4 Care for Patients with Addiction and Concurrent Disorders in Europe, The United States of America, and Canada: Similarities and Differences

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Contents

Abstract

Dual disorders represent a major burden of disease in both North America and Europe. However, there are important differences concerning health systems and their financing as well as vulnerable subpopulations. Due to financial barriers or

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structural deficits, emergency rooms often provide the only available care for patients in the USA and Canada, while stepped care approaches are more common in Europe. Differing attitudes and policies impact on treatment paradigms, such as harm reduction, abstinence, or opioid maintenance treatment. These differences can be observed not only on a transatlantic but also on an intra-European level. Structural components and clinical pathways lead to dissimilarities in access to care, particularly detoxification, rehabilitation, and community services. The role of primary care as an important treatment interface is much more recognized in Europe. While innovation is on-going and great scientific progress has been made in the treatment of dual disorders in recent years, the implementation of these findings into "real-world practice" has been insufficient so far.

4.1 Introduction

There has been an increase of scientific attention in North America on the coincidence of addiction and other mental illness since the 1980s (Alterman 1985; Drake et al. 2008). One reason of this was the observation that substance use among psychotic clients was highly related to treatment drop-out, low retention, and worse outcomes. Classification systems at that time (ICD-9 and DSM-III) did not allow a more descriptive diagnostic approach. They summarized so-called secondary symptoms under the main categories, which supported significant neglect towards more differentiated treatment needs. The neglect of harmful substance use among patients with severe mental illness was typical internationally, having been well documented as clinical evidence as early as the beginning of the twentieth century for schizophrenic patients in hospital care (e.g. by Bleuler 1911).

The paradigm shift towards the descriptive psychopathology in ICD 10 (World Health Organization 1992) and DSM III-R (American Psychiatric Association 1987) addressed that trend and accommodated the fact that dual disorders are more a rule than an exception (Wang et al. 2005).

In response to the obvious clinical problems and special needs of these clients, particularly discussed and acknowledged for the coincidence of psychosis and addiction (Drake et al. 2008), specialized programmes were set up in the USA and very soon in Europe, too. These developments and their outcomes provide an opportunity to study and understand health-care system change in mental health based on research and paradigm shift in substantially different frameworks.

Importantly, despite more attention and some regional initiatives, the care for patients with dual disorders remains one of the biggest problem areas in the system of care (Committee on Crossing the Quality Chasm 2006).

Only every 10th client in the USA is seeing a specialist and 1/3 get professional care mainly through family medicine, while 2/3 receive no help from the system. The coverage in most of Western Europe is slightly better but with the same delay

in interventions and little support for those with addiction and concurrent mental disorders (Wienberg 2001). It takes on average 10 years from first symptoms to first professional interventions.

The United States represent one extreme version of a health-care system based on private insurance models, while many European countries function in the framework of public health care, with general insurance for everybody and sometimes optional additional private insurance. As one of President Obama's most important reform bills, his health-care initiative aims to provide health insurance for everybody.

Canada has a "single payer system", going farther than most European concepts. Due to the "Canada Health Act" (Madore 2005), health care is freely available to everybody and directly funded by the government. These different approaches allow for a very interesting "quasi-natural experiment" comparison and the discussion of a client and needs centred service delivery model.

4.2 Same Burden of Disease, Same Stigma, Different Cultures of Care

4.2.1 Epidemiology in the System

Substance use disorders and concurrent mental illness represent a comparable burden of disease on both continents (Wienberg 2001; Kessler and Merikangas 2004). However, between the USA, Canada, and Europe, but also between poor and rich countries in Europe itself, substantial differences exist in the proportions of subpopulations of complex patients and the barriers to support and health care.

The prevalence of individuals with addiction and mental illness is increasing when moving from the outside to the inside of the system of care. In emergency rooms (ERs) and acute care, patients with substance use disorders and additional mental as well as physical health concerns are more the rule than the exception (see Fig. 4.1). In North America it is a reflection of the existing system of care with little or no capacity for tertiary care services or comorbidity experts in the community. So the populations with high needs are not served and access the system only as emergency cases.

So if you move from milder symptoms not in need of acute or emergency care (level in front) towards a crisis and the need for acute care (level in the back) the complexity of symptoms increases, concurrent disorders become the rule and not the exception.

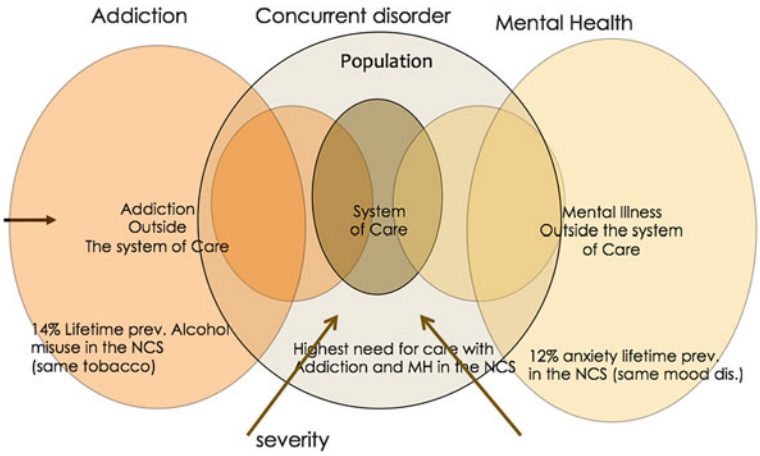

Fig. 4.1 Severe addiction and mental illness (SAMI) based on population and in the system of care; *NCS* National Comorbidity Survey (Kessler and Merikangas 2004)

4.2.2 Special High Need Populations

Patients with addiction and concurrent mental disorders form part of very different populations with all levels of social functioning. This is resulting in varying additional support needs, access to care and treatment options. Due to different social and health-care systems it is important to acknowledge these subpopulations with specific challenges for the system of care and society as a whole in both North America and Europe.

The ongoing *First Nations* and Native American health-care crisis (Krausz 2008; Spittal et al. 2007) is specific to North America. The indigenous population is in an especially critical state due to bad living conditions on reserve, social marginalization, and extreme levels of trauma, substance use, and lifestyle-related physical illness such as metabolic syndrome and obesity, with little or no health care available in their communities. They are also overrepresented in all particularly marginalized groups as homeless, in foster care, or early imprisonment. The prevalence of complex concurrent disorders is much higher than elsewhere in the society (Spittal et al. 2007).

Vulnerable urban populations (Krausz et al. 2013; Linden et al. 2013), including those living in substandard housing or homeless, are typical for large metropolitan areas. In large cities, poor neighbourhoods, like Vancouver's *Downtown Eastside,* are of special concern. They are known for extreme levels of harmful substance use, trauma, and mental illness (Krausz et al. 2013), and difficulties in provision of appropriate care due to the housing situation. That was the reason for a National research demonstration project in Canada, the *At-Home—Chez Soi* project (Goering et al. 2011), exploring housing and support for mentally ill homeless in five Canadian centres. It demonstrated that "housing first" with appropriate community

support enables recovery even of severely affected dual disorder patients (Schutz et al. 2013).

Migrants arriving in a new country are often amongst those listed as a vulnerable group. Language barriers, traumatic experiences, and insecure legal status can further complicate access to any support. In Canada and the USA, migrants in this category form a subpopulation nearly excluded from formal health care (Kluge et al. 2012). Even those able to access the systems have difficulties finding culturally appropriate programmes. In Vancouver, nearly 50 % of the people are of Asian origin, and in California Spanish has become the dominant language.

In Europe, other regionally differing cultures are suffering from exclusion, foremost those of African origin or individuals from the former Soviet Union member states and their political satellites. Even though there are specific programmes for migrants, they often suffer from the separation of treatment systems for substance use and mental health. This can lead to exclusion of patients with substance use in the case of psychiatric centres, or exclusive psychosocial support lacking medical assistance where services are provided by social workers in specific multicultural drug-counselling units.

4.2.3 Stigma and Marginalization in the System of Care

Addiction and mental illness are arguably the most stigmatized and structurally discriminated conditions in health care worldwide. The burden of disease particularly among young people is among the highest of all medical conditions and still growing, and the mortality is huge. Despite these stark facts, compared to other areas of health care, mental health and addiction remain the most underfunded area of medicine (Livingston et al. 2012).

4.2.4 Culture of Care

Stigma, poverty, homelessness and social marginalization, and substance use, mental and physical comorbidities form a vicious circle. Combined with the lack of specialized services these patients are frequently not in any regular mental health-care programmes. Consequently, these people often tumble from crisis to crisis and use ERs as their only access to care.

ERs in North America are often overcrowded and have little to offer in terms of treatment. Moreover, ER's are not funded or equipped to replace community services, especially for high need patients with complex concurrent disorders.

If families in North America can afford private treatment programmes, either residential or community based, a range of specialized providers are available. Particularly university-affiliated clinics offer standardized programmes (Savage et al. 2007; Torchalla et al. 2012) with proven effectiveness. But overall, these are neither accessible nor affordable for the average patient and relevant only for a small minority.

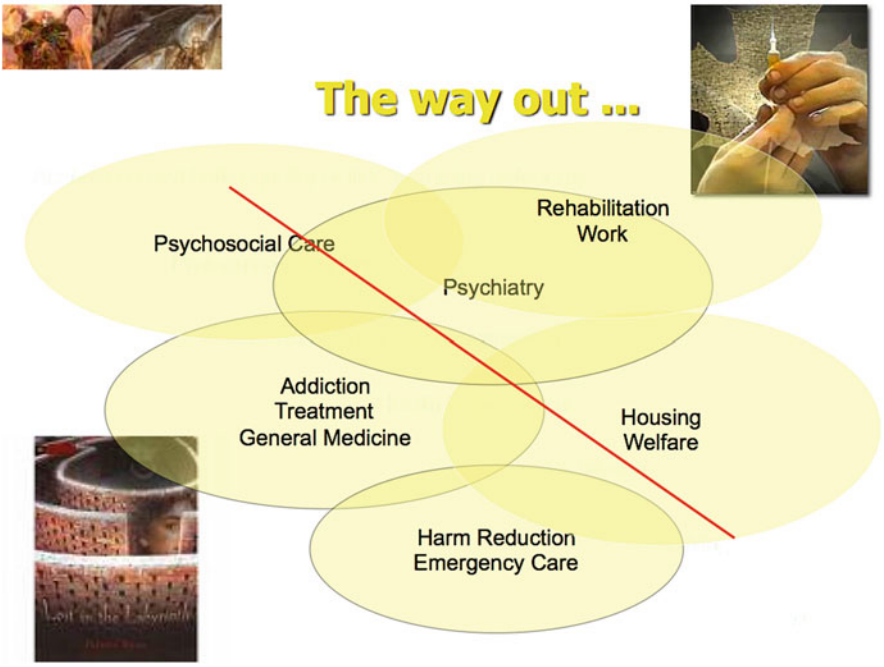

Fig. 4.2 Levels of care

With structural and funding problems in European countries similar trends can develop. Nevertheless clinical pathways and a coherent approach to care are far more common in Europe. Particularly effective are established pathways in the Netherlands with stepped care approaches (Schippers et al. 2002) or Switzerland and Germany (Wienberg 2001).

The Canadian culture of care is similar to the European system. However, while everybody has a right to be treated, the services needed for stepped care such as are mostly missing, so the ERs become the inefficient hub of triage and care.

So as shown in Fig. 4.2, ideally different levels and models should and could connect in clinical pathways (represented through the line), which unfortunately is often not the case. Even if the capacities are available, which is an exception, they are not integrated and connected.

4.3 Treatment Paradigms and Goals

The last two decades have been dynamic in terms of paradigm shifts in the area of mental health and addiction. Nearly every essential concept from harm reduction over methadone substitution, and controlled consumption to abstinence based care was questioned and subject to national and international reviews (e.g. European

Monitoring Centre for Drugs and Drug Addiction (EMCDDA) standards; Heroin assisted treatment (HAT); Harm reduction).

Substantial regional differences in best practice, especially in the treatment of addiction, significantly impact the treatment of dual disorders. The dominant paradigms changed in Europe as well as in the USA and Canada as a result of drug policy under pressure, the response to the HIV epidemic, and the obvious failure of the abstinence focused system of care.

In psychiatry, the neglect of substance use of patients with severe persistent mental illness in treatment undermined psychosocial treatment programmes and lead to low retention and compliance in the hospitals as well as community care. Single programs such as those in Dartmouth, USA (Alterman 1985; Drake et al. 2008), Hamburg, Germany (Krausz and Müller-Thomsen 1994) or Bern, Switzerland (Moggi et al. 2002) or Antwerp, Belgium (Morrens et al. 2011) started to address treatment of comorbid disorders, in particular of psychosis and addiction.

One of the most important lessons of the last decades is that treatment capacity, funding, best practice, and health politics are not only influenced by evidence but also and sometimes foremost by economic considerations and political priorities. Even drastic mortality rates and high public health risks are not per se a reason for most governments to respond. On the other hand, the implementation of harm reduction programmes as well as heroin-assisted treatment is demonstrate the major impact of clinical innovation. They saved thousands of lives, prevented life-threatening infections such as HIV and supported recovery on a large scale.

4.3.1 Harm Reduction

Why is the harm reduction paradigm of any relevance to the treatment of patients with mental illness and severe substance use? There are three reasons:

1. Due to their risk behaviours comorbid patients are very vulnerable to severe infections and physical harm (Dausey and Desai 2003) and need protection and support.
2. For those with dual disorders, access to the system is more complicated due to system thresholds, social marginalization, and homelessness but also due to some clinical disabilities like cognitive impairments. In the BC Homelessness survey we showed, that the sicker patients were, the more difficult it was for them to get appropriate support (Krausz et al. 2013). Harm reduction programmes are an important entry point to connect to mental health or addiction care.
3. Harm reduction is one of the oldest medical principles and the common ground for treatment approaches beyond. Without survival, prevention of physical harm and trauma, any recovery may be impossible. When the "harm" in harm reduction is defined a little wider than just AIDS, e.g. by including social deterioration, deprivation or criminalization, then it becomes obvious that this is a prerequisite for any further step. The identification of dual disorder patients

along with provision of psychiatric services in harm reduction facilities would be "low threshold" indeed. An example of such an intervention is the provision of opioid maintenance treatment (OMT) in safe injection facilities established in some Swiss cities today.

The US government and its funding agencies have only recently opened up to "harm reduction" strategies and approaches. Until the Obama presidency "harm reduction" was more of a "non-word", which might well have influenced the decision of the National Institute of Drug Addiction (NIDA) to withhold funding or any other support from programmes pursuing such harm reduction approach.

Canadian provincial governments, which are in charge of health-care legislation and organization, took a different route, sometimes in conflict with the Federal government in Ottawa. The only official "safe injection site" in North America today, opened in Vancouver backed by the provincial government in British Columbia (BC). *Insite* in Vancouver is still questioned and legally battled by the conservative Canadian federal government (Wells 2011), despite needle exchange and similar low threshold programmes being widely accepted since the HIV epidemic.

In Europe, harm reduction strategies were implemented first in Switzerland, Germany, and the Netherlands in the 1980s with a lag of about 10 years in the southern European states as Spain, Italy, and Greece. This led to up to tenfold differences in the HIV prevalence rate between states. For example in Hamburg, the prevalence rate is about 3 % but in Barcelona about 30 % (EMCDDA 1999). The joint EU guidelines on harm reduction are the result of that experience. Even fierce opponents of harm reduction changed their approach based on an unfortunate "natural public health experience" with hundreds of thousands infected and dying of HIV despite knowledge of what could help to prevent it.

4.3.2 Abstinence and Controlled/Moderate Use

Internationally, most mental health programmes for the treatment of comorbid patients are based on abstinence as treatment prerequisite and certainly as a treatment goal. This is based on the conceptual understanding that substance use including alcohol and cannabis can trigger psychotic symptoms or mood swings. In most Canadian and US health-care institutions, supported housing and other social services, even moderate substance use is unacceptable. Noncompliant patients are either forced to abstain through certification or seclusion, or are denied access to care (e.g., in residential care settings). With this approach the most vulnerable urban populations with complex concurrent disorders and long histories of severe substance use are again excluded from care and social support.

It is only recently that in Germany OMT patients are allowed to participate in residential rehabilitation programmes, which play a major role in the German addiction treatment system. Similarly, there was a trend in Switzerland over the past 15 years in favour of acceptance of OMT in these institutions.

Specialized programmes working with the full range of addiction treatments in medicine are rare. Psychiatry is thus accepting a situation where we are not able to help complex concurrent disorder clients.

In response to the lack of alternatives some treatment providers in Canada have started pilot projects with severely alcohol dependent patients to prevent them from drinking very harmful "non-beverage alcohol" such as hand sanitizer with up to 80 % alcohol, easy to find in any emergency department. These programmes distribute hard liquor to severe alcohol dependent patients in a controlled way, sometimes along with case management.

Despite the scepticism among the AA community, the discussion on "controlled use" initiated a new approach in places such as in Germany (Koerkel 2002). The idea behind this is that for some it is possible to control and limit their use to a non-harmful level. This is much better to try in a structured and supported environment.

The Burnaby-based treatment centre for mental health and addiction is a Canadian example of a service focusing especially on patients (Schutz et al. 2013) with a long history of trauma, severe substance use, and physical as well as mental illness. The goal still is abstinence but with the approach, that relapse is part of the disorder necessitating constructive attention and not exclusion.

4.3.3 Maintenance

Treatment goals and legal regulations of OMT differ not only between North America and Europe. While abstinence is still the mandatory goal in Germany, and treatment providers are sometimes forced to terminate OMT in case of on-going substance use, which is not the case in Switzerland. Furthermore the experience in substitution in the USA showed that the exclusion from methadone maintenance programmes based on additional use led to higher mortality rates and not to improvement (McLellan et al. 1996).

There is a substantial difference in substitution treatment, e.g., in Germany or Switzerland and in the USA. In the former, psychosocial counselling is always available for all clients, who want to have it. In most programmes in the USA and Canada systematic counselling is an exception.

Mental health care is even more complicated to get. Only a tiny fraction of all substitution treatment programmes is provided by psychiatrists. Substance users are still excluded from psychotherapy and marginalized in the system. Likewise in Europe, OMT providers are often not prepared to address comorbid mental illness although it is known how critical and how prevalent trauma, depression, or attachment disorders are for sustainable recovery. For example, the larger part of maintenance treatments in Switzerland, Germany, Austria, etc., is still provided by family physicians (Bundesamt für Arzneimittel und Medizinprodukte 2013; Hošek 2006).

4.3.4 Integrated Versus Sequential Treatment of Dual Disorders

Abstinence based programmes normally focus first on detoxification and start with psychosocial programmes later. Detoxification in North America is also extremely short, less than a week. Thus, many patients leave after just basic stabilization and before detoxification is finished.

That is slightly different in Germany, Switzerland, or the Netherlands where the integration of counselling and cognitive behavioural therapy into the early stages of treatment including detoxification is established and called "qualified detoxification".

Why is that relevant for the treatment of concurrent disorders? There are three reasons:

1. For a substantial group of patients emergency care or detoxification is a short window of opportunity, because they are only in a pre-contemplative phase (DiClemente et al. 2008) and are not sure about additional treatments. The functional component of their substance use (Khantzian et al. 1974) that is, dealing with their "emotional pain," motivates them not to give away this (at least partially) effective tool although they may be conscious of the risks.
2. Acute crisis and the experiences around it play an important role in the perception of one's own mental challenges. A reduction of treatment to the basic minimum of physical management wastes an opportunity and is insufficient.
3. During acute situations all mental symptoms are experienced more intensely. Anxiety, mood swings, psychotic symptoms as well as flash backs intensify the suffering and require a response. When care is insufficient, these experiences are often a reason that patients leave prematurely addiction treatment "against medical advice".

4.4 Structural Components and Clinical Pathways

Treatment settings in the USA, Canada, and the European countries work distinctly and carry different burdens in the system. Primary care is as important in the treatment of comorbid clients as for the treatment of substance use and mental illness "alone" (Wienberg 2001). This fact was acknowledged in Europe decades ago and is a hot topic in the system reform in Canada right now. Family medicine is the main interface to the community but often not equipped and trained to deal with patients who need special care.

The role of emergency departments is a more central one in North America due to the insurance system and a limited availability especially of mental health services (long waiting times, no psychiatrists, no detoxification capacity). As a result, ERs play a key role in several regards. They are no longer just a last resort, to be used if nothing else is available. They are used also because of a lack of access to alternatives and if the person in need is not insured. In these situations emergency rooms can provide emergency triage and support often together with police.

However, despite this important role, acute care has a relatively small capacity. For example, in comparison with Germany, Canada has less than 50 % of the available beds in mental health. Unfortunately community services are also less equipped. Canada is investing about the same amount of funding per capita into health care but psychiatry is the most underfunded area of all.

Although most of the addiction programmes besides OMT in the USA and Canada are based on abstinence, detoxification and residential capacity are only accessible as an exception or for private payers.

These basic features of care are far more accessible in Europe and in better quality. For example, in Germany, a separate system of "rehabilitation clinics" is providing psychotherapy and "psychosomatic" care including addiction treatment, something that does not exist in North America.

4.5 Innovation in Europe and North America

New treatment settings for high need populations are being established in both inpatient and outpatient settings. Psychiatric hospitals mainly in Europe increasingly offer dual disorder units, where, ideally, substance use and comorbidities are being addressed simultaneously (not always, however, do treatment concepts of these units reflect this goal adequately). The Burnaby centre in Vancouver, offering outpatient treatment for dual disorder patients, also reflects this approach. Gradually, in light of the aging population of OMT patients in Switzerland, service providers are integrating somatic health specialists (Krausz 2009). Best practice guidelines are also upgraded and increasingly reflect the common occurrence of dual disorders (see, e.g. Swiss Society of Addiction Medicine (SSAM) 2012).

Progressively, standardized interventions targeting comorbid disorders in substance users are invented, evaluated and established. These include specific training programmes, e.g. *seeking safety*, which targets trauma-related symptoms (Najavits 2002).

Conclusions

Despite very small treatment capacities in both regions of the two continents Europe and North America for the most vulnerable, the last 30 years contributed substantially to the development of more effective and specific treatment approaches.

Differences between the USA, Canada, and Europe are still significant especially in the readiness to build treatment approaches based on health outcomes instead of prohibition and the abstinence paradigm.

Clinical research could demonstrate effective treatment strategies and settings, which, if available, would improve care substantially. If the mental health system were organized more based on evidence and proven effectiveness many more vulnerable individuals would have a chance to survive and recover. Patients with complex concurrent conditions could be treated successfully. That would decrease mortality and save resources from all kinds of ineffective system use.

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