ever more aware support to, and participation in the treatment and rehabilitation program.

8) The family should be helped in reaching the necessary understanding of the problem and be supported in analysing and facing the questions raised both by the client and his/her family.

9) The operator should become aware of and be able to handle in a constructive way his/her own responses and emotions, by developing a professional behaviour and seeing his/her role in accordance with a positive and mature work model. The latter, once acquired, must be reinforced constantly through specific training and permanent education.

10) Information on the individual undergoing treatment should be kept strictly confidential according to the law and to the professional code of ethics which it is referred to. The operator should make sure that no discrimination in any form may weigh down upon the citizen, following his/her participation in the treatment programme.

11) The operator should contribute to make Services disclose and disseminate to the public, in any proper way, the necessary information on the action methodologies and basic principles on which their action rests, as well as on which therapeutic and rehabilitative activities are truly available and on any other piece of information regarding them, which could be of use to clients and to the community as well.

ETHICAL GUIDELINES FOR THERAPEUTIC COMMUNITIES

The following are regarded as priority elements:

1) Therapeutic communities providing psychological and social guidance to individuals suffering from substance abuse or addiction pathologies should make sure that upon admittance their guests are fully aware of the community organisation, its basic principles, the objectives of the programme, methods adopted and community style of life, which they are to comply with, and respect.

2) Therapeutic communities recognise and respect the human and civil rights of all and everyone of the individuals participating in the programmes and ban any form of physical, psychic and moral threat or coercion against them. The voluntary access to, and permanence in the programme should be guaranteed at all times.

3) Therapeutic communities recognise the patient's right to continue the treatment under way, provided it has been prescribed on the basis of sound knowledge and conscientiously by other therapeutic figures prior to the beginning of the community programme. They take upon themselves the responsibility of re-discussing or changing such treatment with the above professionals over time.

4) Therapeutic communities should guarantee that their activities be carried out in conditions favouring the psycho-physic and emotional growth of their guests, with no discrimination due to social, cultural, psychic and physical health conditions. Communities should guarantee also freedom of worshipping without imposing any direct or indirect religious practices which are not shared by their guests.

5) Therapeutic communities are to promote the dignity of the human being as a priority value and consequently pursue the attainment by their guests of a state of progressive maturity and self-reliance.

6) Therapeutic communities have specific projects promoting the social reintroduction of their guests and they pursue socio-rehabilitative goals in any way, so as to make their guests stay in their facilities no longer than what each one of them really needs.

7) Within a therapeutic community roles and responsibilities are assigned respecting the rights and dignity of the user and they are devised to achieve the goals set by the therapeutic programme. Consequently operators must have the necessary 'skills' to be acquired through proper education and specialist training, as well as by constant updating, an indispensable tool to face up to the evolution of the phenomenon.

8) Potential direct requests of support or of any other form of contribution to users or their families should in no way give rise to a privileged condition.

9) Therapeutic communities should disclose and disseminate to the public, in any proper way, the necessary information on the action methodologies and basic principles on which their action rests, as well as on how the rehabilitative projects are organised and what are the main aspects of psychological,

educational and social activities which are planned and carried out within a given project.

10) Therapeutic Communities should keep track of, and register all information necessary to monitor the treatment programme and its users- while at the same time keeping the information confidential, as envisaged by the law. As it is the case with every other Service for drug addiction, they should provide, according to what the code of practice and the law allow for, updated and accurate data on the therapeutic and socio-rehabilitative results attained, by means also of periodic controls on users once programmes have been completed.