

### Responding to Drug Misuse: Research and Policy Priorities in Health and Social Care

edited by Susanne MacGregor. Routledge Taylor and Francis Group, New York, NY, and London, UK, 2010, 247 pages, \$62.32.

As its primary objective, this book describes and evaluates the 10-year drug strategy "Tackling Drugs to Build a Better Britain," undertaken from 1998 to 2008 in the United Kingdom. The first several chapters cover the political, philosophical, and financial foundations of this massive effort, undertaken to increase community safety, reduce drug use by the young, and ameliorate the harm associated with drug use. The middle several chapters address the services offered by various programs that were already in operation and whose efforts were expanded via new government funding. Interwoven with these are chapters on comorbidity and epidemiology. The final several chapters cover newly identified problems that will require novel solutions going forward: eg, long waiting times for services, patients' leaving care prematurely (after crises are resolved but before recovery can begin), ecological barriers to treatment, and the overlooked needs of children whose parents are abusing drugs. A final chapter reviews the challenges that new legislation, health planners, and program directors must confront.

From a comparative standpoint, the United Kingdom and the United States resemble one another in several respects vis-à-vis drug abuse. Prevalence of illicit drug abuse in the United Kingdom approximates that in the United States. Drug courts have been functioning for almost 2 decades, with "coerced-voluntary" treatment being used (ie, convicted addicts can swap treatment time for incarceration). Methadone, buprenorphine-naloxone, and heroin maintenance treatment is available, although the latter modality has decreased notably as alternatives have appeared. Like the United States a few decades ago (and like China a few centuries ago), the

United Kingdom has recently had a "drug czar" to address increasing drug abuse (5,000 cases in 1975 and 281,000 in 2007 [plus 50,000 in Scotland]).

The United Kingdom and United States also differ in some respects. Tax-supported treatment and rehabilitation in the United Kingdom increased 8 times over 12 years from 1994 to 2006. The drug czar's task, in expending these funds, consisted of organizing and coordinating the efforts of various other cabinet officers. These cabinets include health, education, law enforcement, social welfare, and other areas. In the United Kingdom, the Home Minister, who received the bulk of the funds, was more interested in process measures than treatment outcome, so much of the book reviews process changes rather than treatment effectiveness. In the United States, the National Institutes of Health has focused on treatment outcomes (perhaps to the neglect of family and ecological aspects that the UK report has encompassed).

Despite United Kingdom–United States differences, this book contains much salient information for the US reader. For example, about half of drug-abusing patients in the United Kingdom were raising children as biologic parents, grandparents, or partner to the child's parent. (This percentage seemed high compared to that in my patients, but a survey of my methadone, buprenorphine-naloxone, and other patients revealed that indeed half were parenting on a daily or near-daily basis.) The UK project demonstrated the dire effects of addiction on infants, children, and teenagers whose parents were focused on drug use as their first priority.

Another example was lack of staff continuity, as newly hired, often recently trained clinicians left the addiction field to seek employment elsewhere. In this respect, the United Kingdom emulates the United States in not providing sufficient professional training, supervision, support, and between-hires overlap (as one clinician replaces another). They in the United Kingdom, and we in the United States, would not staff a new emergency room or surgical center in this fashion, but slipshod staffing practices seem to be standard with regard to addicts and their families.

Unexpected differences will catch many US clinicians' mid-sentence. For example, chapter authors infrequently employed the term *recovery* and, when they did, seemed not to view recovery as a patient-focused endeavor that exists in parallel with, but distinct from, treatment. In another example, authors realized that practicing addicts were often somatizing, self-centered, and recurrently in crisis, but they seemed unaware of the steps for changing these long-present characteristics within the treatment context. These lapses could lead to the conclusion that the United Kingdom is in the Dark Ages of understanding addiction and its treatment. That would be inaccurate. One of the world's first professional journals on addiction began in the United Kingdom. Deep knowledge of and experience in these matters exist in the United Kingdom, but seem not to have reached the Home Ministry. In this respect, the United Kingdom appears to have the same communication problems across agencies, programs, and disciplines that we encounter in the United States.

Notwithstanding its limitations, the 10-year, well-funded national program did set specific goals that could be evaluated. The UK program succeeded in reducing crime and in improving the health of some drug users (despite continued drug use in 97% of cases). In the 2008–2018 plans, the earlier failed goals of the program have been reiterated (ie, reducing drug supply and drug use among young people). Despite these setbacks, the national will to establish national aims, fund programs to meet them, and then evaluate the national effort sets a high bar for other countries.

Joseph Westermeyer, MD  
weste010@umn.edu

**Author affiliation:** University of Minnesota Medical School, Minneapolis. **Potential conflicts of interest:** None reported.  
doi:10.4088/JCP.10bk06465whi  
© Copyright 2010 Physicians Postgraduate Press, Inc.