



The UK Drug Policy Commission launched with a fanfare of media coverage and high profile support in April. **DDN** visited new chief executive Roger Howard to find out why.

Quest for evidence

In the run-up to a new drug strategy, there is a discernable thud of documents landing on the mat.

Among them, 'An analysis of UK Drug Policy', from the newly formed UK Drug Policy Commission. Drawing on a wide range of expertise, the academic authors looked at what's working in drug policy, and what's not, with the conclusion that there had to be some fundamental changes in approach. The recommendations will underpin the work programme of the UKDPC.

So who are the UKDPC and what will they do with a £1.1m grant from the Esme Fairbairn Foundation over the next three years? What's their remit? And who's in charge?

In the heart of Mayfair, just behind The Ritz, chief executive Roger Howard is enjoying spacious offices before his newly appointed staff – a director of policy and research, and a head of communications – join the team. The offices, which are actually part of the Esme Fairbairn Foundation headquarters, feel as well connected as the new commission – a panel of eminent public figures and academics from diverse backgrounds and areas of expertise, chaired by Dame Ruth Runciman.

But there is an ambitious programme ahead for the next three years, with the first projects defined before the new staff are in their seats. Howard is keen to emphasise, from the word go, that his organisation is not about to replicate what other organisations are doing already.

'We are not a membership body, and we do not speak for a certain constituency,' he says. 'We're not a campaigning organisation either. I suppose the only thing we would campaign on is the need for more evidence and research.'

Neither does he see UKDPC as 'holders of knowledge'. They are, he says, uniquely placed to bring together existing evidence in a systematic way. 'We're going to support rigorous collection and analysis of evidence', he says – and make sure it gets to the media, politicians and the general public, to generate 'a more informed dialogue'.

Many people in the drugs and social care field know Roger Howard already. Until February this year he was chief executive of Crime Concern for three years. Before that, as head of the Standing Conference on Drug Abuse (Scoda), he steered the organisation through its merger with the Institute for the Study of Drug Dependency (ISDD) to lead the newly formed DrugScope for another three years. Further back, during a spell at Nacro in the early '80s, he became particularly interested in drug policy, using experience from a Winston Churchill Fellowship to bring ideas on US community based drugs programmes back home. His name soon became linked with drug and alcohol policy development, including setting up drug action teams in the '90s.

But while he has operated for years at a strategic level, as a consultant and in his senior executive roles, he describes his interest in drug and alcohol issues as a 'journey'. Back in 1975 he worked in corporate planning in Lewisham, 'doing a lot of stuff around corporate development, because it had places like Deptford and New Cross, which were going down the plughole at the time'.

'This was a time when the docks were closing and there was a huge amount of disadvantage,' he recalls. 'And there were major concerns about what we now know as Black and Minority Ethnic Communities and about the real difficulties they had.'

He was lucky that Lewisham was 'pretty advanced, with a very interesting political make-up', he says. Engaging community organisations as well as public services was high on the local agenda, so he worked with police, social services and the health department to build 'community responses to what were essentially major social problems'.

'Drugs didn't really figure in that

day and age; they didn't really pop up on the radar in any significant way at all,' he reflects. Then came a spell working in an East London borough, where he led the local authority side in responding to the closure of two large psychiatric hospitals. It gave him as a crash course in 'health services on the ground – what we now see as community care' and an insight to people in mental health services that were using cannabis. Coupled with the memory of an old schoolmate who had died of a heroin overdose, he realised he cared about the issues and needed to pursue his interest.

While organising training on drugs, alcohol and homelessness for Nacro, Howard had chance to consider how communities could engage with crime prevention – 'the health and crime interface' that made up a vital part of his picture. 'I'd had this long interest in drug problems and how they connected,' he explains. 'I'd had a local authority perspective, worked closely with the health service and police for many years, managed treatment and prevention services, and been responsible through consultancy work for working with commissioners, while developing infrastructure around quality.'

Observing what worked and what didn't, underpinned Howard's work for the Department of Health on planning and commissioning, and laid the foundations for setting up drug action teams. It was also a valuable rehearsal for his new role at UKDPC. He has a magpie's eye for evidence – from the Effectiveness Review in 1996 to the Spending Review in 2000, and the trials and successes of the National Treatment Agency since it geared up to 'provide a service to a growing field of newly emerging commissioner, a whole raft of initiatives and a burgeoning treatment field', in 2001.

Over the next three years he will use this experience to direct the UKDPC towards evidence of what works and what doesn't, in the drugs field. He has made clear that he wishes to steer briskly through previously trampled territory, acknowledging the field's successes and addressing failures by looking at what's working in other areas of public health.

'I do think we are at great risk of polarising this dialogue,' he says. 'What people who argue that it's one or the other – it's a health problem or it's a crime problem – what they're at risk of doing is resorting to a very simplistic analysis of this major

complex social problem.'

With three years to redress the lack of evaluation and research in this country, the work programme swings into action this month, with the Commission's next quarterly meeting and the arrival of the new staff. The UKDPC's first major piece of work will be looking at interventions in the criminal justice system – a project 'that's going to hit fair and square on what are the lessons and sustainability of the Drug Interventions Programme'.

The second piece will be around drugs and BME communities, tackling questions such as: 'When they are in treatment services, how do people in BME communities fare?'; 'Is it true that there seems to be disproportionate arrest and imprisonment?'; and 'Is there any truth in the belief that particular BME groups are more engaged in drug gangs?'

Is Howard worried about delivering within a three-year timescale? He brushes off the suggestion: 'A time span of three years can concentrate the mind to make sure there's a driving force behind us, to make sure we deliver,' he says.

Mentioning that the next three to five years will be 'so constrained in terms of resources, [with] this pressure, this constant pressure on value for money', he issues an open invitation, 'to commissioners, organisations, treatment organisations, police – whoever you are', to join the process of feeding in literature, service reviews, 'grey evidence' and internal reviews, to contribute to the data bank.

'If you can get enough of those, they build up into a systematic picture,' he says. 'They may not be the same quality as gold standard randomised trials, but they're absolutely invaluable.'

'You can't be stuck in the past, you've got to look forward,' he adds, warning to his theme for a final time. 'Let's acknowledge where we've come from, because this whole field has gone from strength to strength. Now's the time to start asking some critical questions as it goes into the next phase of development.' **DDN**

To submit information or research to the UKDPC, email info@ukdpc.org.uk or call 020 7297 4750.

More information on the UKDPC's work and commissioners is on their website, www.ukdpc.org.uk



I used to have a drug problem, but since getting clean have enjoyed my job as a drugs worker. A few months ago I relapsed for the first time. I took leave from work and booked myself into treatment, determined to sort myself out. My problem is that my counsellor at rehab is threatening to tell my employer about my relapse, saying that she has a duty to protect my future clients. I am horrified, as I thought my confidentiality was protected when I went into treatment. Please can anyone advise me on my position? Amy, by email

Flagrant disregard

Dear Amy

I read your letter in absolute despair, disgust and disbelief that anyone could be treated in the way you describe. Unfortunately, of course, I also totally accept and trust that this has happened and I know I should be shocked, but I am not.

Your confidentiality is paramount here and that is final. I am so fed up with listening to stories with this common thread of very poor keyworking and the flagrant disregard some workers have for their clients' basic human rights – let alone their right to an individual package of care which begins and ends with confidentiality and consent to share information.

Your treatment, therapy and recovery is what this person should be concentrating on, and how to best support you on this journey – to enable you to get back to work and continue to help the vulnerable, not wreck your career and the future lives of the people you will work with because of their lack of understanding of the protocols or guidelines that govern their work and protect you.

Best wishes to you,

Ahmed, by email

Trust and rejection

Dear Amy

Firstly, I would like to congratulate you in accepting that you needed more support from your relapse and went into treatment to seek support and more understanding as to why this happened.

To me you write as a sound person and a giver, which is so common for us addicts. However, having yourself worked in a rehab, you know it can be very emotional, stressful and mentally painful sometimes when you're working with ill

people just coming into treatment. Maybe something has been said, or you brought up issues from the past you had not dealt with, that were in your subconscious.

Amy, I can understand why you are horrified that your councillor feels she has a duty to protect future clients coming into treatment. You're not on your own: I know I cannot work in groups, rehabs etc as I feed into others' pain. But it is wonderful that you are determined to sort yourself out once and for all: go for it, lock stock and barre! You are the most important person in this world and if you cannot sort yourself out or recover, then it's a fact – you are no good to anybody else at all.

Look after yourself. Yes, I can see you are horrified with your councillor, because it brings up trust and rejection and for you – maybe more; yet she sounds professionally wise. Please try not to beat yourself up over this. Ask yourself: would you want a user, addict member of staff supervising you? I feel you know the answer – yet addicts as we are, we sometimes need the final hurdle to jump from others understanding and supporting.

Sort all your issues out and look after yourself. Use all the past as a learning process, and you will become stronger, wiser and more able to cope.

I sincerely wish you the best, and that you can decide what is best for your wellbeing. Take care,
Sean Rendell, by email.

Borderline case

Amy,

Are you worried that you might lose your job if your counsellor and employer communicate? Before getting into questions about the rules of confidentiality maybe you should look at your own position as a recovering addict from your position as a drugs worker. If you have

worked in rehabs, you will have experienced the situation in groups where some clients focus too much on their own people's problems thus ignoring their own. Such behaviour is called externalising, denial or deferment and needs to be challenged as a renowned predictor of relapse. So challenge yourself: Maybe you shouldn't be working to help others at this time? There's an old saying: 'You need to be able to help yourself before you can help others.'

As to your counsellor, empathise and think of what you would do in his/her position. It is a very tricky conundrum. I would hate to make such a decision. In my understanding of the rules of confidentiality, a counsellor/therapist is allowed (or is required) to break confidentiality if the client presents a threat to themselves or others. Your situation is a borderline case. From the comfort of home I might say: 'If nobody knows about your relapse, how much of a threat can you be?' and keep your secret while maintaining my faith in your ability to solve your personal problems. However, as a working counsellor I would have all sorts of worries and doubts about the ethics of your situation and would feel compelled to speak with your employer.

But how do you feel? Will you feel comfortable helping others towards a goal that you have failed to achieve? My advice would be to tell your employer face to face. In the light of mutual trust, your employer should react better hearing the news from you rather than second hand via your counsellor. If you open up, it will be beneficial to your own recovery (paramount) and those you work with (12 step style). If you hide the facts and live a lie, it will be detrimental all round and your counsellor may be forced to do that which all counsellors hate to do.

Mike Richardson,
volunteer group worker

Reader's question

I'm on a degree course, studying to become a counsellor and one of my friends, who I'm living with, is binge drinking to excess. When I try to speak to her about it she laughs and says she can handle it, but I can see it's starting to affect her life dramatically. She doesn't seem to think it's a problem – how can I convince her that it is?

Charlie, Manchester

Email your suggested answers to the editor by Tuesday 12 June for inclusion in the 18 June issue.