Groupe Pompidou
Pompidou Group

COUNCIL OF EUROPE CONSEIL DE L'EUROPE

Strasbourg, 16 December 2011 **P-PG/Work(2011)9rev1_en**

AD HOC EXPERT GROUP ON THE PREVENTION OF DRUG USE IN THE WORK PLACE

Second meeting

Council of Europe,
Room 14, Palais de l'Europe, Strasbourg

20/21 November 2011

REPORT

MEETING REPORT

1. Introduction

The meeting was opened by the Expert Group's Chair who welcomed the participants. The list of participants is reproduced in Appendix I. The agenda was adopted as reproduced in Appendix II. The Chair asked the participants to present themselves. Finally, he gave a summary of the decisions taken at the first meeting.

2./3./4. Presentation of the background working document / examination of working framework made in the synthesis report by the consultants and the chair/ In depth-considerations presented by the consultants

(See documents (P-PG/Work(2011)7), (P-PG/Work(2011)5) and Annex III and IV of the present report)

The Chair presented the contents of the synthesis based on written national contributions and elaborated in co-operation with the consultants (P-PG/Work(2011)7) as a basis for reflexion and debate.

The written contributions of delegations are compiled in document (P-PG/Work(2011)5).

These national positions - as comprised in the compilation document or as stated in the first meeting - will not be repeated in this report. The specific considerations submitted by the consultants are reproduced in extenso in Annexes III and IV of the present report. An amended version of document (P-PG/Work(2011)7) comprising new substantial remarks made at the meeting will be circulated at a later stage.

In addition to these positions, participants highlighted inter alia the following points:

Chair:
In accordance with the agenda, the Chair informed the experts that

- there had been a change in French legislation since the group's first meeting: the Law of 20 July 2011 on the organisation of occupational health services made occupational health doctors responsible for preventing alcohol and drug use in the workplace. This new, higher profile combined with an opinion issued by the National Ethics Committee made it possible, in the case of certain safety and security posts indentified jointly by all the parties, to carry out random drug and alcohol testing under the responsibility of the occupational health doctor if provision was made for this in the company's internal rules.
- the results of a survey on psychoactive substance use by economically active persons were about to be released in France (indicators designed to put drug-use events in context and compare them over time. Declarative survey of a sample of 27 600 individuals).
- it was planned to undertake research into the prevalence of drug use in the workplace as part of the new French Plan against Drugs and Drug Addiction (2012-2015).

After announcing these new developments specific to France, the Chair reminded the experts of the three main concerns underlying the group's work:

- **the determinants of drug use**: while drug use was an aspect of an employee's private life which could intrude into his or her working life, it could also be the consequence of a working life subject to excessive pressure which in turn put the employee's private life under pressure. From the legal standpoint, how could one

distinguish between these determinants? From the standpoint of values, could a clear line be drawn between private and public life? How?

- **the responsibility of employers** in terms of promoting employee health and preventing risks. This raised questions on the one hand about the legal uncertainty in which employers found themselves and on the other about the means available to them to meet their obligation to achieve a result. What role could be played by screening tests and what justification could there be for them? Should they be conducted under the exclusive responsibility of occupational health doctors or by other health-care personnel to whom responsibility was delegated for this purpose, or who had a shared competence for administering the tests or interpreting their results?
- **lastly, the expected outcome** upon completion of the group's work: how could a framework for intervention in the workplace be proposed which incorporated elements of specific national approaches but was at the same time broad enough for actions to be renewed on the basis of the principles of responsibility, transparency and respect for individual and collective freedoms; which prompted discussion among the stakeholder categories concerned and was taken on board by each of them to a greater or lesser extent; and which was acceptable to the Council of Europe and of interest to international organisations active in the field?

Mr Parquet (consultant):

- If we are interested in the functioning of the enterprise, why should we further specify an identified risk?
- Why should we only recommend prevention measures for security posts?
- There is a need to reflect on the subject of shared competencies. The sanitary approach would not cover all aspects of the prevention problem. In this view, an integration of the sanitary and the security approach is to be developed.
- Accidents do always have multifactoral causes. How can we attribute the result to the cause of drug use? How can we link dysfunctional behaviour to drug use? Isn't the fact that the drug is illicit enough?
- Concerning drug screening: What should be the objectives and the consequences of these tests? They are a legal issue putting at stake the professional life of the employee.
- Should we look into the link between the task and competence level of a post and addictive behaviour?
- We have to trust the company, when it comes to the choice of primary and secondary objectives of prevention.
- The examination of dysfuntionality circumvents the moral approach of dependency and addictive behaviour.

Mr Windey (consultant): Different substances play a role in different working environments (e.g. beer in brasseries). Do we have to look into the effect of the offered supply on personal use? There is no system to define "optimal functioning" at the workplace. Without detailed description of the expectations, no comparison is possible.

Luxembourg:

- The Health Minister had asked the social partners for a clarification of their position in the matter. In one of the answers received the accent was placed on the polarity between individual freedoms and the employer's obligation to guarantee health and safety of the workers. From this perspective, the Council of Europe is a perfect place to deal with the matter.
- There is a need to look at each post in order to identify the level of security needed.
- An inventory of risks was established on the basis of the enterprise's obligation to undertake regular screening with regard to certain security posts.

Belgium: New research will be launched looking into problems encountered by general practitioners and occupational doctors concerning health supervision. The Belgian approach consists in giving the managers in the field tools for a prevention policy distinguishing the individual and the collective level. Risk assessment should be multidisciplinary. A prevention policy has to take into account the concrete working conditions. The respective law of 1996 obliges employers to introduce prevention policies, among those employers is also the public sector.

Italy: There are two types of risks; the specific risk related to drug use at a specific post and the general risk caused by drug use in the working environment. Drug abuse has two aspects to be looked into: the fact of working under the direct influence of drugs on the one hand, and the general addictive behaviour, which may lead to concrete drug use in the future. There are two approaches concerning testing: the test can occur immediately after a work shift (to investigate if the employee has worked under the influence of drugs or alcohol) or testing can be a requirement to obtain a "license" for a specific job. Testing is under the responsibility of the occupational doctors. For the assessment of the fitness of the employee for "safety sensitive", there should be objective criteria. Fitness to work can only be certified by the occupational doctor. Occupational doctors are co-responsible (with the employer) for prevention strategies, taking into account the parameters of the company. Urine testing, organised by the occupational doctors, are foreseen for safety sensitive jobs. The positive results have to be checked by external laboratories with high accurate methods (based on mass spectrometry). Reporting of confirmed positives to the employer is mandatory, and the consequence is suspension of the specific "risky" activity. The employee is then directed to the Departments on Substance Abuse of the National Health Service for the differential diagnosis of "addiction" or "occasional use". Occasional use falls under the realm of influence of the occupational doctor. In case of substance dependence, the employee can follow disintoxication programmes under the responsibility of the Departments on Substance Abuse of the National Health Service. In case of traffic accidents (which represent a relevant percentage of occupational accidents), there is systematic drug testing; which, unfortunately, is not the case for other types occupational accidents.

Norway: Risk assessment should take a selective focus as certain positions are more at risk than others. Risk assessment varies according to companies. There are links between the type of job and the addiction risk (e.g. jobs implying travelling, managers, etc.). A selective approach has also to be taken, when it comes to testing. Drug testing does not play a big role in prevention policy. On the internet, plenty of recommendations how to circumvent drug test can be found. Companies are given a tool box and each of them has to decide which of the tool is useful in its specific context. Much has still to be done, as the drug use at the work place is a taboo area. Trade unions and employer's organisations have to be involved. Certain elements can lead to deduce a suspicion of addictive behaviour, which the employer may wish to discuss. Prevention policy is also about finding a language for the expression of the problem. There is a Nordic network working on alcohol prevention.

France: Certain drugs are taken to enhance performance, which poses new difficulties. We need to take into account safety, health and security, even harm reduction aspects to make things work. In certain specific cases, local solutions have to be found.

Chair: The provisional conclusions which could be drawn from the presentations included

- the potential impact of drug use outside working hours and outside the workplace on the health and safety of the individual, third parties, the working community and the tools of work, and hence the risk of there being no clear watertight boundary between public life and private life where drug use was concerned;
- the need for a prevention approach incorporating all the different factors in a systemic manner: organisation of work, working conditions, interpersonal relations

within the working community, recognition of the specific characteristics of each category of personnel;
- the intellectual need to distinguish between areas of consensus and areas requiring consultation;
- the fact that risk assessment, based on the implementation of a European Directive, could be usefully extended to drug prevention in the workplace.

5. Preliminary exchange on the organisation of the 2012 Conference on alcohol and drugs and prevention policies, Strasbourg, 14/15 May 2012

(See document (P-PG/Work(2011)8prov) and Annex VI of the present report)

Participants held an exchange of views on potential speakers and the contents of the programme. A draft programme has been developed as reproduced in Annex VI. Participants agreed on the above title of the conference in a subsequent written procedure and confirmed the political profile for participants as defined in the first meeting. Participants underlined that the conference should be a political and not a technical event. The Conference is scheduled for 14 May afternoon and 15 May finishing at 16.00.

The detailed objectives of the conference are to be worded by the Chair and inserted into the programme by the Secretariat. Invitations to the Permanent Correspondents will be circulated after the completion of the programme with the details of the speakers.

The final product of the conference should be a reference framework to be drafted by the Chair in collaboration with the consultants summing up the work undertaken by the ad hoc expert group and taking into account the contents of the debate taking place at the conference. A draft of this reference document will be circulated to registered participants prior to the conference. A final consensual version will be established after the conference.

6. Any other business

None.

7. Date of the third meeting of the ad hoc expert group

Participants agreed to convene the next meeting for 9 and 10 February 2012 in Paris.

APPENDIX I

LIST OF PARTICIPANTS

Ad Hoc Expert Group on the prevention of drug use in the work place

Strasbourg (France), 21-22 November 2011

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APPENDIX II

Agenda

1 **Opening of the meeting:**

- adoption of the agenda
- recall of decisions taken in the first meeting
- presentation of possible new participants
- possible information on new developments or recommendations on a national or international level

2 **Presentation of the synthesis report**

established by Mr Michel MASSACRET (MILDT), Mr Philippe-Jean PARQUET (psychiatrist, addictologist) and Mr Paul Windey (National Work Council of Belgium) on the basis of submitted national contributions

3 **Detailed examination of working framework made in the synthesis report by the consultants and the chair**

4 **In depth-considerations: "Drug consumption by the active population"**

- intervention by Mr Philippe-Jean PARQUET (psychiatrist, addictologist) on the individual factors of protection and vulnerability to take into account in a prevention strategy;

- intervention by Mr Paul WINDEY, lawyer (labour law), President of the National Work Council (Belgium) on the collective factors to be taken into account in a collective prevention strategy at the work place.

5 **Preliminary exchange on the organisation of the 2012 International Conference**

- exchange on potential speakers and the contents of the programme;
- title of the conference;
- confirmation of the participants' profile as defined in the first meeting;
- list of tasks to be accomplished by delegations, Permanent Correspondents, the Secretariat and the Presidency;
- date of the conference.

6 **Any other business**

7 **Date of the third meeting of the ad hoc expert group**

Paris, February 2012

APPENDIX III

CONTRIBUTION BY PROFESSOR PHILIPPE JEAN PARQUET
Strasbourg, 21 and 22 November 2011.

THE CONCEPT OF ADDICTIVE BEHAVIOUR:
The drawing up of any policy relating to addictive behaviour depends on the definition of such behaviour. And any attempt to harmonise policies in this field is dependent, first and foremost, on a common conception of the question. This is the first point of my contribution. I should immediately point out that our conception of this question has varied over time, and that these changes have given rise to different approaches which continue to co-exist.

THE EXCLUSIVELY “PRODUCT”-ORIENTED APPROACH
In the light of the data acquired from scientific research, an emphasis was placed on an approach based primarily on “products”. Data obtained from pharmacology and, more recently, neuro-psychopharmacology made it possible to understand more fully the effects of psychotropic substances on the central nervous system and the whole body. This provided greater insight into the clinical effects, and especially the behavioural effects, of acute or chronic consumption of these substances. This led to an emphasis being placed on the differences between these substances. Tobacco, alcohol, heroin, cannabis and amphetamines were primarily viewed in terms of the inherent properties of each individual substance. And this, in turn, gave rise to a conceptualisation, perceptions, and health, social, cultural and legislative policies specific to each product; the terms used were alcoholism, tobacco addiction, addiction to heroin, cocaine, etc. Consumption of these products was seen as intoxication, but intoxication which could be dealt with through a health-care approach, based on weaning and advocating abstinence. Consequently, the health, social, regulatory and legislative arrangements had to be different. This approach, exclusively based on “products”, was the dominant approach until quite recently. In addition, the familiarity of a given population group with a specific product meant that the consumption of certain products (for example, alcohol) was made legal, and the consumption of others (such as cannabis and cocaine) was declared illegal. In such a situation, it was essential to penalise consumption, forbid the supply of these products and penalise trafficking/dealing. Lastly, the ability given to us to use these chemicals to modify our mental, emotional and social life, and our ability to give ourselves pleasure led us to incorporate these consumption behaviours in our individual and collective social and moral frameworks.

THE CONCEPT OF PSYCHOACTIVE SUBSTANCES
Our conception of drug addiction, alcoholism and smoking was based primarily on this approach. However, a better understanding of the neurobiological mechanisms of human behaviour has put paid to this overly simplistic approach in two ways. All these substances have something in common above and beyond their own pharmacology: they act on the central nervous system via the same neuro-transmitter, dopamine, on a specific part of the brain – the reward system. The effect of this is to encourage the individual to repeat the behaviour providing pleasure. This is called the substance’s addictive power. All these substances should therefore be seen as one large category: psychoactive substances. This conceptual revolution explains the developments we are seeing.

ADDICTIVE BEHAVIOURS – Adopting a human behaviour-oriented approach. The consumption of psychoactive substances can no longer be considered as intoxication but as multi-determined human behaviours, having common characteristics, in particular a propensity to repetition and the probability of developing into dependence.

ADDICTIVE BEHAVIOURS – A set of behaviours

The types of behaviour can be divided into three families: dependence, abuse (i.e. consumption giving rise to impairment, and psychological, somatic, social, cultural and economic damage) and self-regulated or socially-regulated use.

DEPENDENCE is easy to identify. It is a maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the DSM (APA) criteria. These criteria have been internationally validated. Two of these criteria are of more particular interest for our purposes: inability to stop consumption even if one wishes and despite the fact that one is fully aware of the adverse effects caused; - reducing or renouncing everything unconnected with the consumption, which occupies virtually all the individual's personal space. Even though dependence is not the most frequent form of addictive behaviour, it is the most serious and the most detrimental for the individual; it seriously adversely affects that person's whole life. And it is particularly harmful to employees in terms of their occupational performance. It is a pathological form of behaviour which needs to be addressed from a health-care perspective. It therefore requires a multi-faceted approach in a work setting: identification by management, diagnosis by the occupational health team, referral to an outside specialist treatment centre, assistance and support in this regard, and reintegration into the company after the period of treatment. It is in the company's interests to identify dependence because of the harm it can cause and the dangers for safety that it represents.

ABUSE
This is the most frequent form of addictive behaviour. It refers to acute, sporadic but intense or chronic consumption of psychoactive substances. It does not necessarily mean a high level of consumption of products – in certain situations the consumption of a small quantity can have serious consequences. This form of behaviour gives rise to physical, mental, psychological and behavioural harm. Its intensity varies considerably but the following criteria are always present:

- recurrent substance use resulting in a failure to fulfil major role obligations at work, school, or home;
- recurrent substance use in situations in which it is physically hazardous
- continued substance use despite having persistent or recurrent social or interpersonal problems" DSM (APA).

This form of behaviour requires an approach to deal with the addictive behaviour itself and a specific approach to address the type of harm caused, for example, health risks, behavioural problems, safety risks, etc. This type of behaviour is the type most often encountered in the work environment and the one which raises the most problems in terms of identification and management. It is essential to be attentive to identifying:

- a deterioration in the individual's occupational performance,
- probability of a situation or behaviour posing a risk for the safety of the individual or others
- health problems in an individual
- risks for the company.

The company's policy must no longer be solely safety-oriented but also incorporate a health-oriented approach. The implementation of these two approaches must be clearly set out. The roles of the various players and processes must be contractually defined: management must be responsible for identifying a dysfunctioning or a potential risk, and the health-care team must be responsible for diagnosing it as the symptom of addictive behaviour and specifying the measures to be taken or recommended.

SELF-REGULATED OR SOCIALLY REGULATED USE

This covers behaviour which causes neither harm nor obvious deterioration of abilities and performance. Nonetheless, such behaviour poses a risk, as it could signify the beginning of a shift towards abuse or dependence justifying involvement by the medical profession, and under the simultaneous influence of certain factors could give rise to dangers to health and safety. This is a particularly sensitive form of behaviour to deal with, since it is a matter of identifying a potential risk which is not indicated solely by consumption behaviour, but also by the combination of other potentially problematic factors.

ADDICTIVE BEHAVIOUR – AN ASPECT OF HUMAN BEHAVIOUR

Like every human behaviour, there are many causes of addictive behaviour.

Clearly, it is caused by the specific pharmacodynamic properties of the substances consumed. The effects and repercussions of alcohol, cannabis and psychoactive substances are all different. For an equal level of consumption, some people have protection factors which shield them from the addictive power of a substance or other harmful effects, whereas others have factors of vulnerability that are conducive to the development of an addiction and the occurrence of harmful effects. These factors are genetic, biological, psychological or psychiatric. Consumption can give rise to physical illnesses, and especially mental illnesses, depression, behavioural and personality disorders, schizophrenia and intellectual deficiency which could seriously affect the individual's capabilities. Consumption is influenced by the availability and accessibility of products, and by the level of consumption in the individual's own social group. Acute, intense, episodic or regular consumption patterns undoubtedly have a significant influence. It is essential to look at the conditions and context of consumption in order to understand its effects. Alcohol consumption among pregnant women represents a specific teratogenic risk for the foetus, and the effects of alcohol consumption on driving are a further case in point. Working conditions can affect the appearance and consequences of consumption behaviour. This is referred to as a situational factor, which is always difficult to appreciate. This means that working conditions may be considered as conducive to the development of addiction. Here we are talking of induced behaviour, which is distinct from consumption behaviour in day-to-day life. It can also be referred to as imported behaviour or adaptive addictive behaviour. Attention should also be drawn to the difference between individual consumption behaviour and collective consumption which is often an integral part of the life of companies and groups. Here, different approaches are required.

CONCLUSION

For a policy to be consistent, we have to share a common conception of addictive behaviour and the many diverse forms it can take. The roles of the various players must be clearly defined. For employers, the market value of its work is based on the employees' skills, and on everyone's ability to adapt and sign up to the company's aims. Consequently, it is for the company to spot any dysfunctioning in the performance of duties, which may possibly be caused by addictive behaviour; it is for the medical team to make the diagnosis. Recourse to outside operators must be specified in an agreed list of relevant objectives. The safety-orientated approach and the health-oriented approach must be pursued simultaneously. The policy for preventing safety risks and the policy to prevent damage to health must be drawn up and implemented as part of a concerted and contractually negotiated process. The company's policy on addictive behaviour must be consistent with the company's policies on other subjects and with national policies.

APPENDIX IV

Contribution to the "Collective prevention" component

Paul WINDEY, Jurist (labour law)

Strasbourg, 18 November 2011

Need for a preventive policy (Psychoactive Substances – PAS) in enterprises

- The diversity of the products concerned (illicit drugs, alcohol, other psychoactive substances) renders a purely prohibitive policy ineffective. At the intersection of multiple obligations and fundamental freedoms, disciplinary action cannot suffice.
- The growing complexity of corporate life aggravates exposure to the consequences of PAS consumption in terms of:
    - Disruption of organisation and productivity
    - Impairment of workers' capabilities
    - Risks to health and safety for workers, their colleagues and possibly others
    - Relations between colleagues
- Problematic PAS consumption seriously worsens these consequences, as regards the worker's health as well as risks to him/her self, colleagues, others and/or corporate assets.
- Even if not all the workers are individually confronted with the issue, it is a factor that can adversely affect the safety, health and well-being of them all.
- There is a clear interaction, also to be taken onto account, between the use and the consequences of PAS outside and inside the enterprise.These include commuting accidents.
- The employer has prime responsibility for the preservation of workplace health, safety and well-being.
- It is in the interests of everyone in the enterprise to improve functioning on the job, and to guard against and remedy dysfunctions.
- A preventive policy on PAS thus has its proper place in the enterprise and should be incorporated into the principles of prevention, which in most countries is prescribed by the legislation (see EU Directive EEC 89/391).
- Screening (testing/detection) may be authorised subject to certain conditions to be determined, under the responsibility of the competent services (health/safety), for specified security and safety appointments and functions, complying with the framework in which they may be justified, performed, regulated or prohibited.
- Several countries have already devised, or begun considering, a preventive policy at the level of the enterprise (Luxembourg, Norway, Portugal, Slovenia, Sweden, France, Belgium).
- **Need to involve the corporate partners and the workers**

- There is still too frequent unawareness, sometimes even denial ("tabooing") of PAS consumption (Luxembourg, Greece, Lithuania).Dispelling this denial and making PAS policy part of corporate management will be more promising and effective if, at the level of each enterprise, the workers and the employer frame a PAS policy in concert.

- The very effort of organising reflection and opening debate at the level of the enterprise vouches for success.
- This reflection organised at the level of the enterprise also ensures that its specific features are taken into account: a nuclear power station is not like a restaurant...
- For the exercise to be credible, it is important to target and cover the whole staff and to apply the rules consistently to all categories of workers as well as to the management.
- Modern corporate management necessitates transparency, predictability and objectivity where rights and obligations are concerned. All workers should be informed and involved. The more consensus on the corporate PAS policy, the better the chances of its being effective and followed.
- Striking an even, accepted balance between employers' prerogatives and protection of privacy is essential, above all for testing and reporting of the results.
  - **How to facilitate the collective and preventive approach; factors of success**

  - Each country has a specific structure, legal landscape and approach, so this legal architecture should **integrate the collective and preventive approach**.

    A survey and a description of this legal landscape taking in all its facets are therefore most useful:

    - General anti-drug policy, sectoral policies
    - Prevention policies in the public health sphere
    - Social security provision (prevention, curative approach)
    - Rights and obligations of employers/workers (national law, treaty law, employment contracts, internal rules, etc.)
    - Right to protection of privacy
    - Health policy, health/safety at work

    Collection and dissemination of statistical data can fuel and objectify the debate.

It is necessary to have coherence between these various facets, indeed an **integrated strategy**, hence the value of collaboration between the various competent authorities.

- A "top down" approach imposing a "one size fits all" policy can hardly be effective. On the contrary, regard should be had to the possible risks and remedial capabilities, which depend on the size of the firm, its structure, methods and working conditions, as well as the products and its relations with the outside world (customers, distributors, sub-contractors, etc.).This exercise therefore needs to be planned **at the most suitable level**. The corporate partners at the level of the enterprise (the existing entities) are the best placed in that respect.
- However, an impetus, even an "**obligation of best endeavour**" (law or formal undertaking by the corporate partners) can assist the actuation of this exercise in all enterprises (Belgium, France, Sweden, Norway).
- It would be advisable to lay down the **basic principles and the essential conditions** for the success of the preventive action, for example:
- it should be organised at all phases of the risk:
  - at its source, in order to avert it (abide by health and safety rules, establish procedures, awareness-raising actions) or
  - when the risk supervenes (moving the worker away, supportive measures)

    - be tailored to the enterprise
    - comprise several fields: risk analysis, measures to be taken by the employer, workers' information and training, obligations of the line of command and the workers, role of internal and external agencies, operating problems due to any problematic consumption of PAS, prevention, rapid reporting and remedying of operating problems, co-operative definition of the policy, together with its periodical monitoring and evaluation.
    - it should be sustained by the management
    - it is crucial to have the broadest possible commitment of the workers and the employer
    - concern the workers as a whole
    - foster a climate of openness and trust
- Preparation and application of a prevention policy, or comprehensive prevention plan at the level of the enterprise, require a **structured and phased approach**, activating all the internal links of the enterprise.
- Close attention should be paid to the **rules of screening** (testing/detection) for which the conditions, authorisations, rights and obligations should be clearly established.
- There are numerous tools to help set up and implement this exercise, according to the size of enterprises, eg practical guides, "roadmaps", survey of aspects to be addressed, and examples of good practice.

It would be desirable to assist **distribution of and access to these tools**, if possible electronically.

No need to reinvent the wheel (see France: "Repères", Belgium "Vade-mecum", Sweden "Risk use Model", Norway "Akan-Method book")

APPENDIX V

ALCOHOL, DRUGS AND PREVENTION IN THE WORKPLACE: WHAT ARE THE ISSUES AND CHALLENGES FOR THE GOVERNMENT, THE COMPANY AND THE STAFF?

DRAFT PROGRAMME

MONDAY, 14 MAY 2012

14.00 – 14.10	Welcome by Mr Patrick Penninckx (Executive Secretary of the Pompidou Group)
14.10 – 14.30	Opening by Mr Etienne Apaire (President of the Pompidou Group)
14.30 – 15.00	Presentation of the reference framework resulting from the work undertaken by the Ad Hoc Group of Experts (elements to be taken into account and articulated when operating choices in the implementation of prevention policies by Mr Massacret, Prof Parquet and Mr Windey)
15.00 – 15.15	Questions/answers
	Outlook of international organisations:
15.15 – 16.00	Presentation of ILO, Business Europe, ETUC on their field of activities with regard to drug use at the work place
16.00– 16.30	Coffee break
16.30 – 16.45	Presentation of WHO Europe on relevant activities with regard to drug use at the work place
	Preventing drug use and related risks at the work place: which issues?
16.40 – 17.00	“Challenges for society, enterprises and staff with regard to drug use at the work place” (Sweden)
17.00 – 17.20	“Changes in drug markets: current situation and future

	challenges for the prevention of drug use at the workplace" (Italy) – to be confirmed
17.20 – 18.00	Questions/answers

TUESDAY, 15 MAY 2012

Preventing drug use and related risks at the work place: which challenges?

9.30 – 10.00	"Parameters to be taken into account in view of making a prevention policy acceptable in the enterprise" (Luxembourg)
10.00– 10.30	"Major challenges encountered in the field when putting into place prevention policies and suggestions for solutions" (Belgium)
10.30 – 11.00	Coffee break

Types of prevention

11.00 – 11.30	"Different types of prevention et good practice models" (Slovenia)
11.30 – 12.00	"Risk evaluation in the enterprise: Can professional risks related to drug use be inserted into risk evaluation protocols? On which conditions? With which specificities?" (European Dublin Foundation)
12.00 – 12.30	"New evidence-based prevention programmes taking into account shifts in life style and in the representation of drug users in the eye of the public" (Norway)
12.30 – 14.00	Lunch break
14.00 – 16.00	Debate in the light of the various contributions of the reference framework presented in the opening session