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INTERDISCIPLINARY WORK OF THE INTERNATIONAL SPECIALIST SCHOOL FOR PREVENTION, TREATMENT, AND REHABILITATION OF ADDICTIVE DISEASES. EDITORIAL*

For more than a decade the European Center for Peace and Development has been organising the International Specialist School (hereinafter: School) with a focus on contemporary achievements in the prevention and treatment of addiction. Considering that this is primarily the product of a long-term exchange of knowledge and experience of experts in the field of psychiatry from the former Yugoslavia, who deal mainly with the problem of addiction on the basis of their own clinical practice, the need has been highlighted to open the School to other scientific disciplines by involving scientists from the socio-humanistic field, as well as to relevant civil society organisations. As a result, the 11th edition of the School held in Kotor (Montenegro) in June 2019 included in the programme several presentations by sociologists, anthropologists and representatives of associations of treated alcoholics and Croatian Red Cross. Furthermore, a round table entitled "Dialogue between Clinical Addictionologists and Sociologists" has put forward several proposals on the topics of future research and interdisciplinary cooperation.

However, it turned out that, despite mutual respect and understanding professional limitations in the study of the addiction phenomenon, differences in approaches can be identified not only in the terms used by separate disciplinary frameworks, but within them as well. This applies already to the basic terms such as addiction, drugs and their use – it is obvious they are not neutral and do not derive from the substances themselves, but rather suggest the way in which competent social institutions observe these phenomena. In other words, these terms reflect the discourse and the power to create a reality by naming it and giving it a meaning. Since a significant part of the School's participants is professionally engaged in the treatment of addictions, it is understandable that this phenomenon is approached in terms of a disease, by varying the meaning of this determination through the respect for diversity, but also uniformity of the clinical practice experience. However, a space for discursive patterns of the addiction phenomenon reality has been opened up, resulting from different professional and institutionally based experiences, by no means less real, nuanced, and uniform, like those framed by the harm-reduction activism or academic and extra-academic, cabinet and field (ethnographic) research work.

The mentioned round table showed that "dialogue" is not a one-time event, but rather needs to be systematically and benevolently nurtured over a longer period of time. So, through the work of the School and through the communication that followed thereafter, the idea was developed to highlight the focus of the upcoming 2020 School through the subtitle "A Move towards Interdisciplinarity" and in the meantime to

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enable the interested participants to convert their 2019 presentations into articles. The articles published in this number of the INDECS journal have undergone a review process and ultimately received two positive reviews. This thematic number of the INDECS journal features five articles that reflect the cooperation between psychiatrists, sociologists, psychologists, and harm-reduction activists.

The first article (*Development of the Family System-therapeutic Approach in the Addictions Treatment in Serbia*) deals with the historical development of medical alcohology in Serbia and elaborates the process of theoretical and practical deconstruction of the moral approach to alcoholism. In addition, the theoretical features of the systemic approach are elaborated in a detailed way, which enables the understanding of its transformation into a diagnostic tool and its integration into therapeutic practice.

Using a similar approach, the second article (*Comparison of the Development and Functioning of Addiction Treatment System in Croatia*) presents an overview of the situation and the development in the field of professional engagement with the problem of addiction in Croatia and outlines the basic specificities in the historical development of this disciplinary field in Croatia, implying the basic characteristics and differences among the three basic types of addiction (alcohol addiction, drug addiction, and gambling addiction). These types do not only coincide with wider changes in the development of Croatian society at certain points in time but also open up the space to continually redefine the overall phenomenon of addiction and to reflect on new therapeutic strategies.

The third article (*The Role of Social Integration in the Clubs of Treated Alcoholics in Croatia*) presents a further investigation of the rehabilitation system regarding alcoholism in the Republic of Croatia. The possibilities for the sociological study of alcoholism as a disease in terms of a functionalist perspective are elaborated, which is evident in the conceptual reliance on the Parsons model of the sick role. In this way, an opportunity is opened to further elaborate the sociological contributions to issues that have been previously raised by social epidemiology.

The fourth article (*Cultural Patterns of Alcohol Consumption and Alcoholism in the North and South of Croatia*) also focuses on the phenomena of alcohol consumption and alcoholism but from the anthropological point of view. Authors present cultural practices and statistics related to alcohol consumption and alcoholism problems in the context of the Republic of Croatia. In the paper, there is a special focus on gender differences in alcohol consumption and on how these differences are reflected across a plurality of cultural spaces in Croatia.

Finally, the fifth article (*A Sociohistorical Overview of Harm Reduction Development in Croatia*) deals with the basic determinants of the social and cultural context in the development of needle exchange programmes in Croatia over the past three decades. The article suggests the possibility of critically examining earlier canonical explanations for drug use based mainly on anomaly and disorganization theories, and

highlights the importance of decentralisation and social sensitivity in the process of implementation of the harm-reduction programme and its incorporation into the prohibitionist framework of the current government's drug policy.

Basically, all these articles are an elementary basis to further develop the interdisciplinary dialogue initiated in the work of the School last year and enable a clearer presentation of the theoretical and epistemological assumptions about addiction and drug use through their contents, selected topics and presented current scientific and research activities.

Cordially,

Zagreb, 15th March 2020

Guest editors:

Nikša Dubreta

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DEVELOPMENT OF THE FAMILY SYSTEM-THERAPEUTIC APPROACH IN THE ADDICTIONS TREATMENT IN SERBIA

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ABSTRACT

The roots of system-group family therapy in alcoholism, from which the Belgrade School, originated in the socio-psychiatric paradigm (medical model of addiction, psychodynamic orientation and socialization of psychiatry), Led by these socio-psychiatric paradigm was in 1963. formed the Institute for Mental Health and on the same day formed Socio-Therapeuttic-Club of treated alcoholics.Involvement of addict's wife and other family members, and later the professional environment in treatment began in the late 1970s, when *The Day Hospital for Family Alcohol Therapy* (1978) has been formed. A general system theory was introduced very consistently into this therapeutic model, which included emphasizing the psychoeducation of the identified patient and family members as well as the formation of therapeutic groups of multiple families as a form of prolonged treatment (stabilization phase), while, in the same time, preserving the concept of the therapeutic community and socio-therapeutic clubs as a form of prolonged treatment or recovery. The basis of the family-system therapy concept of the "Belgrade School of Addictology" is related to understanding the process of systemic equilibrium, through the processes of morphogenesis and homeostasis, namely through the understanding of pathological aspects of homeostasis called "processes of adjustment of the alcoholic family or system". Eco-system processes significantly determine the characteristics of individuals, families, social institutions, as well as the characteristics of health and specificity of the disease. With that on mind, it is necessary to understand the transformation of therapeutic models that obviously cannot be purely medical, not as purely psychiatric. It has to be understood as a variable and individualized living processes.

KEY WORDS

addiction, systems theory, family therapy

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INTRODUCTION

The development of medical alcohology in Serbia began in the 1950s and is related to the treatment of patients with alcoholic psychosis, alcoholic encephalopathy and neurological damage produced by excessive alcohol consumption – mainly at the departments of psychiatric hospitals (Belgrade, Kovin, Gornja Toponica). Treatment was therefore strictly medical and exclusively hospital oriented. At the start of the 1960s, at the Neuropsychiatric Clinic in Belgrade the first dispenser for alcoholism treatment has been formed. The first Club of Treated Alcoholics at the Department for mental Health has been formed in 1963[1].

All of that, in its specific way started the deconstruction of moral approach to alcoholism and other mental disorders. That has been achieved with focusing more on the methods of daily hospital care rather the classical medicinal model of psychiatry – which has been enabled with the inclusion of community in the process of addicts or mental patient rehabilitation. With the financial support of the welfare state the image of mental institutions has been changed with regard to the mental disorder treatment. With the better image, came the better results of rehabilitation. In addition to that improvement, in 1975, the first Clubs of Treated Alcoholics has been formed in Serbia. Clubs have strengthened the social psychiatry approach and movement – particularly in the alcoholism treatment. The state financial resources allocated to the social psychiatry movement for that time has been satisfying and has been raised frequently. Even with the implementation of half-hospital oriented and outer-hospital treatment, process of rehabilitation mostly began with the alcoholic's admission in the hospital – with the episodic character of addict, because the most common hospital treatment process has been solved with the dismissal after the episode. It all involved the medical model of addiction treatment, which survived through the 2nd half of XX century thanks to the pharmaceutical industry. The strength of the medical model have proven itself harmful, because of the retrograde tendencies in the therapy plan predominantly based on medicalization, shutting down the social psychiatry program, and poor involvement of the welfare state. It has been only in the past three decades realized that there is a need for a new approach and innovations in the process of treatment in which the experts and academic community of different professions should be involved [1].

A critical review of the application of the traditional models of treatment of alcohol and other drugs have yielded changes [2-7]. The treatment approaches have moved away from the old approach to abstinence as a key mission and necessary precondition for the beginning of treatment. Contemporary tendencies are giving up from treating the abstinence as the only condition to stop the damage and disorder and insist on abstinence as the precondition for treatment in medical model allowing for an increase in the approaches which claim that abstinence is not necessary nor it is a goal of the treatment. The more popular are the programs of *harm reduction* and *substitution programs*. That kind of approach has shaken the traditional social psychiatry foundations of addiction treatment. Today, this development of events seems to be immanent considering the little number of the successful treatments conducted by the traditional model.

Already in 1970s system theory in psychology and psychiatry critically challenged the traditional approach primarily by lighting up the humane approach to interaction – the focus has been to improve the interaction of the family with the addict member. Systemic understanding of family interactions has inaugurated the revolutionary concept of identified patient (IP), a different concept, or new paradigm of symptom creation. This triggers the development of a then new and now powerful psychotherapy modality – systemic family therapy.

From the standpoint of general system theory alcoholism and other addictions, as well as other psychosocial phenomena and mental health disorders, are not understood as disorders that determine only the characteristics and events of the individual. Addictions have been seen as a product of systemic interaction disorders and their maintenance is possible because of the pathological stability of the system in which they occurred. In this way, the attachment is maintained in the system and supports the system and its pathological stability [8].

System theory recognizes addictions as a prototype of interacting diseases. This interaction component of addiction as a symptom in the family and in the wider systems is directly related, above all, to the vital emotional attributes of interactions and relationships in the family. Also important are the interactions of individuals with out-of-family groups which are emotionally colored and highly relevant to the processes of learning, developing, and maintaining addiction. The systematic approach to addiction insists on the process of pathological equilibrium between the system at individual level and processes in the family and/or social group. The processes of creating each addictive disease cannot be detached from the wholeness of family interactions and viewed as isolated "whirlpool of alcoholics" or "drug addicts" – in other words, as a special mysterious process that arises only from drinking, "drugging", "gambling". On the contrary, these systemic processes can be clearly found in current events in the family. It is necessary to observe the whole, and these processes are sought through understanding the whole, not by analyzing the states and characteristics of individuals, because, in fact, only holistically we can understand how some traits are formed, how disturbed relationships are maintained, and finally how they are transmitted to some members in the next generation while some of them are not passed on. The origin and the course of their formation can be seen through the analysis of the three-generation or multi-generation "emotional field" of the family.

In this way, consumption of alcoholic beverages is emphasized as a widespread and lasting phenomenon in social systems, with the characteristics of "symptoms in the system". Namely, addictive behaviors, including drinking alcohol in most societies and cultures are socially acceptable, expected and desirable, present for "thousands of years", so we can talk about social-psychological phenomena with elements of the "natural process" present in every part of the World and in extremely different social and psychological circumstances and contexts. It means that any social phenomenon that lasts and survives in natural human systems, inevitably changes the natural characteristics of the participants, so that all addictive behaviors and addictive diseases as long-present pathological behavioral patterns and phenomena with elements of social pathology must be considered as one of such influential processes, influential to the extent that they very seriously alter the natural characteristics of individuals, families, narrower and wider social communities and institutions, as well as social and political systems [6-7].

It can be said with certainty that in the European territories the phenomenon of drinking alcohol as a "symptom of the system" reflects the systemic features of that wide area. Namely, one can notice the regulatory structure of the system (rules, norms, rituals, beliefs related to drinking and intoxication as social behavior) and elements of the process of creating addiction and "progression" of the disorder (predictable course, stages and crises). According to the systemic model of alcoholism, as well as of other addictions and their maintenance as "symptoms of the system", all elements of the system are involved all the time (individuals, families, states, cultural characteristics) through the mutual relations by which the systemic equilibrium takes place. Obviously, this understanding of the onset of addiction is not about one cause, but about the many possible causes of addiction, so – by systemic theorists – the outcomes of the addiction process are very diverse no matter what is considered the cause or causes [1].

This is the systemic concept of circular causality. It indicates that individuals, through their behavior within the whole family system and every other social system, shape each other, so that the behavior of any member influences the behavior of other members of the system. It is equally important to understand the circularity in family interaction processes and the emotions within them, as well as to understand the meaning of homeostasis or the so-called adjustment process in the present system.

It is important to recognize circular causality in the creation of addictive diseases in the individual. Even when applying the medical model, it is clear that addiction develops as a neurobiochemical continuum that has quite predictable stages and symptoms, with abstinence syndrome symptoms appearing as a trigger for process circularity and for maintaining addictive behaviour and thinking in all individual's relationships with the family and the social environment.

Therefore, the development of addiction - within the individual and the family system - through circularity and homeostatic processes, provides a continuum in the formation and duration. These addictions give the characteristics to specific and diverse processes, events and symptoms of the outcome. Forward and backward shifts are also possible. Stopping the flow in this continuous process of development is possible only by stopping the process of pathological homeostasis or adaptation. Some elements of these processes can be identified in the addict, but many exist outside the addict-individual – in the system itself.

It follows that each family has its own addiction, because the processes of creating each addiction cannot be torn from the integrity of family interactions and considered only as some isolated special "mysterious" (neurobiochemical) process in the individual. It can also be said that each social or state community has its own addiction. These views inaugurated the application of systemic family therapy in the treatment of addiction diseases at the *Belgrade School of Addictology.*

Everywhere in the World, the need to treat addiction is enormously high. The treatments implemented, unfortunately, are rare which also indicates strong homeostatic processes in almost all Western societies for the creation and duration of all addiction diseases until definitive damage is created.

To put into the consideration everything written so far about drinking alcohol and the existence of well-developed social psychiatry in the former Yugoslavia, it is quite expected that the beginnings of the application of system theory and family therapy in the field of addictology in Serbia began in the treatment of alcoholism. This has also happened at the Institute for Mental Health (IMH) and is tied to the name of Branko Gačić and the initiation of the first changes in the traditional treatment of alcoholism. In 1973, he and a group of junior associates formed the first treatment group within the IMH Day Hospital at which he began to include alcohol addict's wives in the treatment of their husbands, after completing an episode of hospital treatment. Soon, in his first book in 1978 [1; pp.3-4], he called this form of treatment for alcoholics "Intensive Combined Family Alcohol Therapy" (ICFAT). With the classic and traditional medical parts of the program being referred to as symptomatic therapy and family therapy, orientation to marital and family problems has the significance for etiological therapy [9-11].

In 1978, the Center for Family Therapy of Alcoholism (CFTA) was established, headed by Branko Gačić, which gave additional impulses not only to the family therapy of alcoholism, but also to the further development of family therapy in Serbia. Namely, the first generation of educated family therapists in Serbia soon came of age, completing sub specialization in systemic family therapy, under the programs of the Institute for Family Therapy and Tavistock Clinic, London (1984-1988). Through practical work and educational activities at the Center

for Family Therapy of Alcoholism, the involvement of family members in the treatment of their alcoholics, became a more widely used therapeutic practice in other institutions (Nis, Skopje, Sombor, Zrenjanin, Novi Sad, Belgrade and other cities). Gačić then conducted another complete study of the evaluation of family alcohol therapy for the period 1986-1989 on 1989 married couples and successful access was reaffirmed [11]. This therapeutic approach, which in his 1992 work [5-6] Gačić described as a Belgrade systemic Approach to the Treatment of Alcoholism, was enriched by significantly greater involvement of other social systems in the treatment of alcoholism, and thus became increasingly feature of the so-called network therapies, or in more modern language ecosystem therapies. However, it is essentially a model that can be called Systemic Group Family Alcohol Therapy (SGFAT) [6; pp.12-13]. Over the years, this approach – primarily at the Institute of Mental Health – has been used in the treatment of opiate addiction and other psychoactive substances related addictions, and recently in the treatment of pathological gambling and addiction to video games and the Internet. All these developments allowed for the term "Belgrade School of Addictology". The chronology of Belgrade School of Adictology is shown in Table 1.

Table 1. Chronology of Belgrade School of Addictology development.

1963	Sociotherapy Club for Acoholics Treatment (SCAT)	
1963-1973	A Department of IMH Day Hospital:	Socio-therapeutic group work with alcoholics is applied
1973-1978	Day Hospital for Family Alcohol Therapy	Intensive Combined Family Alcohol Therapy" (ICFAT) • Medical parts of the program (symptomatic therapy) • Wife involvement and orientation to family relationship (etiological therapy)
1978 to the present	Center for Family Therapy of Alcoholism	Belgrade systemic Approach to the Treatment of Alcoholism • Significantly greater involvement of more family members and the professional environment
1993	Clinical Department for the Treatment of Addiction Diseases	Hospital phase of systemic group family therapy for addiction diseases
2001	Addiction Disease Clinic Clinical Department for the Treatment of Addiction Diseases Day hospital with two treatment groups and CTA (Systemic Therapy of Clubs of Treated Alcoholics) Center for Family Therapy of Alcoholism - Two Therapy Groups + Family CTA (Clubs of Treated Alcoholics) Adolescent Day Family Hospital Day Care	Systemic Group Family Addiction Therapy (SGFAT)

BASIC THERAPEUTIC PRINCIPLES OF "BELGRADE SCHOOL OF ADDICTOLOGY"

Elements of the medical model are still used in the Belgrade School. The beginning of treatment has the features of traditional medical diagnosis and can be considered as "making a medical diagnosis more broadly". It is conducted in an active manner according to the principle of "mosaic building" with the aim to, besides medical diagnosis, assess social and family consequences and to continue the motivation of the addict to initiate some of the existing forms of therapeutic or at least counselling interventions. Therefore, in addition to the classic medical examination and psychiatric examination, it is necessary to take into account the interaction or, in other words, family-systemic aspect of the problem in this process.

The next "diagnostic level" is the family-system level of completing the assessment and diagnosis. However, there are several important facts to keep in mind when starting and applying family therapy, such as:

- diversity of clinical images of addiction,
- comorbidity of alcoholism and other additions,
- significant psycho-organic impairment of the addict,
- personality disorders, sociopathic and criminal behaviours,
- permanent bodily harm to addicts.

The family-systemic level of assessment is conducted through a specific diagnostic and motivational procedure throughout and during the so-called bifocal effects on the patient and family. That involves the simultaneous implementation of diagnostic procedures and therapeutic-motivational interventions.

The specificity of this sub-phase relates to the planned and successive involvement of family members and other individuals in the social system. So this is a diagnostic/motivational and mild to moderately confrontational process that is focused on the addict but also the process which gradually also targets the family as a whole. This is necessary in order to obtain valid heteroanamestic data, and above all, to continue motivating or further deepening the data on drinking and the consequences of drinking, thereby achieving therapeutic "pressures", "crises" or "breaking" of the system around the addict. Through the mentioned process, the addiction is successfully controlled and maintained by the addict during the long period of time.

The specificity of family-system diagnostics is the "first family interview" which has elements of a systemic or conjoint session. When done well, it is considered a powerful tool for diagnosing family disorders and ending the motivational process. The therapist conducts an interview with all family members, assessing both verbal and non-verbal communication (sitting schedule, body posture, tension, affective expressiveness, relationship characteristics, who holds control over communications, who most interrupts other members, who with whom mostly communicates, etc). This targeted interview with a dependent member and his or her family members usually takes place after a medical and psychiatric problem identification procedure, i.e., after a number of motivational interviews or screening. It can be performed at a specialist addiction treatment facility, a social work centre, a specialized counselling centre, or very rarely at a GP. Once the diagnostic process is started, it should proceed continuously until the next appointment and some appropriate treatment is agreed and accepted. Sometimes it takes place as a one on one intervention and sometimes as a series or sequence of interventions in one or more institutions. The final diagnosis must be the integration of all the data collected and the "creation of a diagnostic mosaic" [13-14].

A key part of the Family Addiction Therapy Program according to the concept of "Belgrade School" takes place in the conditions of daily hospital treatment. This means that the patient

and the family spend one part of the day in intensive group-therapy work within the therapeutic groups of multiple families, and spend the other part of the therapy day at their home. The therapeutic action is directed to the family as a therapeutic unit, and at certain points in the program, to the social and professional environment as a whole system. This implies for all participants in the treatment the position of an integral part of the patient's addictive system, i.e. for all participants it means taking the position of co-patient contributing to homeostatic processes, the outcome of which is the duration of addiction.

Serious psychoeducation of the patient and the family is necessary in order to qualify their participation in maintaining the dysfunctional system and to achieve the necessary changes in family functioning.

An important feature is the existence of successive phases in the implementation of programs. On the one hand this emphasizes the levels of therapeutic requirements and achieved or unrealized achievements, and, on the other, it determines the order of analysing the dimension of time. Dimension of time looks like this: first, the present is made and then the past is considered. Eventually plans for the future also can be considered. Then it is insisted on specification - individualization of programs for each family through combining techniques and methods of family therapy and group psychotherapy, and through the possibilities of implementing programs at each level of clinical work: clinical ward, day care, hospital, outpatient family groups, club and dispensary depending on patient status and family progression during the therapy program. This program is phased in as group family therapy for multiple families. The groups are of medium size, i.e., 6-8 families. Groups can be structured as groups of married couples with the possibility of involving other family members as well as members of the professional or wider social system (network therapy); groups combined of married couples and single individuals (divorced, widowed) but having a complete family; groups of young alcohol addicts (18 to 25 years old); alcohol addicts' family groups. This is intensive phase of treatment or phase of family reorganization, in which new initial functions without alcohol are established (structural and functional reorganization of the family system from "wet" to "dry" system). During the intensive treatment phase at the day hospital, the therapy protocol insists on the daily presence of families. A necessary therapeutic minimum is the presence of an identified patient and at least one family member. The day-hospital therapy program lasts about 3-4 hours. Namely, direct group therapy work lasts 3 hours (twice for 90 minutes each). Families spend the rest of their day in a day hospital in so-called home activities, socialization and recreational activities. The family is there to help plan, organize, and accomplish their alcohol-free lives.

The daily life of the family (daily routines, communication, daily plan realization) during the intensive phase of treatment is analysed and corrected through a continuous group procedure called "actualities". In parallel with the "actualities" there is a psycho-educational process for the patient and the family – about alcoholism, its occurrence and maintenance in the family as a system and about the consequences in all areas of functioning. The aim of this psycho-education is not only to acquire knowledge and successfully pass the exam, but also to recognize one's "case" in theoretical settings, which is the main criterion for assessing the degree of completion of this task. In this way, participants obtain a "qualification" for further treatment, that is, for a favourable and "reasonable" view of the past. Thus, this process is also characterized by intense joint learning of the theory of alcoholism and the family. Given that the couple is tasked with learning together from one material ("from one book"), such a way of learning and taking the exam together is one of the therapeutic techniques which tests the intrinsic motivation of the couple/family but also restores broken communications and disturbed community of the couple or family. The exam is taken as a classic exam in front of a group which, together with the therapist, assesses the result of the exam. It is assessed

whether the family has passed, therefore, individual achievement is not valued, but both success and failure are common products.

After passing the exam, approximately three weeks after joining the group, the married couple, with older children (over 12 years of age) and significant persons from the family and social network (usually 5-10 people), have a so-called "Big show". "Big presentation" is a therapeutic task that seeks to make the patient and family look at the facts of the past in a new way, based on the acquired theoretical knowledge and knowledge about the systemic model of family dependency. Great representation carries the therapeutic elements of self-discovery – insight and discovery before others. This insight is not psychoanalytically conceptualized, but represents an awareness and understanding of the process of the emergence and intensification of alcohol addiction and the consequences that have taken place in the family. This insight has the meaning of moral inventory[2].

The grand presentation has the form of presenting an autobiography, but very self-critically connoted, with the aim of "soberly perceiving the drunken/addictive self, and of dry system seeing the pre-existing wet system". It only somewhat carries elements of insight in a psychodynamic sense, since one of the tasks within the great representation is to look at one's own development and relationships with the primary family and key persons within it, but through understanding the family as a whole system – "family as a whole" (in the time dimension of the system model of the family). This part is the most complex and is largely conditioned by the quality of group dynamics and the knowledge and skill of the therapist. It is the hardest feasible due to the existence of rigid defence mechanisms – such as mutual projection, negation, minimization, but also emotional attributes from "coalitions", "fatigue" *"and" contracts "or" pacts* among family members, especially partners, because of the massive manipulations and strategies of alcoholics to maintain control and power in the system, sometimes making it difficult to differentiate manipulations from psycho-organic impairments, i.e. cognitive deficits and permanent personality disorders in both the patient and family members.

So, there may be resistance to looking at the past by every family member, and even the entire family system, (not just addicts) in order to maintain homeostasis, or more precisely, "pathological balance" or "pathological gain" from alcoholism. The "big presentation" is prepared by all family members participating in the treatment. They talk about the past, look at their behaviours, think and write down their newly discovered views and form a written text, which is a kind of "novel" or "public recognition".

An unsuccessful grand presentation cannot actually exist. Difficulties in perceiving family alcoholism are in fact the reason for additional work with the family. Work on the "big presentation supplement" takes place with a therapist or group, and sometimes requires a so-called a team intervention or the help of older group members. The "supplement" is done in front of the group. Key resistances may stem from "pacts" and "coalitions" in the family, so a change in the form of treatment may be needed. Therefore, a large representation is a key "crossroads" in the therapeutic process. The therapeutic goal of great representation is successful if, through the exposure of the addicts and other family members as a whole, an "insight" is achieved that should be accompanied by a milder or more intense emotional experience similar to catharsis. Thus, it is expected to "see" the whole system through the emotional expression of the members of the system, verbally redefining dysfunctional communications, irrational emotions and erroneous role-playing, inversion of positions and interpersonal relationships. Success and failure can be viewed through the fact that each person spoke of himself/herself and his/her behaviour, his/her responsibility for the outcomes and consequences for the family, not about the others, without explaining his/her behaviour according to the other's feelings and behaviour. For an alcoholic, this is difficult because of

the massive deposits it has formed through social comparisons, negations, and tactics of "keeping" addiction symptoms, but also because of a disturbed value system, disturbed behaviour patterns, and psycho-organic disorders. However, this is difficult for alcoholic, mainly because of the fear of losing position in the "playful scheme", which also loses the key support that provides that person with a sense of dominant relationship with the object. For other members of the family, especially for the wife of the addict, the difficulties are the same, because she is also a person with a high degree of dependence on her husband. Her defence mechanisms are similar and integrated into the marital relationship. In addition, it is difficult to relinquish the "gain from alcoholism" (or other addiction) and from a high degree of control in relation to the addict or to the system he or she has exercised during the addiction of her husband or other family member. It is especially difficult for her to remove the "culprit label" from the addict. Successful realization of insight, through successful "big representation", creates relief of tension in the family system, but also represents a new opportunity for crisis through the creation of feelings of "false confidence". *The phase of extended family therapy* at the Belgrade School is represented by an essential novelty in the recovery of addicts and their families. The original name, the rehabilitation phase of family therapy, is a somewhat outdated term stemming from the social-medical era, so the newer names were promoted - the reintegration phase; the recovery phase; a rehab/recovery plan, which signifies therapeutic work focused on "residual consequences". The danger of crisis is manifested in the fact that "protection against therapies system" ceases, as the daily encounter and analysis ends, and the "new life of the dry system" begins in the old environment, which most often has not changed or, possibly, changed only slightly.

The main form of extension treatment is therapeutic groups, colloquially referred to as *family extension groups*. These groups for families on long-term treatment represent the continuity of existence and duration of treatment groups that existed and "worked" in the intensive phase of treatment. Therefore, the created homogeneity of the groups, which function as open groups, usually with the therapist as member of the intensive phase team, is maintained, thus ensuring continuity of working together and closeness to the family and to the elements of the Sociotherapy Club. However, there is a solid structure of group work with its confrontational potential in need of the additional clarifications to further deepen insights. An important group-therapy instrument and the pillar is the "rehabilitation and recovery plan", which provided a family focus on key problems and group structure and homogeneity, but also emphasized the diversity of family problems and goals.

The "rehabilitation and recovery plan" at this stage of family therapy is linked to the process of systematic graduation of the family. Namely, given the line of systematic matriculation of the family at this stage of treatment, participants look at the "unfinished business" in the family life cycle and plan together with the therapist important developmental tasks that they need to perform at a given stage. The timeliness and completeness of these "jobs", that is, timeliness and unfinished work, must also be tested, as they also indicate not only the state and quality of relationships, but also the processes of transgenerational transmission. The following issues are tested and evaluated: nuclear family boundaries; family rules on environmental relations; functionality and separation of children; the main "themes", that is, the key value systems that the family fights and advocates for. According to the findings of the one study [6], families which join family alcohol therapy are most often in the middle stages of systemic matriculation, but their "maturity" status is not adequate at that stage[3]. While working with them, it is necessary to assess the conformity or mismatch of the developmental stage, in which the family should be at the level of its dysfunctionality or "immaturity" in relation to the developmental stage.

Adolescent addiction treatment families are most often at a stage when children need to begin serious independence and separation. The family should be in the stage of full maturity as it turns to the future. Attention is drawn from the selection of thematic options so far, towards the attempt to determine a family identity and a "family place in history". The assessment of the condition of the family and the degree of conformity-inconsistency with the requirements of a particular stage, also provides opportunities for planning and application of therapeutic interventions that seek to, for example, changes in intergenerational relationships or other changes related to characteristics within family boundaries.

When a family has setbacks and distortions in the middle stages of their development (families with primary school children), the interventions focus on the dynamics of the marital relationship. This primarily means exploring the alcoholics marriage, (but also another type of marital system within the family for treatment) in relation to length of life; breakups; conflicts; emotional distance; communication with children and domination; submissions in reactions; relationships and functioning in systems outside the family; relationships with children; and relationships with primary families.

In doing so, we receive material for therapeutic interventions, because through the quality and manner of emotional relationship in marriage (any dependency involved) – we can inform about the quality of relationships with close and significant persons from the primary family and with the quality of emotional and transgenerational process within the primary family, that is, their relationship to their mother, father, and the dynamics of their parent's marriage. In doing so, we gain a deeper understanding of the inner dynamics of the individuals they bring into their marital relationship. Since the genogram preceded this "job", the type of psychological defence mechanisms that partners predominantly use (projection, projective identification, splitting, less often suppression) must now be accurately recognized. The effects of these defences will not be found only in the relations of partners, but also in the relations with children – in various forms of interaction (coalitions, conflicts, distancing); in unresolved fusions in the primary family; and in unresolved relationships with the father, mother or other significant person from the family's past.

Essentially, at this stage, patient recovery and family progression occur through the use of multiple family group therapy, with the possibility of applying family therapy in a narrower sense, and through a much lower frequency of meetings, as sessions with family or family group meetings take place only once a week. However, at this stage, the processes of significantly greater therapeutic depth are most often taking place, and it involves taking on different modalities of family therapy in addition to the ordinary life and functioning in one's social and professional environment. Extension groups are led by educated therapists (psychiatrists, psychologists, social workers, special educators) who participate in intensive-day, day-hospital therapy groups. This provides 5-8 "extension groups" for one working week.

Thus, formed and conceptualized therapeutic groups of multiple families can function as homogeneous therapeutic groups with strictly defined program duration. One family's treatment is formally contracted and can last 1 or 2 years after which the treatment ends with a summary of the treatment that may have elements of the ceremony for success, but also the elements of separation. Then the family or couple leaves the group or can join the already existing Sociotherapy Club. Often a whole group of multiple families can spontaneously transform into a newly formed family club. After termination of work in the therapy group of multiple families, it is possible to continue working with the family through occasional conjoint sessions. These "follow-up" sessions should therefore be reconceptualised as integral steps in the process of active termination of treatment, which should be extended to additional several months. In this sense, the Belgrade School's view is that the already

established links with the family therapist and the family institution should remain a readily available resource that can be reused to solve emerging problems. Since 2001, when the Clinic for Addiction Diseases was established, training in Family Therapy for Addiction Diseases began for 4 semesters, attended by professional workers from IMH and other institutions in Serbia.

FINAL CONSIDERATIONS AND FUTURE PERSPECTIVES

The roots of systemic group family alcohol therapy from which the Belgrade School originated can be recognized in the social-psychiatric paradigm (medical model of addiction, psychodynamic orientation and socialization of psychiatry), which represented the basis for the foundation of the Institute for Mental Health in 1963. Not long after the Sociotherapy Club of Alcoholics have been formed. Elements of this paradigm when it comes to the treatment of alcoholism were realized in the work of the so-called A-section of the Institute's Day Hospital (therapeutic community, group psychotherapy, socio-therapeutic club), which is closest to the so-called Minnesota model. The involvement of the wife and other family members, and later of the professional setting in treatment began in the late 1970s when the Day Hospital for Family Alcohol Therapy was formed in 1978. A general system theory was introduced very consistently into the therapeutic model, which included emphasizing the psychoeducation of the identified patient and family members and the formation of therapeutic group families of multiple families as a form of extended treatment (stabilization phase). With that, the preservation of the concept of the therapeutic community and socio-therapeutic clubs as a form of extended treatment or recovery has been made possible – according to the terminology encountered in recent professional literature.

The application of system theory to addictology, and somewhat earlier to psychology and psychiatry, shed light, first and foremost, on the psychological aspects of human interactions, notably the interactions in the family. The systematic understanding of family interactions inaugurated the revolutionary concept of identified patient, therefore, a different paradigm of symptom creation, in which the identified patient (IP) is the only carrier of the symptom.

Beyond the concept of IP, an important, almost revolutionary paradigm is the circularity in understanding causality (rather than linear determinism). Members of the treatment system and at the same time the behaviour of these individuals are influenced by each other reflection in their process of interaction. This implies the importance of understanding the meaning of family interactions and understanding the nature of the existence or non-existence of the present interactive systemic processes (homeostasis, morphogenesis, adaptation processes).

The basis of the family-system therapy concept of the "Belgrade School of Addictology" is related to understanding the process of systemic equilibrium, through the processes of morphogenesis and homeostasis, namely through the understanding of pathological aspects of homeostasis called "processes of adjustment of the alcoholic family or system". When the creation of an addiction disease in an individual is considered through the medical model, it is emphasized that addiction develops as a continuum that has quite predictable stages and symptoms, and even outcomes.

However, looking at the development of addiction using the system model, – within the family system, this continuum receives the characteristics of a specific and very diverse process. Namely, alcoholism and other addictions should not last as long and their consequences would be larger and harder as time goes by. It also could not be tolerated and accepted for so long – that, in parallel with the adaptation of the addict's organism and psychological processes in the addict, similar adaptation processes do not take place in the family and environment of the addict. These processes are, by their nature, psychological or,

more precisely, primarily emotional and in their form they are communicative i.e., interactional. In their essence they are circular, because they belong to the domain of mutual relations and communication among the family members to whom the addict belongs all the time and in which he/she exists together with everyone else and with his/her alcoholism. In sum, these are the mutual relations of the individual addict with the individual family members, with the family as a whole and with the family environment as an ecosystem.

Addictions (as well as other psychiatric and social phenomena) are therefore not understood as disorders that define or condition only the characteristics of personality and events in an individual, but are quite clearly defined (and manifested) as a disorder of interactions in the system and as conditions for the process to take place over time (maternal life cycle) Maintenance of this disorder is possible due to pathological stability or homeostasis of the system ("adjustment processes"). Addiction appears as stress and as a process that organizes the family. That way the conditions for the addiction containment and functionality of the addict inside the very system are made possible. With it, the system itself is sustained by the environment but at the cost of its pathologic stability, future dysfunctionality through the process of entropy [1, 8], which condition the non-acceptance of treatment or late start of treatment so that the recovery can be made more difficult (as the family reconstruction is not possible).

Stopping the flow in this continuous process of development is only possible by stopping the process of adaptation. The extent to which an individual or family will arrive in that continuum depends on the characteristics of the self-process or on the characteristics of the system. Some elements of these processes are in the addict, but many are outside the addict-individual, so all elements are in the system.

The key systematic attitude of the "Belgrade School of Addictology" is that each family has its own specific addiction. In other words, the processes of creating each addiction cannot be torn from the totality of family interactions and considered as a separate "whirlwind" around a dependent individual or as a special "mysterious" (neurobiochemical) process in an individual, which can only arise from excessive substance use. Every systematic interaction process can be clearly found in current events in the family and social environment. Therefore, the whole should be observed, because the processes of reciprocity are at stake and can be understood through an understanding of the whole, rather than by analysing the states and characteristics of individuals.

So, it is only from understanding the whole that we can also understand how some traits have arisen and how disturbed relationships are currently maintained; how addiction intensifies; and finally how it is passed on to individual members in the next generation (some of it are not passed at all). So, all the members of the system participate in these processes all the time.

At the end of the 20th century and with the beginning of the process of globalization, as well as the political and economic transition in region, there is an increasing number of alcohol addicts, but also an increasing number of young people addicted on other psychoactive substances (cannabis, heroin, stimulants), and so-called non-chemical addicts (pathological gambling, video games, internet addictions). At the Institute of Mental Health, the application of systemic group family therapy of all addictions is continuing, now in the newly formed Clinic for Addiction Diseases in the clinical ward and in three day hospitals. Due to the heterogeneity of the population of new addicts and the disappearance of the welfare state, systemic group family therapy is applied in a modern format with much more application of eco-system elements and with attempts to integrate ecosystem and family-system elements. It is obvious that one can speak of the Belgrade School of Addictology as a theoretical and therapeutic uniqueness.

Instead of a conclusion, I would like to emphasise clearly the fact that the history of the development of therapeutic concepts in the treatment of addiction diseases in Belgrade and Serbia, indicates the obvious existence of a process in which changes took place. Namely, therapeutic concepts are inevitably marked by eco-systemic events in times and places where we live and work. Eco-systemic processes significantly determine the characteristics of individuals, families, social institutions, but also the characteristics of health and specification of the disease, including diseases of addiction and therefore, almost passively, the transformation of therapeutic models that obviously cannot be purely medical or purely psychiatric is made. Addictology should continue to be integrative, based on existing concepts that have preserved the sustainability and vitality of the "School" with the use of novelties and necessary transformations, which have emerged from the peculiarities of the population of new addictions, so the Belgrade School of Addictology should remain and be at its core eco-systematic, live process; counteracting with it the interactions as it is exposed due to the increasing homeostatic events through which the "old" and "new" addictions are produced.

REMARKS

[1]In the late 1950s, major changes in the field of psychiatry occurred in the world. Society's calls for more humane treatment of psychiatric patients and their inclusion in the community, as well as new breakthroughs in pharmacotherapy, have led to fundamental changes in the understanding of psychiatry and psychiatric care to date. Led by these changes, a group of Serbian psychiatrists conceived and formed the Institute for Mental Health, which in 14th April 1963 officially opened The first psychiatric institution in this part of Europe with a complete socio-psychiatric orientation began to operate, placing the focus of care and support on patients in the community and insisting on social and psychological methods of treating psychiatric illness. Then, the daily hospitals were introduced as a semi-hospital type of psychiatric treatment, as well as numerous psychotherapy and group therapy methods in treatment (by developing a democratic therapeutic milieu through the organization of therapeutic communities of staff and patients, https://imh.org.rs › about -institute› history.

[2]The description of a key point in systemic family therapy of addictions with the name "large representation" is given through an example of the treatment of alcoholism, or through the description of a "large representation" of a spouse from an alcoholic marriage. The principles of performing this therapeutic intervention are the same for other types of addictions and for other types of addictive families (adolescent addictions, women's addictions, divorced addicts, pathological gambling, internment addiction).

[3]In the systemic matriculation of the family, the middle stage is the stage of consolidation during which the choice of "themes and opportunities" of the family is made. At that stage, the family is highly reactive, but significantly conditioned by the type of relationships that are established in the family among its members and above all in the marital subsystem. In one family, spouses can form egalitarian relationships, so the parallel course of their individual development will positively evolve. In the other family, the primacy of spousal behaviour within parental functioning may influence the appearance of the child or children as major family themes – goals. (e.g. fatigue, parental projection).

REFERENCES

[1] Nastasić, P.: *Psychosocial treatment of the addiction diseases of communities in transition.*
In: Djukić-Dejanović, S., ed.: *ADDICTION DISSEASES – Contemporary achievements in the prevention, treatment and rehabilitation*. European Centre for Peace and Development UPUN, 2018,

[2] Rehm, J., et al.: *Statistical modeling of volume of alcohol exposure for epidemiological studies of population health: the US example.*
Population Health Metrics **8**, No. 3, 2010,
http://dx.doi.org/10.1186/1478-7954-8-3,
[3] European Medicines Agency: *Guideline on the development of medicinal products for the treatment of alcohol dependence.*
European Medicines Agency, London, 2010,
[4] Rehm, J., et al.: *Alcohol consumption, alcohol dependence and attributable burden of disease in Europe: Potential gains from effective interventions for alcohol dependence*.
CAMH, Toronto, 2012,
[5] National Institute for Health and Clinical Excellence: *Alcohol use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence*.
National Institute for Health and Clinical Excellence, London, 2011,
[6] Nastasić, P.: *Alcoholism and transgenerational transfer*.
Tehniss, Belgrade, 1998,
[7] Nastasić, P.: *Development and Implementation of Systemic Family Therapy in Social-psychiatric Institution in the Period of Transition.*
In: Veselinović, J., ed.: *The Challenges of Family and Family Therapist in Balkan Transition*.
Centre for Family, Belgrade, pp.121-126, 2004,
[8] Nastasić, P.: *Eco-system Approach to Alcoholism*.
Publikum, Belgrade, 2012,
[9] Gačić, B.; Ivanović, M. and Sedmak, T.: *Compensation and Decompensation Crisis of the Family System in the Development and Treatment of Alcoholism.* In Serbian.
Psihijatrija danas **13**(3), 229-237, 1981,
[10] Gačić, B.: *Belgrade systemic Approach to the Treatment of Alcoholism: Principles and interventions.*
Journal of Family Therapy **14**(2), 103-122, 1992,
http://dx.doi.org/10.1046/j..1992.00446.x,
[11] Gačić, B. and Marković, M.: *Evaluation of the Family Role Changes in the Family Therapy of Alcoholism – Research Results.* In Serbian.
Psihijatrija danas **24**(1-2), 11-27, 1992,
[12] Steinglass, P.; Bennett, L.; Wolin, S. and Reiss, D.: *The alcoholic family*.
Basic Books, New York, 1987,
[13] Stanković, Z.; Trbić, V.; Nastasić, P. and Mladenović, I.: *Diagnostical and therapeutic guidelines on Alcoholism*.
Institute for the Mental Care, Belgrade, 2009,
[14] Mladenović, I., et al.: *National Guideline for Good Clinical Practice*.
In: Šternić Čovičković, N., ed.: *Republican professional committee for the development and implementation of the guideline of good clinical practice*. Belgrade, 2013.

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COMPARISON OF THE DEVELOPMENT AND FUNCTIONING OF ADDICTION TREATMENT SYSTEMS IN CROATIA

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ABSTRACT

The article describes the historical development of treatment systems related to the use of alcohol, drugs and pathological gambling in the Republic of Croatia. The specifics of the functioning of each system, the common points of contact, the mutual advantages and disadvantages, as well as the challenges posed by the further development of the treatment system are outlined.

KEY WORDS

addiction treatment systems, addictology, community psychiatry

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INTRODUCTION

The historical course of monitoring the phenomenology of addiction, primarily on alcohol, has been present in the world for the last two hundred years, and has been present in Croatia for the last hundred years. Rush [1] and Trotter [2] were the first to recognize the direct link between alcohol drinking and liver damage, promoting the idea of drinking as a habit, moving it away from the moral model, by then widely prevalent.

Gudrum's work in Slavonski Brod and Vinkovci is of pioneering character in the implementation of programs for the prevention of alcohol related problems, distinguishing him as a health teacher. Gudrum started the magazine "Alcohol – Poison" in 1904 and published the book "Alcohol and Children". The first sobriety association, "The Society of Abstinents of Slavonia and Croatia", was founded by Gudrum [3]. Since the 1920s, the health and enlightenment work of Andrija Štampar has been emphasized, with professional and scientific focus on the protection of health. From the position of Head of the Department of Hygiene of the Kingdom of SHS, Štampar had established the so-called Hygiene Station. In Karlovac he published a series of books entitled "Booklet Against Alcohol" and "New Paper – Sobriety". Together with Vuk Vrhovec, Štampar had edited the magazine "Yugoslav Movement of Sobriety" [4].

In addition, The Red Cross and the association of former alcoholics "Revival" in the became the pivot organization for the prevention of drinking problems in 1950s. A couple of years later, in the late 1950s and early 1960s, Hudolin began to take over combating a drinking problems, primarily through leading the Alliance of Anti-Alcohol Societies. Since 1964, the Center for the Study and Suppression of Alcoholism and Other Addictions had been opened in Zagreb at today's Clinical hospital Sisters of Mercy, developing into the nucleus of creating a model of integrative approach to the problem of drinking, as well as the initiator and cornerstone of the establishment of treatment programs and self-help groups through which primary, secondary and tertiary measures will be implemented [5]. According to the territorial principle, several clubs for the treatment of alcoholics were established, with first club in Zagreb but soon, with the support of the wider community, also in other cities throughout the Croatia. Simultaneously with the development of a network of dispensaries and clubs in Zagreb, the establishment of a dispensaries and the development of a network of clubs throughout the country are encouraged. The basic idea of Hudolin was to enable every alcoholic who engaged the inpatient treatment to continue practical rehabilitation through the self-help groups [6].

Unlike the problems related to alcohol use, which have been described in Croatia since the beginning of the twentieth century, only in the mid 1960s did Croatian society encounter the experience of consuming other psychoactive substances. Initially these experiences were related to the first by-products of organized tourism, but soon they were outspread to establishment of hippie and related youth subcultures. Since the 1980s, the opiate intravenous drug use (IDU) scene had been steadily expanding, resulting in a real epidemic during the Croatian War of Independence in the 1990s. Since the early 1980s, the first Department of Addiction at the Clinical Hospital Center "Sisters of Mercy" in Zagreb has been established with a multidisciplinary team hired. As part of a systematic approach, a system of treatment in penitentiaries was also launched altogether with the work of the therapeutic community and the club of treated addicts. Sakoman [7] has successfully promoted the issues of integration of treatment systems, prevention through the school system, and the reduction of drug availability on the market through the Ministry of the Interior. A National Strategy for Combating Drug Abuse was adopted in 1996 by the national Commission on Drug Abuse. Unlike the treatment of alcohol-related problems, where the system relied mainly on health professionals and social work, a political consensus emerged in the area of other drugs,

bringing police, health, justice, education and social work professionals together. This unified approach with political support (manifested in organizational, and primarily financial, support), was rapidly leading to the strengthening of multidisciplinary services in the field. Since 2006, Addiction Centers have been under the auspices of county public health institutes. In line with the proclaimed principle of policy coherence in the field of drug, alcohol and gambling addiction treatment, efforts have been made to synchronize the functioning of the institutional and non-institutional (NGO) part of the system [8]. Although in the 1990s the system still had doubts about the primacy of the institutional part of treatment over the therapeutic communities, for the last seven years the system has been consolidated with the principle of equality of all sectors, both institutional and non-institutional.

In contrast to the considerable and extensive experience in the field of prevention and treatment of alcohol related problems and somewhat more modest experience in the prevention and treatment of psychoactive substances (drugs), the experience in gambling problems has been very modest. Although the phenomenon of gambling has been known to civilization for several thousand years, the scientific study of this phenomenon has been present for the last fifty years [9]. Before the war in the 1990s, there was a state lottery in Croatia, which organized lottery games. There were no problems with addiction, except for sporadic excesses and individuals who developed addiction while staying abroad. With the liberalization of gambling legislation in the 1980s in Croatia, and the granting of concessions to more gambling companies, supply on the market is growing exponentially, drawing on an increasing number of addicts [5]. The higher the supply, the greater the demand, and with the game a certain number of addicts exceed the threshold that divides the over-enjoyment of the game from the addiction. Institutions, just like NGOs, were initially unprepared to address the epidemic rise in pathological gambling addicts, and it took several years to organize the first therapeutic responses.

The prevention and treatment of pathological gambling problems has begun to be implemented through experimental models of gambling clubs (Club of treated gambling addicts; Croatian acronym KLOK – which has been in operation since 2007), and through organization of the first departments for partial hospitalization in Zagreb clinics and psychiatric hospitals [10]. Assistance to the addict is carried out through the NGO sector (KLOK), and the story of the 1950s, when the teaching of the adictology profession was based on the experience of Alcoholics Anonymous (AA) groups, is repeated.

ALCOHOL ADDICTION TREATMENT SYSTEM

The system for the treatment of alcohol addiction has been developing around the world since the mid-1950s, thanks in large part to Jellinek, who transforms the experience of AA self-help and mutual aid groups into doctrine adapting them to clinical work [11]. Hudolin in the mid-1960s integrates the experience of AA groups, the Jones therapeutic community, and Bierra group therapy, and creates treatment clubs for alcoholics who become the cornerstone of the community-based process of rehabilitation of a drug addict. Specifically, in the late 1950s, Hudolin adopted the experience of working together with veterans of World War II, using the experience of a therapeutic community, which revolutionized the socio-therapy of psychiatric patients as well as addicts. Namely, until the establishment of the theory and practice of Jones's therapeutic community, psychiatrists failed to find the answer to the question of how to avoid patient passivity in treatment as part of patient resistance and secondary gain. Through regressive behavior and imitation of somatic patients, the patient focused the efforts of the therapy staff on the symptoms, i.e., on the physical complications of the treatment itself, and was not interested in the very essence of the problem, that is, addiction. Only by leveling the roles of staff and patients within the work of the therapeutic community conditions were created for each patient's contribution to their own treatment as well as for

treatment of other members. In addition to group therapy and the therapeutic community, Hudolin also adopts the principle of self-help and mutual assistance groups, modulating them by introducing a group therapist in combination with a family approach. Hudolin masks the traditions and steps of AA groups, since in the then socialist state that proclaimed atheism, that model would initially be doomed and rejected.

Accordingly, unlike AA groups, clubs of treated alcoholics have a professional staff member (doctor, psychiatrist, specially trained nurse, social worker, social educator) and nurture a family approach. A family member in the Club of Treated Alcoholics, unlike AA groups, is in the focus of treatment, being an equally valuable member of the group [5].

Along with numerous dispensaries for alcoholism and other addictions, motivated and educated social workers, a network of clubs in the field, and a cooperation with other clubs in the country and the region, the general public is sensitized to problems related to alcohol use, and the professional and scientific progress of this young professional and scientific disciplines. Numerous preventive activities are being carried out, prevention and treatment at the regional level are organized, GPs and social workers are motivated to spot problems early and encourage treatment. The Zagreb Alcohol School stresses from the outset the importance of sensitizing the community to alcohol-induced problems and requires the active involvement in preventative and rehabilitation procedures as well as organizational and financial support for institutional efforts. In the 1960s and 1970s, clubs were closely linked to the institutions, and today, in accordance with EU legal norms and trends, they were formed as part of an NGO system, a multi-family community, a medium-sized group, and included in a wider territorial network.

The crowning contribution of the Zagreb Alcohol School is represented in the expansion of clubs in the surrounding countries, especially in Italy since 1979., when the first Club of Treated Acoholics was established in Trieste. Soon, the development of a large number of clubs across Italy followed, primarily in the northwestern parts, but then also across the country, and around the world, largely due to the Italian diaspora.

Along with encouraging continuous professional development and scientific contribution through the dissemination of professional and scientific knowledge and evaluation of work, the Zagreb School of Alcohol also promotes a psychotherapy approach, mainly systemic therapy, but also uses elements of psychoanalytic work, cognitive-behavioral therapy, existential analysis and other psychotherapy methods. Individual psychotherapy, although used in some cases as an analytic therapy, is primarily of a supportive type, and exclusively replacement therapy. Through individual psychotherapy, the patient is educated and motivated to enter treatment, stabilize abstinence, and interpret reality problems through the analysis of transfers and countertransfers. Group therapy strengthens the individual's "No" to drinking, strengthens the collective "No", and thus encourages addicts to maintain abstinence through relationships with other group members and the group itself. Namely, it is the development of individual responsibility for the group members and the group itself that often stabilizes the individual's abstinence, raising the sense of self-esteem and reputation in the eyes of the group members.

Through relationships with other group members, the patient enhances self-esteem and develops social skills. Strengthening social skills is of great importance in the process of recovering alcohol addicts, as they have been damaged to a greater or lesser extent through years of drinking and discarding responsibilities towards other members of the system.

Systemically, an individual lives and operates within several systems and super-systems, starting with the family towards the workplace, the local environment, the work environment, finally towards the state and civilization. For this reason, group therapy is complemented by therapy using a family and social network, involving members of the wider family and friends, or neighbors, and work colleagues. Without these supersystems, abstinence is

possible, but its elimination is problematic, often impossible. Ever since the beginning of the system, Hudolin has emphasized the importance of addiction socio-therapy, using group socio-therapy, community therapy, occupation and recreational therapy, and teaching patients for social life. Critically questioning the model of the Zagreb School of Alcohol, we must state that, according to world experience, these models, based on absolute abstinence, manage to include only a small number of patients in treatment, while most of them remain outside the treatment system. We attribute the high percentage of untreated alcohol addicts to the facts of a relatively narrow range of therapeutic options, especially in the area of abuse and consequent aggressive behavior, low level of social awareness about problems related to alcohol drinking, resistance of society to view problems related to alcohol use, stigmatization of alcohol addicts, and even the treatment system itself that deals with addicts. Insufficient capacities of treatment systems, i.e., insufficient number of skilled and motivated staff and the number of beds or chairs in the departments of partial hospitalization, also limit the number of alcohol addicts treated. The decrease in the number of beds and chairs is also due to the "rationalization" of the system by the state health insurance, which has significantly reduced accommodation capacities over the last ten years, especially in the clinical hospitals, since the cost of treatment in hospitals is the highest. Sensitization of general practitioners to work with alcohol addicts and their families is also insufficient, prompted by the lack of gratification for work by both society and alcohol addicts and their families. The stigmatization of alcohol addicts by society is perhaps the main contributor to this problem. The education of medical and paramedical experts in the field of addiction diseases, both in undergraduate and postgraduate teaching, is not intensive enough, nor is it of high quality.

CHARACTERISTICS OF DRUG TREATMENT SYSTEMS

The drug market in Croatia is part of a wider drug market in EU countries. Croatia is primarily a transit country, with smaller quantities of self-produced drugs, mainly for personal use. The decrease in supply on the market, as well as the inclusion of a large part of the addictive population into the treatment system, have brought positive trends in the number of newly registered addicts annually in the last few years, reducing the number of newly registered persons to the treatment system by up to four times [12].

Programs for prevention and suppression of drug use, as well as treatment for problems and disorders related to drug use, were coordinated in the Republic of Croatia until 2018 by the Government Office for Combating Drug Abuse, while the Croatian Government Commission for Drug Control monitors implementation and plans measures and activities. Unfortunately, over the past year, as a by-product of drug policy, the Government Office has been relocated to a service within the Croatian Institute of Public Health, which is a backward step for the treatment itself, since it significantly reduces the Office's authority slows its operation.

The most complex, and also the most responsible part of the treatment for addicts' care are the county services for the prevention and treatment of addiction at the county mental health institutes, organized according to the territorial principle of equal access throughout the country. The services are organized as specialized units within the primary care setting, ensuring easy access for addicts to treatment, without a referral from a GP. The basic features of the model are to avoid formalism around the referral, to allow receiving treatment as soon as possible, as a rule, on the same day that the addict arrives for treatment. The principle of availability, that is, rapid entry to treatment, without unnecessary formalization and waiting lists, is one of the main advantages of the system. The so-called "revolving-door" system, that is, the principle of easy return to treatment, which is responsible for many years of retention in the treatment of a large number of addicts, and for the reduction of health and social complications of addiction, is continued.

In its beginnings, the treatment was dominated by the paradigm of initial detoxification, that is, heroin withdrawal, especially for younger addicts. Thus, all younger addicts initially underwent a detoxification procedure, with the all-or-nothing option, that is, the imperative of swift and unconditional opiate withdrawal. The experience of severe abstinence in immature personalities, the consequent short abstinence, especially after discharge from hospital treatment, and the frequent recurrence of opiate abuse and fatal overdose, has led to a change in the paradigm of options and desirable treatment goals. Therefore, today, initially, all newly registered addicts in treatment first seek to achieve stabilization through substitution therapy (methadone, buprenorphine or a combination of buprenorphine and naloxone) over a period of time, and then motivation for a gradual detoxification procedure. In addition, as part of comprehensive treatment, the addicted person tries to motivate the patient to go to treatment in therapeutic communities, where socio-therapeutic and psychotherapy procedures seek to work on the maturation of the patient, to change preson's value system, as well as to foster the cultural and spiritual development of the personality.

Comprehensive therapy involves pharmacotherapy, most commonly in the form of a substitution, which ensures the psychophysical and social functionality of the patient. In addition to pharmacotherapy, individual type and often supportive psychotherapy is also used, altogether with group therapy and therapeutic community [5]. As a rule, pharmacotherapeutic procedures are necessary to stabilize the addict psychomotorically and make him available to psychosocial interventions, which are part of everyday work with the addict. In addition to detoxification, inpatient psychiatric treatment also serves to stabilize psychomotorically, psychophysically and socially destabilized patients. Social welfare centers, together with therapeutic communes and employment services are of great importance for the rehabilitation of drug addicts in the community. As a rule, through the fieldwork employees of social welfare centers are in daily contact with the consequences of their clients' addiction, both on a personal or family and social level. It is the quality of education and networking of social workers with other actors in the comprehensive treatment system for addicts that is of great importance. An addict without the support of a social worker, as well as his or her family, as a rule find it difficult to find solutions to numerous complications of their own addiction and lifestyle. The coordinating function of the social worker connecting the system's employees to the healthcare system is very important. At the same time, with the efforts of health professionals and social workers, employment services should provide adequate work for addicts, which is invaluable in stabilizing opiate abstinence and in the social rehabilitation of addicts. Until the great economic crisis, some ten years ago, significant financial efforts were invested in the employment of addicts, which, after the outbreak of the crisis, would first be denied to funding for the employment of addicts. Without re-establishing the priorities of their employment, and investing money in co-financing wages, all efforts to rehabilitate them are compromised.

The Croatian model advocates the principles of equal treatment for addicts in penal institutions. Probation offices coordinate and control the implementation of alternative sanctions for addicts. Multidisciplinary treatment services in penitentiary institutions, along with substitution treatment, seek to work with addicts on rehabilitation, additional education, life skills acquisition, and the achievement of desirable social goals. The treatment services work closely with the addiction treatment system, providing joint training and co-operation in both treatment and rehabilitation.

PATHOLOGICAL GAMBLING TREATMENT SYSTEM

Considering that the Republic of Croatia has been facing gambling-related problems only for the last twenty years or so, prevention and treatment systems that have been implemented in a

relatively short time throughout the country have failed [13]. Interventions have developed in the direction of preventive and therapeutic activities. Universal prevention is conducted through educating society about possible gambling problems, and regulating and encouraging responsible gambling by the gambling industry. At the same time, the responsible attitude of the individual gambler towards the game is encouraged. Selective prevention measures are targeted at identified individuals at risk of developing addiction, most often through peer groups, but also at other indiviuals through various self-assessment questionnaires that are made as a part of programs for the responsible gambling system. Education of teachers in schools and the gambling industry employees who are at increased risk for developing addiction is an essential part of prevention activities [14].

Throughout the institutional part of the treatment, counseling and short interventions are used to help so called risky gamblers. For pathological gamblers, psychosociotherapy techniques are used, either through institutional treatment or through self-help groups and mutual aid groups. Since 2007, KLOK has been operating in Zagreb. In the form of a medium-sized, multi-family group, which meets once a week, it nurtures psychotherapy and socio-therapeutic work with the addict and his family, trying to encourage the dysfunctional system to function more adequately in the crisis, with gambling abstinence being a fundamental part. Dismantling the homeostasis of a gambling dysfunctional family system, and bringing it into a crisis situation, with the potential to resolve the situation by establishing abstinence and taking on new patterns of communication, are the main points of therapeutic interventions. A special feature of the pathological gambling prevention and treatment approach is the attempt to co-operate with market regulators (the Ministry of Finance), gambling organizers developing a responsible gaming system, and the profession responsible for prevention and treatment. Although direct funding of pathological gambling prevention programs and treatment of pathological gamblers on a basis of gambling funds has not been managed so far, such regulation would provide in the future a lasting, reliable and substantially broader financial and organizational framework to achieve preventive, therapeutic and rehabilitative goals.

Characteristics common to all three treatment systems (alcohol, drugs, gambling) are found at the levels of society, the individual in problem, his or her narrower and wider environment, and the profession itself.

At societal level, drinking and gambling are legal, socially accepted activities that are encouraged by society through their rituals, which have a significant impact on filling the state budget, from which many useful activities are financed (one of the largest beneficiaries of tax finances on gambling traffic is a drug treatment system). The supposed social "benefit" of alcohol and gambling, which can be easily expressed financially, is attributed mainly to the alcohol and gambling industry and the Ministry of Finance, while for the consequences of drinking and gambling "the weak individual" is blamed. The situation is the different with drug addiction, as drug use is an illegal and prohibited activity. It is therefore much easier to reach a social consensus and regulation in the area of drug abuse.

As for the individual in the problem, all three types of addiction are characterized by insufficient insight into the potential danger of developing addiction, insufficient personal insight into own addiction sometimes based on immature justifications, and lack of criticism regarding the need for treatment. As a result of the lack of insight, with already advanced physical, psychological and social consequences of addiction addicts are late to seek help. It is the addict's family that most often brings the addicted person to treatment, exacerbating a crisis within the family system and forcing itself as well as her/him to change. The family is generally the most important segment of the treatment system, as a rule more interested in treatment than the addict. In the absence of a family, wider relatives, friends or workmates may be

involved in supporting the patient. Based on years of experience in working with addicts, it is often concluded that family is the most vital part of the welfare system in the country.

The adictology profession in Croatia itself has undergone various models of development in relation to the addictive substances. Alcohol addiction physicians are professionally trained under the decisive influence of Hudolin's model of alcoholism, based on a multidisciplinary, integrative approach that includes pharmacological, psychological, sociological, cultural and spiritual dimensions. As a consequence of the integrative approach, from the mid 1960s to the late 1980s, a model of psychotherapy and socio-therapeutic work was nurtured in alcohololology,with parallel creation of networking systems and the collaboration of experts of different profiles. In the mid-1980s, after Hudolin's retirement and his departure for Italy, where he established and expanded a network of alcohol-treatment clubs, Croatian clubs' developmental momentum stalled and their number declined. This process was catalyzed in the 1990s, during the war, when social and health service shifted priorities to address the problems of war victims and refugees while the number of clubs halved. As regards clubs, renewed momentum has been seen afrer 2000, and their numbers are gradually increasing with network spreading throughout Croatia. A new, so to say, middle-generation of alcohologists, following its predecessors, has approached treatment issues supporting the integrative, multidisciplinary (ecosystem) approach and the work of self-help and mutual aid groups (Clubs of Treated Alcoholics). Along with the national network, a cooperation with the countries of the region is encouraged, as well as joining in the World Organization of Alcohol Treatment Clubs which work according to the Hudolin methodology. The World Association of Alcoholics Clubs (WACAT) is conceived as a coordinating body between national federations, which fosters collaboration, mutual motivation, exchange of experiences, continuing education and sensitization of societies for alcohol-related problems.

Modeled on the treatment of alcohol-related problems, pathologic gambling and associated consequences are also encountered by the mid-2000s. It is the middle generation professionals, which, following the previous advances in adictology, renewed and strengthened the work of Acoholic Clubs, and founded the first self-help and mutual-help groups dealing with population addicted to pathological gambling. Gradually, programs based on partial hospitalization and day hospitals have also been established, modeled on practices in the treatment of alcoholism.

Unlike treatment for alcohol-related disorders and problems, drug treatment professionals have gone a slightly different developmental path. In the mid-1980s, faced with the first major epidemic pressures of newly registered drug addicts, an attempt was made to take over the alcohol addiction treatment system aimed at absolute abstinence. This option proves to be too demanding for the largest number of patients, resulting in the disappointment of both patients and their families and the professionals themselves. Due to the extremely difficult working conditions or the patients themselves, as well as to the fact that gratification in dealing with drug addicts is generally absent, few experts decide to work in this field. The chronic shortage of psychiatrists is sought to make up for the introduction of different doctor profiles. Thus, the work of the Addiction Treatment Services involves epidemiologists, school medicine specialists, GPs, becoming competent adictologists over time and gaining experience. However, the consequence of their different professional and educational background, along with prevalence of substitution based therapy, which quickly benefit the addict, results in forsing the more pharmacological than psychotherapeutic and socio-therapeutic work with addicts. This achieves rapid stabilization of the patient's condition, eliminates acute health and social problems, but also misses the possibility of sociocultural and spiritual development of the personality, since it is not feasible without long-term orientation in psychotherapy and socio-therapeutic techniques.

During the 1990s and 2000s, there was a dichotomy, that is, the division of experts between those who work with alcohol addicts and pathological gambling, and those who work with drug addicts. Their education, training and supervision are separated altogether with corresponding scientific conferences, and communication between them is insufficient. It has been only six years since education and communication within the two previously separated sectors have been consolidated. The consensus has been reached in adoption of stance that adictologists are not primarily concerned with means of addiction, but with a persons inclined to take a psychoactive substance, and with their relationships and with the consequences of addiction.

For the last fifteen years, the adictology profession has been faced with the new challenge of problems and disorders associated with computers, Internet networks and video games [15]. The main challenge facing the profession is to modify the "all or nothing" paradigm, which has been valid for the treatment of alcohol, drug or gambling problems, while not applicable to these addictions. Namely, it is not possible today to insist on complete abstinence from activity in the age of total use of the computer and realworld "dependence" on it. Attempts are being made to assist addicts through the implementation of partial hospitalization models, work in therapy groups, a family systemic approach, work through self-help groups and mutual assistance. An additional problem is posed by the overuse of computer games among the juvenile population, which by law can only be taken care of by pediatric psychiatry specialists. In the absence of sufficient staff, they are most often preoccupied with other casuistics, but also insufficiently educated and experienced in the field of prevention and treatment of problems and disorders related to the use of contemporary media. Therefore, the treatment is modeled on experimental therapies, in certain institutions and NGO groups, which is insufficient and does not meet the principle of easy accessibility and quality standardization of treatment throughout the country.

CHALLENGES TO ADDICTION PREVENTION AND TREATMENT SYSTEMS

Considering the history of the development and operation of systems for the treatment of problems related to the use of alcohol, drugs and pathological gambling, as well as their present moment, several challenging implications are posed.

The first imperative is to ensure the continued expansion of the network of systems throughout the country, in order to respect the principle of equality in access to medical care regardless of place of residence. In addition to this principle of equality of access, the impact of the system network on the local community through preventive activities is also important, as this system prevents the development of other types of addiction through the coverage of both families in problem and school children.

Another imperative is to ensure the quality of addiction related education, both in undergraduate and postgraduate schools of medicine, as well as through various seminars and training workshops. The focus on the study of medicine, has to be wide enough to include also the assisting professions (nursing school, educational-rehabilitation study, social work, ...). This should certainly allow addiction related courses to be run by professionals who are really involved in the treatment of addiction and have extensive experience, which is often not the case.

A third imperative is related to the continued motivation of young professionals to become involved in the work with addiction through additional training and supervision. The opportunity to encounter holistic psychiatry through nurturing addiction related education, and a biological, psychotherapeutic, socio-therapeutic and spiritual approach, should be attractive to young professionals. In the field of adictology, there is an opportunity for rapid advancement for young specialists, psychiatrists, or adictologists, who, through a wide range

of psychotherapies and socio-therapeutic methods, help addicts and simultaneously gain knowledge and experience.

The fourth imperative is to make efforts to sensitize the public to addiction issues, with an emphasis on involving non-expert community members in assisting and working in the prevention, treatment and rehabilitation systems, most often as skilled workers in self-help and mutual assistance groups. The experience of qualified staff educated over the last twenty years in the Reference Center testifies that members of the community, especially those with close or extended family experience, are interested in investing efforts in education and work in this area.

The fifth imperative is the continuity of program evaluation through scientific research, in order to monitor the performance of systems and to compare them to each other, and to worldwide experiences. Scientific evaluation of the treatment system may have been seen as relatively poor, since the number of articls published in this field are relatively small. On the other hand, when applying for funding at national or EU level, scientific evidence of the effectiveness of treatment within the system is not only welcomed, but crucial.

Finally, the sixth imperative stems from the need to shift responsibility for the operation of prevention and treatment systems from the profession to the wider community, through encouraging the development of community psychiatry. Responsibility for the functioning of the system has often been passed on to the back of experts who were dealing with addictions, and most often they did not have the power to make decisions about the functioning of the system and ensuring the finances for its continuous and smooth operation. By shifting responsibility for the functioning of the system to the profession, the state with its power to secure the financial framework did not participate in the responsibility for planning and implementing the programs. The model of clubs in Italy can serve as a roadmap for the further development according to the community psychiatry system, as well as for the responsibility for not only preventing and treating alcoholism, but also fostering healthier ways of communication and the lives of individuals, families and the entire local as well as the wider community.

An addiction treatment system, especially for the treatment of alcohol related problems, has been one of the main levers for the development of social psychiatry (ecopsychiatry) and community psychiatry over fifty-five years.

REFERENCES

[1] Rush, B.: *An inquiry into the Effects of Spiritous Liquors in the Human Body*. Thomas Andrews, Boston, 1970,

[2] Trotter, T.: *De ebrietate, ejusque effectibus in corpus humanum. An essay, Medical, Psilosophical and Chemical*.
In: *Drunkeness, and Its Effects in the Human Body*, the 1st Philadelphia ed. Boston, Bradford and Read & Finley, Philadelphia, 1813,

[3] Jandrić-Balen, M. and Balen, I.; *Fran Gudrum and Andrija Štampar – Similarities and Differences.*
Anali zavoda za znanstveni i umjetnički rad u Osijeku **28,** 93-101, 2012,

[4] Turk-Kuči, M.: *Slatina Alcoholic Programes 1975.-2015.*
UKLA, Slatina, 2016,

[5] Zoričić, Z.: *Addiction – prevention, treatment and recovery*.
Školska knjiga, Zagreb, 2018,

[6] Hudolin, V.: *Antropologycal Spirituality*.
In: Hudolin, V., ed.: *Clubs of Treated Alcoholics.* European School of Alcohology and Ecological Psychiatry, Trieste, 2000,

[7] Sakoman, S.: *Treatment of Opium Addicts.*
Referal Center Ministry of Health of Addictions, Zagreb, 2013,

[8] Jerković, D.; Vugrinec, L. and Petkovic, Ž.: *Coherency Assessment of Policies on some of the Psychoactive Substances and Addictive Behaviour in the Republic of Croatia.* Criminology & Social Integration **21**(2), 113-126, 2013,
[9] Kozjak, B.: *Gambling – from leisure to the social pathology.* TIM Press, Zagreb, 2016,
[10] Torre, R. and Zoričić, Z.: *Gambling and lottery games – from game to addiction.* HSKLA, Zagreb, 2013,
[11] Jellinek, E.M.: *The Disease Concept of Alcoholism*. Hilside Press, New Haven, 1957,
[12] European Monitoring Centre for Drugs and Drug Addiction: *EU drug markets report, In-depth analysis.* Luxemburg Publications Office of the European Union, 2016,
[13] Zoričić, Z.; Torre, R. and Orešković, A.: *Gambling and Betting – Modern Addictions.* Medicus **18**(2), 205-209, 2009,
[14] Torre, R.; Zoričić, Z. and Škifić, B.: *Incidence and legal regulation of gambling.* Medica Jadertina **40**(1-2), 27-31, 2010,
[15] Mladenović, I. and Lažetić, G.: *Pathological gaming – with therapeutic manual*. Čigoja štampa i autori, Beograd, 2014.

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THE ROLE OF SOCIAL INTEGRATION IN THE CLUBS OF TREATED ALCOHOLICS IN CROATIA

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ABSTRACT

Social integration and its role on a population's general health is an oft-debated concept; primarily through the sub-field of social epidemiology. This research takes the concept and correlates it with some aspects of physical and psychological well-being of the individual. However, there is a lack of the research discussing the roll of social integration in the addiction rehabilitation, especially in regard to alcoholism treatment. With that in mind, the main goal of this article is to discuss and identify the connection between the perception of social integration and the process of alcohol addiction treatment in the Clubs of Treated Alcoholics in Republic of Croatia. A discussion about the following subject is based on the theoretical redefinition of the Parsons Theory of a Sick Role. A synthesis of the empirical and theoretical level of analysis is constructed through the research, which has been conducted on the case of Clubs of Treated Alcoholics in Republic of Croatia. Through the convenience sampling method, there were 255 participants. Results have been showing a statistically significant connection between the sense of belonging in the rehabilitation group and the perception of the treatment success. Participants of the study who were more integrated in the rehabilitation group have found their treatment more successful.

KEY WORDS

sick role, social integration, alcoholism, Clubs of Treated Alcoholics in Croatia

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INTRODUCTION

Social integration and cohesion have preoccupied academics since its establishment under the scientific discipline of sociology. The very canon of sociology, starting with Comte through to Marx and Durkheim [1], sought to find a universal answer to the question of why people get together and why does it matter for person to be a part of a larger group, or society. Only recently has this debate extended to the question of the correlation on health and social integration. To be more precise, during the 1980s there has been an increase in research pointing out that social relationships and affiliation is a powerful agent of physical and mental health [2]. However, this correlation was predominantly investigated by the relatively new sub-discipline of epidemiology – social epidemiology. Social epidemiology is *a branch of epidemiology that studies the distribution and determinants of health and disease in populations* [3, 4]. There is no dispute of the great contribution of social epidemiology for this field of research, but where is the place for sociology; or more importantly, why did the sociology of health and medicine be set aside even though it holds the traditional importance for sociology? Surely inside of the social epidemiology, the work of the classical sociology – such as the one of Durkheim about suicide – is appreciated, but that does not neglect the question of how this sub-discipline of the bio-medical field take dominance in the area of research in which sociologist should find themselves in [5]? The answer to the proposed question could be found in the sub-specialization of the so-called special sociologies. The area of the social impact on health and medicine should belong to the sociology of health and medicine. That is indeed true in the majority of cases. However, sociology of health and medicine have been predominantly focused on the medical institutions and *problems defined by epidemiologists and policy makers* [6]. The aspects of individual or smaller groups, and their dynamics regarding disease, have not been given enough credit by the general aspects of the field. The argumentation presented here is such that sociology of health and medicine has been focusing more on the macro context and policy-making analysis, discourse change, or structural components in constructions of health and medicine. By that development, the other aspects, such as the contextual analysis of the social impact on health and medicine, has been taken over by other disciplines such as social epidemiology. To contribute more to the field of sociology of health and medicine in that matter, while not marginalizing the contribution of social epidemiology, the primary goal of this article is to analyze the importance of social or group integration in the process of alcohol treatment in the Republic of Croatia inside the Clubs of Treated Alcoholics. In other words, this article analyzes the dynamic of social integration of alcoholics in the process of rehabilitation. In this analysis, the socio-cultural profile of the alcoholic has been questioned as well. More importantly, the article addresses how group integration correlates with the aspects of alcoholism as a disease.

CURRENT RESEARCH ON THE BENEFITS OF SOCIAL INTEGRATION TO HEALTH

As already mentioned, there have been several studies that investigated the benefits of social integration for health encouragement and disease prevention. That has been investigated under the *rubric of social support* [7]. Studies, according to Seeman, have been focused on the measurement of the existing ties, on more functional characteristics mostly included emotional/instrument support that have been provided to individuals [7]. For example, Falci and McNeely [8] pointed out the need of a few friends for adolescents in order to prevent the manifestation of depressive symptoms. What was important in this research is that they argued the bad influence of so-called *over-integration*, where many low-quality friendships can lead to a boomerang effect and reflect negatively on the mental health of an adolescent. However, a large number

of friends could also lead to the higher levels of mental health [8]. These findings indicate one of our hypotheses regarding the importance of social solidarity in the health benefit.

These two contradictory findings about quantity of connections can be theoretically explained. What these studies have been missing is the concept of social solidarity. Social solidarity gives the intrinsic feeling of belonging and active participation inside the group of people which a person finds themselves close to. Social solidarity (in sociological term) is what gives the quality characteristic of social connection. If social mechanisms cannot achieve solidarity, a pure amount of connections have no internal meaning for the individual.

In that sense, the results are not unique purely because of the chosen methodology. Social solidarity and morals of that kind (in larger group setup) should be investigated qualitatively so that the meaning of these large connections for an individual can be reached. There, the exact experience of the belonging in a large "group of friends" can be reached from the perspective of the direct actor (individual).

On the other hand, some studies focus more on the effect of social integration on physical health. From the physical perspective, it has been shown that there has been an increased risk of developing angina for people with higher levels of family problems [9]. Another study on physical health and its connection with social integration has shown a higher risk of the myocardial infection among those with fewer social connections [7, 10]. Marital status is also important factor for the individual's well-being. In general, the mortality rate is higher for the unmarried then for the married [11, 12]. What all of the mentioned studies have in common is the process by which social relations, throughout social control, can affect the health behaviors and by that have an impact on physical health and mortality [11].

A SOCIOLOGICAL APPROACH TO THE CONNECTION OF DISEASE AND SOCIAL INTEGRATION

Although the purely sociological aspect of the aforementioned correlation has not been thoroughly investigated empirically; sociological theories of the illness and disease have been focused on defining the sick role and its relation to society. Parsons has theoretically defined the sick role in the aspect of the structural functionalism and system theory. He argues that the sick role is a variance of social exclusion by which the deviance of illness is prevented [13]. Society is prescribing the roles for the sick. For this process, the doctor holds the social credibility and legitimacy for defining who is sick and who is not. In that regard, Parsons defined four expectations in the situation of the "sickness". First, a sick person is allowed an exemption from his ordinary social obligations. Secondly, a sick person is not responsible for his or her own state. Therefore, a sick person must be motivated (or self-motivated) to get better as soon as possible. The fourth expectation is that the sick person should seek professional help, which would legitimize his or her state. Cooperation with all factors in the sickness dynamic is obligatory [13]. This model has gone through a lot of critique. Parsons focused more *on the manifest function of the sick role in contributing to the social stability and health of society* [6]. What is important, and what Morgan et. all have been noticing is that he focused more on the social system sustainment, not giving any attention to the social integration that is happening in the process of the sickness; especially to the internal integration of the *sick* who are forming a new kind of solidarity (which is yet to be investigated, especially in the field of addiction). In this article, it is argued (and later empirically presented) that this process is of high priority in defining the *sick* role of addicts (in this article; alcoholics). Alongside that, what is problematic with the addiction *sickness* is the second expectation of Parsons' ideal types. The social exemption of responsibility in the case of an alcoholic is not achievable if we consider that the alcohol-related problems are

highly connected to morality[1]. Degradation of the socially constructed moral creates a stigma, which not only neglects the exemption of the responsibility for the state of alcoholism but also intensifies it (responsibility). From the societal perspective, an alcoholic has mostly him/herself to blame for their state. That situation creates the need for a different kind of solidarity. It is important to mention that the concept of solidarity[2] has been latently included in the concept of *sick role* [13]. Social solidarity for the *sick* has been important for the process of their reintegration into society. Solidarity in the case of alcoholics has to be achieved differently because of the moral problem mentioned above. Solidarity is constructed in the micro situation where the new ways of social integration take place. Alcoholics in the process of rehabilitation are forming a new friendship and new roles for each individual in the group. They also share the common morality and ground rules. For example, in the experience of Alcoholics Anonymous, there is a so-called *12-step program* that includes checkpoints in the process of rehabilitation. These steps are not the only way person will get better, as there are also the rules of behaving in the group. It has been pointed out in the research of Caldwell and Cutter [15] that people who attend meetings more frequently are going to embrace the program and fellowship dimensions within it more easily. It goes together with the formation of the ritualized praxis of this program, but also of forming the moral ground for new ways of solidarity. What is important is that the process of the sick role of an alcoholic and other addicts are created in a different structural context than other sickness roles.

All of these factors point out the importance of research on the topic of the structural dynamic of sickness in addicts (alcoholics). The first step for this project is the investigation of the process of formatting a group dynamic from one side and benefits of this dynamic for the rehabilitation on other side. All of this is investigated amongst the alcoholics undergoing rehabilitation in the Republic of Croatia.

A CONTEMPORARY APPROACH TO ALCOHOLISM IN CROATIA

Before we can enter the complex analysis of the social integration and its importance for alcoholism rehabilitation, it must be pointed out that the context, or to be more precise, the "situational frame" has to be considered. The framework in which this article operates is in the cultural space of the Republic of Croatia which has been (in the matter of alcoholism rehabilitation) set by Vladimir Hudolin. Hudolin pointed out a dysfunctional correlation of alcohol and culture within the Mediterranean countries [19]. Dominance in this relation holds the so-called *moral perspective of alcohol,* which characterizes an alcoholic as a morally deviant person, but alongside of that consumption of alcoholic beverages is highly supported by the structures of interaction in which consumption becomes the part of a ritual chain [20]. Moderate drinking is considered neither bad for society nor for individual health [19]. In that way, only moderate drinking is considered to be "normal" while abstinence and excessive drinking is deviant. In that sense, sciences with the strict boarders between disciplines, cannot answer this challenge. Bio-medical treatment cannot solve a problem that has a socio-cultural etiology (not just a biological one).

What is important to address in this context is the phenomena of "Croatian socio-cultural space" which should be thoroughly investigated in order to address the addictions (namely alcoholism) properly. In that sense, psychiatry could benefit from the sociological knowledge of social context, solidarity and integration. All those terms are extensively reviewed and investigated through the tradition of sociological research and theory. Implementing the social context in the process of treatment of alcoholism could reduce the social stigma given to the alcoholic. It could also provide the psychiatrist with the insight of indexation of alcoholism regarding the specific community or society.

According to that need, Hudolin suggested an alternative to the purely bio-medical treatment of alcoholism. He developed the so-called *systematic model of alcoholism* treatment [19]. By that model, alcoholism is not only the fault of the alcoholic, but of his social environment; first of all, family. The concept of family holds the biggest importance for his new approach of alcohol treatment. When we speak of family in his terminology, we speak of *family in larger sense, as a social system which holds the emotional, friendly, and other relations for an individual who has a problem with alcohol* [19]. By that relatively new paradigm, "family" in a broader sense is continuously included in the process of alcoholism treatment of individual. Although family is the largest factor in relation to alcohol and the individual, it is important to mention that several other social systems have their own impact on the process of creation of significance in relation to alcohol or alcoholism (religion, economy, employment).

In this article, it is of crucial importance to investigate how the process of alcoholism treatment (in Croatia – Hudolin model) connected with the perception of the *inner* group integration, cohesion by the alcoholics in the treatment process. In a theoretical context, the question is discussed: does the role of the *sick* (the second phase - alongside Parsons theory of *sick role*) construct itself inside group therapy? The current project phase consists of a quantitative analysis which will furthermore be investigated qualitatively, so we can gain more concrete insight into the aspects of social solidarity that take place in the group therapy in Clubs of Treated Alcoholics.

METHODOLOGY

The main goal of this research has been to identify the connection between the social integration and the process of the alcoholism treatment in the Clubs of Treated Alcoholics in Republic of Croatia. It is important to add that this subject is formed through the addict's (alcoholic) perspective and self-reflection regarding the process of rehabilitation. Alongside the goal of this research and theoretical background, four hypotheses were formed:

- **H_1**: the alcoholics that are experiencing higher integration in rehabilitation groups are more satisfied with the treatment process in the Clubs of Treated Alcoholics,
- **H_2**: the alcoholics that are experiencing higher integration in rehabilitation group consider their treatment to be more successful,
- **H_3**: there is no statistically relevant difference in the degree of integration considering the sex of participants,
- **H_4**: there is no statistically relevant difference in the degree of integration considering the age.

On that matter, the self-evaluating survey has been submitted on the population of the alcoholics in the process of alcohol treatment in the Republic of Croatia that are part of the Clubs of Treated Alcoholics. The convenience sampling method was used, and the sample has been achieved with the help of the national center for the addiction rehabilitation in Croatia – Clinical Centre Sisters of Charity. Alongside the center, a survey was dispatched in the clinic for psychiatry Vrapče. The acquired sample size was 255 surveys. This research has been under the surveillance of the research coordinator and one psychiatrist from the helping institution. Before the research field, we have conducted an ethic approval from the ethics committee on Croatian Studies of University of Zagreb. The survey itself consisted of 21 questions and 42 variables. The questions of the perception of social integration and belonging within the rehabilitation group have been formed using the Likert scale. There were three questions that measured the perception of belonging. Furthermore, there was a set of questions with the topic of evaluation of the current satisfaction and effectiveness of the treatment (also

in the perception of the participant of survey). The survey method has been paper-pencil. The participants have been given the survey during the meetings. After its completion, the surveys were put into the sealed envelope so that we could guarantee the anonymity of participants. The survey duration took two weeks, after which the surveys were collected and analyzed.

A χ^2 analysis was conducted to answer to the first two hypotheses, while the third and fourth hypotheses have been analyzed through the Mann-Whitney test, since the normality of the distribution has not been achieved. Therefore, non-parametric tests were used.

RESULTS

The first hypothesis assumption is that people integrated within the rehabilitation group were more satisfied with their own rehabilitation and treatment procedures in relation to those who were not considered to be integrated. In order to examine this, the initial assumption was that there is a significant relationship between the examined variables of "satisfaction with the treatment procedure" and a "sense of belonging" from those who went to rehab. Both variables were five-degree categorical variables, so a χ^2 (contingency table, Table 1) was used to test this assumption. According to the χ^2-test, at a significance level of 5 %, we failed to reject the null hypothesis that the variables are independent: $\chi^2(16, N = 211) = 13{,}014$, $p > 0{,}05$. The results indicate that the first hypothesis cannot be confirmed. However, since the results in the descriptive sense indicate that 78 % of those who are satisfied and very satisfied with the treatment also have a strong sense of belonging to the group even with the rejection of the null hypothesis. According to that, hypothesis H_1 should not be discarded in the future research since on the larger sample this close rejection could be shifted in the direction of confirmation.

Table 1. Cross tabulation for variables of "satisfaction with the treatment process" and a "sense of belonging" from those who went to rehab.

A sense of belonging to a rehabilitation group	**How satisfied are you with the treatment procedures so far?**					
	Very satisfied	Rather satisfied	Neither satisfied nor dissatisfied	Not very satisfied	Not at all satisfied	**Total**
1 – not belonging	1,4	1,4	0,5	0,0	0,0	**3,3**
2	0,5	1,9	0,5	0,0	0,0	**2,8**
3	8,1	7,1	1,4	0,5	0,0	**17,1**
4	13,3	13,7	0,9	0,5	0,0	**28,4**
5 – belonging	28,4	15,6	3,8	0,0	0,5	**48,3**
Total	**51,7**	**39,8**	**7,1**	**0,9**	**0,5**	**100,0**

Regarding the second hypothesis, the assumption is that the individuals integrated within the rehabilitation group considered their treatment more successful in relation to those who were not considered to be integrated. The above was examined using two variables: "Consideration of one's own successful treatment" and a "sense of belonging" from those who went to rehabilitation. The dependency was examined among these two variables, and since both variables are the categorical type with a degree from 1 to 5, the χ^2 (contingency table, Table 2) was used. The results show that the null hypothesis of the variables' independence can be rejected: $\chi^2(16, N = 211) = 29{,}070$, $p < 0{,}05$, $V = 0{,}186$. There was 80,9 % of the respondents, among those who rated their rehabilitation with the grades of 4 or 5, who also gave a grade of 4 or 5 regarding the success of their treatment. Furthermore, only 38,5 % of the respondents who rated their rehabilitation with grades of 1 or 2 gave a rating of 4 or 5 regarding the success of their treatment. The hypothesis H_2, based on the described results, is thus confirmed.

So far, the two assumptions have been tested in regard to the relationship between the degree of respondent integration within the rehabilitation group and: (1) their satisfaction with the

Table 2. Cross tabulation for variables of "considering one's own treatment as successful" and a "sense of belonging" from those who went to rehabilitation.

A sense of belonging to a rehabilitation group	How successful do you consider your treatment to be?					
	1 – very unsuccess-full	2	3	4	5 – very successfull	**Total**
1 – not belonging	0,5	0,5	0,9	0,9	0,5	**3,3**
2	0,0	0,5	1,4	0,5	0,5	**2,8**
3	0,0	0,5	4,3	8,1	4,3	**17,1**
4	0,5	0,5	4,7	10,4	12,3	**28,4**
5 – belonging	0,5	2,8	5,7	16,1	23,2	**48,3**
Total	**1,5**	**4,7**	**17,1**	**36,0**	**40,8**	**100,0**

treatment so far, and (2) their perception of treatment success. The results have shown that there is a dependence between the degree of integration into the group and the respondent's perception of the treatment success, but there is no dependence between the mentioned integration and the respondent's attitude toward their treatment satisfaction. The third hypothesis in this article starts with the assumption that there is no difference in the degree of integration within the rehabilitation group with respect to the respondent's sex. Because the variable about the respondent's sense of belonging to the rehabilitation group was constructed through a 5-point ordinal scale, a non-parametric test was used; the Mann-Whitney test. At the significance level of 5 %, it was shown that the degree of integration in the rehabilitation group of female subjects (*Mdn* = 4,0) was not statistically different from the degree of integration of male subjects: (*Mdn* = 5,0), *U* = 2 913, *p* = 0,585. Based on the obtained result, it can be considered that the assumption from the hypothesis H_3 is confirmed.

Similar to the third hypothesis, the fourth and final hypothesis in this article starts with the assumption that there is no significant difference in the degree of a respondent's integration within the rehabilitation group with respect to their age. As noted above, integration within the rehabilitation group was examined using a categorical variable, whereas a respondent's age was examined using an open-ended question. To answer the hypothesis, the variable age was recorded into two respondent groups: younger respondents up to 48 years of age, and older respondents 49 years of age and older. The median value of the variable (*Me* = 48) was the boundary between the two age groups. Using the Mann-Whitney test at a significance level of 5 %, the degree of integration in the rehabilitation group of younger subjects (*Mdn* = 47,0) was not statistically different from the degree of integration of older subjects (*Mdn* = 59), *U* = 3 585,5, *p* = 0,855. Based on the obtained result, the hypothesis H_4 can be considered confirmed.

DISCUSSION

The results of this research demonstrate that there is a clear importance of the inner group integration (perception of that integration) for the individual perception of treatment success. People who have considered themselves integrated in the rehabilitation group had a positive perception of a treatment's success to a larger extent than those who did not consider themselves connected to the group. It goes along with our theoretical background where we suggest that the sick role of an addict (alcoholic) is formed within the inner group, which supports the individual's will to get better. While there is a stigma of deviance in the general society, alcoholics (and other addicts) can only get better in an environment that is supportive and cohesive. Social integration and the perception of it is of key importance for every other step of addiction treatment. Clubs of Treated Alcoholics provides a safe haven for people who have lost their social role. To reintegrate with society means to come back to the meaningfulness of the collective identity of one's society. To achieve this, there is a need to

feel connected to someone without stigma. Alcoholics are institutionalized (in the medical system) but are not provided the sick role by society. The sick role and exclusion of their own condition comes with the acceptance of their new identity and new group cohesion. In a general sense, if a person can feel connected to the group, to the new situation, then they can start with the active and functional process of rehabilitation – but only inside the newly formed sick role specific for addictions. For this to happen, however, old roles and stereotypes must be dismissed. That can be seen throughout the elaboration of the third and fourth hypothesis where there is no significant difference in the process of integration in regard to sex and age. The generation gap which is produced by the different understanding of the stock of knowledge is not present in the new solidarity and the ways of integration formed by the Clubs of Treated Alcoholics. There is a unique focus of attention, and that is the well-being and abstinence from alcoholic beverages. That abstinence is a mutual goal that transcends all other forms of identity distinctions (brought on by the structures of society). In one way, it can be said that the social solidarity of Clubs of Treated Alcoholics is one that is functioning on the principle of the similarity with no strict roles of the members – mechanic solidarity (see Durkheim [21]). These indications, however, require further investigation. The fourth hypothesis goes along with a similar conclusion. The sex and gender gaps in the micro community of Clubs are not of great importance. The results indicate that there is no difference in the ability to integrate into the Clubs between male and female participants. That fact is important because it propose a new theoretical and empirical questions; are the dominant roles of patriarchy in the process of addicts inner group integration left aside? This question leads to the new problematic within the research of relation of social integration and addiction that exceed this article. However, further investigation of this matter should be considered.

Separation of the larger forms of social integrations (and entering a new micro, inner group integration) is important because it removes the stigma and prejudices about alcoholics from the firsthand experience. The stigma remains in the consciousness of the alcoholic, but its impact on the psyche of the individual is reduced. This stigma happens outside the inner circle of trust (once a person integrates into the club(s)). But as we can see, not only does the stigma of alcoholism remains outside, but so does all of the other stigmatized characteristics as well (age and sex in terms of this research). These results show that there is a need of further research on the topic of the values inside the Clubs of Treated Alcoholics, so the group dynamic (now that we know some basic propositions) can be achieved in a way that is helpful to an alcoholic regaining their mental and physical well-being.

CONCLUSION

The primary goal of this research was to identify the connection between social integration and the process of alcohol addiction treatment in the Clubs of Treated Alcoholics in the Republic of Croatia. According to the following goal, research has been constructed to test the four hypotheses, of which three have been confirmed and one has been rejected. The research has shown us the importance of the group integration for the perception of the successfulness of treatment (from the viewpoint of alcoholics in the Clubs of Treated Alcoholics). Also, further elaboration of research has shown us that there is no difference in the degree of integration regarding the sex and the age of participants of the research.

According to the results, it can be concluded that social integration holds a crucial importance for the functionality of rehabilitation, but only throughout individual internalization of group belonging. That group belonging does not rely on the macro-structural roles. It relies on the new ways of the social solidarity within the very group. Sick role in that regard is not structurally achieved, but acquired within the rehabilitation group – in the cohesive interaction between alcoholics inside the clubs. The clubs are providing the individual relief

of societal responsibility and stigma. Belonging to the group is of high importance for maintaining the abstinence of alcohol. In a specific way, Clubs of Treated Alcoholics are providing the individual with a new meaning of collective support. According to mentioned, the sick role, the concept of Talcott Parsons, should be redefined for the addictions – in our case, alcoholism treatment. The steps of the sick role remain the same, but they only happen after the initial group cohesion and integration of the individuals inside, where the new ways of social solidarity are being formed.

The results of this article and the research are also bringing about new questions. According to the acceptance of the third and fourth hypothesis, which have shown that there is no difference in the degree of integration between males and females, or age difference, we should investigate the concept of hierarchy and values inside the very clubs further. In other words, are clubs forming a new kind of relation in the matter of classical distinctions in the macro levels of society? Furthermore, how does the homogenization of the values and differences in life habits happen within the very group? These questions transcend the conclusion possibility of this article, but are indeed opened within the theoretical analysis of the (here presented) results.

REMARKS

[1]Alcohol-related problems from the aspect of society has two main perspectives; moral and medical [14]. This approach has been investigated in the reflection of the social status of an individual. Blum et al. has investigated this issue in the state of Georgia (USA). The perspective has been connected with the education and income of the research participants. Lower income and lower education were connected with the moral perspective and reflection to alcoholism [16].

[2]In this article, the term "solidarity" is defined as a form of social relations inside which individuals have homogenous interests (which are in cohesion). Solidarity is a responsibility of one to all, and all to one [17, 18].

REFERENCES

[1] Kalanj, R.: *Contemporariness of the Classical Theory.*
Politička kultura, Zagreb, 2005,

[2] Berkman, L.F. and Glass, T.: *Social integration, social networks, social support and health.*
In: Berkman, L.F. and Kawachi, I., eds.: *Social Epidemiology.* Oxford University Press, New York, pp.158-162, 2000,

[3] Succer, M.: *Causal thinking in the health sciences: concepts and strategies in epidemiology.*
Oxford Press, New York, 1973,

[4] Honjo, K.: *Social epidemiology: Definition, history, and research examples.*
Environmental Health and Preventive Medicine **9**, No. 193, 2004,
http://dx.doi.org/10.1007/BF02898100,

[5] Durkheim, E.: *Suicide.*
Beogradski izdavačko-grafički zavod, Belgrade, 1997,

[6] Morgan, M.; Calnan, M. and Manning, N.: *Sociological Approaches to Health and Medicine.*
Croom Helm, London, 1985,

[7] Seeman, T.E.: *Social ties and health: The benefits of social integration.*
Annals of Epidemiology **6**(5), 442-451, 1996,
http://dx.doi.org/10.1016/S1047-2797(96)00095-6,

[8] Falci, C. and McNeely, C.: *Too many friends: Social integration, network cohesion and adolescent depressive symptoms.*
Social Forces **87**(4), 2031-2061, 2009,
http://dx.doi.org/10.1353/sof.0.0189,

[9] Medalie, J.H. and Goldbourt, U.: *Angina pectoris among 10,000 men. II. Psychosocial and other risk factors as evidenced by a multivariate analysis of a five year incidence study.* The American Journal of Medicine **60**(6), 910-921, 1976, http://dx.doi.org/10.1016/0002-9343(76)90921-9,

[10] Vogt, T.M.; Mullooly, J.P.; Ernst, D.; Pope, C.R. and Hollis, J.F.: *Social networks as predictors OS ischemic heart disease, cancer, stroke and hypertension: Incidence, survival and mortality.* Journal of Clinical Epidemiology **45**(6), 659-666, 1992, http://dx.doi.org/10.1016/0895-4356(92)90138-D,

[11] Umberson, D.: *Family Status and Health Behaviors: Social Control as a Dimension of Social Integration.* Journal of Health and Social Behavior **28**(3), 306-319, 1987, http://dx.doi.org/10.2307/2136848,

[12] Berkman, L.F. and Syme S.L.: *Social Networks, Host Resistance and Mortality: A Nine-year Follow-up Study of Alameda County Resident.* American Journal of Epidemiology **109**(2), 186-204, 1979, http://dx.doi.org/10.1093/oxfordjournals.aje.a112674,

[13] Parsons, T.: *The Social System.* Routledge & Kegan Paul, London, 1951,

[14] Ames, G.M. and Bennett, L.A.: *The American Experience with Alcohol: Contrasting Cultural Perspectives.* Springer US, New York, 1986,

[15] Caldwell, P.E. and Cutter, H.S.: *Alcoholics Anonymous affiliation during early recovery.* Journal of Substance Abuse Treatment **15**(3), 221-228, 1998, http://dx.doi.org/10.1016/S0740-5472(97)00191-8,

[16] Blum, T.C.; Roman, P.M. and Bennett, N.: *Public Images of Alcoholism: Data from a Georgia Survey.* Journal of Studies on Alcohol **50**(1), 5-14, 1989, http://dx.doi.org/10.15288/jsa.1989.50.5,

[17] Strika, M.: *Perspectives of the Interrelation Between Solidarity, Trust and Voluntarity in the Croatian Society.* Bogoslovska smotra **75**(4), 1153-1174, 2005,

[18] Lozina, D.: *Some Notes of the Term Solidarity.* Zbornik Pravnog fakulteta u Zagrebu **37**(3-4), 564, 1987,

[19] Hudolin, V.: *Alcoholism – Way of Life of the Alcoholic*. Školska knjiga, Zagreb, 1987,

[20] Brezovec, E.: *Consumption of Alcohol in Croatian Social Reality Alcohol as Part of Interaction Ritual Chain.* Alcoholism and psychiatry research: Journal on psychiatric research and addictions **53**(2), 139-146, 2017, http://dx.doi.org/10.20471/dec.2017.53.02.04,

[21] Durkheim, E.: *The Division of Labour in Society*. Prosveta, Beograd, 1972.

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CULTURAL PATTERNS OF DRINKING AND ALCOHOLISM IN NORTH AND SOUTH OF CROATIA

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ABSTRACT

Drinking patterns and types of alcoholic beverages consumed in Croatia vary from culture to culture as well as between different social strata. Alcohol drinking in Croatia is a socially accepted behaviour, and society has a high tolerance for drinking alcohol as a cultural pattern and an accepted style of behaviour deeply rooted in tradition. In its continental part, Croatia belongs to the pattern of drinking of Eastern and Central European peoples by drinking alcoholic beverages, while in the coastal areas, it belongs to the Mediterranean pattern, dominated by wine drinking. Taking comorbidity into account significantly contributes to the quality and success of alcoholics' treatment and improves prognosis. Abuse and alcohol addiction in women have been steadily increasing in recent decades. The results of numerous studies, as well as the experience gained in clinical work, show that there are significant differences in the customs, phenomenology and cultural patterns of alcohol consumption in the north and south of Croatia, and that alcoholism can be associated with suicide rates, Post traumatic stress disorder (PTSD) and depression in the north and south of Croatia. Analyses of the phenomenology and cultural patterns of alcohol consumption in the north and south of Croatia in this article, as well as the results of numerous studies, indicate the need to take into account the sociocultural influences and specificities of a particular country when designing prevention and promotion programs as a precondition for their success, and that in planning interventions and therapeutic procedures in alcoholics should always be sensitive to cultural differences.

KEY WORDS

cultural patterns, alcoholism, North of Croatia, South of Croatia, comorbidity

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INTRODUCTION

Culture (lat. colere – cultivate, nurture) is an integrated system of attitudes, beliefs and patterns of behaviour that are characteristic of members of society, and are not a result of biological heritage, but a social product that is created, transmitted and maintained through communication and learning. Culture is by its very nature a social and psychological product because human nature a political being, a "zoonpoliticon" as Aristotle puts it, a community being, a social being [1].

Alcohol consumption is as old as humanity, archaeological findings suggest that, as early as 30 000 years ago, humans knew that fermentation could produce alcoholic beverages [2]. Beer was known in ancient Egypt for 5 000 years BC and was drunk mostly by the poorer population, while the wealthy drank wine. In India, beverages were made from rice (surah) 3 000 years ago, and in Greece, mead was produced. Before the new era, people made wine, and the first description of distillation dates back to 800 AD (the Arab invention). The first descriptions and warnings about the harmfulness of excessive drinking were found in written documents from ancient Babylon, Egypt, Greece and Rome. The Greek god of wine was Dionysus, and the Roman god of wine was Bakus. The Bible says that Jesus created wine from water, and the Church preached that "wine is the blood of Jesus". Wine is still used in Christian rituals today [3].

Alcohol has been used in the past as a medicine or foodstuff, as a means of relaxing, warming or sleeping, as an integral part of social rituals and celebrations. Among orthodox Jews, alcohol is used as a ritual drink, but it plays no role in daily consumption, while in Italy and France alcohol is a foodstuff, and intoxication is condemned.

Customs, habits, intensity of consumption, type of alcoholic beverages, differences in alcohol consumption by gender, age, religious affiliation differ from culture to culture. Numerous sociological studies address the influence of religious beliefs, and the consumption of alcoholic beverages is linked to a number of factors, one of which is the degree of religiosity of the population. The influence of religious beliefs on alcohol consumption to alcohol consumption in a country varies and depends on many factors, including the degree of religiosity of the population. A significant correlation between alcohol consumption and religion is evident in Islamic law-enforced countries where alcohol and alcohol consumption are prohibited, and in the case of Judaism that permits alcohol consumption, however, the rate of alcoholism among the Jewish is extremely low. Jewish people are specific in terms of alcohol consumption because research shows that 90 % of the Jewish consume alcohol, but the rate of alcoholism is extremely low [4]. Christianity has different views on alcohol consumption; Roman Catholic, Eastern Protestant, and some Protestant churches allow moderate alcohol consumption, while some churches impose abstinence from alcohol, such as the Baptist, Methodist, and some Protestant churches.

R. Bales divides alcoholic beverages according to their function, citing a religious, ceremonial, hedonistic and utilitarian function which addresses certain needs such as relieving oneself from weakness, oblivion, hunger, in the function of warming and repelling fatigue and recall sleep. The hedonistic function refers to the need for feasting and euphoria [4].

D.J. Pittman classified cultures according to their attitude to drinking. He thus distinguishes four basic types of cultures: the first are cultures that condemn the use of alcoholic beverages in any form (Muslims, Hindus, and ascetic Protestants), the latter are ambivalent cultures in which a negative attitude towards alcohol coexists with the idealization of intoxication (English speaking countries, Scandinavia) [5]. Third are tolerant cultures that tolerate moderate alcohol consumption but condemn drunkenness (the Jewish and Italians).

Over-tolerant cultures are the fourth in which very indulgent attitudes toward intoxication and drunkenness are widespread (French, Japanese, and Camba culture in eastern Bolivia).

From an ethnic standpoint, Štifanić describes completely abstinent peoples such as Arabs, then nations with a low incidence of alcoholism as the Jewish, and those with a high incidence of alcoholism as Irish, Scandinavians, Russians, Slovenes, and Croats. According to the same author, sociology explains five basic approaches that deal with the problem of alcoholism: a functionalist, socio-cultural, sociographic, symbolic-interactionist, and social-political approach [4]. The sociocultural approach addresses the historical aspects of alcohol consumption, examines the ways in which individual societies approach the problem of alcohol consumption, and the meanings that alcohol consumption has in a particular society. Drinking alcohol has the function of enhancing social cohesion; Alcohol consumption rituals symbolize the closeness and solidarity of social groups, and also serve to signify a change in status at birth, wedding, funeral and similar ceremonies where alcohol drinking is inevitable in many societies.

Drinking patterns and types of alcoholic beverages differ from culture to culture as well as between different social strata, but they also have many common characteristics that allow us to distinguish several different patterns of consumption across Europe.

The Mediterranean drinking pattern is typical of the European Mediterranean, and is characterized by excessive drinking without intoxication, socially unobtrusive drinking and tolerating excessive drinking. The alcoholic beverage that is most consumed is wine, which is why the countries of the European Mediterranean are classified in the so-called wine zone (Spain, Portugal, Italy, France, Montenegro, Macedonia and others). This drinking pattern is based on frequent consumption of alcohol, but without the loss of control over drinking. Alcohol is consumed in small quantities, but throughout the day, usually with meals. In the countries of the European Mediterranean, a tolerant attitude towards alcohol consumption is present, drinking is advocated and tolerated, but heavy alcoholism is still condemned. Due to the most frequent consumption of beer, the countries of Central Europe are classified in the beer belt, and they have an ambivalent attitude towards alcohol consumption, i.e. in some situations they advocate drinking and in some of them they prohibit and condemn it (Great Britain, Ireland, the Netherlands, Belgium, Germany, Austria, Denmark, Czech Republic, Slovakia, Poland). Northern Europe as well as the Slavic peoples have a highly tolerant attitude towards alcohol consumption. Drinking is advocated, drinking is allowed at every social occasion, and even heavy drinking is tolerated. Spirits are being drunk, and the vodka/brandy belt includes the Nordic and Baltic states, Poland, Ukraine, Russia and Belarus. [6].

ALCOHOLISM AS A SOCIAL PROBLEM

T. Troter pointed out 200 years ago that he considered alcoholism a disease. In the 19th century, M. Huss considered alcoholism a disease [7].

The definition of drinking alcohol as a deviant behaviour, together with the definition of this problem in medical terms and the identification of adverse effects, began only in the 19th century, with changes in the conception of personality and the concept of addiction. From the 1960s onwards, anthropology began to free the drinking of the shackles of human pathological and deviant behaviour and began to view it as a social act, and since the 1970s, anthropology has described and developed a view that drinking alcohol in most cultures is a feature of festivities in which drinking, even excessive, is implied and considered normal [8].

Clinical practice and numerous studies of alcohol abuse in recent decades show that alcoholism is associated with psychiatric disorders and criminogenic behaviour, and knowledge of the personality of each alcoholic is a necessary precondition for therapy. Alcoholics change their personality over time. They only start worrying about the supply and

consumption of alcohol. They lose the interests they had before, they do not care about family and work. They become indifferent, aggressive and overly irritable, and alcohol becomes a shield to defend against the demands of reality. The ability to concentrate and think straight disappears. Abulia occurs, gratification is missing, new information is difficult to grasp, and old information is lost. Ultimately, they come to the stages of disinhibition, their reactions become impulsive, they insult and abuse others. Neglecting body hygiene is also commonly reported. Personality changes are added to already existing imbalanced personality traits [9]. Žarković Palijan in her doctoral dissertation states that psychodynamic tests have been used in many researches of alcoholics personality, the results of which mostly show that alcoholics are more often characterized by schizoidness, masochistic reactions, passivity, poor organization of the ego, ambivalence and a vague concept of self, impulsivity, low tolerance for frustration, satisfaction with short-term rewarding, difficulty in establishing adequate object relationships, sexual identity problems, and negative self-conceptions [10]. Despite some similarities, alcoholics show marked differences in the way these lines manifest themselves. The author concludes that, while it is important to know some of the general facts and common characteristics of alcoholics, it is even more important for the clinical practice to know the differences between them, which allows a more appropriate approach to each individual patient as a unique personality.

What is needed in this situation is a truly broad theoretical framework within which each individual can be placed, and from that frame, practical procedures that represent the basis of the treatment, are derived. She also points out that alcoholism is difficult to treat according to theorists, precisely because of its deep oral fixation and the difficulty in establishing transfers due to rigid defences. Antisocial personality disorder is often associated with alcoholism, and the typology of alcoholics is also based on the difference between alcoholics with antisocial personality disorder and those without antisocial personality disorder. It has been established that alcoholics with antisocial personality disorder start drinking alcohol earlier and show faster development towards more severe alcoholism [10]. Most psychoanalysts believe that the cause of alcoholism happens because of the multitude of specific failures in emotional development and because of the circumstances in the family. The earlier the psychobiological development at which the individual stopped, the more immature his behaviour, personality and defence mechanisms were. The more severe his drinking problem was if he became an alcoholic, the poorer his prognosis was. Alcoholism is socially manifested mostly in the workplace and in the family.

Alcoholism is easier to hide in the workplace, so it first manifests in the family in the form of a loss of family cohesion. It is often the children who suffer the most from neglect of family and parenting responsibilities [11]. Results of two longitudinal (US) studies examining the impact of father's alcohol use on childhood development, the Michigan Longitudinal Study (MLS), which monitored a sample of alcoholic families with 3-5-year-old children over a 20 year period and the Buffalo Longitudinal Study (BLS), which monitored a sample of alcoholic and non-alcoholic families starting from a child's age at 12 months, independently provided evidence that alcoholic fathers directly and indirectly had negative influence on the social-emotional and cognitive development of their very young children. Alcoholism of the fathers alone or in combination with simultaneous psychopathy (the most common antisocial behaviour) can lead to psychopathology in children as early as infancy. Parental alcoholism has been characterized as a family stressor and a reason for parental neglect of children [12].

Alcoholism is an important socio-economic problem in modern society, since it can result in the loss of human lives, increased costs of treatment, loss of manpower and increased crime. In their study, Coeteti, Ion et al. analysed the factors that may determine or facilitate the intergenerational transmission of alcoholism, and the results showed that the mechanisms of intergenerational transmission of alcohol consumption and consumption patterns are complex,

determined by a number of factors including both genetic and family factors. Children of alcoholics have a statistically increased risk of alcohol and other substance abuse, with paternal alcoholism as the dominant factor in predicting offspring alcohol dependence [13].

The results of a study conducted by Nastasić and his associates in 1998 on 60 married couples where the husband (father) is an alcoholic showed that the majority of alcoholics (58 %) have a positive history of alcoholism in the family, while their wives' percentage is lower (40 %), and that alcoholism and marriage begin almost simultaneously in at least 60 % of cases, i.e. the average duration of marriage without alcoholism by about 40 % is barely three years. The authors also point out that research data indicate that alcoholism becomes apparent at the very beginning of marriage, so it seems that personality traits associated with alcoholism have an impact on the choice of spouses, that alcoholism interferes with family life at an early stage of maturation and family development, and that most families report seeking treatment at time when the middle stage of matriculation normally takes place, i.e. in a phase when regulatory processes have already been formed, so they are already significantly (pathologically) stabilized due to the presence of alcoholism (about 10 – 11 years). Significant is also the fact that 81,1 % of children are less than 15 years old at the time of starting their parents' treatment, which means that their psychosexual development is hindered very early, in the most favourable combination it starts at 4,5-5 years, but in most cases even earlier (from birth or at 2-3 years) [14].

Considering the quality and characteristics of the process of transgenerational transmission in the family of the alcoholic husband, Nastasić states that the families of the alcoholic husband are characterized by a straight-line progression, i.e. a permanent slight increase of the fusion indicator from generation to generation, which means that emotional events in each successive generation will be characterized by an increasing degree fusions in relationships and an increasing number of dysfunctions and symptoms. It has also been observed that the transfer in the families of women whose father is not an alcoholic differs from the transfer in the families of those women whose father was an alcoholic, which depends on the length of the interval of trust. The intergenerational transfer of alcoholism takes place according to Orford, Velleman and Nastasić, through a positive relationship with a single parent or through a deficient relationship with one of the parents, i.e. the choice of partner may be affected by the repetition of the pattern of parental alcoholism or the repetition of the pattern of behaviour of the other parent, which subsequently leads to choosing/marrying an alcoholic [14].

From the above, the author also explains the more socially accepted drinking of men, because they have less emotional burden of their father's drinking, while experiencing their own drinking with less feelings of threat and guilt, they may even experience it positively. A group of authors (Hoel, Magne, Erikson, Breidablik, Meland) in their 2004 article prove that excessive drinking is a very important factor of social acceptance in the adolescent population. In contrast, abstinence and drinking small amounts of alcohol are associated with better psychological and emotional health. Excessive drinking also leads to increased problems in the family and at school. Adolescents who are more attached to family are more likely to be abstinent. Early onset of excessive drinking in adolescence is an indicator of poor mental health, and later onset, especially in young men, suggests mental problems and difficulties in adopting adult behavioural patterns. Getting into the world of drinking too early in both young men and girls is an indicator of mental problems [15].

Social compulsion to drink alcohol has evolved into such a psychological power today that people who do not drink (abstinent people) do not have the courage to refuse alcohol when offered because they are afraid to oppose existing social customs. In addition, young people want to go through the puberty phase as soon as possible and become adults. And they see the fastest way to this in precisely the forms of behaviour that they were always forbidden when they were

children, and parents and other parents were allowed to do so. That is why young people try to express their "adulthood" and their entry into the adult world by consuming prohibited means [16].

The incidence of substance abuse or dependence between relatives of first-born alcoholics is 44 %, of which 80 % is related to alcohol abuse or dependence [17].

ALCOHOLISM AND COMORBID DISORDERS

Alcohol-related disorders are widespread. It is estimated that only 10 % of the world's population has never drunk alcohol. There are different data on the number of alcohol addicts – generally ranging from 5-8 %. About as many people drink at the abuse level. In Croatia, 7 000 alcoholics are treated for the first time for alcoholism, but the number of hospitalizations is much higher, which tells us that recurrence is very common and that post-hospital care is still poor or underdeveloped [7].

Taking comorbidity into account significantly contributes to the quality and success of alcoholics' treatment and improves prognosis. The study of comorbidity has been enhanced by the use of standardized psych diagnostic instruments, as well as diagnostic criteria for the diagnosis of primary and secondary psychiatric disorders set out in DSM-IV-TR and MKB-10. In approximately 37 % of cases, alcoholics are diagnosed with other psychiatric disorders that may be primary (promote drinking and alcohol addiction), secondary (develop as a result of alcoholism), or may occur at the same time as addiction. Dependence is known for "self-healing", that is, alleviating insomnia, anxiety and depression. Primary or comorbid psychiatric disorders occur before drinking or while drinking. Comorbid disorders can stimulate drinking, hide drinking problems, contribute to alcohol dependence, which ultimately complicates diagnostic procedures and treatment. Secondary psychiatric disorders are diagnosed if symptoms of a psychiatric disorder develop during intoxication or within one month after intoxication or onset of abstinence and cause clinically significant difficulties with regard to work, family and social functioning. In clinical work, it is very difficult to distinguish primary from secondary psychiatric disorders, so it takes two to four weeks of abstinence to evaluate [18]. Psychiatric disorders related to alcohol dependence are: anxiety, Posttraumatic stress disorder, depression, bipolar disorder, personality disorders, eating disorders, schizophrenia, concomitant alcohol and drug addiction, pathological jealousy, aggression, states associated with brain damage [19]. The rule is that comorbid psychiatric disorders are treated concurrently with treatment of alcohol abuse [18].

Abuse and alcohol addiction in women have been steadily increasing in recent decades. The question of why this is so, and the answer are to be found within a sudden change in the role and position of women in society in the last century. Thaller et al. state that excessive drinking and alcohol addiction in women is proportional to the degree of freedom, women's emancipation and employment [19]. Women have fought for many rights and equality in almost all walks of life in a relatively short period of time, but they have also received many new commitments, while maintaining all the old ones. Today, in addition to her traditional roles in the family, as a mother and wife, a woman also has her vocation, which requires a lot of work, effort and proving oneself. The constant desire to satisfy and be "perfect" in all areas of life is a source of constant tension, insecurity, fears and frustrations.

The way out was to drink alcoholic beverages which, through its anxiolytic action, provide temporary relief and escape from reality. The societal tolerance of moderate alcohol consumption has only further enhanced such choices, putting the woman at risk of sinking deeper and deeper towards alcoholism, because over time, only by increasing the amount of alcohol will it have the same effect. From everything previously stated, we can conclude that the increase in women's drinking is a rare negative consequence of emancipation [19].

This is confirmed by the findings of about fifty years ago, which stated that the ratio of male alcoholics to female alcoholics was about 1:10, and twenty years ago 1:7. Over the last ten years, epidemiological studies show that women are drinking more and that the ratio of male alcoholics to female alcoholics is around 1:3,5 today [19].

Interesting are the results of a multi-national study conducted in 13 European and 2 non-European countries that examined the differences in drinking between women and men. In the introductory article, Bloomfield, Gmel and Wilsnack state that the gender difference in alcohol consumption is one of the few universal gender differences in human social behaviour [20]. However, the magnitude of these differences varies greatly from one society to another. The results show that the higher the gender equality in a country, the smaller the differences in sexual behaviour in drinking. In most analyses, the lowest gender differences in drinking behaviour were found in the Nordic countries, followed by the western and central European countries, and the largest gender differences in countries with developing economies.

Although alcoholism in women is mostly symptomatic, the socially permissible amount of alcohol in women is increasing, which may affect the development of primary (male) alcoholism. Many studies attribute the worrying increase in alcoholism in women to the primary or male (social) type of alcoholism, which is increasingly occurring in working women [21].

Some of the risk factors that lead to excessive drinking in women are the same as in men, such as: hyperactivity, psychopathic personality, spouse or drinking friend, genetic load, but with the emphasis that all these factors, except hyperactivity more prevalent in women who drink excessively than in men [22].

Women start drinking excess alcohol at a later age. Although they start drinking later, women perish faster than men, and develop addiction and socially intoxicated alcohol addiction more quickly. Women who drink, drink significantly less alcohol than men who drink. Their partner is also very likely to drink excessively. In addition to the diagnosis of alcohol addiction, they have other psychiatric diagnoses, and in addition to alcohol, they abuse other psychopharmaceuticals. Drinking largely causes and deepens depressive disorders and vice versa, and for this reason over-drinking women are more prone to suicide. They are often adults or in families of drinking, and are often victims of physical or sexual violence. Their episodes of excessive drinking are generally associated with some stressful event. The mortality rate of women who drink excessively is higher than that of men who drink excessively [23]. The results of a study conducted in 2011 indicated some interesting points regarding differences in family characteristics and psychosocial development characteristics between female and male drug addicts show that, with regard to the sociodemographic status of the primary family, female addicts are more likely to come from families with better material status of excellent and very good status (women 31 %, men 12 %), unlike men who most often come from families of good status (men 70 %, women 57 %), and are more frequent in order births of the first and only family member (68 % female, 43 % male) [24].

Furthermore, the results show that female addicts statistically differ significantly in their emotional relationship and communication with their mother in childhood and adolescence, and that female addicts perceive their relationship with their mother more negatively than men, and more often describe their communication with their mother as defensive and critical. However, with regard to emotional relationship and communication with the father, which is generally negative for both men and women addicted, there is no statistically significant difference, although women perceive their relationship with their father somewhat more negatively than men (40 % women, 34 % men), and men perceive their communication with their father as somewhat more defensive than women (women 53 %, men 64 %) [24]. Although the study was

conducted on a sample of drug addicts, these characteristics of emotional relationships and psychosocial development are observed in clinical practice in alcohol addicts as well. Suicide rates in the northern counties of Croatia are higher than in the southern counties, and alcoholism is known to be a risk factor for suicidal behaviour. Brečić states that 20-50 % of suicide victims are alcohol addicts, i.e. 30-80 % of suicide victims were intoxicated at the time of suicide [25].

According to the data provided by the Croatian Institute of Public Health, age-standardized rates of suicide deaths in Croatia for all ages and ages up to 64 show fluctuations until 1997, and since 1998 there has been a fall in rates (in 2016, the rate of 13,2/100 000 for all ages and 10,9/100 000 for ages 64 and up). For ages 65 and older, the rate, with more pronounced fluctuations, has also declined substantially since 1998 (in 2016, the rate was 31,3/100 000) [26].

According to other Croatian authors, a significant progression of suicide among youth has been observed in our country, especially after the Homeland War. According to data from the past 10 years, an average of 56 children and young people have committed suicide in Croatia annually, which may be related to the occurrence of more frequent consumption of alcoholic beverages by young people, which begins at an earlier age [27]. There are differences in age-standardized rates among Croatian counties. Counties in the coastal part of Croatia have lower rates of suicides than individual continental counties [28].

Addiction has become a major problem in modern society, as evidenced by the 2009 World Drug Report [29]. Although this report concerns psychoactive drugs, not alcohol, the effects of consumption and prevention can be applied to all forms of addiction, including alcohol. The report states: "The problem of drug addiction is a global health and social problem of the modern world, which is essentially a drama for all those involved, especially for a family that is often faced with the inability to successfully confront the problem. The increasing prevalence of drug abuse is consequently leading to the crisis of modern society, the crisis of the family, endangering fundamental societal values and the rise of crime" [29].

DIFFERENCES IN ALCOHOL CONSUMPTION BY REGION

The study, based on data from the 2003 Croatian Health Survey by Benčević-Striehl, Malatestinić and Vuletić, aimed to assess regional and gender differences in the prevalence of alcohol abuse in Croatia. The results of the study indicated that the highest prevalence of alcohol consumption in men was observed in eastern Croatia (14,1 %), which also recorded the lowest prevalence of alcoholic beverages (0,3 %). The highest proportion of women who reported drinking alcohol was recorded in northern Croatia (1,5 %) [30]. The results show the expected gender gap in alcohol consumption. This underscores the potential, but underutilization, of primary prevention and health promotion with particular emphasis on regional customs [30].

In Croatia, according to estimates by Mustajbegović et al., 2 260 540 people drink alcohol, 11 330 351 men and 930 196 women [31]. From this, we can see that 81,3 % of the male population drinks, while the percentage of women is 51,2 %. The frequency of alcohol drinking by counties in Croatia is also indicated. Data from the analysis of the mentioned authors showed that most alcohol is drunk in the Varaždin and Koprivnica-Križevci counties, as well as the Istrian and Šibenik-Knin counties, more than 65 %. At least 30 % of alcohol is drunk in the County of Lika-Senj. In the Lika-Senj County, 85 % are predominantly men, and women predominate in Virovitica-Posavina County with more than 50 %. The county with the same number of men and women who drink alcohol is Varaždin. The majority of alcohol is drunk by the 35-64 age group, but there is also a shift to the younger generations up to 34 years, especially in Vukovar-Srijem, Brod-Posavina and Koprivnica-Križevci counties.

People drink all alcoholic beverages, but mostly wine and water, followed by beer. The amount of drinking is analysed in glasses. People mostly drink a combination of wine and water (bevanda, spritzer) in Dubrovnik-Neretva County, above 8 glasses. This is followed by the County of Šibenik-Knin with about 7 glasses and the County of Krapina with about 4 glasses. The combination of wine and water is being followed by beer consumption, mostly in the County of Lika-Senj with more than 4 glasses. In the County of Lika-Senj, people drink mostly spirits, with about 3 glasses. In the City of Zagreb and the County of Karlovac, people equally drink beer and the combination of wine and water (spritzer) [31].

CULTURAL FEATURES OF ALCOHOL CONSUMPTION IN CROATIA

Alcohol consumption in Croatia is a socially accepted behaviour, and society has a high tolerance for drinking alcohol as a cultural pattern and an accepted style of behaviour deeply rooted in customs. Drinking alcohol is favoured even when the consequences of alcohol dependence on health, family and work function are evident. The norms of behaviour are such that drinking alcohol is also expected even when a person does not want to drink alcohol, out of respect for those who celebrate, grieve, get a job, retire or have a significant event in their lives. Croatia consumes 12 liter per capita in the upper EU countries in terms of alcohol consumption, and the actual consumption of alcoholic beverages is unknown due to a large number of private alcoholic beverage producers. According to the Customs Administration, in 2017 there were 41 650 small producers of strong alcoholic beverages in Croatia reported, and it is estimated that there are significantly more of them in real terms. In both the north and the south of Croatia, almost every house has traditionally produced its own wine for personal use, and today, part of that tradition is preserved, but to a lesser extent [32].

When it comes to attitudes towards alcohol drinking, Croatian society has an ambivalent one. Negative attitudes towards alcohol consumption, especially of young people, are recognized in the legislation and the ban on the sale of alcoholic beverages under the age of 18 and in a public place, in the views of professionals in the health and education system, but on the other hand, it is allowed to advertise alcoholic beverages in the media. Many celebrities from public life participate in those advertisements. The main objective of the research conducted in 2015 as part of the Joint Action to reduce alcohol-related harm (JA RARHA) was funded by the European Union Health Program sponsored by the Croatian Institute of Public Health in the Republic of Croatia to benchmark and monitor the epidemiology of alcohol, including the amount of alcohol consumed, and drinking patterns and alcohol-related harm in the EU [33]. Croatia was one of the 19 EU countries included in the survey, with a sample of 1500 respondents, of whom 49,9 % were male and 50,1 % were female respondents aged 18-64. According to the results of that survey, 78,1 % of all of the respondents drank alcohol in the last 12 months, men 85,3 % and women 71,0 %, and this difference was statistically significant [33].

The results also indicate a tendency to reduce alcohol consumption as a function of age. The majority of alcoholic beverages were drunk by the population between the ages of 18 and 34, 85,0 %, followed by alcohol consumption by 76,7 % between the ages of 35 and 49, and more than 72 % of the population by the age of 50. Among men, 8 % were absolute abstainers, and 19,8 % of women had never drunk alcohol in their lives.

Young men are more prone to drinking than girls in all age groups and 40 % of young men by the age of 15 are more prone to drinking compared to 24 % of girls. The Standardized European Alcohol Survey (RARHA-SEAS) found that in Croatia, the incidence of excessive episodic drinking at least once a month in the last 12 months is 11 %, and is highest in the 18-34 age group and is 17 %. Most people drank (once a week and more often) in their own homes (30 %) and with friends, colleagues, and acquaintances (30 %) [33].

In the last 12 months, 66,2 % of all respondents have drunk beer, 58,2 % drank wine and 45,4 % drank spirits. In the total volume of pure alcohol in the Republic of Croatia in the last 12 months to which the research referred, beer ranked at 56,0 %. %, wine 34,0 %, and spirits 10,0-11,1 % of all respondents drank excessively, i.e. at least once a month, including 16,7 % of male and 5,5 % of female respondents. 16,8 % of them, again, belong in the age group from 18 to 34 years old. Ultimately, the study concluded that Croatia is among the countries (along with Portugal and Romania) with the largest significant gender difference: Croatian males are 5 times more likely to have alcohol problems than Croatian women [33].

DIFFERENCES IN DRINKING CULTURE BETWEEN NORTHERN AND SOUTHERN CROATIA

Croatia is a very traditional wine-growing country. Wine and the production of wine and other alcoholic beverages have a prominent place in various folk customs and are associated with wine and alcohol with a whole set of customs and beliefs. In some areas, this connection is more pronounced, depending on the middle ground, the rootedness of tradition, and the customs that accompany and emphasize that tradition. Croatian viticulture is an integral part of every farm. But there are differences between north and south in the sale of wine and its role in the community. The importance of viticulture in the north was more strongly related to its integration into the culture, customs and mentality of the population while in the south, existential dependence was more pronounced [34].

In its continental part, Croatia belongs to the pattern of drinking of Eastern and Central European peoples by drinking spirits while in the coastal and coastal areas, it belongs to the Mediterranean pattern of wine-dominated drinking. Croatia has for centuries developed a positive attitude towards alcoholic beverages and drinking alcoholic beverages, and a tolerant attitude towards excessive drinking. In the north, the host, the boss, the head of the house in the family, during various social events and occasions, friendly gatherings and parties, shows his power, hospitality, generosity by constantly pouring "cups" (glasses). Wine is a sign of abundance, friendship and welcome [35].

In this part of the article we will describe the phenomenology and customs related to wine drinking in the north and south of Croatia, from personal and professional experience. As we have already said, the tradition of drinking wine in our region goes back to the past. The phenomenology of wine drinking in the North and the South differs in certain details and reflects the character of the North – the "Northern" way of drinking and the character of the South – the Southern (Mediterranean) way of drinking, its relation to wine and the meaning attached to it. In the north, the host, the boss, the head of the house in the family, during various social events and occasions, friendly gatherings and parties, shows his power, hospitality, generosity by constantly pouring "cups" (glasses). Wine is a sign of abundance, friendship and welcome. Constant pouring, drinking a "cup" bottoms up is a sign of accepting the welcome and respect of the host, as well as expressing the power and health of both the boss, the head of the house and the drinker – a common belief that a strong and powerful, healthy person can drink a lot. The aforementioned paradigm is also seen on daily occasions as calling (paying) a "round" for the friends in the circle, in which the ordering person plays the role of the boss who demonstrates his power. After the first round, it is customary for every member of the circle to call for at least one more round. Workers in Austria and Germany have brought to the northern parts of Croatia the custom of calling the "round" (a drink for everyone in the inn) by ringing the bell (usually at the bar), which is accepted in many hospitality facilities. Each encounter begins with a welcome drink, and ends with a so called 'one for the road' drink, which usually does not end with one last, complimentary drink, but multiple. In situations where one hesitates when drinking, they are urged to hurry

and drink the already poured alcohol, so that they can pour new ones, to toast and "clink glasses" and to drink bottoms up. If he refuses, his masculinity is called out, and he is encouraged to drink and warned that "only a woman (the weaker sex) can be topped up" (literally and figuratively), but "real men" cannot. In this way, members of society, men, are encouraged to drink bottoms up so that "fresh wine" can be poured. This is how the model of wine drinking develops – to the point of intoxication – excessive drinking without real need and pleasure. Wine is being glorified, quantity and quality go without saying. In this way, the power of both the one who pours (not sparing) and the one who drinks is glorified, because well, he can drink a lot (a symbol of male strength and health). He acts as though he enjoys it, and, in turn, the one who drinks or toasts, is graced by the acceptance from his drinking friends through being loud and gesturing accentuated by such behaviour – constant toasting, lifting and clinking of glasses.

In the south, in Dalmatia, drinking bevanda is traditionally nurtured. One reason is the awareness that wine is "strong" for quenching thirst, and the other reason is "sparing" ("frugality") as a rational approach in a situation of poverty. Old customs in the south say that only the host can drink "as much as he wants," and the rule for others is that they can only 'wet the palate' with wine and praise the aroma and taste of the host's wine. The emphasis is on the pleasure; quality over quantity. The host can drink as much as he wants because he is experienced, smart, wise and also aware that the year is long, so he will drink a little too, because tomorrow is another day. There is little wine in the glass, but the quality of it is boasted even when there is nothing to boast. This is probably due to the lack of large quantities of wine and the negative effect on human behaviour correlated with the amount of wine drunk, which is not being approved in the south of Croatia.

In addition to wine, the grape brandy (from grains, residues) is baked in the south, which contains fragrant herbs and mostly medicinal herbs and green nuts (walnut brandy). The brandy is not drunk bottoms up, it is drunk only slightly, in a shotglass called "Bićerin" (a glass less than 0,5 ml), and often it is poured into the Bićerin for stimulation (morning, before meals) or in the evening for "fatigue relief". Especially strong brandies (spirits, first fruits) are used for external use. Because of the very high concentration of alcohol, there is no pleasure of drinking and it is harmful, so the first fruits are not drunk. The first fruit (the name itself tells them that it is the first brandy that comes out during distillation), come in very small quantities and they are used for massages sick people and disinfection. Cherry brandies are also very famous, which are made by fermenting cherries in jars with added sugar (in the villages there are frequent scenes of cherry jars on windows facing the sun - south). This is generally done by women and it is often women who drink it as liquor in very small quantities in order to enjoy the aroma and taste of this drink. In the north, brandy is baked from various fruits and produced in large quantities (plum, apricot, pear, apple, cherry). Men take care of orchards and vineyards, but men, in general, do not eat the fruit but bake brandy from it.

When we talk today about the St. Martin's Feast, we regularly think of celebration, wine, booze and fun. Ever since and to what extent is wine connected with St. Martin in the northwestern Croatian territories, and whether people have always looked forward to Martin's Day, are questions that are almost impossible to answer. The Croatian northwest includes Zagorje and Međimurje geographically, traditionally wine-growing regions whose main and most attractive annual feast from ancient times to the present day has remained dedicated to St. Martin [36], Figure 1.

Wine in the south is given the significance of a hedonistic remedy (the pre-Christian culture of celebrating the Roman god of wine Bacchus, the Greek god of wine Dionysus) to the Christian culture of moderation summarized in the slogan – "drink a little, drink well." Only

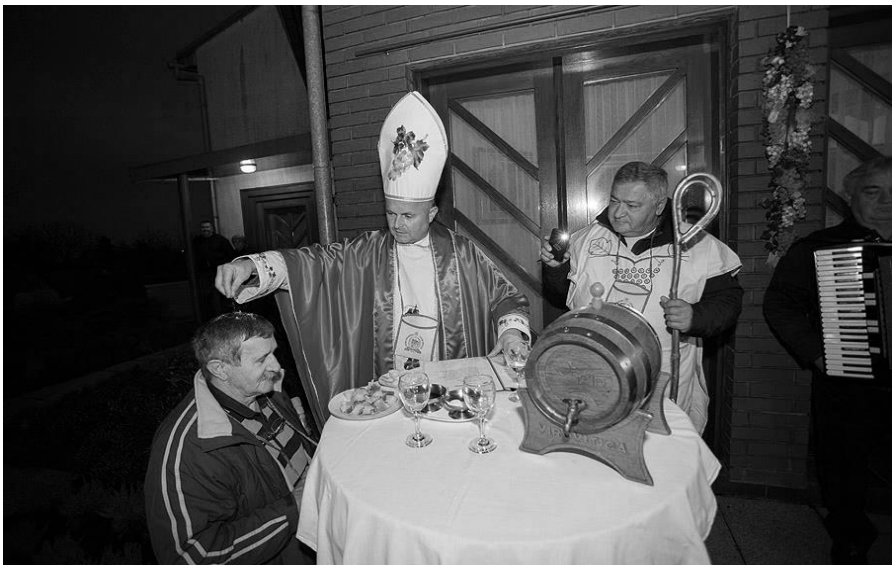

Figure 1. "Martinje on Vidikovac", downloaded from http://virovitica.net.

Figure 2. Celebration of Bacchus. "K.D. Bakove svečanosti" from Imotski. downloaded from http://imotski.in.

on Good Friday is wine given a religious meaning – it is believed that red wine that is drunk during Good Friday is directly converted to blood, Figure 2.

The aforementioned phenomenology and customs related to drinking vary from place to place, from village to city, and lately there has been a noticeable change in the drinking paradigm in both the north and the south – the advancement of viticulture, competition in the quality and knowledge of varieties, flavours and aromas, especially in elitist circles of society, which tends to change the paradigm of traditional customs described. It should also be emphasized that statistic have confirmed an increasing number of beer drinking in the male population in the wine-growing regions of the north and south of Croatia.

The customs described are mostly related to men. The roles of women – mothers in the family and attitudes towards women in the north and south also differ, and these differences need to be taken into account in clinical work and in the therapeutic approach. The family approach to alcoholism treatment was introduced by Hudolin long ago, and he based his method of

treating alcoholism (today's Zagreb School) on family therapy through the Clubs of Alcoholics in Treatment.

Our clinical practice shows us the differences in the traditional role of women in the north and south of Croatia, which are reflected in the dynamics of the partner relationship, the occurrence and maintenance of alcoholism of men (partners) and its treatment. Leinert Novosel's research shows that in Croatian society, women continue to retain the traditional role of caring for children and families. In our experience of working with families of alcoholics, we notice a difference in the role of women in the north and south of Croatia, which will be discussed further in the text.

DIFFERENCES IN THE ROLE OF WOMEN IN FAMILIES IN NORTHERN AND SOUTHERN CROATIA

As stated earlier, in the northern parts of Europe, where gender equality is higher, the gap between the incidence of drinking alcohol between men and women is decreasing. On the other hand in longitudinal research Leinert Novosel showed a high degree of egalitarism in the Croatian public sphere, controlled by different kinds of profession and role characteristics but in the private sphere, it was shown that women today have even more difficult role in the family than before – women again play their traditional roles, such as taking care of children [37].

In the north, the mother is powerful, firm and determined, often performing "men's jobs" (working in the field, caring for livestock, etc.), setting boundaries in the family and emphasizing a rational approach. It is often dominant in the private as well as in the public sphere. The woman often assumes responsibility for the family, provides material resources for her survival, takes care of the upbringing and health of children and the husband, most often neglecting her own health and neglecting her own satisfaction in the partnership and family. Due to the stated role of women in families in the north, families in which the father is an alcoholic do not perish (materially, economically). Family failure is more likely if the mother/wife becomes an alcoholic.

This is stated in the well-known poem from Međimurje county "Children, My Children", by Elizabeta Toplek, which states: "My children, my children, you shall never have anything, your mother is to blame, she drank it all"! And many studies show that parental alcohol abuse, especially maternal alcohol abuse, has extremely damaging psychological and social consequences for children who themselves are at risk of developing addiction [29]. There are probably many factors that have contributed to women's dominance and family structure in northern Croatia. Poverty of the predominantly rural population of Međimurje and close proximity to the border, transport and historical connection with the countries of Central Europe caused the emigration of the population, mostly of men in earlier periods, and the expansion of emigration and chain migration was recorded in the 1960s when about 10 % of the total population of Međimurje emigrated [36]. Absence of husband/father (fieldwork, working abroad, alcoholism) is certainly an important factor that has determined the dominant role of women in the family. Also, in the not-too-distant past, it was common in the northern parts of Croatia and Slavonia to marry (arranged or "for love") at an earlier age, so newlyweds were often 16/17 years old. Brides, girls, have been more mature and thus often assumed a more dominant role in the partnership that took place during marriage, and by transgenerational transmission this way of domination of the woman and her role in the family was passed on to and to younger generations, and partly preserved to this day.

According to our observation, the role of the mother in the southern parts of Croatia, the mother has a paradigmatic Marian role: she is the one who supports the patriarchal family structure. The emphasis is on the principle of sensitivity and unconditional love. According to the children, the mother is "weak", indulgent, difficult to establish discipline and boundaries,

and in the absence of her father (e.g. work abroad) has problems due to a withdrawal of authority and setting the boundaries. In the southern regions, because of that, the child is presented with a father figure in the form of threats, of course, in situations of "female" powerlessness: "you will see when He (your father) gets you!" It should be noted that these patterns of mother's role in the family vary from family to family, from woman to woman, and that generalizations are not possible, but should be taken into account when reflecting family dynamics and the impact on family relationships, and the possible role in the genesis of alcoholism in family members.

Because culture is a social product that is created, transmitted, and sustained through communication and learning, so are the social narratives and behavioural styles associated with drinking wine and alcoholic beverages generally important for the genesis of alcoholism. Although it is necessary to take into account the influence of biological, psychological and social factors contributing to the onset of alcoholism and the outcome of therapy, as well as the success of changes in the whole family system, we wanted to emphasize in this article the need for a therapeutic approach in the treatment of alcoholism that will take into account the differences in the drinking culture and the role of women in families in the north and south of Croatia. The differences observed in clinical work, as well as the results of other authors' research, indicate the importance and need to investigate addiction through a gender-responsive approach, and the need to take into account the specificities arising from these differences when planning addiction prevention programs and treatment programs (Wetheerington, 2007.) [29].

The relevance of alcoholism as a medical and social problem will also be demonstrated through the prism of the number of suicides committed and the number of hospitalized persons from post-traumatic stress disorder, who are ethiopathogenically likely to be interconnected and often intertwined with alcoholism. This is important because of its impact on the therapeutic guidelines and the outcomes of the treatment itself [18, 19].

SOME STATISTICAL INDICATORS OF ALCOHOLISM AND MENTAL DISORDERS IN CROATIA

Hudolin et al also noted that at least 20-30 % of psychiatric diagnoses were caused by alcohol, but few were verified to be a result of alcoholism. In a study conducted in 2014 by M. Rapić and M. Vrcić-Keglević, the results of the study indicated that, in parallel with the increase in the total morbidity registered in family medicine from 1995 to 2012, the incidence of mental illness also increased. Mental illnesses accounted for 4,2 % in 1999, and 5,8 % in 2012 for total morbidity. An increase was observed in all mental illness groups, except for conditions related to alcoholism. In 1998, alcoholism accounted for 9 % of the total mental illness, and in 2012, only 3,2 %, with a decrease in all age groups. Looking at the absolute numbers, only 21 077 patients with alcoholism were registered in general practice in 2012, i.e. 0,6 % of the adult population. The authors rightly conclude that the number of registered alcohol-related diagnoses, especially their steady decline, is unlikely to be true [38]. The 2003 studies by Benčević-Streihl et all. on alcohol consumption in Croatia indicate that excessive drinking is present at 12,3 % of men and 0,7 % of women surveyed [30].

According to the Croatia Institute of Public Health (CIPH) data, alcoholism is number one reason for morbidity of hospitalized patients due to mental disorders in northern parts of Croatia and schizophrenia is the number one reason for morbidity of hospitalized mental disorders in southern parts of Croatia [39].

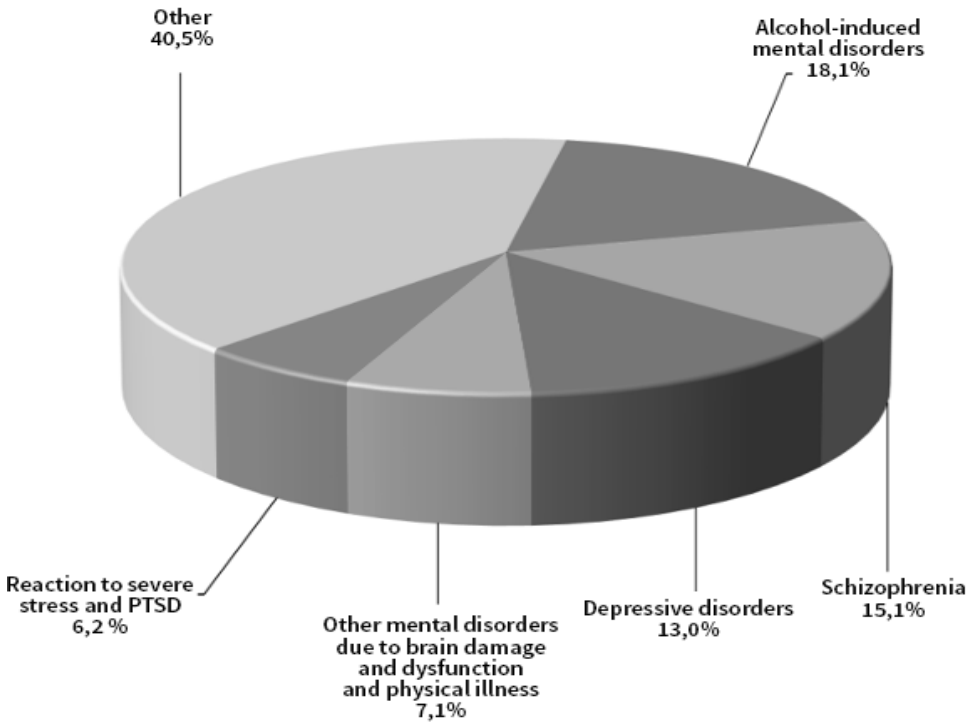

Figure 3. Leading diagnostic categories and share of hospital morbidity due to mental disorders in Croatia 2017 [39].

According to the CIPH data in the publication "Mental disorders in the Republic of Croatia" from 2018, it is clear that mental disorders caused by alcohol, schizophrenia, depressive disorders, mental disorders due to brain damage and dysfunction and physical illness and reactions severe stress and adjustment disorders, including post-traumatic stress disorder (PTSD), as separate diagnostic categories, account for almost two-thirds of the causes of hospitalizations for mental disorders [29], Figure 3.

According to the CIPH, of all the diagnostic categories of mental disorders, mental disorders caused by alcohol are the most common cause of hospitalizations at a rate of 18,1 %. Compared to hospitalization data in general practice, mental disorders are markedly neglected. According to the CIPH data for 2017, the prevalence of mental disorders and behavioural disorders in primary health care is significantly lower, amounting to only 4,9 % of all [39], Figure 4.

Rapić and Vrcić-Keglević in their work Alcoholism – Forgotten Diagnosis in Family Practice analyse mental illness (category "F", ICD-10) in family medicine with special reference to alcoholism (F10.2) from 1995 to 2012, and note that in 1998 alcoholism has contributed 9 % to mental illness in family medicine, and in 2012 only 3,2 %. The authors wonder whether the phenomenon of stigmatization of alcoholism is still present, not only among patients and their families, but also among doctors, whether these are difficulties and uncertain outcomes of treatment, or whether other, more modern, diseases have suppressed this disease in the subconscious of doctors[38]. Other issues could be added to these issues, such as those related to the content and scope of undergraduate medical students and subsequent specializations in general medicine in the field of psychiatry and mental health care, such as the lack of primary care psychologists, the less frequent conduct of systemic exams and changes in the labor market.

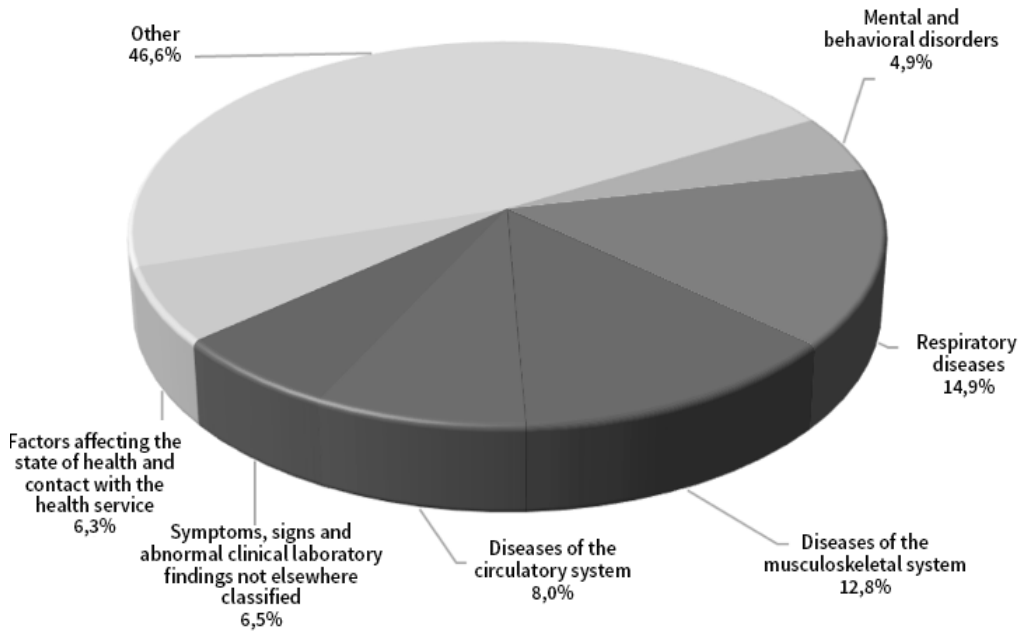

Figure 4. Diagnostic subgroups and the proportion of mental disorders at the primary care level in Croatia in 2017 [39].

There is also a marked coincidence of suicide rates with the prevalence of alcoholism and the rate of mental disorders caused by stress. In almost the same observation period (1995 to 2017), according to CES data, it is noticeable that women are significantly more hospitalized for depression (F32-F33) and men for PTSD (F43.1), which is understandable for the participation of men in the Homeland War, Figure 5. A disease specific to the veteran population is post-traumatic stress disorder (PTSD). According to data during 2016, 31 337 Croatian veterans used health care for this disorder. The largest number of such veterans is 5 397, from Split-Dalmatia County, followed by 4 510 veterans from Osijek-Baranja County, 2 993 from Vukovar-Srijem County and 2 615 from City of Zagreb [25]. According to the CIPH data (2017), 21 236 veterans were registered in the Republic of Croatia in 2016 who, because of their depressive disorders, used health care [25]. Veterans are particularly vulnerable to the suicides of their fellow soldiers. Between 1991 and 2015, 2 734 veterans committed suicides in the Republic of Croatia. In the last three years (2013-2015), the veteran population has committed twice as many suicides as other civilians, making it the most vulnerable social group. About 150 veterans' suicides occur annually and this number is on the rise, and according to media reports in September 2019, 3 246 veterans have committed suicide since 1991 [40].

Comparing the rate of hospitalizations for mental disorders in the Republic of Croatia, the rate of hospitalizations for mental disorders caused by alcohol, the rate of hospitalizations for severe stress reactions and adjustment disorders including PTSD and the rate of suicide by sex in the Republic of Croatia from 1995 to 2017, according to the data from CIPH [39], which is significantly dominated by men, there is no doubt that mental disorders caused by alcohol are probably factor in making this difference at significantly higher rates in men more than in women, Figure 5.

It is also important to analyse the suicide rate in the Republic of Croatia due to the well-known fact that completed suicides are dominated by men and in women's attempts, and that up to 80 % of suicides have been committed while intoxicated - three quarters of men and a quarter of women who commit suicide (75,6 % of men according to 25,4 % of women) committed suicide while intoxicated. [40] Generally speaking, psychiatric disorders are the most common causes of suicide, in almost 90 % of cases. Of these, depressive disorder is the

cause of suicide in 60 % to 80 % of cases. Abuse of psychoactive substances and alcohol, especially in young people, is the second most frequent cause of suicide, from 5 % to 15 %, while psychotic disorders are the third cause of suicide in about 10 % of cases, followed by dementia and delirium. Mourning and prolonged social difficulties (e.g. unemployment) are the causes of suicidal behaviour. Social isolation – Single life, lack of confidence and warmth can also be a causal factor for suicidal behaviour [42].

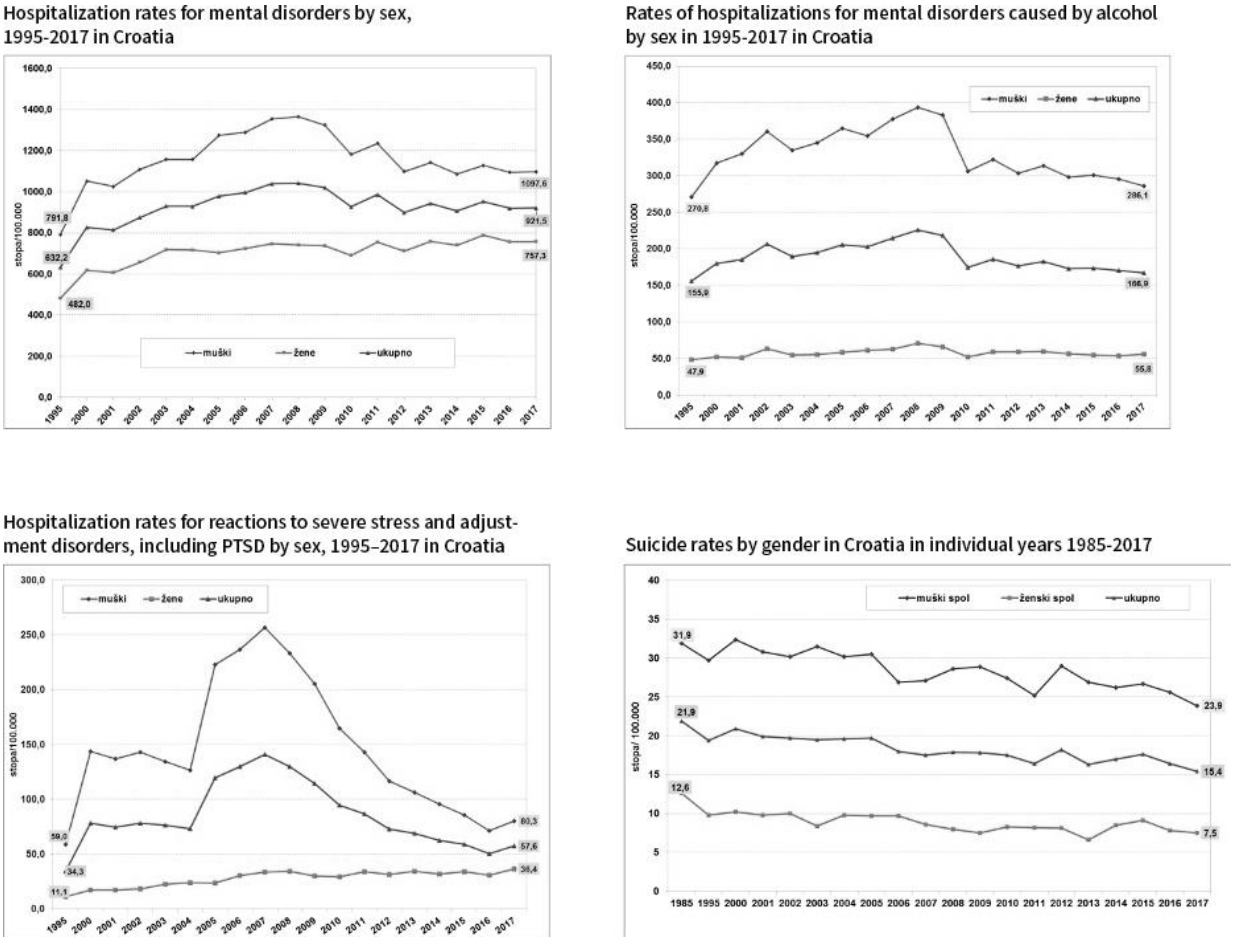

Figure 5. Comparison of rates by the number of hospitalizations for mental disorders, alcohol-induced mental disorders and PTSD and rates of suicide by sex in the Republic of Croatia [39].

It is also important to compare suicide rates by county, which could be put in the context of drinking culture, the incidence of alcoholism and the impact on suicide rates in the population, Figure 6.

Figure 6 shows that the suicide rate is higher in the northern counties and is above the Croatian average, while the suicide rate in Split-Dalmatia county is the lowest (7,5). The fact is that the suicide rate in the northern counties of Croatia is higher than in the southern counties, and alcoholism is known to be a risk factor for suicidal behaviour. Brečić states that 20-50 % of suicide perpetrators are alcohol addicts, i.e., 30-80 % of suicide victims were intoxicated at the time of suicide [25].

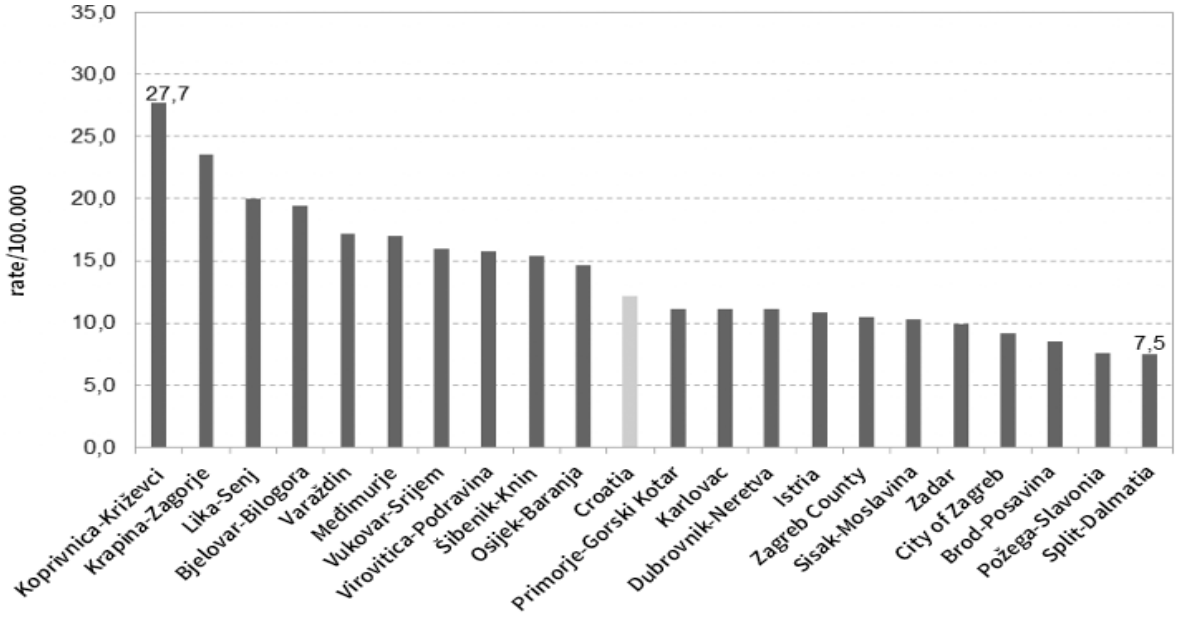

Figure 6. Age-standardized suicide death rates for all ages total by county of residence in 2017 [39].

According to the data provided by the Croatian Institute of Public Health, age-standardized rates of suicide deaths in Croatia for all ages and ages up to 64 show fluctuations until 1997, and since 1998 there has been a fall in rates (in 2016, the rate of 1,2/100 000 for all ages and 10,9/100 000 for ages 64 and up). For ages 65 and older, the rate, with more pronounced oscillations, has also declined significantly since 1998 (in 2016, the rate is 31,3/100 000). There are differences in age-standardized rates among Croatian counties. Counties in the coastal part of Croatia have lower rates of suicides than some continental counties [26].

What many experts agree on, as indicated by the results of numerous studies, is the need to take into account the sociocultural influences and specificities of a particular country when designing prevention and promotion programs as a precondition for their success, and that there should always be sensitivity to cultural differences when planning interventions and therapeutic procedures in the treatment of alcoholics.

CONCLUSION

In this article, we have described the customs and culture of drinking wine and alcoholic beverages in the north and south of the Republic of Croatia, and the impact of culture on the incidence of alcoholism and problems related to excessive drinking.

The increased incidence of alcoholism in the north compared to the south of Croatia and the increased prevalence of alcoholism in men are related to the culture and tradition associated with drinking alcoholic beverages. The incidence of alcoholism is influenced by many factors, ranging from the biological and psychological characteristics of individuals and their families, as well as social attitudes related to drinking and excessive drinking. The social acceptability of excessive drinking is particularly emphasized in the northern parts of Croatia, and the influence of drinking culture on behaviour, especially of men, is undoubtedly important, which affects the choice of therapeutic techniques and therapy goals, as well as the treatment outcomes and the occurrence of recidivism. Data from clinical practice and numerous studies support the reduction of differences in alcohol drinking between men and women as a negative consequence of gender equality by adopting the same patterns of alcohol-related behaviour and the early entry of young people into the world of alcohol consumption. Because of the

above, interventions in terms of changing the social narrative related to drinking alcohol and respecting the cultural and historical legacy of alcohol consumption in the north and south of Croatia in treatment could have a beneficial effect on reducing the incidence of alcoholism, suicide, and recidivism.

Involving the family in the treatment of addiction is of great importance (the role of Clubs of Alcoholics in Treatment – CAT), as well as the involvement of the entire work and social environment in reducing the harmful effects of alcoholism on the individual, family and the wider community. Although it is necessary to take into account the influence of biological, psychological and social factors that contribute to the onset of alcoholism and the outcome of therapy, as well as the success of changes in the whole family system, in this article on alcoholics, we wanted to emphasize the need for a therapeutic approach in the treatment of alcoholism that will take into account the differences in the drinking culture and the role of women in families in the north and south of Croatia.

Social change in the drinking culture requires broader social engagement and public health policies that promote non-drinking, which in the long run will change attitudes, values, and behaviours related to alcohol drinking and the emergence of alcoholism, which is still a major public health problem without adequate prevention and with an underdeveloped rehabilitation. The article emphasizes the need to take into account the sociocultural influences and specificities of a particular region when designing prevention and promotion programs as a precondition for their success and the need to always have a sensitivity to cultural differences when planning interventions and therapeutic procedures in the treatment of alcohol addicts.

REFERENCES

[1] Jakovljević, M., et al.:*Mental health, culture and society.* Pro mente, Zagreb, 2014,

[2] Hudolin, V.: *Alcoholism, the lifestyle of alcoholics*. Školska knjiga, Zagreb, 1987,

[3] Popović, V.: *Alcoholism, an epidemic of our age*. Sven, Niš, 2015,

[4] Štifanić, M.: *Alcoholism and the social sciences*. Društvena istraživanja **4**(4-5), 703-719, 1995, http://hrcak.srce.hr/32374,

[5] Popović, M.: *Beverages in Croatian and Russian proverbs*. Ph.D. Thesis. University of Zagreb – Faculty of Humanities and Social Sciences, Zagreb, 2018,

[6] Prekratić, S.: *A sociological analysis of alcoholism – A sociographic approach.* University of Zagreb – Faculty of Humanities and Social Sciences, Zagreb, 2016,

[7] Bagarić, A. and Goreta, M.: *Psychiatric expertise of drug addicts and gambling*. Medicinska naklada, Zagreb, 2012,

[8] Milanović, N.: *Thinking alcohol and drinking socially: Shifting from socio-medical standpoint towards drinking culture.* Antropology **16**(1), 89-102, 2016,

[9] Bodor, D.; Tomić, A.; Ricijaš, N. and Filipčić, I.: *Impulsiveness in Alcohol Addiction and Pathological Gambling.* Alcoholism and Psychiatry Research **52**(2), 149-158, 2016, http://dx.doi.org/10.20471/apr.2016.52.02.05,

[10] Žarković Palijan, T.: *Personality characteristics of alcoholics of offender and non-offenders.* Ph.D. Thesis. University of Zagreb – School of Medicine, Zagreb, 2004,

[11] Hotujac, Lj., et al.: *Psychiatry.* Medicinska naklada, Zagreb, 2006,

[12] Fitzgerald, H.E. and Eiden, R.A.: *Paternal Alcoholism, Family Functioning and Infant Mental Health.*
Zero to Three **27**(4), 11-18, 2007,
[13] Coteti, A., et al.: *Like Parent, Like Child? Considerations on Intergenerational Transmission of Alcoholism.*
Journal for Multidimensional Education **6**(2), 39-53, 2014,
[14] Nastasić, P.: *Alcoholism and intergenerational transmission.*
Tehniss, Beograd, 1998,
[15] Hoel, S.; Eriksen, B.M.; Braidablik, H.J. and Meland, E.: *Adolescent alcohol use, psychological health, and social integration.*
Scandinavian Journal of Public Health **32**(5), 361-367, 2004,
http://dx.doi.org/10.1080/14034940410027894,
[16] Manenica, B.: *Addiction.*
August Šenoa d.d., Zagreb, 1997,
[17] Ercegović, E. and Milošević, M.: *Excessive drinking and working ability in men.* In Croatian.
Sigurnost **54**(2), 127-135, 2012,
[18] Buljan, D., et al.: *Psychiatry comorbidity of alcoholism (dual diagnoses).*
Alcohol Messenger **6**(180), 4-14, 2010,
[19] Thaller, V., et al.: *Alcohology.*
CSCAA, Zagreb, 2002,
[20] Bloomfield, K.; Gmel, G. and Wilsnack, S.: *Introduction to special issue: "Gender, Culture and Alcohol problems: a multi-national study".*
Alcohol and Alcoholism **41**(1), 13-17, 2006,
http://dx.doi.org/10.1093/alcalc/agl070,
[21] Juraj, J.: *Alcoholism and women.*
In: Golik-Gruber, V., ed.*: Anthology of expertise journal of alcoholism*. Croatian Association of Alcoholics Treatment, Zagreb, pp.147-151, 2003,
[22] Torre, R.: *Decline of alcoholics.*
Profil knjiga, Zagreb, 2015,
[23] Torre, R.; Zoričić, Z. and Orešković, A.: *Women and alcoholism: specifics of drinking and treatment.*
Socijalna psihijatrija **38**(3), 190-196, 2010,
[24] Ivandić Zimić, J.: *Women and addiction: differences in family characteristics and characteristics in psychosocial development between women and men drug addicts.*
Criminology & Social Integration : journal for criminology, penology and behaviour problems **19**(2), 57-71, 2011,
[25] Brečić, P.: *Suicidality in psychiatrics disorders.*
Medicus **26**(2), 173-183, 2017,
[26] Croatian Institute of Public Health: *Croatian health and statistical yearbook for 2016.*
Zagreb, 2017,
[27] Vulić-Prtorić, A.: *Depression in children and adolescents.*
Jastrebarsko, Slap, 2003,
[28] Croatian Institute of Public Health: *Suicide registry of Croatia.*
Zagreb, 2019,
http://www.hzjz.hr/aktualnosti/izvrsena-samoubojstva-u-hrvatskoj-2019,
[29] Unodc: *World Drug Report 2009.*
United Nations,
http://www.unodc.org/unodc/en/data-and-analysis/WDR-2009.html,
[30] Benčević Striehl, H.; Malatestinić, Đ. and Vuletić, S.: *Regional Differences in Alcohol Consumption*.
Collegium Antropologicum **33**(1), 39-41, 2009,

[30] Benčević Striehl, H.; Malatestinić, Đ. and Vuletić, S.: *Regional Differences in Alcohol Consumption*.
Collegium Antropologicum **33**(1), 39-41, 2009,
[31] Sršen, M.: *Population health status in the Republic of Croatia: Analysis of regional inequalities.* B.Sc. Thesis.
University of Split – Faculty of Economics, Split, 2017,
[32] Agrobiz.hr: *Agro news*, 28.03.2019.
http://www.agrobiz.hr/agrovijesti,
[33] Croatian Institute of Public Health: *Standardised European alcohol survey*.
RARHA SEAS, Zagreb, 2017,
http://www.hzjz.hr/wpcontent/uploads/2017/06/Standardizirano-europsko-istra%C5%BEivanje-o-alkoholu_RARHA-SEAS_20_-06.pdf,
[34] Kmic, A.: *Viticulture as a traditional economy*. B.Sc. Thesis.
University of Zagreb – Faculty of Humanities and Social Sciences, Zagreb, 2015,
[35] Mesarić, R.; Žapčić, S. and Tošić Grlač, S.: *The aromas and flavors of the homeland in the emigration.*
Institute for Migration and Ethnicity, Zagreb, 2019,
[36] Zaradija Kiš, A.: *Martinscak, Martinscina, Martinje: the development of the cult of St. Martin in northwestern Croatia.*
Folk Art **39**(2), 199-215, 2002,
[37] Leinert Novosel S.: *Social position of women in Croatia: Women and family (1999. – 2016.).*
Political Thought **55**(1), 53-72, 2018,
[38] Rapić, M. and Vrcić Keglević, M.: *Alcoholism – a forgotten diagnosis in family medicine.*
Journal of the Croatian Association of Family Medicine **22**(2), 1-86, 2014,
[39] Croatian Institute of Public Health: *Mental disorder in the Republic of Croatia.*
Zagreb, 2018,
[40] Zadarski.hr, 22.09.2019.
http://zadarski.slobodnadalmacija.hr/regional/clanak/id/624455/snimljen-dokumentarac-o-3069-suicida-branitelja-redatelj-govori-o-razlozima-njihovih-samoubojstava,
[41] Kozarić-Kovačić, D.: *The epidemiology of suicide in Croatia – some of the world´s epidemiological indicators.*
Proceedings of the 1st Croatian Congress on Suicidal Behaviour, Zagreb, 2000,
[42] Labura, D.: *Suicidal behaviour.*
Zadar, 2006.

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A SOCIOHISTORICAL OVERVIEW OF HARM REDUCTION DEVELOPMENT IN CROATIA

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ABSTRACT

Harm reduction is viewed as a public health aspect of drug policy in Croatia. The development of needle exchange programs and opioid substitution therapies are discussed herein by sketching the basic contours of the Croatian social and cultural context in which these activities have taken place over the past several decades. Along with the critical reflection of the approaches in which drug use in Croatia is considered in the matrix of anomie and disorganization explanations, two phases were identified in the development of harm reduction programs. The first phase marked the initial establishment of these programs in the context of strong growth in the number of heroin users in the 1990s, while the second phase allowed for the further development of these programs during the 2000s. It has been shown that, in contrast to anomie and social disorganization related approaches, the economic and political development trends of Croatian society are not clearly unambiguous in relation to the development of harm reduction programs, thus indicating that consideration of harm reduction development is more appropriate to link to the decentralization of related activities and the incorporation of these programs into intravenous drug use population's social insurance. In this way, immediate and non-patronizing access to the intravenous drug use population throughout Croatia is enabled. However, although embedded in the prohibitionist government's drug policy, the current implementation of the harm reduction programs in Croatia is still characterized by the unpredictability of official drug policy action as well as the general changes in drug use, with problems associated with the use of new psychoactive substances representing the greatest challenge.

KEY WORDS

harm reduction, drug policy, needle-exchange, decentralization

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INTRODUCTION

The issue of drug related benefits and harms is inherent in the use of various psychotropic substances and is historically framed by features of the political, socio-economic, and cultural context in which it takes place [1]. During the 1980s, in the context of a global prohibitionist drug regime that was further emphasized in some leading industrial societies through the War on Drugs policy, the subject theme of harm reduction appeared as the backdrop of numerous reports of the devastating consequences of intravenous drug use. Bewley-Taylor points out that the problem was recognized by different actors who had been working with the intravenous drug use (IDU) population in Europe, Oceania, and parts of North America, and comprehended largely in terms of the spread of HIV/AIDS and Hepatitis C (HCV) as the most significant blood-borne infections [2].

Since then, the term has become recognizable and widely used, mainly through its simultaneously narrower and broader meanings. On the one hand, in practical terms it most often refers to a form of direct action toward intravenous drug users (needle exchanges, opioid substitution programs, etc.), while on the other, it implies questioning the dominant drug policy and is used in various ways - denoting a "principle, concept, ideology, policy, strategy, set of interventions, target and movement" [3]. Harm Reduction International (HRI) suggests that there is no comprehensive and generally accepted definition. However, HRI approaches harm reduction as a term that refers to "policies, program, and practices that aim to minimize the negative health, social, and legal impacts associated with drug use, drug policies, and drug laws. Harm reduction is grounded in justice and human rights – it focuses on positive change and on working with people without judgment, coercion, discrimination, or requiring that they stop using drugs as a precondition of support" [4].

In regard to the aforementioned multiple meanings, a corresponding diversification is visible in numerous scientific research where it is comprehended through ideological turns in the development of both harm reduction movement and official agendas in public policies of particular countries [5]; discursive features of context with drug user as its key actor [6]; ethnographic findings on drug use scenes, lifestyles, and drug use practices [7]; and a consideration of the main ways in which the public health perspective views harm reduction [3] etc. Putting the term aside for a moment, some studies have indicated that when it comes to the unwanted consequences of drug use, the approaches that focus on the harm reduction has long been at work, dating back throughout the history of humankind, and more specifically through efforts aiming at risk minimization in the 20th century [2]. From this perspective, the concept of harm reduction could be widely absorbed into the mainstream approach. Nevertheless, this perspective also has its critics as well – for example, Ettore [8] argued that harm reduction represents a business philosophy drawn from the health and insurance industries and applied to a different use field, and as such may have some value but should be nuanced, primarily through its gender dimension.

Ball points out that, so to speak, a binary opposition between narrow and broad definition of harm reduction still exists and is "hotly debated" several decades after the onset of the HIV epidemic [3]. Maybe it's not so surprising, because any discussion on drug use is emotionally driven with ideological and often uncompromising stances. However, Fromberg [5] claimed that already in the 1990s the ideological disputes behind the harm reduction became more perplexed when the basic views on drug use were related to attitudes toward the legal status of drugs.

In the area of drug policy, harm reduction most often represents a public health approach aimed at a targeted population of intravenous drug users (IDU), but applicable to other types of risky drug use. In this context, harm reduction includes interventions, programs, and

policies that seek to reduce the health, economic, and social harms resulting from the use of drugs by an individual, group, or community [9]. In some studies, such actions are based on the assumption that, in order to reduce the harm intravenous drug users inflict on themselves and others, assistance should also be given to those drug users who are unable or unwilling to relinquish their addiction [10]. Although this is an incomplete designation which implicitly suggests that drug users are at the same time the only actors in creating drug-related harm, the associated values suggest harm reduction as a health alternative to an inpatient model in which addiction is viewed through a matrix of morality and criminalization. This means that abstinence may be the preferred outcome of addiction treatment, but alternatives that primarily reduce the harm caused by drug use are accepted. Action is directed at needs articulated by IDU users themselves and not predefined by policies based on unrealistic and highly moralistic goals. Through harm reduction, drug users are allowed to access and seek help from the services charged with dealing with them without moral obstacles and conditions. In other words, as a public health approach, harm reduction opposes moral idealism and the unrealistic ideals of a drug-free society, while promoting pragmatism based on the belief that drugs have always been used in human societies in different ways and with different purposes and outcomes, and are likely to be so in the future [10].

In technical terms, the harm reduction policy currently covers several core interventions. These are, first, programs for anonymous and the free replacement of syringes and needles for intravenous drug use, which include the work of mobile teams operating in places where intravenous drug users are located and fixed locations where users can bring already used equipment and exchange it for a new one. The second type of intervention refers to the establishment of counseling centers where intravenous users can obtain all kinds of information about addiction, IDU-related infections, and corresponding topics. Third type refers to the drop-in centers, i.e., places open 24 hours a day and available to intravenous users, including a number of homeless addicts, to meet the basic needs, such as showering, changing clothes, and getting warm meals. Fourth are injecting rooms, i.e., spaces where users can inject drugs freely with the use of sterile accessories and with the unobtrusive presence of professional staff who can intervene in cases of an overdose and other consequences of risky behavior. Finally, the fifth form of intervention involves the organized distribution of substitution therapy, with methadone maintenance therapy (MMT) remaining dominant. More recently, "the mixed opioid agonist/antagonist buprenorphine is being used with evidence suggesting that it may usefully complement methadone, especially in cases where people may be moving toward a reduction in use" [2].

Given that Croatia is a signatory to all key UN conventions that define the framework for drug prohibition policies, in this article we are dealing with a sociohistorical overview of the basic social contours in the development of harm reduction policy as an approach that has (at least partially) established itself in the Croatian officially prohibitionist and strictly abstinence-oriented ideological and political environment. In this regard, several stages of harm reduction development in Croatia are considered. These developments have not questioned the dominant abstinence-oriented political paradigm, but nevertheless opened the door for challenging the official drug policy as being inappropriate and sometimes completely powerless in solving the problems arising from risky forms of drug use.

This article discusses the elements of the social context, especially in the development of needle exchange programs, because it is a type of intervention that has been synonymous with harm reduction programs in Croatia for the past thirty years. Although the opioid substitution program has been developing over the same period, it is, in contrast to the referent literature, considered primarily in terms of the treatment of addicts and placed beyond the chapter on harm reduction in documents that shape Croatian drug policy [11-13].

Given that illegality is a common feature of the use of various substances (previously known or new, but also those incorporated into "public knowledge" as "soft" and "hard" etc.), the developmental stages of establishing harm reduction could not be considered without observations related to the social context of drug use in general. The relatively small number of scientific studies in the social context of drug use in Croatia has additionally contributed to this approach.

EARLY DEVELOPMENTS IN DRUG USE

Illegal drug use began in Croatia in the 1960s, and its rise in use has been occasionally interpreted in epidemic terms, and has become recognized as a social problem during the 1980s, most notably through the growing number of heroin users in some Croatian cities, the emergence of new synthetic drugs, and the somewhat normalized images of cannabis smoking. The Croatian social context of drug use during the 1960s and 70s has not been scientifically researched and is indicated by a number of clues about the former Yugoslavia as a transit country, i.e., the trafficking (Balkan) route, about the types of drugs used in the beginnings of fragmentation of youth subcultures and about the specific places in large cities where drug users began to gather during that time [14-16]. Since we could not find a source offering the sociodemographic features of the then users, we may refer only to subcultural explanations that insist on the primary importance of cultural contrast to a society in which socioeconomic differences are manifested in social consciousness through representations of the predominance of middle class [15, 17-18].

However, not all drugs appear in the same proportions and at the same time. Sakoman [14] indicated that heroin appeared more significantly in the early 1980s when amphetamine powder (also known as "speed") and cocaine use were low, while inhalant use had become recognizable in the mid-1970s. By that time, various drugs were taken, often all that would be found "at hand", with the hashish, pills, LSD and opium being the most common.

The first addictive careers began to form in the mid-1970s. In regard to the presence of opium and pills among users, breaking into pharmacies to procure morphine, codeine, ephedrine, and other opium preparations was one of the more striking patterns of drug procurement [19]. Essentially, illicit drug use manifests itself in a way that can be largely captured in terms of subculture. Subcultural elements thus integrate the processes of creating symbolic structures (which, in individual and collective forms, indicate a departure from socially dominant attitudes to drugs) with real problems arising from the fact that taking illicit drugs can result in imprisonment, psychiatric diagnoses, and various deviant labels, preventing any discourse on normality and opportunities for successful maneuvering in everyday life – like finishing school, finding a job, or establishing the preconditions for differentiating drugs and solving addiction problems, etc.

Drugs were not a common component in the adolescent stages toward adulthood, but rather the choice of a minority that was committed to their effects: some former users reported that opium was more prevalent than heroin during the 1970s, but this does not fully match the assertions in corresponding literature [16, 19].

Illegal drugs and their use will remain poorly visible until the mid-1980s. However, this could imply that the small number of specific places where drugs were used was relatively easily identified and often mystified both by users' subcultures and social control services, with images that only partially correspond to the real situation. In the 1970s and 1980s, some places in major Croatian cities gained the status of a negative symbol ("drug addicts' gatherings places") and were somewhat differently indicated and described in the literature [14-15, 17]. With basic indications of youth subculture fragmentation, but not exclusively in accordance with it, by the mid 1970s drug use scenes had separated in Zagreb [17, 20], suggesting that soft and

hard drug use corresponded to some extent with other subcultural preferences, but nevertheless brought together all drug users with regard to the illegal status of both cannabis and heroin.

Data on the number of heroin users for the whole period are fragmentary and largely based on estimates. Kušević [19] estimated that 5-18 % of heroin users enter the system that was not based on any of the modern harm reduction practices. According to data from the then Center for Psychoactive Drug Problems (which was established by the Institute for Health Protection of the Federal Republic of Croatia), Kušević estimated that the number of heroin users in Croatia ranged from approximately 2 000 to 7 000 in 1985. However, it is only possible to speculate on the number of heroin users to whom the assessment relates. In any case, Kusević pointed out that until the second half of the 1980s, the numbers themselves were not as troubling as the continuous and steady increase in the number of new addicts.

More accurate data was collected in individual cases at the local level. For example, the Department of Addiction at the University Hospital Center "Sisters of Charity" in Zagreb has epidemiologically monitored the incidence of addiction since the 1970s, indicating a steady and continuous increase in the number of newly registered addicts from the 1970s to the 1990s. Even here, until 1990, the absolute figures were not too alarming (a total of 641 new addicts), but the increase was significant especially in the last three years of that period with the significant rise of newly registered opiate addicts in 1988 [21]. Sakoman suggests that in regard to the figures, it is difficult to estimate the total number of heroin addicts, since their significant portion remained in the gray zone, avoiding treatment that was not yet based on opioid substitution programs. In addition, in some areas, such as Split, in which the uncontrolled expansion of heroin use occurred in the second half of the 1980s, no treatment program existed, which implies that there were no associated recordings [21].

Harm-reduction practices were not institutionally considered or supported until the end of this period and the addictive population at registration was referred for inpatient detox and withdrawal treatment. Since the mid-1980s, due to the coincidental spread of HIV with the uncontrolled spread of heroin addiction in major Croatian cities (Zagreb, Split), activities aimed at introducing a program of free drug paraphernalia began [21]. Its implementation started in conditions of deep mistrust: addicts had been skeptical about typically repressive official programs and often unaware of the health consequences of shared accessories; on the other side, the official actors in charge of implementation of the program often had been poorly informed about HIV infection and had hostile attitudes toward addicts based on prejudices and the long-term stigmatization of any drug use.

THE INTRODUCTION OF HARM REDUCTION

In the early 90s, the social context in Croatia was characterized by two key factors. The first refers to the beginning of the Croatian economic and political transition, i.e., the establishment of a multi-party political system and the introduction of a market economy. The second relates to the beginning of the War of Independence, which lasted until 1995. In parallel with the above-mentioned social changes, an enormous rise in epidemiological numbers occurred. For example, the number of new heroin addicts seeking treatment at the Center for Addiction at the Clinical Hospital of the Sisters of Mercy in Zagreb jumped from 80 in 1990 to 261 in 1991. A year later, 211 new addicts were recorded, and in 1993 another 289 were added [21]. The number of newly registered heroin users continued to increase until the late 1990s, when for the first time in that decade, the rise of new addicts stalled, ranging approximately between 300 and 350 new addicts. A corresponding increase has also been reported in the use of other, previously known, illicit drugs, new illicit substances (such as MDMA and legal and prescribed drugs), tobacco, alcohol, and sedatives.

Most research that sought to interpret changes in trends and incidences of drug use in Croatia during the 1990s highlighted several major, dominant social processes. Oftentimes, these are the economic and political crises of Croatian society from the late 1980s and early 1990s, the transition process, the war in Croatia [15] and the post-war period [21]. These processes are approached as causes of the evident increase in drug use, especially among young people. War, transition, crisis, devastation, etc. are elaborated as key markers of Croatia's distinctiveness compared to other countries in the world.

In that way, a basic contour of the rapid development of drug use in Croatian society in 1990s – with implicit and explicit causation – are outlined in terms of social disorganization, anomie and (youth) delinquency [15, 21, 22]. Although their analytical usefulness is enshrined in sketching the contours of the social context that significantly characterized Croatian society during the 1990s, it is possible to critically consider their determinist and reductionist theoretical framework which missed both, a number of societal features which mediated circumstances of drug use in Croatia at that time and the eventual usefulness of supranational level of analysis which could more thoughtfully relate local trends to the development of drug use in other European countries.

For example, one of the factors that are indispensable for considering the socio-cultural context of drug use in Croatia during the 1990s was the vigorous moral campaign that has integrated the alleged problem of drug use amongst the youth. In the broader process of sociocultural disruption with a socialist heritage together with the insistence on the spiritual renewal of Croatian society, campaigns to ban abortion and a promotion of increased control over the fragmentation of young people's lifestyles, particular attention has been paid to the problem of drugs, primarily through the actions of moral entrepreneurs from ruling power structures and through the media. Death, fear, punishment, expulsion, extermination, crime, illness, debauchery, hedonism, along with the associated over-dimensioning and constant promotion of sport as a desired goal, represented significant factors for understanding and action regarding drug use and addiction integral to the activities of key promoters of the moral campaign [18]. In addition, a markedly hostile attitude toward the IDU population (as well as users of other illicit drugs) was promoted through a series of suggestive, but inaccurate information. For example, the statement on 20 000 heroin addicts in Split that was given by the most prominent moral crusader at that time was broadcasted in the most of media, while, at the same time, the study made by Psychiatry Department of University Hospital "Firule" in Split and "Pulse" research agency, which referred to approximately 1500-2 000 IDU users in Split had went almost unnoticed [23].

However, although it included all the key elements in the concept of moral panic, such as distortion, exaggeration, divination, symbolization, and advocacy of a repressive normative framework [24, 25], the moral campaign did not stop the development of several harm reduction practices, which since their beginnings in early organized forms of actions were embedded in the public health perspective and appropriately institutionalized.

Namely, as early as the second half of the 1980s, the first educational measures were taken by the existing treatment system with the purpose of helping heroin addicts in preventing the spread of HIV. At the turn of the 1990s, an internal agreement was reached with pharmacies regarding the unrestricted purchase of supplies for intravenous use, thereby opening guidelines for further action to maintain the number of HIV seropositive part of the IDU population below 1 % [21]. At the same time and for the same reasons, the application of the opioid-substitution (methadone) program as a public-health activity had begun at the University Hospital Center "Sisters of Charity" in Zagreb. Initially, it was evident that heroin users were accepting the aforementioned changes in the work of official bodies and, according to the methadone

program providers themselves, the huge increase in the number of new registered addicts in the early 1990s could be partly explained by the registration of already existing heroin users who previously had avoided hospital-type treatment, considering the existing drug-free and abstinence programs to be inappropriate [21]. In addition, Sakoman suggests that some of the newly registered heroin users actually had previously joined the methadone maintenance program in Belgrade. When Yugoslavia broke up and the ties with Belgrade were cut, a number of heroin users from Croatia decided to continue methadone maintenance therapy in newly established programs in Zagreb.

According to Sakoman [21], the first interdepartmental commission was established at the Ministry of Health in 1991 to design and implement a national drug abuse prevention program. Three years later, the Commission for the Suppression of Drug Abuse was established under the Government of the Republic of Croatia, proposing the first National Strategy on Combating Drug Abuse in 1995.

Harm reduction became part of a national strategy primarily through facilitating and encouraging free needle exchanges to prevent the spread of HIV and Hepatitis C (HCV) and to mitigate the criminalization and stigmatization of heroin users. Harm reduction was interpreted predominantly in terms of a cost-benefit analysis (less contagion, less burdening of judicial and the prison system etc.). In fact, in some ways, the authors of the strategy legitimized harm reduction through the open recognition that all drug treatment and rehabilitation programs are essentially an attempt to reduce the harmful effects of drug use [11]. The intention was to approach hard-to-reach segments of the IDU population, so harm reduction was considered as an integral part of a wider range of outreach programs in the health and social care system. Also, unconventional actions are envisaged while respecting the basic harm reduction strategy and avoiding the classic casework that was prevalent in services dealing with this issue [11]. Finally, it was undoubtedly pointed to the ineffectiveness of the repressive system, that is to the disputed parts of the then Criminal Code, which did not clearly delineate possession of drugs for personal use from possession of drugs for the purpose of illegal trafficking. The strategy proposed that the possession of one dose on which the individual is dependent should be treated as a misdemeanor, and that each other possession, depending on the type and quantity, can be proportionately sanctioned [11].

Non-governmental organizations began with harm reduction activities in the early 1990s. First, "HELP" was founded in Split in 1992 and focused on replacing accessories, voluntary counseling, testing for HIV and HCV, distributing educational materials, providing free condoms, raising public awareness about HIV and AIDS, and caring for people with HIV [26]. The Croatian Red Cross as a non-profit legal entity began implementing a harm reduction policy in 1998 in Zagreb, Zadar, and Pula through the needle exchange and other programs for the replacement of accessories, which active intravenous drug users needed. All activities were undertaken at fixed locations and through field work [10].

Overall, the 1990s represent a period of establishing harm reduction programs in Croatia in terms of public health perspectives. The whole process took place at a time of rapid increase in drug use, war events, and in a social climate in which drug users were exposed to substantial marginalization and criminalization. Nevertheless, the two constituent elements of harm reduction, the opioid substitution program, and the needle exchange activities are legitimized as an integral part of the government's official drug abuse program.

RECENT DEVELOPMENTS

After a brief stabilization of the number of opiate users in the late 90s, their numbers have continued to grow throughout the first decade of the 2000s. Similarly, other drug-use surveys

indicate an increase in experimentation and recreational use [27], as well as specific changes in trends and patterns of use among adolescents as a predominantly examined population [28]. However, since 2012, the number of registered opiate users has stabilized with a slight decline in the coming years (Table 1). Also, the number of newly registered opiate users has declined significantly since 2009, while their share has been on a significant decline since 2006, suggesting that the most-treated opiate users have been in some form of treatment for several years. The age of registered users increased from 29,7 in 2007 to 37,3 in 2017 [29].

Table 1. The number of treated, first-time treated, and the share of first-time treated opiate users in Croatia from 2000 to 2017. Source: Croatian Institute for Public Health (adapted overview).

Year	The number of all people treated for opiates	Opiate users treated for the first time	The share of first time treated in total number of persons treated for opiates (%)
2000	2 520	1009	40,0
2001	3 067	1066	34,8
2002	4 061	846	20,8
2003	4 087	802	19,6
2004	4 163	732	17,6
2005	4 867	785	16,1
2006	5 611	876	15,6
2007	5 703	800	14,0
2008	5 832	769	13,2
2009	6 251	667	10,7
2010	6 175	430	6,7
2011	6 198	343	5,5
2012	6 357	313	4,9
2013	6 315	270	4,3
2014	6 241	205	3,3
2015	6 123	175	2,8
2016	5 953	178	3,0
2017	5 773	204	3,5

Overall, from 2000 onwards, the total number of people taking heroin in Croatia is estimated at 10 000-13 000, assuming that approximately 50 % of them are in some form of medical treatment [21]. A similar framework for estimating the number of heroin users is presented by Andrijašević and Lalić, in an analysis of the effects of public policy in addressing the problem of addiction in Split [30].

In most studies, drugs are viewed negatively in terms of abuse and the unintended consequences for society and the individual [21, 28]. The social context of drug use has not been specifically investigated in the 2000s, and this is not the focus of epidemiological overviews. Predominantly anomie-based explanations from 1990s with references to wartime events, the socio-economic crisis, and the political transition of Croatian society have given way to approaches that view drug use as a worldwide phenomenon and one of the major problems in public health [21, 31]. In a way, this interpretative turn was expected since Croatian society was undergoing economic growth and recovery during the 2000s, and gradual adjustments were made to the practical realization of multiparty political system and to wider involvement in the European integration processes. However, the economic and financial crisis that hit Croatian society in 2009-2014 coincided with the first significant stabilization of the number of registered and new opioid users, and with a decrease in that number during and after the

crisis. In other words, just as Croatia's economic recovery in the early 2000s did not halt epidemic growth, neither did the economic crisis of 2009-2014 accelerate this long-term growth, but it simply coincided with the beginning of its long-standing decline.

Some explanations for these developments are based on a consideration of supply-and-demand dynamics, arguing that the repressive system's services, by focusing on significant smuggling chains and actors, have successfully reduced the supply of heroin in the domestic illicit drug market [21]. In addition, it has been claimed that the recent decline in heroin use in Croatia is the outcome of a long-term development of those aspects of Croatian drug policy, which some authors consider as the specific national model of opiate addiction treatment. Its organizational parts largely involve the active role of family physicians and their ongoing collaboration with teams in the centers for the prevention and outpatient treatment of opiate addicts. Substitution therapy has also been covered by regular health insurance, which has enabled many heroin users to access these programs for free or inexpensively. In this way, it was possible to reduce the need for hospitalization and to include a number of elements in the therapeutic procedure - from pharmacotherapy, i.e. opioid replacement therapy, to measures aimed at preventing the spread of viral diseases [32]. These developments suggest that the system of prevention and treatment of the IDU population have developed somewhat independently of the strictly economic changes in the immediate social environment. Therefore, the previously mentioned interpretations in which drug use and the epidemiological development of opiate addiction during the 1990s have been approached as related almost exclusively to the issues of socio-economic crisis and transition could be theoretically and empirically challenged.

The concept of transition as the analytical tool for considering the dynamics of Croatian social development has been challenged in a number of other studies [33], with critical considerations related to its inherently reductionist and teleological understanding of social development. However, there has been little social research on drug use since the 2000s, with transition and socioeconomic development being only sporadically affected. Andrijašević and Lalić analyzed public policy elements in sociohistorical research regarding the issue of drug addiction in Split, determining the rise of heroin use in the 1980s in terms of social crisis and a sense of "hopelessness" in the final years of the socialist political order, but also indicating the elements of normality in terms of perceived drug use among the youth population at that time and the importance of linking grass-roots initiatives with local and state institutions in identifying and organizing harm reduction practices during the 1990s [30]. In a study focusing on cannabis use in Croatia, the socio-cultural context was considered a departure from anomie-based approaches, and viewed more in terms of the relationship between, on the one hand, normalizing aspects of cannabis use already clearly visible in Croatian society and, on the other, the regressive aspects of societal reaction aimed at the criminalization and stigmatization of drug use in general [18].

Moreover, the institutionalization of harm reduction since 2000 has been marked by pronounced decentralization and the gradual establishment of governmental offices for the implementation of opiate treatments at the regional level and by the development of civil society organizations at the local level. Since it has been followed by the involvement of family medicine physicians, almost all local and regional critical areas in Croatia are covered over the last twenty years. However, the dynamics of this process are mediated by political developments at the societal level, most notably in political struggles for power, which had reflected some key elements in the process of creating the entire drug policy. In the early 2000s, these struggles culminated in the wide public debate among actors who aimed at the position of the Head of the Government Drug Office. Different stances have most clearly manifested through conflict between, on the one hand, actors who advocated greater emphasis on the introduction of therapeutic

communities and strict abstinence, and, on the other, actors who had for years been implementing and advocating the methadone maintenance program and broader adoption of harm reduction activities. While it can be assumed that the outcomes of these conflicts strictly coincide with the political clash between conservative and liberal drug policies, it may be more plausible to say that this aspect of the institutionalization of harm reduction reflected much more the dislike and disinterest of the largest political parties for anything beyond the occupation of political positions, including that of the Head of the Drug Office [21].

Notwithstanding the aforementioned political aspects of institutionalization, harm reduction programs have remained an integral part of the two National Drug Abuse Strategies since 2006. However, in all of the national strategies since 1996, opioid substitution therapy is not considered in the chapter on harm reduction. It is rather seen as a part of inpatient/outpatient and psychosocial treatment of the IDU population. In technical terms, harm reduction is viewed through needle exchange and other programs aimed at attracting IDU populations to non-abstinence-based programs that are primarily aimed at improving the health status of heroin users and preventing the possible spread of blood-borne infections [11-13]. In other words, harm reduction strategies are mainly considered through expanding opportunities for the free distribution of clean syringes and the supply of other necessities, such as alcohol pads, distilled water ampoules related to safe heroin use, and the collection of impure and used injection equipment.

Since 2000, the harm reduction activities as defined in the National Drug Abuse Strategies have been largely implemented through NGO activities. There are currently six NGOs that are focused on continual and trusting contact with the active IDU population, the free exchange of needles and syringes, counseling activities, the use of libraries and the Internet, helping to reconnect addicts with their families, the distribution of information materials on infectious disease protection and safe intravenous use, the eventual reintegration of addicts through job-finding and occupational therapy, and finally, the provision of free testing for HIV and HCV [10]. The available data for the harm reduction activities of the Croatian Red Cross (Table 2) from 2009 to 2018 shows that the number of heroin users entering harm reduction have been increasing by 2012 and have declined since.

Table 2. Croatian Red Cross harm-reduction activities 2009-2018.

Year	Number of users	Syringes and needles provided	Syringes and needles collected	Other accessories provided*	Persons tested	
					HIV	HCV
2009	1962	23 934	15 612	41045	0	0
2010	2 080	25 382	9 558	54742	30	23
2011	2 985	32 334	16 935	53428	21	84
2012	2 071	28 092	9 714	74978	72	118
2013	1573	33 340	22 943	98714	87	126
2015	1931	92 677	20 214	132957	67	69
2018	1184	97 385	34 885	105770	149	111

*alcohol pads, distilled water ampoules, condoms etc

These changes have not been systematically monitored and there is currently no reliable research data as to what is happening to drug addicts over time. One can assume some users change their residence, some ends up in prisons, some pass away, and part of them simply disappear. It can be said with some certainty that the number of clients is decreasing by 2018, because epidemiologically (as elsewhere in Europe) the number of heroin addicts is decreasing, especially new ones. Generally, mainly older users remain in Croatian harm reduction programs.

Similarly, the number of new clients has yet to be systematically investigated. According to the harm reduction practitioners' field experience, working with addictive populations

involves changes that cannot always be fully explained due to the highly individualized approach to each user, with the character of this relationship with each user being crucial. This also applies to the numbers showing the amount of provided injection equipment; although this amount increases over the years, it should be noted that the drug injection method is also individual, with some users taking more needles and syringes to distribute to users who do not want to enter the program because of the fear of being recorded, the stigma, or the heroin-related sense of paranoia. When it comes to returning needles and syringes, it is known from harm reduction practice that returns are never 100 %. Although it has grown over the past few years, the return reaches levels of 35-40 % and expresses the specificities of addictive scenes which vary regionally, and by city, but also within cities. Other shared supplies are dominated by alcohol pads, because they are additionally used not only for cleansing the skin before injection, but also for the general cleaning of hands, glasses, as makeup remover, etc. Finally, oscillations are visible over the years in the number of people tested for HIV and HCV, and this suggests the uncertainty of the outcome in efforts to get users to test. Therefore, the marked increase in testing in 2018 cannot yet be seen as an indication of the change that will manifest itself in the coming years, but it may be linked to the popularization of testing by the Croatian Red Cross and the expansion of the network of free testing centers. It is informally argued by harm reduction practitioners that 50 % of testing is related to the same people, i.e., those who were negative in previous testing. Testing is anonymous, performed by rapid saliva or blood tests, by laboratory blood sampling, or by the ELISA (enzyme-linked immunosorbent assay) technique. In the case of a positive finding, users are referred for additional checks.

We have collected the available data for the harm reduction activities of NGOs throughout Croatia in 2015 and 2018. The data presented in Table 3 was collected directly from local harm reduction program providers. Considering that they are quite oscillating or unclear in details, here we can consider only the data from the Croatian Red Cross to be reliable. However, data on the number of clients, the amount of material exchanged, and the number of persons tested is presented for all harm-reduction NGOs in Croatia. On the whole, this data is provisory in the estimation of activities of harm-reduction associations in Croatia and, if anything, show that in the work with IDU population classical statistical rules do not always fit. In other words, it is rather difficult to find standard models of explanations or causes in analysis of IDU population behavior, because the scene is very flexible, prone to changes in trends, and is very specific to the individual.

In Table 3, this can already be seen in terms of the locality of NGO activity. This means that the variability in each area can be caused by factors such as the departure of users from that place of residence/stay, users going to jail, or therapeutic community treatment, or factors mediated by the character of the work of social control services, primarily the police, and by informally developed (sometimes pervading) fears and skeptical stances on the providers of harm reduction.

A certain decline in the total number of clients participating in harm reduction programs is also evident in Table 3, and it can be assumed that this data is in line with the epidemiological trends presented earlier at the national level. The population of opiate users is growing older, which may be an indicator of the quality of the system as registered users remain in some form of treatment for a long time. The future will show what will happen with intravenous injections with respect to new psychoactive drugs. Similarly, when it comes to exchanged injection accessories and other supplies, it is also extremely difficult to offer standard explanatory models. The variations among the NGOs are enormous, and the oscillations make it impossible to see a steady trend.

Table 3. Harm reduction activities by NGO in 2015 and 2018.

NGO (Area of action)	**Number of users**		**Injection equipment provided**		**Injection equipment collected**		**Other supplies provided***		**People tested for infection**	
	2015	2018	2015	2018	2015	2018	2015	2018	2015	2018
Croatian Red Cross (Zagreb, Zadar, Nova Gradiška, Krapina)	1931	1184	92677	97385	20214	34885	132957	105770	136	260
Help (Split, Dubrovnik, Šibenik, Knin, Osijek, Vukovar, Varaždin)	1089	1300	618034	203069	168395	52979	21155	6338	284	150
Terra (Rijeka, Primorje-Gorski kotar County)	671	281	74816	165536	13302	51686	63732	74446	0	0
Institut (Pula, Istria County)	422	451	139730	118875	251000	283000	509784	47400	0	0
Neovisnost (Osijek)	42	304	1560	1224	578	964	965	5872	25	0
Let (City of Zagreb, Zagreb County)	650	150	137923	175000	31346	25500	99788	92500	0	0
Total	4805	3760	1064740	761089	484835	449014	828381	332326	445	410

*alcohol pads, distilled water ampoules, condoms etc

Therefore, there is a certain need to conduct research that would gather more reliable data and offer more comprehensive explanations. When it comes to the number of people tested for HIV and HCV, there was a notable drop in testing rates at the Croatian Red Cross in 2018, because some of these activities (for example, in Zadar) have been taken over by the local Public Health Institute. Other organizations carry out tests periodically, mainly in consultation with local public health institutes and do not have continuity of testing.

According to the practitioners involved in the implementation of harm reduction programs, distrust and resistance to social institutions still dominate the attitudes of heroin users. Such a stance is supported by rigid repressive practices and penal policies, which increase the possibility of identifying addicts with criminals [10]. In addition, rejection, marginalization, and stigma have supported the neglect of the addiction by the highly bureaucratized welfare and health systems.

CONCLUDING REMARKS

The development of harm reduction in Croatia can be viewed as public health concern in regard to drug policy that was primarily aimed at preventing the strong epidemiological growth of heroin use. Up until the early 1990s, this growth was seen as a potentially greater

challenge than the total IDU population, and the linkage of addiction to blood-borne infections was a key element in the first initiatives to introduce harm reduction under conditions where the abstinence-oriented paradigm left no room for its own questioning. The huge leaps in the number of registered heroin users in the early 1990s and their continued growth until the middle of the first decade in the new millennium can be seen as a key element in the introduction of part of the harm reduction practices in Croatia, most notably opioid substitution therapy and needle exchange programs.

In explaining steady epidemiological growth, a number of studies approached the social context through a narrow explanatory pattern focused predominantly on the economic and political problems that Croatian society has faced in the late 1980s and through the 1990s. Its major weaknesses can be identified in the relatively poor shading of economic and transitional elements as determinants of changes in drug trends that have not only been seen in Croatia but also worldwide and in the pronounced determinism that viewed socioeconomic developments as a key indicator for the growth of drug use. On the one hand, this means that the anomie/transition approach remained concentrated on illicit drugs with no broader elaboration of the relationship of Croatian social specificities with the use of alcohol, sedatives and tobacco-nicotine. On the other hand, in the case of drugs as a whole, such an approach missed the opportunity to consider the Croatian context of drug use in comparison with its significant increase in use, which was evident in different transition countries, as well as in the European Union and the United States in the 1990s [34, 35]. Finally, the increase in drug use was evident in the period from the beginning of the 2000s and occurred independently of the economic stabilization of Croatian society, while significant indicators of the decline in the number of new addicts have coincided with the beginning of the economic crisis in 2009. In summary, that anomie based approach is problematic in solving the problem of addiction and drugs has been pointed out a long time ago [36] through the appreciation of a multitude of drug-focused motives beyond those caused by anomie and withdrawal, and by pointing out that, in slightly more Durkhemian terms, it can be assumed to be quite the opposite – that addiction (heightened by alienation and despair) can lead to anomie.

Despite the war, problematic privatization, rising unemployment, and falling standards of living [15], it is precisely in transitional conditions that opportunities for the pluralization of drug discourse had begun to open. This also applies to the institutionalization of harm reduction practices that, in these circumstances, have become an integral part of Croatian drug policy.

If something can be significant for further developments in harm reduction, then it is related to the character of its institutionalization, which integrated harm reduction into a prohibitionist drug policy, primarily through a pronounced decentralization and incorporation of a social component without which these programs would remain financially unavailable to the most of IDU population. Decentralization has enabled the development of a network of non-governmental organizations and other activities within the health system and can perhaps be seen as one of the most important factors in the development of harm reduction in Croatia. The process, which began in the mid-90s, has resulted in strong developments in the coming decades where, through the combined action of NGOs and governmental organizations, local action and addressing addiction in the field are strengthened. In this way, it was possible to face the problem of addiction in the field head-on through direct work with the IDU population and its gradual inclusion in the programs, which it still approaches with fear and skepticism. However, as was evident in the early 2000s, political disputes in the formulation of drug policy in Croatia did not crucially limit the further development of harm reduction programs, so today it is not entirely certain to predict future developments, since government action in this area is often and still fairly opportunistic (especially with regard to financing), while harm reduction program

providers in the field still have to unequivocally confirm their credibility in dealing with the IDU population while adapting to changes in trends of drug use; perhaps most notable in the problems currently manifested in the emergence of new psychoactive substances.

REFERENCES

[1] Courtwright, D.T.: *Forces of Habit. Drugs and the Making of the Modern World*. Harvard University Press, London, 2001,

[2] Bewley-Taylor, D.R.: *International Drug Control. Consensus Fractured*. Cambridge University Press, London, 2012,

[3] Ball, A.L.: *HIV, injecting drug use and harm reduction: a public health response*. Addiction **102**(5), 684-690, 2007, http://dx.doi.org/10.1111/j.1360-0443.2007.01761.x,

[4] Harm Reduction International, *What is harm reduction*. https://www.hri.global/what-is-harm-reduction,

[5] Fromberg, E.: *The Ideologies behind harm reduction*. 6th International Conference on the reduction of drug related harm, Florence, 1995,

[6] Moore, D. and Fraser, S.: *Putting at risk what we know: Reflecting on the drug-using subject in harm reduction and its political implications*. Social Science & Medicine **62**(12), 3035-3047, 2006, http://dx.doi.org/10.1016/j.socscimed.2005.11.067,

[7] Rhodes, T.: *Risk environments and drug harms: A social science for harm reduction approach*. International Journal of Drug Policy **20**(3), 193-201, 2009, http://dx.doi.org/10.1016/j.drugpo.2008.10.003,

[8] Ettorre, E.: *Revisioning women and drug use: gender sensitivity, embodiment and reducing harm*. International Journal of Drug Policy **15**(5-6), 327-335, 2004, http://dx.doi.org/10.1016/j.drugpo.2004.06.009,

[9] Rhodes, T. and Hedrich, D.: *Harm Reduction: Evidence, Impact and Challenges*. European Monitoring Centre for Drugs and Drug Addiction, Portugal, 2010,

[10] Zovko, S.: *Influence of Harm Reduction to Intravenous Drug Users*. Ph.D. Thesis. University of Zagreb, School of Medicine, 2011.

[11] *National Strategy for Drug Abuse Suppression in the Republic of Croatia*. Office for Combating Drug Abuse, Zagreb, 1996,

[12] *National Strategy for Drug Abuse Suppression in the Republic of Croatia 2006-2012*. Government of the Republic of Croatia. Office for Combating Drug Abuse, Zagreb, 2006,

[13] *National Strategy for Psychotropic Drug Abuse Suppression in the Republic of Croatia for the Period from 2012 to 2017*. Government of the Republic of Croatia. Office for Combating Drug Abuse, Zagreb, 2012,

[14] Sakoman, S.: *Background: Drug Abuse in the republic of Croatia*. In: Power, R. and Mimica, J.ed.: *Drug Abuse in the Republic of Croatia*. UNDCP, Zagreb, 1998,

[15] Lalić, D. and Nazor, M.: *Dope-fiends: Deathnotes*. Alinea, Zagreb, 1997,

[16] Torre, R.: *Drugs: Long Journey into the Night*. Promotor Zdravlja d.o.o., Zagreb, 2001,

[17] Perasović, B.: *Urban Tribes: Sociology of Subcultures in Croatia*. HSN, Zagreb, 2001,

[18] Dubreta, N.: *Society and It's Relation to Drugs. Socio-Cultural Context of Cannabis Use in Croatia*. HSN, Zagreb, 2005,

[19] Kušević, V.: *Drug Abuse*. Grafički zavod Hrvatske, Zagreb, 1987,

[20] Kulović, R.: *Drug. My Life With and Without It*.
C.A.S.H., Pula, 1998,
[21] Sakoman, S.: *Drug Free Society?*
Institue of Social Sciences Ivo Pilar, Zagreb, 2008,
[22] Power, R. and Mimica, J.: *Drug Abuse in the Republic of Croatia*.
UNDCP, Zagreb, 1998,
[23] Lalić, D.: *Economic reproduction of heroin addiction: the city of Split in the 90's*.
Sociological Review **26**(3-4), 2019-218, 1995,
[24] Cohen, S.: *Folk Devils and Moral Panics*.
MacGibbon & Kee, London, 1972 & 1980,
[25] Becker, H.: *Outsiders: Studies in Sociology of Deviance and Social Control*.
Free Press, New York, 1963,
[26] HELP, Youth Assistance Association: *About Us.*
http://helponline.hr/index.php/o-nama, accessed 17th November 2019,
[27] Hibell, B., et al.:*The ESPAD report 2003: alcohool and other drug use among students in 35 European countries*.
The Swedish Council for Information on Alcohol and Other Drugs (CAN), The Pompidou Group at the Council of Europe and the authors**,** Stockholm, 2004,
[28] Sakoman, S.; Brajša-Žganec, A. and Glavak, R.: *Indicators of Early Recognition Among Croatian Youth at High Risk of Substance Abuse*.
Social Research **11**(2-3), 291-310, 2002,
[29] Katalinić, D. and Huskić, A.: *Report on persons treated for drug abuse in Croatia in 2017*.
Croatian Institute of Public Health, Zagreb, 2018,
[30] Andrijašević, I. and Lalić, D.: *From a Lost-Cause City to a Model City: Determinants of the Policy of Drug Addiction and Abuse Control in the City of Split (1994-2007).*
Annals of Croatian Politological Society **5**(1), 417-439, 2018,
[31] Glavak Tkalić, R.; Miletić, G.M. and Sakoman, S.: *Prevalence of Substance Use Among the General Population: Situation in Croatia and Comparison With Other European Countries*.
Social Research **22**(4), 557-578, 2013,
http://dx.doi.org/10.5559/di.22.4.01,
[32] Tiljak, H., et al.: *Primary health care and family medicine – Possibilities for treatment of opiate addicts*.
Acta Medica Croatica **66**(4), 295-301, 2012,
[33] Žažar, K.: *What after the (Social) Transition? Critical Remarks Regarding the Use of the Transition Approach in Sociological Examinations of Croatian Society*.
Croatian Sociological Review **45**(2), 171-199, 2015,
http://dx.doi.org/10.5613/rzs.45.2.3,
[34] Parker, H.; Aldridge, J. and Measham, F.: *Illegal Leisure: The Normalization of Adolescent Recreational Drug Use*.
Routledge, London, 1998,
[35] Shiner, M. and Newburn, T.: *Taking Tea with Noel: The Place and Meaning of Drug Use in Everyday Life*.
In: South, N., ed.: *Drugs. Cultures, Controls & Everyday Life*. SAGE Publications Ltd, London, 1999,
[36] Lindesmith, A. and Gagnon, J.: *Anomie and Drug Addiction*.
In: Clinard, M.B., ed.: *Anomie and Deviant Behavior*. Free Press, New York, 1964.

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