ADCA

Making Values and Ethics Explicit

The Development and Application of a Revised Code of Ethics for the Australian Alcohol and Other Drug Field

DISCUSSION PAPER

March 2007

ALCOHOL AND OTHER DRUGS COUNCIL OF AUSTRALIA

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This discussion paper is based upon the author's recent ethics research (including most recently the first national study of the place and practice of ethics in the Australian AOD field), select publications from this program of work, and other key literature from a variety of sources.

Overview

The Alcohol and other Drugs Council of Australia (ADCA) commissioned a project in 2005 to develop a revised code of ethics for the Australian alcohol and other drug (AOD) field. ADCA has a code of ethics that was endorsed in 1993. However, there have been concerns about the current level of awareness and uptake of this and about the profile of ethics in the AOD field generally. AOD practitioners, policy makers and researchers frequently do have ethical concerns, but recent research suggests there is also a lack of knowledge, training and formal networks to adequately contextualise these for the purpose of applied ethical decision-making. What is needed is a way to engage the field on ethics, and promote greater ethics engagement.

Recent developments in the field since the early 1990s have further highlighted the need to revisit the existing code as an initial strategy for raising the profile of ethics in the AOD area. One such development has been the increasing focus on the moral underpinnings of harm reduction (which may be understood as part of the wider growth of public interest in and scrutiny of science). At times, proposed new harm reduction initiatives have posed significant challenges for society. This gives rise to important questions about the core values of the AOD sector and how ethical considerations figure in the various elements of AOD practice. Another development is emerging international dialogue at the cutting edge of drug policy on issues as varied as drugs and autonomy, addiction vaccines, pharmaco–genetics and pharmaco–genomics, and resource allocation in the AOD area. Finally, there is increasing interest in the fields of public health and bioethics in how engagement with applied ethics can enhance practice and research outcomes for the community.

Questions of values and ethics are fundamental in all specialty areas of health. The case of alcohol and drug practice, research and policy is no exception. It is clear that those working to reduce AOD related harm in Australia face many important ethical challenges, at both the macro and micro level. Regrettably, despite the apparent centrality of ethical concerns in the AOD specialty area, there appears to be little dialogue or scholarship on key ethical issues. This represents an area of vulnerability for the field, heightening the potential for preventable ethical breaches, undermining the quality of innovative research and practice, and representing a threat to public acceptance and funding. It is also an area of risk for funding bodies, which may be drawn into disputes about the ethical conduct of funded services and implications of supported research.

In liberal democratic traditions, ethics can sometimes be thought of in limited terms as a merely regulatory concern. The application of ethics for the governance of individual behaviour is clearly important. However, in the field of public health there are promising new debates occurring around the question of how communitarian or social approaches to ethics may help define its application as a constitutive resource.

This document describes the discussion and rationale for the ADCA Code of Ethics project, and canvasses the following issues:

- the context of ethics in the Australian AOD field
- unique ethical challenges in AOD work
- current profile of AOD ethics and implications
- overview of the first national study of the place and practice of ethics in the AOD field (significant ethical challenges, current responses, training and professional development needs, implications)
- opportunities for making AOD values and ethics explicit (lessons from public health, workforce development, applied ethics frameworks)
- key issues in the development of codes of ethics (processes, format and purpose, regulation and enforcement, relevance and uptake, relationship with other codes).

Codes of ethics are an essential tool for any profession or specialty field. Having a code of ethics represents a sign of maturity for specialty fields, signalling preparedness to take responsibility for ethics engagement around accepted standards. Through stipulating a platform of core values and principles, codes of ethics may fulfil an important role in facilitating dialogue and engagement with ethics, and development of ethics resources (e.g. curriculum, guidelines). Greater engagement with the values and ethics in our work can provide a potent tool to enhance AOD policy, practice and research leading to better outcomes for all stakeholders similar to the way we think about scientific, empirical, clinical and other practice tools. Just as AOD practice should be evidence-based, it should also be explicitly values-based in the sense of aligning with the accepted values and ethics of the field.

The focus of this project is upon AOD practice (including prevention, intervention and treatment). This is not to say that the other areas of AOD work, including policymaking, research etc, are less important, or give rise to less pressing ethical dilemmas. Indeed, there is some sense in which 'AOD work' is not easily segregated into mutually exclusive work domains. For many of us in the AOD field, while the extent of it may vary considerably depending on experience and skills, our work may take us in and out of direct practice, policymaking, research and everything in between. In this sense, while the current project has focused upon developing a code of ethics for 'AOD practice', the content and issues covered are relevant also for the AOD field generally.

As the national peak body for the sector, with a membership of over 400 individuals and organisations Australia-wide, ADCA is uniquely placed to facilitate the development of a code of ethics and to promote debate about ethical issues within the sector. This in turn is expected to inform and support ethics-related curriculum and workforce development for the AOD sector. The aim of this innovative work is to enhance the responsiveness and professionalism of the sector, encouraging practitioners, policy makers and researchers alike to reflect on current and future practice from a diverse range of perspectives and make ethical decisions regarding the way forward.

Beyond the anticipated applied utility of this new ethics resource for the AOD field, the project also has broader national relevance for the National Drug Strategy 2004–2009. For example, the National Expert Advisory Panel, as a key level of the National Drug Strategy (NDS) advisory structure, is expected to contribute to the capacity of the Ministerial Council on Drug Strategy (MCDS) in relation to a number of areas, including in particular, *"providing advice on current legal, medical, scientific, ethical, social and public health approaches to reducing drug-related harm"* (Ministerial Council on Drug Strategy, 2004: p.20). This project also has relevance for public health generally and is consistent with one of the NHMRC's strategic directives of improving the health of all Australians through (amongst other things) *"promoting informed debate on health and medical research, health ethics and related issues"* (see http://www.nhmrc.gov.au).

Discussion Paper

Making Values and Ethics Explicit: The Development and Application of a Revised Code of Ethics for the Australian Alcohol and Other Drug Field

How often do we ask ourselves, "What should I do?" or "What is the right thing to do?" For many working in the broad and complex field of health, perhaps more so those involved in direct health care delivery or other service provision, these sorts of ethical questions are frequent. It is noted in one of Australia's peak ethics documents that *"ethics and ethical principles extend to all spheres of human activity"* (National Health and Medical Research Council, 1999 p.1). Questions of values and ethics are fundamental in all specialty areas of health, and the case of alcohol and drug practice, research and policy is no exception.

'Ethics' may be defined as *"the set of rules, principles, values and ideals of a particular group of people"* (Beauchamp & Steinbock, 1999: p.4). Ethics, however, is too often thought of as a merely regulatory concern, where the provision of rules and guidelines for behaviour in different settings may come to represent a list of things that we can't or shouldn't do. As Witkin has argued, *"…our ethics discourses are more reactive than proactive, more about acts of commission than omission, more about individual conduct than collective responsibility, more about right or wrong than issues of power…more about sexual improprieties than draconian economic policies, more about poor people than rich people, and more about individuals who suffer from physical and emotional pain than those who restrict and profit from their care"* (Witkin, 2000: p.199).

At some level, this aspect of ethics has a place. However, in the increasingly pluralistic world in which we live and work, what is required from ethics is better guidance around the things we *can* and *should* do that is, a process of proactive ethical problem solving (White & Popovits, 2001). This is especially important in the specialty public health area of alcohol and other drugs, where the workforce is often required to respond to a host of complex issues proactively. In terms of applied ethics this necessitates a greater level of awareness of and engagement with ethics than appears to be the case currently in many areas of public health. It is also clear that this engagement should be facilitated and supported.

One of the biggest challenges in achieving this is to determine how best to proceed amidst a diversity of value sets and ethical perspectives. Another challenge is for us to be prepared to consider how applied ethics may be mobilised as a tool to enhance, rather than restrict, AOD policy, practice and research-leading to better outcomes for all stakeholders. This possibility requires us to elevate ethics above its current status as a 'second-order concern', and think about its potential applications for the betterment of practice in the same way we do for scientific, empirical and clinical practice tools.

ETHICS IN THE AUSTRALIAN ALCOHOL AND OTHER DRUG FIELD

CONTEXT OF ETHICS

Society vests in health professionals the obligation to promote and protect both individual and population health and wellbeing. Recently, we have witnessed a minor revolution in terms of the extent of public scrutiny of the 'health science sector'. This has been particularly evident in the fields of biotechnology and biomedical science, where the latest advances in medicine, genetics and reproductive technology, for instance, have highlighted complex ethical dilemmas for society (Kuhse & Singer, 1999). The resulting public and academic discourse on these issues has raised the profile of bioethics and guided applied ethical decision-making in these fields. In addition to the public benefits this has delivered in terms of responsible policy making and practice, the biomedical professions have also benefited from this attention to the ethical challenges in their work. Bioethics, with its focus upon ethics skills and ethical problem solving has resulted in important advances in the area of bioethics training and workforce development opportunities (Fox, Arnold & Brody, 1995; Nicholas, 1999; Birkelund, 2000).

The alcohol and other drug field is a specialty health area that deals with equally important societal concerns.

Alcohol and other drug use in certain circumstances is responsible for significant mortality and morbidity (Collins & Lapsley, 1996), and there are a host of less tangible, though no less important, social and community harms that may be exacerbated by certain conservative political, legal and moral stances towards drug use. Effective responses to the health challenges surrounding alcohol and other drug use have required a mix of evidence-based health promotion, prevention and treatment approaches targeted at often vulnerable, marginalised and difficult to reach groups. Australia's achievements in the alcohol and other drugs (AOD) sector have been won through creative strategies of community contact and engagement, scientific and methodological innovation, and a commitment to social mobilisation and advocacy. At times, proposed new initiatives (e.g. bans on smoking in public places, restricted alcohol availability in defined communities, heroin trials, drug diversion schemes, supervised injecting rooms) have challenged society by testing the boundaries of evidence and policy, and stretching the moral imagination of the community.

Important ethical challenges exist along this frontier of innovation, and it has been recognised that in the AOD field *"…there is not a day that passes without an encounter with an ethical dilemma, a moral challenge or an outright breach of legal boundaries"* (Babor, 2003: p.1). There are first-order or 'macro-ethics' questions for the AOD sector that require attention. For example: What health promotion, prevention and treatment initiatives should be developed? What research should be conducted? How should consumers be involved in the development, implementation and evaluation of these initiatives? What responsibilities do harm reduction practitioners have to the community before, during and after an initiative? There are also a host of applied or 'micro-ethics' issues in AOD practice or service delivery (e.g. voluntary informed consent in the context of dependent relationships, intoxication, duty to treat, unsolicited treatment offers, impact of clinical trials, privacy and confidentiality, and mandatory reporting): those which relate to *research* (e.g. limits to assurances of participant confidentiality when researching illegal acts, participant payment, inducement and voluntary consent, collection of body samples, the impact of intoxication on informed and voluntary consent) and those relating to *policy* development (e.g. resource allocation, community consultation and participation, conflict of interest and organisational change).

UNIQUE ETHICAL CHALLENGES

Beyond the specific challenges themselves however, there are a broader set of factors which make ethics in the AOD field unique. One central issue for the field is the existence of competing views about the concept of an individual right to use potentially harmful licit and illicit drugs, and the state's or community's duty to determine how or if this is practised (Fry, Treloar & Maher, in press). One of the difficulties is that it is not always clear in the AOD context what form this 'right' might take (Hunt, 2004, 2005). How are we to reconcile for example public health interventions that proscribe models of drug use behaviour (e.g. as in the case of supervised injecting facilities, supply reduction initiatives for diverted pharmaceuticals), that may be at odds with drug user defined models that may be less regulatory in spirit and based upon different value sets pertaining to 'risk' and 'harm'? In the AOD field, is the right to use drugs only a right in the form in which AOD professionals define it? Does it exist at all? The issue of the 'right to use drugs' is in essence a question about how we may define individual autonomy in relation to drug use and dependence. It is therefore a core concern in relation to many of the macro- and micro-ethical challenges identified above, and is an issue that requires further debate.

Another way in which ethical considerations in the AOD sector are unique has to do with the influence of the harm reduction philosophy, which is acknowledged to have played a key role in underpinning the development of pragmatic drug policy in many countries (including the 'harm minimisation' variant in Australia) (see Fitzgerald & Sewards, 2002). There is, however, an unresolved tension between the conceptual formulation of harm reduction as 'value neutral' when responding to AOD-related harm (see for example: Strang, 1993; Erickson, Riley, Cheung & O'Hare, 1997; Keane, 2003), and the everyday reality of practice, research and policymaking in this area. Harm reduction seeks to bypass the moral questions about drug use and drug users, to focus instead on drug-related harm. In the Australian context, some have called this a drug policy ethic of *"humane pragmatism, a practical fairness in our social and professional lives…manifest in a commitment to supporting the most vulnerable in our community"* (Fitzgerald & Sewards, 2002: p.xi).

The compelling aim of this approach seems to be an attempt to sidestep moralistic definitions of drug use, and punitive moral stances where people are blamed and punished for drug use and have other civil liberties

and rights infringed. However, some have argued that the consequence has been a brand of harm reduction that emphasises technical skills, evidence, and methodological innovation, to the detriment of articulating the core values that underpin this work. Hathaway in particular has argued that *"playing down values has hampered the movement… as reflected by the dissension over harm reduction policy in practice and more general state of confusion as to harm reduction's guiding principles."* (Hathaway, 2002: p.398).

To the extent that values should inform practice, this lack of ethics engagement has been one factor that has probably limited the capacity of AOD practitioners in navigating some of the ethical challenges encountered in this specialty area of public health (Fry, Treloar & Maher, in press). To some degree the diversity of the AOD field which is comprised of a variety of knowledge bases, practice and research disciplines (e.g. nurses, doctors, psychologists, social workers, youth workers, community development workers, ex-users, peer workers, researchers, teachers, psychiatrists, counsellors, needle and syringe program workers etc) has also contributed to this by making it difficult to conceptualise ethical standards to suit the broad scope of AOD endeavours and interests (White & Popovits, 2001), as it has also been said of public health generally (Daly & McDonald, 1996).

Neither harm reduction nor AOD practice can be truly value neutral or value free, as the overarching goal of reducing harm is in itself a value notion. But where values and ethics are assumed as self-evident or de-emphasised next to empirical, clinical and political considerations (including the role of government in determining the lives of its citizens), their absence from dialogue means that an important opportunity is missed to further strengthen harm reduction practice. As in public health generally, the AOD field is currently without an agreed set of core values and related resources to guide decision-making around the unique ethical issues that exist in this area (White & Popovits, 2001). Some of the consequences of this are considered in the next section.

PROFILE OF ETHICS AND CONSEQUENCES

In contrast to the response of bioethics to the dilemmas of biomedical research, biotechnology and genetics, there has been a lack of critical discussion in the AOD field (nationally and internationally) of either the ethical underpinnings of AOD work, the everyday ethical challenges that may arise in its conduct, or how AOD professionals respond to such challenges (Fry, 2002; Fry, Treloar & Maher, in press). The low profile of ethics in the AOD field and its consequences may be seen at a number of levels.

For example, the published literature contains relatively few papers on AOD ethics concerns (Fry, 2002), and up until recently ethics has rarely figured prominently in the programs of the AOD field's major national and international conferences and other meetings. In Australia,

ethics features only generally in the AOD qualification competency units specified by the Community Services and Health Training Authority of Australia and recognised by the Australian National Training Authority (Network of Alcohol and Other Drugs Agencies, 2003).[1] Similarly, the curricula of specialised AOD undergraduate and postgraduate courses on offer in Australia do not routinely include special AOD ethics subjects (National Centre for Education and Training on Addiction, 2004). Despite the articulation of 'knowledge diversity' as a key principle of workforce development, AOD ethics has to date not been considered a key issue in this area, as evidenced by its absence from recent major reviews (Roche & McDonald, 2001; Skinner, Freeman, Shoobridge & Roche, 2003).

There are some general and AOD-specific vocational education and training resources for the sector in relation to practice ethics (see, for example, NSW Health and Network of Alcohol and Other Drug Agencies, 2005). However, like AOD settings internationally, the Australian AOD workforce must negotiate daily ethical challenges without an accepted national framework of standards for decision-making on the special ethical dilemmas in AOD practice. White and Popovits make the following observation: *"It has become painfully evident that the field [addictions] has not developed a paradigm or process for ethical problem solving nor has it developed a fully articulated set of ethical standards to guide professional practice. The field…does not have a framework of ethical standards and ethical decision-making that can consistently protect our service consumers, our workers, our organizations and the public"* (White & Popovits, 2001: p.1).

White and Popovits (2001) also state clearly what they consider to be one of the barriers to ethics dialogue in the AOD field, and what is needed in response: *"There are strong no-talk rules within the addictions field on many issues* [ethics] *Such rules spring not from any orchestrated conspiracy but from the shameful sense that ethical breaches are idiosyncratic to person or organization rather than systemic. The silence is fuelled by fear that open discussion of such events and issues would harm the organization and the professional field. However, these issues need sound and air and light."*

In terms of AOD research, in accordance with national research funding policy requirements, most AOD researchers in Australia observe the National Health and Medical Research Council (NHMRC) peak guidelines for ethical conduct in research involving humans (National Health and Medical Research Council, 1999). However, while these guidelines provide an accepted national framework for institutional ethics committee review of research and for research conduct, their value in guiding researchers on the situation-specific ethical dilemmas that arise in multidisciplinary health research has been questioned (Daly & McDonald, 1996). Applied ethics guidelines are starting to emerge in the AOD field to provide clearer guidance on ethical challenges in relation to AOD research (see AIVL, 2003; Fry & Hall, 2004). However, in the absence of a national mechanism for ethics promotion in the AOD field, the extent of their uptake and influence on current practice is unclear.

The current low profile of AOD ethics represents an area of vulnerability for the AOD field. It heightens the potential for preventable ethical breaches, undermines the quality of innovative research and practice, and represents a threat

[1] Ethics is an essential knowledge component of some compulsory competencies, though the content of most training is prescriptive rather than methodological (involving ethical problem solving processes) and often fails to address the subtlety of ethical issues that may be experienced in AOD practice (White & Popovits, 2001).

to consumer and public acceptance and funding (see Fry, Madden, Brogan, & Loff, in press; Fry, Treloar & Maher, in press). The apparent lack of ethics dialogue in the AOD arena may also send a message that ethical considerations are subordinate to the empirical, clinical, policy and other issues that attract the bulk of attention. In turn, this may create a false impression for newcomers to the AOD arena that it is 'uncontroversial' when it comes to questions of ethics, or that most of the important ethical challenges have been resolved. By failing to engage with the applied ethical issues and questions that exist in the AOD field, we deny ourselves a potential tool for improving the design, implementation, evaluation and impact of new treatment, research, and policy initiatives. The question that therefore arises is 'How do AOD professionals currently respond to the ethical dilemmas and complexities of their work?'

NATIONAL STUDY OF THE PLACE AND PRACTICE OF ETHICS IN THE AUSTRALIAN AOD FIELD

In 2003, a study funded by National Centre for Education on Training and Addiction (NCETA) was undertaken to examine the place and practice of ethics in the Australian AOD field (Fry, forthcoming). Postal surveys were forwarded to members of Australia's two peak national representative organisations for the AOD sector (ADCA and APSAD) to canvass the following issues: core values in the AOD field, applied ethical challenges encountered by AOD practitioners, researchers and policy makers, current responses to ethical challenges, and levels of training and expertise in ethics. 208 completed questionnaires were received (response rate of 34%), with representations from each State and Territory, a wide range of organisations (e.g. specialist AOD, community health centre, university, mental health, law enforcement, government, NGO), and 27 different professional and para-professional groups currently working in the AOD sector (represented in the areas of policy/government, clinical services and other health/welfare services, research, education and training) the most common of these included; drug counsellors, psychologists, general practitioners, physicians, nurses, researchers/academics, and addiction medicine specialists.

Significant ethical challenges: Of the large number of examples of current ethical challenges in the AOD field provided by respondents, those most commonly identified included: drug policy reform (ongoing debate and advocacy around harm reduction and zero tolerance), balancing individual and community rights, privacy, resource allocation, confidentiality, discrimination and equity of service access, maintenance of professional boundaries, respect for client autonomy, and increasing workforce awareness and training on ethics in the AOD field.

Current responses: A number of opportunities to discuss ethics were identified, including: informal discussions as issues arise, formal discussions at meetings, discussions when preparing ethics committee applications (for research approval), discussions when preparing reports, and discussions when deciding on resource allocation. Some of the common elements of the responses made to the ethical challenges encountered in AOD work included: dialogue, information gathering and use of external authority, incident reporting and adversarial mechanisms, critical reflection on own practice, maintaining respect for client choice and assisting in decision-making, and supervision, training and policy development.

Despite this, one-third (35%) of respondents reported that there had been instances where they were unable to resolve ethical challenges that arose in their AOD work. Most also indicated that they had previously felt pressure to act against their ethical values during their AOD career (92%), and that they had also witnessed AOD colleagues acting unethically (94%).

While more than 30 different examples were identified by respondents when asked about ethics guidelines they most used in AOD work, there were low reported rates of use for the main formal guidelines and codes of relevance for the AOD sector. The NHMRC national statement for ethics in human research was identified most frequently by 26% of the sample, with the next most commonly mentioned including: the Australian Psychological Society ethics code (18%), the Australian Association of Social Workers code (5%), and the Australian Medical Association code of ethics (4%). Surprisingly, 12% of the sample reported that they did not use any ethical guidelines in their AOD work. Only two respondents specifically nominated the ADCA code of ethics.

AOD ethics training and professional development needs: Respondents were clear that the responsibility for ethics in the AOD field should be adopted by all workers (95%). Other common responses included professional bodies (38%), ethics committees (30%), community/society (23%), government (22%) and clients (12%). Relatively few respondents thought that AOD ethics should be the sole responsibility of ethicists (4%),

philosophers (4%) or the clergy (2%). Respondents offered a number of suggestions for how existing ethical guidelines could be improved. The most common recommendations were for current ethics guidelines to be updated and made less theoretical and more relevant to applied AOD practice, perhaps with illustrative case studies. Respondents also acknowledged that guidelines alone do not provide all that is required for ethical practice.

While 44% of respondents had completed ethics subjects in undergraduate studies and 34% in postgraduate studies, only a quarter (26%) had received education and training covering ethics in AOD work. A third of respondents (33%) were able to identify training or professional development needs in AOD ethics. These included suggestions for development of 'train the trainer' style ethics training packages, provision of ongoing professional development opportunities in AOD ethics (e.g. workshops and seminars), and facilitation of greater ethics discussion and advice (e.g. through supervision, mentoring or other mechanisms). Some of the core values that might inform this include respect (83%), avoiding harm to others (77%), integrity (77%), individual rights (72%), honesty (69%), transparency (69%), human rights (67%), community rights (61%), and justice (59%).

Implications: This study provides the first empirical data on the significant ethical challenges and current responses in the Australian AOD field. A diversity of examples of key ethical dilemmas was identified by respondents in the areas of policy/government, clinical services and other health/welfare services, research and education, and training. While the findings indicated that a range of formal and informal opportunities currently exist to discuss ethics in AOD work, there were generally lower than expected rates of use of the main available ethics guidelines and codes of relevance for the AOD sector. That 12% of respondents use no ethical guidelines in their AOD work and only two respondents could nominate the ADCA code of ethics is a concern. This, and the reported experiences of unresolved ethical challenges and ethical breaches, raises concerns about the basis upon which the AOD workforce responds to ethical dilemmas in AOD work and highlights the need for enhanced workforce awareness and training on ethics. Respondents acknowledged this as an important challenge for the AOD field into the future, and were clear that the responsibility for this falls upon all workers as well as professional bodies, government and other regulatory systems.

The study findings also suggested a number of opportunities for ethics education and training and other workforce development initiatives. While there was evidence of past exposure to generic and AOD-specific ethics training, respondents identified a number of training and professional development needs in AOD ethics (e.g. applied AOD ethics guidelines, ethics training packages, ongoing professional development, and ethics dialogue forums).[2] Respondents were also able to identify a wide range of what they considered were core values that could inform future response to the ethical challenges that currently exist for the AOD field.

Overall, the findings showed that ethics is a core concern for the AOD field. The AOD workforce grapples with a wide range of complex ethical challenges across diverse areas of work. While there is some evidence of awareness in the Australian AOD sector of available resources for ethics decision-making, and a range of opportunities for dialogue on key ethical dilemmas, there appears to be a need for formal ethics education and training and other workforce development initiatives to supplement what exists currently (e.g. curriculum development and training packages).

MAKING VALUES AND ETHICS EXPLICIT

WORKFORCE DEVELOPMENT

Roche (1996) and others (Glass-Crome, 1992) have stated that the effective functioning of the AOD workforce in response to drug problems depends critically upon adequate education and training. However, Roche (2001) has also observed that the training of AOD workers generally does not keep pace with advances in the field. As already noted, the issue of AOD ethics is a specific case in point. If we accept that values and ethics are fundamentally important in alcohol and drug practice, then it follows that a sound knowledge and skill base in relation to ethics should be viewed as a critical component of best practice in responding to drug problems. Important

[2] As a core competency in the United States addictions accreditation system, specific 'ethics for addictions' courses are available (including online packages: Distance Learning Center for Addiction Studies http://www.dlcas.com).

workforce development opportunities exist in relation to policy development and education and training around the ethics of AOD work. Such a focus is warranted given the importance of AOD issues in our society, the specific challenges created by legislative and policy progress, and ongoing developments in research and service delivery.

Engagement with ethics is particularly important in the specialist AOD sector where difficulties exist in attracting and retaining qualified staff. Growing demands on AOD organisations and increasing emphasis on evidence-based practice have not been matched by funding to develop policies, systems and structures to underpin a qualified workforce (ADCA Workforce Development Policy, 2003). As we have seen, research shows that AOD practitioners, policy makers and researchers frequently do have ethical concerns, but these are often obfuscated through the lack of knowledge, training and formal networks to adequately contextualise these for informed ethical decision-making (Fry, forthcoming). What is needed is a way to engage the field on ethics.

LESSONS FROM PUBLIC HEALTH

In the wider sphere of public health, a similar lack of ethics engagement has been identified. Poor ethics literacy amongst public health professionals, and the lack of an agreed framework for analysing ethical dilemmas in public health, have been discussed (Callahan & Jennings, 2002; Roberts & Reich, 2002). Unlike the AOD field, however, in response to these concerns vigorous international debate and scholarship is emerging on public health ethics and is beginning to explore important topics such as: conceptual models for public health ethics, multi-disciplinary codes of ethics, individual rights and public health nexus, and globalisation and public health.

In particular, the creation of new public health codes of ethics in some countries (e.g. United States, see Thomas et al., 2002) has in turn facilitated public health ethics curriculum development through stipulation of a platform of core public health values as a basis for dialogue and to inform research, policy and practice (Jennings, Kahn, Mastroianni, & Parker, 2003). Advancement in dialogue on the core values of public health has been viewed as a core step towards development of a suitable framework for ethical decision-making in public health (Rogers, 2004).

However, we should proceed with caution. Despite a recent massive increase in the provision of university and workplace based education on public health ethics in the United States, commentators have noted that public health professionals generally have not yet developed a practical or applied ethics literacy, the result of which being that many important ethical issues and questions for public health have yet to receive adequate attention (Callahan & Jennings, 2002; Levin & Fleischman, 2002). The mobilisation of the education and training on ethics is therefore a necessary but not sufficient response. If capacity development in this area is to be sustainable and deliver the kinds of outcomes imagined, it must be predicated on a solid base of knowledge—in this case of the salient ethical challenges the workforce is likely to encounter.

A Role for Dialogue

This requires a greater level of 'ethics engagement' than appears to exist currently in the AOD field. Put simply, the AOD workforce needs to engage in greater dialogue around the everyday ethical dilemmas encountered in AOD practice. Further, this dialogue should be disseminated and shared beyond the local settings in which it first occurs, and is in this sense a communicative strategy. The imperative for making core values explicit in public health generally has been clearly stated: *"Society is increasingly demanding explicit attention to ethics, as in an increasingly pluralistic society the values from a single culture, religion or disciplinary perspective cannot be assumed, and it is necessary to work out our common values in the midst of diversity"* (Sindall, 2002; p.201).

Therefore, one of the key requirements for this type of 'communicative approach' to ethics engagement in the AOD field (or 'ethics as discourse'—Witkin, 2000) is also the development of an explicit statement of core values. Meeting this requirement will involve attention to the question of whether our applied ethics practices are best derived from core principles and values (a deductive 'top down' process), or alternatively that our applied ethics practices actually help to identify core principles and values (inductive 'bottom up' process).

ETHICAL THEORY AND PRACTICE

Biomedical Ethics and Public Health

Biomedical principlism emerged from the post-WWII Anglo-American approach to ethics in response to medical research abuses and developments in biotechnology and patient rights (Callahan & Jennings, 2002). It defines the boundaries of ethical research with reference to the core principles of: *autonomy* (respecting the actions of rational persons and valuing informed voluntary consent, confidentiality and privacy), *non-maleficence* (minimising research risks and harms), *beneficence* (ensuring research benefits outweigh risks), and *distributive justice* (equitable distribution of risks and benefits).

These principles underpin most international guidelines for human research (Beauchamp & Childress, 2001) and Australia's 'National Statement of Ethical Conduct in Research Involving Humans' (NHMRC, 1999). The principles have also been influential in defining professional codes of ethics (historically those in medicine) and guiding professional practice in the health field in the context of the widespread changes in medical science and delivery of medical services (and concomitant rise of the consumer/patient rights movement) post-WWII. (For an excellent historical account, see Siggins, 2002.)

Concerns have been raised on a number of fronts about the suitability of biomedical ethical principles as a framework for the ever-diversifying sector of public health (Callahan & Jennings, 2002; Levin & Fleischman, 2002). Broadly, critics

claim the liberal origins of biomedical ethics and historical focus on *individual* rights and autonomy are at odds with the population focus of public health (promoting and protecting *collective* rights), where numerous ethical perspectives exist, one or more of which might be appropriate for any specific ethical problem (Callahan & Jennings, 2002; Thomas, Sage, Dillenberg & Guillory, 2002). Some examples in the AOD field where the balance between individual and community rights and interests is contested include: consent processes in epidemiological research in developing countries, investigation and control of communicable diseases, genetic research consent and privacy, mandated vaccinations, and compulsory treatment orders.

Principlism, as an example of a deductive approach, has also been criticised as an uncritical application of ethical norms with little reflection (Clouser & Gert, 1997). It has also been suggested that the prescriptive use of ethical principles may discourage consideration of alternative ethical perspectives, such as those emphasising collective rather than individual responsibilities (Witkin, 2000). Witkin in particular has warned that ethical principles may therefore be seen as instruments of control rather than benevolent moral guidelines (2000). Broad principles have been said to provide only limited guidance for public health in response to a *"multiplication of ethical issues, explosion of protocols and emergence of unfamiliar research designs"* (Daly & McDonald, 1996: pxvi).

Alternative Frameworks

There are many competing value frameworks that may assist in identifying what conduct is right or good, including principles-based deontological ethics, utilitarian ethics, casuist case-based ethics, narrative ethics, feminist ethics, and virtue ethics (Kuhse & Singer, 1999; Somerville, 2000). All of these approaches are thought to capture some aspects of ethical reasoning, but none commands universal agreement. As the embodiment of social values, moral positions are historical rather than timeless or static, and subject to revision and augmentation.

In the absence of consensus on a universal theory of ethics, ethical analysis cannot be a matter of deducing moral rulings from categorical imperatives or applying a utilitarian calculus to all candidate courses of action. Ethical analysis does not always achieve consensus (nor is this necessarily its aim) but the range of morally acceptable behaviour may perhaps be narrowed by ethical debate. A dialectical process can identify common moral rules and shared justifications for morally acceptable courses of action. This has been described some time ago by Rawls as the method of "reflective equilibrium", involving the testing of ethical principles (that may be derived from one or more ethical theories) against widely shared moral rules and judgements that have been called the "common morality" (Rawls, 1971).

There are a number of accounts of how this ethics dialogue may occur, and broadly these may be categorised as either 'deductive' (starting from general principles to derive the particular) or 'inductive' (starting from particular cases to derive the principles). It is beyond the scope of this paper to fully outline the different ethical frameworks in each approach. Instead, a thumbnail sketch will be provided of those in which run a consistent theme of valuing discussion around potential ethical practices, rather than the universal prescription of normative rules (MacIntyre, 1981).

One recent form of the inductive approach to ethics has been called pluralistic casuistry (Brody, 1998). Brody argues that, in contrast to the monistic ethical theories that attempt to reduce morality to a single value or set of principles, pluralistic casuistry reflects the reality of how we engage in moral reasoning. Casuistry or case-based ethics is a method of practical ethical reasoning emphasising the value of our moral intuitions about particular cases over theories or principles (Weed & McKeown, 2001). Pluralistic casuistry recognises that multiple moral values may co-exist and are modifiable with reflection on more cases. Casuistry is also sympathetic to communitarian ethics, where morality is also seen as contextual and where divergent ethical values of different communities are respected. A common theme in pluralistic approaches to ethical analysis is the key role of public discussion in achieving a balance between competing ethical values (Hampshire, 1982; Nussbaum, 1993). Witkin (2000) has argued that by ignoring alternative ethical perspectives we limit our capacity to assess the limits of our own belief systems, and so engage in ethical discussions only within boundaries of the taken-for-granted.

Another approach to ethics in which diverse perspectives and dialogue is featured, in the sense of being 'ethics-engaged', is communitarian ethics which focuses more so on the common good and public interests than individual autonomy. Communitarian ethics *"emphasizes social connectedness, and sees individuals as members of a community embedded in the community norms and history, and not as the atomised individuals of classical liberalism"*

(Sindall, 2002: p.202). Bell (2001) has further suggested that *"the distinctive communitarian political project is to identify valued forms of community and to devise policies designed to protect and promote them"*.

According to Callahan, communitarian ethics comes down to *"a set of analytical skills and personal virtues, not a set of decision procedures"* (Callahan, 2003a: p.288). Callahan (2003) considers the most important analytical skills to include *insight* ('sensitivity to the embedded quality of our lives'), *imagination* and *rationality* (including reasoning and emotion). It may also include *reflexivity* as a practical resource for guiding action which Guillemin and Gillam (2004) have defined recently as *"acknowledging and being sensitized to the micro ethical dimensions for research practice and in doing so, being alert to and prepared for ways of dealing with the ethical tensions that arise"* (Guillemin & Gillam, 2004: p.278).

Similar themes may also be seen in Biggs & Blocker's (1987) notion of being ethics engaged, adapted recently by White & Popovits who define 'ethical sensitivity' as *"…the ability to step outside oneself and perceive the complexities of a situation through the needs and experiences of the client, the agency, allied institutions and the public. It is the ability to project the potential consequences of one's own action or inaction on these various parties. It is the ability to recognize when one is in ethical terrain. It is the ability to identify and analyze the precise ethical issues involved in a particular situation and to isolate and articulate conflicting duties. It is the ability to weigh the advantages and disadvantages of various actions and to formulate ethically appropriate resolutions to complex situations"* (White & Popovits, 2001: p.7).

At the simplest level, communitarian ethics is about promoting active engagement with ethics and, in so doing, a *"communitarian will emphasize receptiveness to important local cultural traditions in the good life"* (Agar, 1998; p.178). This version of communitarian ethics therefore may provide a useful framework or method for defining and informing responses to the ethical challenges (or 'ethically important moments' (Guillemin & Gillam, 2004).) that arise in AOD practice.[3] Through this it may be possible to reap the likely benefits from a kind of 'communitarian solidarity' that may emerge from an explicit commitment across the AOD field to actively engage in ethics.

Supporting the development of an AOD code of ethics is just one level at which we may engage with ethics. Using this as a platform of values, a starting point, this may be utilised to inform the development of other applied ethics resources for the field (e.g. local ethics guidelines and materials for AOD practice, policy and research). The following section explores the 'codes of ethics' issue further.

[3] While Guillemin and Gillam (2004) discuss these themes primarily in relation to research, they may also be applied for AOD practice generally.

CODES OF ETHICS

OVERVIEW

Codes of ethics are an essential resource for any profession or specialty field. Having a code of ethics is a symbol of maturity for specialty fields, signalling preparedness to take responsibility for ethics engagement around accepted standards. Rather than being merely regulative of 'unacceptable' behaviours, codes of ethics that enunciate core values and standards can also be thought of as constitutive resources (Gaita, 2004). Through stipulating a platform of core values, codes of ethics may fulfil an important role in facilitating dialogue and engagement with ethics, and inform the subsequent development of applied ethics resources (e.g. curriculum and guidelines) which may be utilised to guide and improve current practice for the benefit of all.

Some of the potential weaknesses or concerns that exist for ethical codes include: the difficulty of ensuring familiarity and uptake amongst intended target professions, their use as another tool for elevating the professions by claiming the high moral ground, questions about their utility if not accompanied by practical guidelines (e.g. case studies) and methodological resources for ethical decision-making processes (Coady & Bloch, 2002).

RELEVANT AUSTRALIAN DOCUMENTS

In the current document, some of the key Australian ethics and related resources are highlighted for the information of readers. These were identified on the basis of the author's research into the place and practice of ethics in the Australian AOD field, where current AOD professionals (ADCA and APSAD members) were asked to identify the ethics resources (i.e. codes, guidelines etc.) commonly employed in their work. More than 30 different documents and other resources were nominated, the most frequently mentioned of which have been reviewed for the current exercise. While the purpose of this project was not to undertake a comparative evaluation of these resources, they are listed in Appendix C along with their web-links/URLs for the information of readers.

ADCA Code of Ethics (1993)

ADCA's first code of ethics was endorsed in 1993, and it provides an important starting point for the current project. However, there have been concerns about the current level of awareness and uptake of this and about the profile of ethics in the AOD field generally. Recent developments in the field since the early 1990s have further highlighted the need to revisit the existing code as a mechanism for raising the profile of ethics in the AOD area. One development has been the increasing focus on the moral underpinnings of harm reduction (consistent with the global increase in public interest in, and scrutiny of, science generally), particularly in relation to areas of innovation in AOD science, policy and practice (e.g. addiction vaccines, bans on smoking in public places, supervised injecting rooms, web-based research and counseling).

ANCD Alcohol and Other Drugs Charter

The Australian National Council on Drugs (ANCD) undertook consultations to develop an Alcohol and Other Drugs Charter, the purpose of which was to identify principles that stakeholders in the AOD sector may draw from in developing and implementing drug policy. The Australian Alcohol and Other Drugs Charter (2007) outlines expectations of the community with regards to drugs in relation to topics including: the whole population, children and young people, parents and caregivers, drug users, health care and welfare providers, law enforcement and corrections personnel, educators, government and community organisations, policy makers and program providers, and the alcohol and tobacco industry. The intention underpinning the current revision of the AOD code of ethics was that the revised code and accompanying supporting structures and process resources would exist as applied ethics companion pieces to the ANCD Charter. In revising the draft AOD code on the basis of sector feedback from the consultation process around this, efforts will be made to ensure that the final AOD code is compatible with the ANCD Charter. The similar timing of the development of the ANCD Charter and AOD Code of Ethics presents an important opportunity for harmonisation of these documents.

Other Ethics Codes

Other local ethics codes and policy and procedures exist, and represent an important resource base. However, these are typically not disseminated beyond the local settings in which they have been developed. Other national guidelines exist for research ethics concerns (i.e. NHMRC National Statement) and there are specific ethics codes for some professional groups working in the AOD area (e.g. Australian Medical Association, Australian Psychological Society, Australian Nurses Council, Australian Association of Social Workers, Royal Australian and New Zealand College of

Psychiatrists). However, recent research suggests that there is a level of dissatisfaction with these, and concerns about the level of awareness and uptake and their relevance for the particular applied ethics issues that arise in the specialty AOD field in the areas of research, practice, policy and training.

Some early work was also undertaken in 1995 towards the development of a code of ethics for the Australasian Professional Society on Alcohol and Other Drugs (APSAD) (McDonough, 1995), later developed further as part of a workshop conducted at the 2002 APSAD conference and updated discussion document (Gijsbers, McDonough, Fry & Whelan, 2002; 2003). The 2003 document (Gijsbers et al., 2003) covered issues such as: individual autonomy, confidentiality, impaired fellow professionals, informed consent, research payments, knowledge of illegal activities, harm minimisation versus abstinence, addictive drug substitution therapy, involvement in political process, self-inflicted injury, research ownership, sponsorship, and breaches of professional boundaries. Despite plans to distribute the revised document to APSAD members for comment, to date this has not occurred. These materials have been considered in the current project and incorporated where appropriate.

DEVELOPING A CODE OF ETHICS: KEY ISSUES

Format and Purpose

The formalisation of accepted ethical norms may take a variety of forms. Stated ethical norms may take the form of oaths, codes of ethics/conduct/practice, charters, and guidelines. In general terms, regardless of form, the most common purposes of codes of ethics include: the promotion of the professional status of a particular field through signalling maturity, and preparedness for self-regulation and responsibility on ethics, for use as a tool for ethics education and development, and to foster a collective recognition of ethical responsibility and an environment of ethics engagement and practice standards. Codes of ethics may vary significantly in terms of format and purpose, though for the most part the majority of existing codes of ethics have a focus that is 'aspirational' (i.e. describing the ideal) or 'lowest common denominator' (i.e. describing behaviours that are either prohibited or warranted), or sometimes both.

There is a degree of similarity among existing codes of ethics in the Australian health sector. Most are developed around core 'human services' values such as dignity, social justice, humanity, competence and integrity. Where existing codes will most likely differ is around the level of specificity concerning prescribed behaviours and the extent to which a sanction system is attached for the purpose of regulation. There are examples of ethical codes that focus initially upon more general content on ethical ideals. Some of these have accompanying ethical guidelines that further detail practical guidance on ethical issues (e.g. Australian Psychological Society), while some codes incorporate this detail alongside the broader statements of values and principles.

Figure 1 is adapted from Coady and Bloch (2002), and provides an overview of some of the different types of normative ethical documents and the relative level of focus and underlying frameworks. Figure 1 portrays a sense in which the 'starting point' for applied ethics may be the description of broad principles that inform the core values and vision for a given profession or sector. From this may flow the more specific articulation of policies and rules that constitute key components of the governance of behaviour in these settings.

In practice, the process is not necessarily a linear one as suggested by Figure 1. For example, another approach is to focus first upon current behaviours and practices and derive (or indeed test) broader principles and core values from these. Nevertheless, this schematic representation provides a useful guide for how we may conceptualise some of the possible applied relationships between broader values on the one hand, and more concrete acts and omissions on the other.

Figure 1. Schematic representation of various levels of normative ethics (adapted from Coady & Bloch, 2002: p.92).

Level of focus	Legal/governance framework	Sociological/cultural framework	Forms of Codes
Broad Specific	Principles Policies Rules	Values & vision Norms & attitudes Behaviours & actions	Codes of ethics Codes of practice Codes of conduct Codes of behaviour

Consensus

A number of authors have suggested that consensus on core values within codes of ethics is unlikely (Bloch & Pargiter, 2002). White and Popovits (2001), writing about the AOD field, argue that *"Ideological splits, competition, and a marked propensity for organizational isolation make it unlikely that the whole field will come together to fully back a single set of ethical standards and values. There is, however, a movement within local programs to more clearly define ethical standards and processes of ethical decision making."*

Consensus on core values therefore may not be achievable: however, as some have suggested *"mere convergence does not make standards ethical, nor does variation imply a problem"* (Dickert, Emanuel, & Grady, 2002: p.373). Further, the process of explicit identification of candidate values and dialogue around these, and recommended processes for ethics engagement in the AOD field, is nonetheless very important.

Development Process

The literature contains numerous descriptive sources that recommend processes and steps for the development of codes of ethics (refer to Appendix C for links to further information). White and Popovits's (2001) suggested process for the development of a professional code of practice in the AOD context included the following steps:

i) preliminary discussion with leaders in the field and other peak professional bodies around need for a code and endorsement requirements

ii) inform stakeholders of the purpose of the planned code and developmental steps being undertaken

iii) establishment of ad hoc steering group or committee to guide the process

iv) review of existing codes of ethics in related fields

v) consultation process on the content of the new code involving process for review and comment on draft code

vi) revision and finalisation of new code

vii) release and integration of new code of ethics

viii) establish mechanism for periodic review and refinement of new code.

In terms of the typical timelines required for developing codes of ethics and related guidelines, the literature shows that practices vary widely, depending on the intended purpose and content of particular codes. Callahan and Jennings have noted that *"Code developments and revisions…have often been most successful when they are accompanied by lengthy and strenuous debate engaging the entire professional community and not simply those with a special interest in ethics"* (Callahan and Jennings, 2002: p.173). White and Popovits (2001) suggest that the development of a code of ethics can take between 12 and 24 months depending on the size of the field and the extent of other ethics resource development activities occurring in conjunction with the creation of a new code.

Regulation and Enforcement

A generally stricter range of regulation and enforcement options are potentially available for professional groups where adherence to stated ethical practice guidelines may be a stipulated condition of organisational membership or professional registration or licensure (and included in bylaws and complaints processes). One of the main concerns about codes of ethics exists in relation to the challenge of enforcement. A variety of statutory and contractual actions are available in the case of breaches of ethics, from de-registration, suspension of membership, termination of employment and the like (Skene, 2002). However, the literature suggests that many codes of ethics are not enforced (Coady & Bloch, 2002).

Beyond the local organisation/agency level policies and procedures that outline employer responses when employees contravene ethical standards, it is difficult to see how an AOD code of ethics could be enforced at a national level without the development of systems and structures to oversee such a function. In any case, the regulation and enforcement of penalties for transgressions of the code would be costly, time consuming and perhaps unnecessary in relation to matters already covered in legislation and other regulatory systems (e.g. mandatory reporting, client confidentiality, dual relationships). Further, these would require the establishment of structures and systems to support this new level of AOD ethics regulation no small task considering the challenge of addressing possible issues of jurisdiction over professional groups (for whom generic codes of ethics and practice exist), and indemnity and related ethico-legal concerns. Further, in the case of AOD professional groups who, in addition to the new AOD code of ethics would also be bound by the codes of their respective professional bodies (e.g. Australian Psychological Society, Australian Association of Social Workers, Australian Nursing & Midwifery Council, Royal Australasian College of Physicians etc), there would be important jurisdiction and governance issues to resolve where breaches of ethics are identified.

While the enforcement issue is an important consideration in the design of new codes of ethics, it should be remembered that *"…a code of ethics can serve important functions even without or apart from sanctions"* (Lichtenberg, 2002: p.14). In the multidisciplinary health sector, this should be considered in relation to an awareness and understanding of the various other existing professional codes and guidelines that may be relevant to the diverse workforce.

Relevance and Uptake

A sense of ownership is important in both the development and definition of ethical norms. A variety of issues should be considered in relation to coverage, relevance to different professional groups, and the professional settings in which the code of ethics applies. As noted already, one of the challenges in developing ethical codes is ensuring familiarity and uptake amongst intended target professions. A related concern exists in relation to the utility of new codes if not accompanied by 'translational resources' such as practical guidelines, or other methodological tools for ethical decision-making processes.

Despite a long history of institutionalised ethics review and regulation, we are still at a rudimentary stage with regards to the development of applied ethical resources in the multidisciplinary areas like public health (including the AOD sector). The assumption that ethical codes and other similar normative documents are sufficient for ensuring ethical behaviour ignores one significant fact about ethics as a social practice: that is, that it also requires 'more local' structures to promote engagement with applied ethical issues.

Ethical Decision-Making

What is generally less often a feature of codes of ethics and related resources in the health area is the provision of methodological resources with which to enhance decision-making processes around the local level ethical dilemmas. White and Popovits (2001) suggest that ethics should be addressed as a systemic issue, where multi-level approaches are needed to promote ethics engagement and decision-making. To guide the development of a comprehensive approach to promoting high standards of ethical conduct in AOD practice, they outline a checklist of strategies at the levels of knowledge and skills, ethical standards, organisational culture, ethical decision making and ethical breaches (see Appendix A for an adapted version). White and Popovits's (2001) ethics promotion checklist provides a useful tool through which gaps in the above areas may be identified, and utilised to inform the targeted development of applied ethics resources.

White and Popovits (2001) also recommended a simple model of ethical decision-making comprised of a series of related questions they suggest can be considered in relation to ethical dilemmas that arise in AOD practice:

(1) Whose interests are involved and who can be harmed?

(2) What universal or cultural-specific values apply to this situation and what course of action would be suggested by these values?

(3) Which of these values are in conflict?

(4) What standards of law, professional propriety, organisational policy or historical practice apply to this situation?

White and Popovits's applied ethics decision-making model is noteworthy as it is informed by their belief that ethics must be addressed as a 'personal-professional' and 'systemic' issue. Consistent with a communitarian ethics approach, White and Popovits call for the development of 'ethical sensitivity' in the AOD field: *"… the ability to step outside oneself and perceive the complexities of a situation through the needs and experiences of the client, the agency, allied institutions and the public"* (White and Popovits, 2001: p.7). To promote this, their simple decision-making model is developed around a set of what they consider as core values and principles applicable to the AOD field. An adapted version of the model in the form a worksheet to guide discussion on ethical issues is presented in Appendix B.

If we are committed to ensuring good uptake of an AOD code of ethics, we must therefore consider a range of structures, processes and resources that may be harnessed for this end. The utility of codes of ethics may be undermined if not accompanied by mechanisms designed to promote awareness among professionals (both those established and new to the field), and uptake across the diverse professional groups and settings of the AOD field. In relation to ethics, AOD professionals should be able to readily answer questions such as, "How is this *relevant* for me and my work?" and "How might this be *applied* in my work?"

THE CURRENT PROJECT

Making decisions about what is ethical is about more than just following accepted prescriptions and principles (Benatar & Singer, 2000). The main virtue of ethical principles such as autonomy and beneficence is that they alert us to important ethical issues; they do not solve ethical problems. Such principles must be applied and tested in the analysis of specific cases by a process of

open debate and discussion if they are to be interpreted at the practical or applied level (Fry & Hall, 2005).

As we have seen, the current low profile of ethics in the AOD field represents an area of vulnerability, heightening the potential for preventable ethical breaches and undermining the quality of innovative research and practice. However, in recognising this lack of ethics engagement in the AOD field, we also have an opportunity to consider how AOD ethics may be promoted in sustainable ways that can enhance AOD practice to deliver better outcomes for all.

With these points in mind, the purpose of the current project is to consider how the AOD field may be better sensitised to the everyday ethical challenges that arise in AOD practice (including prevention, intervention and treatment), and how it can actively respond to these in an informed manner. The primary initial vehicle for this is the revised AOD code of ethics. ADCA first endorsed an AOD code of ethics in 1993. However, there have been concerns about the current level of awareness and uptake of this, and developments in the field since the early 1990s have further highlighted the need to revisit the existing code as one strategy for raising the profile of ethics in the AOD area.

The main goal of the project is to facilitate greater ethics engagement in the AOD field, not to prescribe a standard set of values for this area. The current paper provides important background and a content guide for the revised code, as well as a comprehensive consultation process leading to endorsement of the code of ethics for this field. These are written from an applied ethics perspective, informed in part from a communitarian ethics approach, which in simple terms preferences open dialogue around the variety of value perspectives that may exist in relation to the ethical dilemmas arising in the AOD field.

Implicit in this document and accompanying resources is a recognition that ethical challenges in AOD practice often involve tensions between a number of competing principles and values. In reality it is the AOD practitioner that must decide on the balance they will strike in responding to these everyday dilemmas. Codes of ethics and other similar values statements represent core resources for the field in addressing these issues. However, these should be accompanied by methodological guidelines on approaches to decision-making around ethical challenges, and practical guidance in relation to case examples of common ethical dilemmas.[4]

Beyond the anticipated applied utility of this new ethics resource for the AOD field, the project also has broader national relevance for the National Drug Strategy 2004–2009. For example, the National Expert Advisory Panel, as a key level of the NDS advisory structure, is expected to contribute to the capacity of the Ministerial Council on Drug Strategy in relation to a number of areas, including in particular, *"providing advice on current legal, medical, scientific, ethical, social and public health approaches to reducing drug-related harm"* (Ministerial Council on Drug Strategy, 2004: p.20). This project also has relevance for public health generally and is consistent with one of the NHMRC's strategic directives of improving the health of all Australians through (amongst other things) *"promoting informed debate on health and medical research, health ethics and related issues"* (see http://www.nhmrc.gov.au).

[4] Case study resources in public health ethics are available (e.g. Coughlin, Soskolne & Goodman, 1997).

Appendices

APPENDIX A: SAMPLE CHECKLIST OF ETHICS ENGAGEMENT NEEDS

The following is not intended as an exhaustive list, though use of this will assist in providing a focus for considering current needs (at the organizational and/or professional or sector levels) in relation to ethics.

Yes	No	Knowledge & Skills
		Are education, experience and certification/licensure requirements for positions within the agency set at such a level as to increase the likelihood that staff have prior knowledge and skills in ethical decision-making?
		Have ethical issues been addressed within the in-service training schedule, not just as a special topic, but integrated as a dimension to be addressed across all training topics?
		Are there opportunities for staff at all levels to explore ethical issues with other professionals within and outside the agency?
		Does the agency have access to outside technical expertise for consultation on complex ethical-legal issues?
Yes	**No**	**Ethical Standards**
		Does the agency have a code of professional ethics integrated within its personnel policies or corporate compliance program?
		Have staff had the opportunity to participate in the development or episodic review of the professional practice standards?
		Are the ethical standards and values written with sufficient clarity and discussed sufficiently to allow their application in daily problem solving?
		Are violations of ethical conduct addressed immediately and consistently?
		Could staff when asked define the core values of the agency?
Yes	**No**	**Organisational Culture**
		Are ethical issues raised within the context of employee hiring and new employee orientation?
		Do agency leaders talk about ethical issues in their communications with staff?
		Is adherence to ethical and professional practice standards a component of the performance evaluations of all staff?
		Does ethical conduct constitute a core value of the agency as reflected in agency history and mythology, the designation of heroes and heroines, agency literature, storytelling, symbols and slogans?
		Are rituals built into the cycle of agency life that help identify practices that undermine or deviate from aspirational values and which provide opportunities to celebrate and recommit ourselves to those values (e.g. staff meetings, retreats, planning)?
		Are the mechanisms in place through which agency leaders can identify and rectify environmental stressors (e.g. role overload, role conflict etc) that can contribute to poor ethical decision-making?
		Does the agency have an active employee assistance program that addresses areas of personal impairment that could affect the ethical judgement and conduct of staff?

Yes	No	**Ethical Decision-making**
		Have staff been oriented to the multiple parties whose interests must be reviewed in ethical decision-making?
		Does the agency have a clear mechanism for reporting and investigating ethical violations?
		Are the forums clearly defined within which ethical issues can be explored (e.g. supervision, team meetings)?
Yes	**No**	**Ethical Breaches**
		Are the potential consequences of breaches of ethics clearly defined and communicated to staff?
		Does the agency have a clear mechanism for reporting and investigating ethical breaches?
		Are the procedures through which ethical breaches are addressed at the agency clearly defined and communicated to staff?
Yes	**No**	**Other?**

Adapted from White & Popovits (2001)

APPENDIX B: SAMPLE WORK SHEET FOR DISCUSSION ON ETHICAL ISSUES

Adapted from White & Popovits (2001)

ETHICAL ISSUE # ______________

ETHICAL ISSUE: ____

1(a) Whose interests are involved and who can be harmed?

____

____

____

1(b) Which interests, if any, are in conflict in this situation?

Interests & Vulnerabilities	*Significant*	*Moderate*	*Minimal/None*
Client/family			
Staff member			
Agency			
Professional field			
Community/public safety			

2) What universal or cultural specific values apply to this situation?

	Access – ready access to services needed
	Autonomy – enhance freedom of personal destiny (individual and relational)
	Beneficence – help others
	Compassion – embracing the common humanity
	Competence – be knowledgeable and skilled
	Community – collaboration, democratic participation, equity of access, diversity
	Conscientious refusal – disobey illegal or unethical directives
	Diligence – work hard
	Discretion – respect confidentiality and privacy
	Equity – equal treatment for equal needs
	Fidelity – don't break promises
	Gratitude – pass good along to others
	Health – all people have a right to resources necessary for health
	Honesty – tell the truth

	Loyalty – don't abandon
	Justice – be fair, distribute by merit
	Non-maleficence – actively avoid harm to others (individual and social)
	Obedience – obey legal and ethically permissible directive
	Reciprocity – in-kind positive response towards the actions of others
	Respect – prejudice free consideration of the rights, values and beliefs of all people
	Restitution – make amends to persons injured
	Self-improvement – be the best you can be
	Self-interest – protect yourself
	Stewardship – use resources judiciously
	Transparency – openness in relation to the decisions affecting others and limitations

3) What laws, standards, policies or historical practices apply to this situation?

4) Discussion notes

APPENDIX C: RECOMMENDED ETHICS RESOURCES

CODES OF ETHICS

Australian Association of Social Workers
AASW Code of Ethics http://www.aasw.asn.au/adobe/about/AASW_Code_of_Ethics-2004.pdf

Australasian Chapter of Addiction Medicine
Ethical issues in treating drug-related problems (Competency 8 in training manual)
http://www.racp.edu.au/public/addictionmed.htm

Australian Counselling Association
http://www.theaca.net.au/docs/code_conduct.pdf

Australian Medical Association
AMA Code of Ethics (2004)
http://www.ama.com.au/web.nsf/doc/WEEN-5WW5YY/$file/090304%20Code%20of%20Ethics%202004%20(final,%20March%202004).pdf

Australian Nursing & Midwifery Council
ANMC Code of Ethics for Nurses in Australia (2002), developed under the auspices of the newly formed ANMC, Royal College of Nursing Australia, Australian Nursing Federation.
http://www.anmc.org.au/website/Publications/Codes%20of%20Ethics%20and%20Professional%20Conduct%20for%20Nurses%20in%20Australia/ANMC%20Code%20of%20Ethics.pdf
Code of professional conduct (2003)
http://www.anmc.org.au/website/Publications/Codes%20of%20Ethics%20and%20Professional%20Conduct%20for%20Nurses%20in%20Australia/ANMC%20Code%20of%20Professional%20Conduct.pdf

Australian Psychological Society
Code of Ethics, Ethical Guidelines and related resources
http://www.psychology.org.au/aps/ethics/default.asp

The Royal Australasian College of Physicians (RACP)
Ethics Manual for Consultant Physicians
www.racp.edu.au/public/Ethics_Manual.pdf
Ethical guidelines in the relationship between physicians and the pharmaceutical industry.
www.racp.edu.au/public/Ethical_guide_pharm.pdf

Royal Australian and New Zealand College of Psychiatrists
Code of Ethics
http://www.ranzcp.org/pdffiles/ethguide/Code%20of%20Ethics%20Document.pdf

OTHER GUIDELINES

AIVL (2003). A national statement on ethical issues for research involving injecting/illicit drug users. Canberra: Australian Injecting & Illicit Drug Users League. http://www.aivl.org.au/files/EthiicalIssuesforResearchInvolvingUsers.pdf

Australian National Council on Drugs (2005). Alcohol and Other Drugs Charter. Canberra: ANCD. http://www.ancd.org.au

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Witkin, S. L. (2000). Ethics-R-Us. *Social Work. 45*(3). 197–200.

ETHICS WEBSITES

Applied Ethics Resources
http://www.ethicsweb.ca/resources/index.html

Australian Association for Professional and Applied Ethics
http://www.arts.unsw.edu.au/aapae

Codes of Ethics Online
The Center for the Study of Ethics in the Professions, Illinois Institute of Technology, USA
http://www.iit.edu/departments/csep/codes/
(Accessed September 22, 2005)

NSW Health, Health Ethics Branch
http://www.health.nsw.gov.au/healthethics/index.html

Philosophy in Cyberspace
http://www-personal.monash.edu.au/~dey/phil/ethics.htm
(Accessed September 22, 2005)

Procedural Ethics Webliography
Bowling Green State University, USA
http://www.cs.bgsu.edu/maner/heuristics/bib.htm
(Accessed September 22, 2005)

GENERAL AOD ELECTRONIC FORUMS

Drug and Alcohol Nurses Australasia Forum
http://www.danaonline.org/phpBB2/

ADCA Update and Drugtalk
http://www.adca.org.au/drugtalk.htm

NSP Forum
listserv@lists.spmed.uq.edu.au

Australian Injecting and Illicit Drug Users’ League (AIVL)
http://www.aivl.org.au//forum/default.asp

APPENDIX D — SELECT APPLIED MODELS FOR ETHICAL DECISION-MAKING

Benaroyo, L. (2004). Méthodologie en éthique clinique: une approche intégrant les diverses dimensions éthiques du soin. *Medecine et Hygiene,* 2486, 1304–1307.

An applied ethics process, the goal of which is to reach consensus decisions on ethical challenges, through structured open discussion in a series of steps:

1) identify the practical ethical problem
2) identify the client's individual context
3) identify the duty of care responsibilities of each staff member
4) identify the values staff consider essential to responding to the problem
5) identify any conflicting values
6) identify alternative solutions to the ethical conflicts identified
7) choose the consensus option best suited to the program objectives; and
8) provide justification for the choice.

Canadian Psychological Association (2000). Canadian code of ethics for psychologists. 3rd Edition. Ontario: CPA.
http://www.cpa.ca/ethics.html

Present a summary of steps that are claimed to typify approaches to ethical decision-making:

1. identification of the individuals and groups potentially affected by the decision
2. identification of ethically relevant issues and practices, including the interests, rights, and any relevant characteristics of the individuals and groups involved and of the system or circumstances in which the ethical problem arose
3. consideration of how personal biases, stresses, or self-interest might influence the development of or choice between courses of action
4. development of alternative courses of action
5. analysis of likely short-term, ongoing, and long-term risks and benefits of each course of action on the individual(s)/ group(s) involved or likely to be affected (e.g. client, client's family or employees, employing institution, students, research participants, colleagues, the discipline, society, self)
6. choice of course of action after conscientious application of existing principles, values, and standards
7. action, with a commitment to assume responsibility for the consequences of the action
8. evaluation of the results of the course of action
9. assumption of responsibility for consequences of action, including correction of negative consequences, if any, or re-engaging in the decision-making process if the ethical issue is not resolved
10. appropriate action, as warranted and feasible, to prevent future occurrences of the dilemma (e.g. communication and problem solving with colleagues, changes in procedures and practices).

van Hooft, S., Gillam, L., & Byrnes, M. (1995). Ethical Decision Making. Facts and Values: An Introduction to Critical Thinking for Nurses. Philadelphia: MacLennan and Petty.

1. Define the problem.
   a) Be aware that, in defining the problem, you are also defining the range of possible solutions.
   b) Define the problem in such a way that the range of possible solutions is maximized.
2. Gather information.
   a) Collect information that is relevant to the problem as defined.
   b) Organize this information by category.
3. Identify constraints that limit possible solutions.
   a) Consider facts about the situation that cannot be changed.
   b) Consider limits or requirements imposed by the problem-solver.
4. Generate possible solutions (or courses of action).
   a) Generate as many different courses of action as possible, virtually all possibilities.
   b) Include non-action as one possibility.
5. Identify criteria for judging the best solution.
6. Evaluate possible solutions according to these criteria.
   a) For each possible solution, list advantages and disadvantages relative to these criteria.
   b) Will the solution actually achieve what is wanted?
   c) Will the solution violate any of the constraints identified earlier?
7. Select the solution that best fits the criteria.
   a) If the criteria are ranked or can be ranked, identify the solution that best meets the most important criterion.
   b) If the criteria are unranked, identify the solution that best meets all the criteria.
8. Implement the solution.
9. Check progress of the solution.
10. Modify the solution, if necessary.

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