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## Contents

2.1	History .....	14
2.1.1	Mental Health/Psychiatry .....	14
2.1.2	Biopsychosocial .....	15
2.1.3	Based on Evidence .....	16
2.1.4	Addiction Treatment .....	17
2.1.5	Dual Disorder .....	17
2.2	Care Systems .....	19
2.2.1	Treatment Drugs-Related Disorders .....	19
2.2.2	Treatment for Alcohol-Use Disorders .....	20
2.2.3	Mental Health Care .....	21
References	.....	26

## Abstract

In all European countries there are institutions for mental health care and addiction treatment. The way in which they have developed, however, is different in each country. In addition, institutions for mental health care and substance abuse treatment have evolved mostly independently of each other. This hinders an integrated treatment for people with both addiction and other mental disorders.

This chapter gives an overview of the health-care systems in Europe in this area. Furthermore, a description of the European institutions that develop policies on this subject and monitor the developments in the various countries will be provided.

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## 2.1 History

### 2.1.1 Mental Health/Psychiatry

In the approach to mental disorders, including addiction, we can distinguish a number of waves. Such waves exist relating to the following topics:

- The approach of psychopathology (including addiction) from the perspective of disease (and therefore the involvement of doctors) versus sin (religion) or public disorder and crime (police and justice).
- The emphasis on a natural, biological (hereditary or ‘organic’) explanation for psychopathology versus pointing to (also) external, psychological, or social backgrounds of an issue. Historically also ‘possessed by the devil’ fell under the set of in life acquired forms of psychopathology.
- The focus on asylum, nursing, and care (often from churches or religious organizations) versus the attention focused on treatment.
- Regarding treatment: accent on purely medical-somatic treatment versus (also, or explicitly) an accent on a social psychological or psychotherapeutic therapy.

Many historians begin their history of psychiatry shortly before 1800, because only then there were, on a relatively larger scale, medical centres specifically for people with mental disorders. Moreover, only in that period there were doctors who were specialized in psychopathology. However, psychiatry is in fact of much older date and actually runs parallel to the history of medicine in general. The ancient Greek, Roman, Muslim, and Christian doctors focused both on physical and psychological symptoms. It is even questionable whether they—like we have become accustomed to—made such a distinction between mental and physical illnesses. See Sadock et al. (2009) for a compact but well-documented overview of the history of psychiatry.

Important events in the history of modern psychiatry are in the first place the humanization of the psychiatric centres and the ‘moral’ therapy that was brought into practice. As far as we can ascertain, the conditions in the still scarce psychiatric institutions in the eighteenth century, were pitiful. There was no or hardly any therapeutic policy. Patients were locked up as imbeciles, idiots, or insane people and more or less left to their own fate. This changed gradually around 1800. The establishments became more humane and a search for effective therapies began. This can partly be traced back to the works of Philippe Pinel (1745–1826) and Jean-Étienne Dominique Esquirol (1782–1840). Pinel is in our memory the symbol for the literal liberation of psychiatric patients from their chains. This took place at the end of the eighteenth century in the Parisian Hôpital Bicêtre. His commitment marks the development of psychiatry as a medical discipline: ‘lunatics’ became ‘patients’. Of interest, this action is falsely attributed to Pinel. In fact, it was his assistant Jean Baptiste Pussin who did this historic act in 1797.

The ‘moral therapy’—we would now speak of psychological treatment—was based on the idea that mental disorders were the result of genetic as well as

environmental influences. The treatment was focused on education and (on belief-oriented) conversations with patients. This therapy worked only modestly. Therefore, psychiatrists also sought refuge in other, in our eyes sometimes ‘barbaric’, methods. In this way, they tried to call agitated patients with bizarre, violent (or aggressive) behaviour to order. However, this did not have a truly therapeutic effect.

In the first half of the twentieth century, experiments were done with limited effective biomedical interventions. Examples are inducing fever using malaria infection to treat psychotic symptoms as a result of general paresis. Real results were only realized when, starting from the middle of the twentieth century, chemicals were discovered that proved efficacious for the treatment of mental disorders. Examples of disorders that could be treated with medications are schizophrenia, bipolar disorder (manic depression), depression, or anxiety disorders. The advent of antipsychotic drugs for the treatment of patients with schizophrenia contributed to a substantial decline in the number of psychiatric hospitalizations.

As a result of different views about the treatment of psychiatric patients and strong criticism on the large psychiatric hospitals (often far away from the population centres), a movement to de-institutionalize psychiatry arose. The aim was to reduce the number of inpatient admissions, to reduce the dependence on caregivers and to rehabilitate the social position of psychiatric patients. It was realized that it makes sense to help those affected to reintegrate in society and to increase their self-reliance, despite having a chronic mental illness. Psychiatric patients were people with a mental limitation, but with plenty of opportunities for a humane existence.

### 2.1.2 Biopsychosocial

In psychiatry, the biological dimension has from time to time been emphasized. An example of this is the German physician Wilhelm Griesinger (1817–1868) who stated that all mental disorders are ‘brain diseases’. Therefore, psychiatry had to be a medical discipline. At the same time, there are people who have stressed the importance of the psychological and social dimensions (without neglecting the biological). Influential was the American Adolf Meyer (1866–1950), who developed the concept of psychobiology. In the wake of this, he introduced psychosocial treatments. Meyer also advocated that patients had to be treated as much as possible in their own environment.

In the 1970s, the American psychiatrist George Engel (1913–1999) proposed the biopsychosocial approach to illness, which he presented as an alternative to the traditional biomedical approach. This is focused on the treatment of diseases or on the related symptoms, but there was little attention for the psychosocial context in this approach (Engel 1977; Frankel et al. 2003). The biopsychosocial approach is based on system theory. It was a very important innovation and has been of immense significance, especially for psychiatry. Engel insisted on looking at different levels, from the perspective of different disciplines. He considered the

tangle of problems that often exist with different types of health problems, while stressing the importance of paying attention to the complexity of such problems. This was better than to reduce them to separate components or separate aspects. Apart from psychiatry, this way of thinking has especially taken hold in general practice.

Engel (who would have had no qualms to add also the cultural dimension to his biopsychosocial approach), made it clear that the biopsychosocial approach holds true for schizophrenia as well as for diabetes or addiction. He pointed out that regardless of what the aetiology is of a condition, a layered and multi- or interdisciplinary approach is always preferable compared to the traditional biomedical approach. Schizophrenia and diabetes are in this perspective both a 'somatic' condition as a 'mental' condition. And social problems can be part of both illnesses: when the course is chronic, the consequences of the condition are not limited to one level or domain.

Engel was far ahead of his time in theoretical terms and built on the insights of Adolf Meyer. In the practice of medicine in a broad sense, the consequences of his approach are far from being understood. Moreover, there is the continuous risk of a relapse in the classical biomedical approach. In this sense, his approach is still very 'modern'.

The relevance of the biopsychosocial approach is particularly reflected in the transition that currently takes place in mental health: the recovery-oriented care. Serious mental disorders take for a large part a chronic course. 'Healing' is not possible for this group. On the other hand, in biopsychosocial and cultural terms, there are many possibilities for those concerned to recover.

### **2.1.3 Based on Evidence**

Under the name of evidence-based medicine there exists, from the end of the twentieth century, a movement to review medical procedures as much as possible by experimental, scientific research. Based on the outcomes are subsequently treatment recommendations and guidelines designed, which also happens in psychiatry or substance abuse treatment. Before, there were initiatives going on to test interventions in experiments, but there was still a lot of critique or doubts regarding the methods that were used. And there were no databases yet that could quickly determine whether an intervention or therapy was working, and that such a ruling was based on evidence. Nowadays, statements about the strength or weakness of a recommendation are based on the analyses of a series of experiments in a laboratory. Then, these are tested in practice. The randomized controlled trial (RCT), a randomized and controlled trial in which ideally the subjects do not know which treatment they undergo, now has the status of 'gold standard'. The evidence-based medicine has a long history. Philippe Pinel, one of the founders of modern psychiatry, advocated for more than 200 years ago the use of statistics for making statements about treatment methods.

### 2.1.4 Addiction Treatment

Substance abuse treatment is younger than the general mental health services or psychiatry, although there are many parallels with the description above.

In many cases, relatively independent of psychiatry or mental health care, separate institutions for addiction treatment have been established in most countries in Europe. There were initiatives from the nineteenth century when organisations for the temperance movement emerged. Just as in psychiatry, the attention was first focused on asylums or clinics for alcoholics, but also outpatient facilities arose gradually. Until the 1960s, the attention was concentrated mainly or exclusively on problems with alcohol. However, the rise of illegal drugs from the seventies of the twentieth century (such as heroin, amphetamine, cannabis, cocaine, and years later ecstasy) led to a boom in new centres. These were partly the same facilities targeted on alcohol problems, but a large number of facilities focused exclusively on issues related to drug use. This separation is understandable because the target groups, and their social backgrounds, were different from one another. The rise of the Human Immunodeficiency Virus (HIV) that causes Acquired Immune Deficiency Syndrome (AIDS) gave the drug services in the 1980s even more clearly its own distinct position: the discussion thrived on the question if *harm reduction*, by improving the sanitary conditions of drug users (distribution of condoms for safe sex, swap used syringes for clean ones), was not more important than achieving abstinence as the primary purpose of the care.

Finally, also the importance of a biopsychosocial-cultural approach is relevant to the substance abuse treatment. The same applies to working according to evidence-based guidelines.

### 2.1.5 Dual Disorder

For the treatment of people with addictions and a co-morbid or co-occurring mental disorder (or vice versa: dual disorder), it is of great importance that there are facilities available that are able to respond adequately to both problems. In no country, in Europe or elsewhere, this is the rule. In most countries there are—often already since the nineteenth century, or longer ago—psychiatric hospitals. After World War II, in the one country faster than in the other, ambulatory facilities emerged also. Even more recent is the closure of these hospitals or at least a reduction in the number of beds. But, as a rule, the attention to addiction problems was and is herein limited, or secondary. This has to do with the fact that addiction—to this day—is not nearly everywhere and by everyone recognized as a mental disorder. Indeed, the ICD and the DSM—in various editions—have listed addiction definitely as illness or disorder. In public opinion, but also by many clinicians, addiction is often approached as something special: for example as a form of deviant behaviour, as an expression of moral weakness, or as a form of crime. This has resulted in a situation where drug addicts or alcoholics were not—as a matter of course—admitted to psychiatric (ambulatory or clinical) facilities. That

does not mean that there were (and are) not a lot of people with addiction problems that were hospitalized. This has always been the case: the prevalence of use, abuse and dependence of people with a mental disorder is, compared to the general population, relatively high. This means that even though the policy was and is aimed to ward off people with addiction problems, it is unlikely that this really was successful.

Together, a landscape was created in which facilities for alcohol and drugs emerged relatively independently from each other, and often still function apart from each other. This has inevitably consequences for the organizational conditions of the treatment of people with dual disorder problems. Caring for people with addictions is—unfortunately—not a natural part of mental health institutions. And the reverse is also true: the treatment of co-morbid mental disorders in substance abuse treatment is not standard practice. Even if one would like to do this, there is often a lack the skills and resources. What often happens is that clients or patients will be referred between services for addiction and mental health. This happens as soon as a mental disorder of a client in substance abuse treatment is so severe that psychiatric intervention is necessary. Conversely, a patient can be referred to a service for addiction care when the substance use is so strong that this frustrates a psychiatric or psychological treatment.

From this point of view, the integration of these facilities should be obvious. To this end there are indeed initiatives in many places. This has been done by initiative of either addiction care or mental health care (or together) in the form of ‘double disorder’-clinics. These provide a treatment specifically for people with dual disorder problems, and in which patients do not have to be concerned that they will be discharged because they do not meet the exact admission criteria. Also in the form of outpatient programs or projects there are many initiatives on dual disorder. Yet, taken together, the range of these services is limited. We can assume that roughly at least half of the people with a (severe) mental disorder are excessively taking substances or might be addicted (at least addicted to tobacco). And conversely, we can assume that perhaps half of the (seriously) addicts have an additional mental disorder, such as Attention Deficit-/Hyperactivity Disorder (ADHD), depression, personality disorder (borderline or antisocial personality disorder), or post-traumatic stress disorder. While this does not mean that both problems (addiction and the other disorder) always need to be addressed, or that they are always closely linked, it is plausible that this is often the case. In such a case, it is desired that organizations or treatment teams are able to deal with both problems—parallel or in series. To achieve this, projects are set up in many mental health and substance abuse treatment institutions to educate each other’s expertise to staff. This diminishes the need for organizational changes (and eventually mergers). However, the chance that something is changing in favour of clients does increase with this approach.

In the literature, researchers, policy makers and professionals use the term co-morbidity or dual disorder to indicate the combination of addiction problems and another mental disorder. In this handbook, the term dual disorder will be used.

In the remainder of this chapter I give an overview of the main similarities and differences in Europe in the field of addiction treatment and mental health care. It focuses on a description of some of the major organizations that make periodic reviews in Europe: epidemiological data, policy developments and trends, and characteristics of the health-care providers. Unfortunately, the fragmentation described above is also present in the European institutions. As a result, it is difficult to describe the state of the art in the organization of the treatment of comorbid problems. The World Health Organization (WHO) is incidentally a good exception to this. This organization makes reviews in which somatic disorders, mental disorders and addiction to alcohol and drugs are discussed in conjunction. Nevertheless, there is a considerable lack of knowledge on how the approach of dual disorder problems in the different European countries could be improved.

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## 2.2 Care Systems

### 2.2.1 Treatment Drugs-Related Disorders

With under-treatment we mean the functions aimed at people who because of substance (ab)use are in need of help. It concerns early detection, detoxification, provision of substitutes and other medication, psychotherapy, risk and harm reduction (prevention of the transmission of infectious diseases), rehabilitation, social reintegration, and recovery. Ideally, there is also attention to gender specific issues, problems of minorities, and age-specific differences.

The main source on drug use and drug policy in Europe is the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA; [www.emcdda.europa.eu](http://www.emcdda.europa.eu)). It is established in Lisbon. The EMCDDA collects data from all EU countries plus Norway. Leading are the annual reports that are produced in co-operation of the member states. These give overviews of the state of affairs on drug use, drug policy, and treatment or rehabilitation. The EMCDDA also publishes thematically oriented reports. The centre is the focal point for the development and implementation of the EU drugs strategy. Recently, the new strategy for 2013–2020 has been made public (Council of the European Union 2012). In the first two decades since its founding, the EMCDDA was focused on reducing supply and demand. As a new policy issue, the ‘reduction of the health and social risks and harms caused by drugs’ has been added to this. This means that in the coming period the treatment of addiction the social integration and recovery of all drug users will receive increased attention. This applies both to those receiving voluntary assistance as to those in a forced framework (prisons). This recognises that the fixation on achieving abstinence has had insufficient results. Direct access to mental health services or psychiatry for addicts is not in the European Union (EU) strategy. Yet, this does not mean that the importance of dual disorder within the EMCDDA is not recognized. In 2004, this Centre published an overview of co-morbidities in which the relationship between drug use and mental disorders has been described (see below) (EMCDDA 2004a).

In addition to the EMCDDA, the Pompidou Group ([www.coe.int/t/dg3/pompidou](http://www.coe.int/t/dg3/pompidou)), connected with the Council of Europe, is active in the field of drug use and drug services. In 2010, it published an extensive review of the treatment systems in Europe (Muscat and members of the Pompidou Group treatment platform 2010). The review is divided into four blocks: North of Europe, Centre and East of Europe, West of Europe and South of Europe. It describes—per block—the epidemiology of drug use, and, briefly, the history of the drug treatment. The review makes clear that there are differences in the positioning of drug treatment: either under the umbrella of health care system or under social services. It can be presumed that attention to dual disorder is greater when drug treatment is seen as part of the (mental) health care.

The report of the Pompidou Group gives per country a quantitative and an as differentiated as possible description of the availability of facilities. Traditionally, it was focused on heroine use (and dispensing methadone); but now also other forms of drug abuse are addressed. It goes without saying that—partly as a result of epidemiological, cultural and financial characteristics—the countries differ in strengths and weaknesses. The Eastern European countries had in the 1990s lack of knowledge and facilities, but also there significant improvements have been made.

Unfortunately, the Pompidou Group has indicated that there are hardly any facilities in European countries for the dual disorder treatment.

### 2.2.2 Treatment for Alcohol-Use Disorders

There is no European institute that, similar to the EMCDDA, makes detailed annual reviews of the progress of the alcohol services in different countries. This has to do with the fact that, for the past 25 years, drugs (production, trade, and use) has been given a prominent place in government policies. Most drugs are illegal; the production and trade are linked to criminal organizations. And also the use of drugs is often classified as an offence or a criminal act. However, from a physical and mental health-point of view, the abuse of alcohol is a much bigger problem. Alcohol consumption in Europe is relatively high, though it has declined in recent years. Alcohol is causally related with over 60 different medical conditions (Room et al. 2005). Because of the relatively high consumption, the prevalence of these disorders in Europe is troubling. Additionally, numerous social problems are related to alcohol abuse. However, the gap of lacking a separate institute is compensated by the efforts that WHO Regional Office for Europe has been made to this theme ([www.euro.who.int](http://www.euro.who.int)). Furthermore, with the support of the EU, there is the Amphora-project ([www.amphoraproject.net](http://www.amphoraproject.net)), which develops and disseminates knowledge about alcohol policy and promotes its implementation.

From a number of recent publications a picture can be drawn of the alcohol problem in Europe and the available facilities to reduce the problem. WHO Regional Office for Europe recently published a very extensive status report on alcohol and health in 35 European countries (WHO Regional Office for Europe

2013). This report provides data on treatment of problematic alcohol use, but unfortunately, this information is very brief. The document is nevertheless important because of the various references.

Drummond et al. (2011) recently published a literature review of the range of facilities and questioned the possible gap with the needs for care. They concluded nevertheless that it is difficult to answer this question because of a lack of comparative data. This problem is also described by Drummond et al. (2013). The authors conclude the following on the basis of their comparison of six European countries (Austria, England, Germany, Italy, Spain, and Switzerland):

1. There is considerable variation in the implementation of alcohol interventions across Europe, partly related to national strategies and devolved responsibility.
2. There is a need for a more concerted effort across Europe to implement evidence-based alcohol interventions.
3. There is a lack of comparable high quality information on the prevalence of alcohol use disorders and access to interventions.
4. A Europe-wide system for estimating prevalence or alcohol use disorders and monitoring implementation of early identification and treatment is needed.

In the past few decades, a great deal of knowledge about effective treatment for alcohol problems has been developed. Rehm et al. (2013) made an overview of the availability of formalized guidelines that are formed on the basis of this knowledge. They found, however, that less than half the EU countries use a guideline. The analysis made clear that ‘abstinence is the usual treatment goal’, but in most guidelines there is nowadays also a focus on intermediate goals, such as reduction of drinking or controlled drinking. The overview also made visible that cognitive behavioural therapy, motivational interviewing, and family therapy are often mentioned for relapse prevention—this in combination with medication.

### 2.2.3 Mental Health Care

The prevalence of mental disorders in Europe and the adverse impacts on the social functioning are considerable. Yearly, over a third of the population has to do with a mental disorder. Noteworthy is that only a third of them receives aid (Wittchen et al. 2011).

The European Observatory on Health Systems published a sound and still useful overview of the policies and the relating practice in the European field of mental health care in 2007 (Knapp et al. 2007). This report provides insight into the history, recent developments and prospects. It gives further insight into the development of treatment strategies, financing, legislation, strengthening the role of primary care, decreasing the importance of psychiatric hospitals and ambulatory services, the fight against the rise of stigmas and social exclusion, the promotion of social integration (housing and employment), the meaning of the user and survivor movement, the role of carers and families, and the developments in former eastern

bloc countries. This report also deals with addiction and substance use, but unfortunately gives no attention to dual disorder.

A more practical view of the situation for policy makers of mental health and mental health care in Europe was published in 2008 by WHO-Europe (WHO Regional Office for Europe 2008). The WHO found that compared with 5 years ago, the countries had made significant progress, but there were also several weaknesses signalled. A weak point is the lack of consensus on definitions of concepts and the absence of a compatible data collection. Further, the wide variety of facilities and funding opportunities signalled the fact that the level of mental health in the various countries can differ significantly within Europe. The conclusion was: 'If one word could summarize this report, it would be diversity. Many sentences and tables in the chapters are characterized by various differences' (WHO Regional Office for Europe 2008, p. 79). Of course, it is not the case that diversity always points to shortages. Mental health care is most effective when it is closely connected to the particular characteristics of regions, target groups, and cultural conditions. The WHO concluded that there is also a trend to more convergence. The priorities of the Mental Health Declaration for Europe (WHO European ministerial conference on mental health Helsinki 2005) may be a guideline. These are:

1. Foster awareness of the importance of mental wellbeing.
2. Collectively tackle stigma, discrimination and inequality, and empower and support people with mental health problems and their families to be actively engaged in this process.
3. Design and implement comprehensive, integrated and efficient mental health systems that cover promotion, prevention, treatment and rehabilitation, care, and recovery.
4. Address the need for a competent workforce, effective in all these areas.
5. Recognize the experience and knowledge of service users and carers as an important basis for planning and developing mental health services.

The report further recommended prioritizing services for vulnerable groups, including people with dual disorder problems 'i.e. where mental health problems occur jointly with other problems such as substance misuse or physical illness' (WHO European ministerial conference on mental health Helsinki 2005, p. 81).

The European Commission has recently published the most comprehensive report on mental health systems in Europe (European Commission 2013). In addition to a review of the relevant European literature, the report includes systematic country profiles. On the basis of these, cross-country comparisons have been made. Important is that the country profiles also mention substance abuse treatment facilities and programs. This provides an important basis to examine the consistency and to stimulate cooperation in the future.

These three facilities for additional mental health data are important:

1. WHO European Health for All database (HFA-DB): [www.euro.who.int/en/data-and-evidence/databases/european-health-for-all-database-hfa-db](http://www.euro.who.int/en/data-and-evidence/databases/european-health-for-all-database-hfa-db).
2. OECD Health Care Quality Indicators: [www.oecd.org/health/health-systems/healthcarequalityindicators.htm](http://www.oecd.org/health/health-systems/healthcarequalityindicators.htm).
3. Eurostat: [http://epp.eurostat.ec.europa.eu/statistics\\_explained/index.php/Healthcare\\_statistics](http://epp.eurostat.ec.europa.eu/statistics_explained/index.php/Healthcare_statistics).

Another important source for knowledge about health care in Europe is the European Observatory on Health Systems and Policies ([www.hspm.org](http://www.hspm.org)). This institute works closely with WHO-Europe. It offers the possibility of looking into quantitative data from countries and compare these directly online. In addition, there is an extensive search function for documentation on health policy in the various European countries.

### 2.2.3.1 Dual Disorder Treatment

In a report released in 2004 by the EMCDDA on dual disorder (the EMCDDA uses in its documents the term co-morbidity), a series of obstacles for its treatment were signalled (EMCDDA 2004b):

1. Problem drug users, more often than not, suffer from mental disorders. Both psychiatric teams and drug services regularly fail to identify patients with dual disorder.
2. In the dual disorder treatment, there is no single psychosocial intervention for drug addiction that is superior to all others.
3. Dual disorder clients are often sent back and forth between psychiatric and drug services, not receiving proper assessment or treatment.
4. Treatment staff is often not trained to deal with dual disorder clients, since their training usually is specialised (medicine, psychology, social work, etc.).
5. Currently, dual disorder treatment is often not effectively organised and lacks quality management. This leads to inefficient treatment and high staff turnover.
6. Treatment of dual disorder patients involves different services over a long time.

In the international literature different forms of service delivery are described: (1) sequential or serial delivery, (2) parallel treatment, and (3) integrated treatment. While the last form is the most desirable in many cases, in 2004 facilities for such cases were only sporadically available in Europe.

The EMCDDA formulated the following policy considerations (ibid):

1. Dual disorder patients often have many mental, physical and social problems, which have to be identified and diagnosed.
2. Treatment is effective if delivered according to evidence-based practice, planned and managed individually.

3. Dual disorder patients need carefully coordinated and integrated services in order for treatment to be successful. Case management is a particularly effective approach for these patients.
4. Training at all levels of each involved organisation is necessary to enhance staff capacity to deal with dual disorder patients in a holistic way and increase treatment success.
5. Coordinated, integrated and flexible treatment services based on scientific evidence and with regular monitoring will reduce staff turnover and be cost-efficient.
6. Aftercare and social reintegration efforts are important in order to avoid relapse and renewed need for cost-intensive care.

Recently, the EMCDDA (2013) published an update. The focus of this document was on the available epidemiological data about dual disorder (co-morbid substance use and mental disorders) in Europe. The EMCDDA found that in Europe the most common combinations are:

- Alcohol use and depression or anxiety;
- Opioid use and personality or behavioural disorders;
- Cannabis use and schizophrenia;
- Amphetamines use and psychotic disorders.

The EMCDDA concluded that there is still a huge lack of uniform criteria for the sampling of national data on this subject. The national reports demonstrate a disputable variation in the quality and quantity of the available statistics. There is some progress in the way countries are collecting national data. However, to date, as a result of the fragmented way data are collected in Europe, it is impossible to compose a reliable and valid overview. As a consequence of that, North-American literature is frequently referred to in order to give an impression of the prevalence of dual disorder. The EMCDDA has announced to stimulate their partners to harmonise future data collection. This requires agreement on methodologies and criteria about the registration of disorders and substances. Of note, the EMCDDA focuses on illicit drugs, although it would be wise to include alcohol and tobacco.

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### **General Findings and Conclusions**

In general, we can state that in most European countries some general developments are taking place in mental health care: the importance of clinical facilities is decreasing, more ambulatory work is being done, the primary care is becoming more important, and the activities are better supported by scientific research (guidelines). But the differences between countries and even regions are great. It seems unlikely that this will change soon. The same trends apply also more or less for substance abuse treatment. However, moral standards and legal regimes play here an even bigger role than in mental disorders. This explains partly why countries differ so much from each other in this respect.

Organizationally, facilities for substance abuse treatment usually exist separately from those for mental health care. This is rarely expressed as a real problem, which points out that the attention to the dual disorder treatment is not central to the policies of international organizations and countries. This applies also to the question of how these can be better organized. The organizational conditions for the treatment of dual disorder problems are therefore not optimal. Yet, it cannot be concluded that this would not be possible. Mental health care and substance abuse treatment institutions can decide to adjust their treatment policy, which also applies to the professionals working there. The possibilities for this vary from country to country. Usually, the financiers limit the policy freedom.

A known issue is that national data collection is not uniform in Europe. However, after a few years the EMCDDA has shown that it is possible to change this. It yearly publishes in-depth reviews on drug use, drug policy, and drug services, which clarify the differences between countries and their background. Unfortunately, the EMCDDA does not make reviews about alcohol problems.

Another shortcoming is that the view on the outcomes of care is limited. Although there are data on inflows and outflows, whether treatments really work cannot be derived from these data. Also, there are no reviews showing whether in Europe—by country—evidence-based strategies are applied. And if so: which one.

The dual disorder treatment (substance abuse or dependence and mental illness) presupposes in the first place a sufficient overview of clinical-epidemiological data. These should answer the questions how many clients experience dual disorder problems, what combinations of disorders it concerns, and what the nature and the severity of their condition is. Secondly, there is a need for a collection of well-researched methods: biomedical and psychosocial techniques and strategies for rehabilitation and recovery. Ideally, these are brought together in a treatment-guideline. Thirdly, professionals need to have sufficient skills to be able to treat dual diagnosis problems effectively. They can develop this usually only when they are encouraged or challenged and that assumes that in the policy of their work organisation this theme is considered to be important. Fourthly, there is a need for integrated facilities: institutions for mental health care that work well together with institutions for addiction care, or institutions that have created integrated facilities internally. Sometimes, this arises only after external policy makers put pressure on the facilities. Finally, there is a need for sufficient funding. And there should be a procedure that guarantees patients access to integrated care.

The care is still diverse and fragmented in Europe. And there are still few policies designed to improve the care to people with dual disorder problems. Also international organisations in this field are not yet tightly integrated. However, a lot can change in the next decade. An important condition for change is that addiction is understood as a mental disorder and that the ‘status aparte’ will disappear.

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