

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

Zoran Zoričić

University Hospital Centre Sisters of Charity – Department for Psychiatry
Zagreb, 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 Abstinent 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 Alcoholics 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 person'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 individuals 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 alcoholology, 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 after 2000, and their numbers are gradually increasing with network spreading throughout Croatia. A new, so to say, middle-generation of alcoholologists, 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 articles 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.

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