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Foreign report

Substance misuse services in the USSR*

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Exchange visits with Soviet colleagues are being encouraged. I recently had the opportunity of spending two weeks visiting services for drug misusers in the Soviet Union with two colleagues, a visit sponsored by the British Council as a UK/USSR collaborative project. We spent most of our time in Leningrad and the surrounding region, and a short time in Moscow. Since then a party of Russian specialists has visited the Wessex Region to see drug and alcohol services.

Until very recently the USSR did not admit to having any problems with drugs; it was after *glasnost* began in the mid-1980s and social problems began to be discussed for the first time that substance abuse problems were first acknowledged (Kramer, 1988). Alcohol problems, numerically much greater and with much greater adverse effects on Soviet society, were highlighted by Gorbachev. An ill-fated attempt to reduce alcohol consumption was made by reducing the production of vodka and by increasing its price. The result was large-scale illicit distillation of spirits, the disappearance of sugar from the shops to make it with, and the inevitable medical problems from imperfect distillation. The policy had to be reversed.

One of the difficulties in getting any real idea of the extent of drug addiction in the Soviet Union is that the law requires addicts to be officially registered with implications that include the possibility of enforced treatment and imprisonment. As a result, there is a powerful disincentive to drug users to make themselves known to the authorities. Officially there are 3,000 addicts in Leningrad, but unofficially this number has to be multiplied by at least a factor of ten. Illegal opiates are mostly produced from indigenous poppies. Dried poppy heads are treated with ammonium and white spirit and boiled; the resultant liquid is heated, leaving a residue of opium which is treated with vinegar to produce an injectable liquid-compote. Amphetamines are produced from commercially available ephedrine to which is added potassium permanganate to produce a liquid preparation – ephedrone – which is injected. Prescribed medication is quite widely available on the black market, mostly benzodiazepines. Prescriptions are forged and certain doctors prescribe excessively for money.

Narcology, the specialism of substance abuse, has been developed as a separate discipline in the Soviet Union over the past ten years. There are now over 50 institutes of narcology and some ten thousand narcologists. Most of the narcologists are doctors, although there are a small number of specialist psychologists working in the field. Of the doctors, about 30% have had training as psychiatrists. Training for narcology is in the form of short training courses at postgraduate medical institutes, lasting from a few weeks up to three months. These courses are still few and far between. For example, the Leningrad Postgraduate Medical Institute (the first such establishment in the world created expressly for the training of postgraduate doctors) only set up a department for the training of narcologists in 1989.

The state services for substance abuse are based on the narcological institutes, which are hospital-based, complemented by the narcological dispensaries or out-patient clinics. These are large-scale enterprises. In Moscow the narcological services have over 6000 beds – though two-thirds of these are occupied by patients who work during the day. In the region surrounding Leningrad there are over 1000 beds for a population of 1.6 million. We visited several hospitals in and around Leningrad, and one in Moscow. The buildings were all very much the same, built in a uniformly functional and characterless style round scruffy courtyards with unkempt grass and a few straggly silver birch trees. The buildings themselves looked unkempt and dilapidated and in need of decoration, and the entrances always seemed to be unmarked and to be dark and pokey.

The beds were grouped into units with up to 60 beds in each unit; there would be up to ten bedrooms on one or two floors with a large day room and separate dining area. The living areas were usually made quite welcoming with pictures on the wall and pot plants. Most of the beds are for those with alcohol problems; in one Leningrad hospital, out of 800 beds only 40 were for drug users. There is a considerable

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emphasis on work therapy; after detoxification and initial rehabilitation, patients will work in various local factories and come back to the hospital at night. Thus a significant proportion of the beds are occupied by patients who work during the day.

Admissions to narcological institutes have fallen in recent years in spite of evidence that the incidence of problem drug and alcohol use is increasing. As more than one person told us, narcology has a bad image; there seem to be a number of reasons for this. Alcoholism carries a considerable stigma in Russian society, drug addiction even more so, and as a result patients are only admitted to hospital when they have no choice. Alcoholics are often in a physically deteriorated state on admission, and are frequently unconscious or in withdrawals. Until recently, doctors seeing alcoholics were legally obliged to register them officially; their names were passed to the local police and they remained on this register for three years. Follow-up was designed to ascertain whether or not the patient was sober, rather than to provide continuing support and treatment, and relapse could result in compulsory treatment in hospital. It is not, therefore, surprising that people kept away from narcologists! Recently, however, so-called 'anonymous' treatment has been available, which means that people can come for advice and treatment without giving their names and being registered.

The situation for addicts is worse (Babayan, 1990). The majority, 80%, are in hospital because they have no alternative. After being picked up by the police and appearing in Court, they are required to have treatment; if they refuse they are given a custodial sentence. Registration for addicts lasts for five years. Those discovered to have a drug problem in prison can be sentenced to a form of work therapy that can last up to two years. Clearly such punitive attitudes are not going to encourage people with drug problems to declare themselves and come for treatment, and this has rather belatedly been recognised by the Soviet authorities. The Ministry of Health has recently allowed some narcological institutes to treat drug users on an anonymous basis.

A change in Soviet law in 1987 allowed the setting up of cooperatives – groups of employees providing a service or selling goods for profit (Hosking, 1990). Essentially this has been the start of officially sanctioned private enterprise and, among others, groups of doctors and health workers have set up cooperatives. We visited a cooperative in Leningrad called 'Narcolog' set up to treat substance abusers; most of these have alcohol problems as the law does not yet allow the private treatment of drug addicts. Most of the cooperative members were doctors, a few were psychologists. They are paid on the basis of fees earned by seeing patients; 5% of the fees goes towards renting accommodation and equipment. The cooperative has rented both in-patient and out-patient accommodation from the State – usually in existing hospital accommodation that was not being fully used. In the early days of the cooperatives many of the more senior narcologists were opposed to them. Interestingly many have since changed their minds, and we had the impression that most of the more go ahead specialists had joined cooperatives, usually on a part-time basis. Certainly money is one incentive. The average salary of a state employed doctor is 150 roubles per month (the official exchange rate is one rouble to the pound; banks in the Soviet Union give 10 roubles and the black market rate is 20 to the pound). Depending on the number of patients seen, a doctor might earn 500–800 roubles a month working for a cooperative. Freedom from the state bureaucracy is also a strong incentive; cooperative members have personal control over their work, and the harder they work the more they earn. It seems that the cooperatives are popular with patients, more of whom are going to them.

The treatment of drug and alcohol abuse in the Soviet Union is still very hospital based, and patients are usually admitted requiring detoxification. Many of the treatments are similar to those we are familiar with. However, a number of non-medical treatments are also used, for example, herbal remedies and acupuncture. Until very recently there was little in the way of social or psychological support for patients; after detoxification, work therapy was seen as the principal way to rehabilitate people. However this is beginning to change following contact with American Alcoholics Anonymous (AA) programmes, and we saw interesting examples of the way in which this approach is being enthusiastically embraced by the Russians.

In the Moscow narcological institute, a joint US/USSR project is being run by a bilingual American alcohol specialist. He is training alcohol counsellors and is planning to open a 24 bed unit to run a programme on AA lines within the hospital. There are now a number of AA groups in Moscow and Leningrad. The chief narcologist of the Leningrad region had visited the US and returned very enthusiastic about what he had seen. It is clear that for those senior narcologists who have travelled abroad their thinking about the treatment of substance abuse problems has been revolutionised. Traditionally treatment has been very medicalised, with patients being expected to follow the treatments prescribed for them. Giving patients the responsibility for their own rehabilitation is a new concept. The AA programmes emphasise the importance of continuing support after detoxification, and this type of aftercare is also a new feature for the Russians. Indeed community care as we know it is virtually non-existent in the Soviet Union.

It is a truism that substance misuse and substance misuse services mirror the societies in which they occur. The changes that have occurred in the Soviet Union in recent years are reflected in the way in

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which drug and alcohol problems are perceived, and how they are approached (Feltham, 1989). We found a considerable interest on the part of the people we met to learn how we tackled these problems and a willingness to discuss critically their traditional approaches. There is certainly scope for continuing exchange with Soviet colleagues.

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Letter from . . .

Sittard (The Netherlands)

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The Psychiatric Department of the General Hospital (PDGH) Sittard/Geleen has a catchment area of about 160,000 people. As a PDGH we have 42 beds and five seclusion rooms available. Besides this we offer day-treatment (16 places), run an out-patient department, provide psychiatric consultation and training facilities.

At the moment there are 65 similar PDGHs in the Netherlands. This does not include departments, generally small, which do not meet the required criteria to be officially recognised. The total number of PDGH-psychiatrists is estimated at 160. There are 15,000 admissions annually, accounting for 34% of the total number of psychiatric admissions in the Netherlands.

It might be interesting to give a short review of the history of the PDGH in the Netherlands.

The oldest PDGH has been in existence since 1931. In the '60s and '70s the number of PDGHs increased rapidly. Also around this time, the majority of combined neurology/psychiatry departments were split up. At the beginning of the '70s a series of articles, reports and papers began to shed more light on the subject of PDGHs.

A characteristic description might be that PDGHs are small-scale, low threshold departments evenly distributed throughout the country, in which a clear inter-relationship exists with both the other specialties and the partners within the regional mental health care system. Their aim is to provide primary, non-stigmatising and relatively short-term psychiatric intervention for a fairly large and differentiated population. The emphasis lies on integral diagnosis in parallel with a modest range of therapeutic possibilities.

At present, consideration is being given to functionally oriented management and organisation of mental health care facilities with classification according to target group (youth, adults, the elderly, addicts, etc.) and type of care (preventive, curative, etc.).

Mental health care in the Netherlands has been sub-divided into approximately 40 regions, so called Regional Institutes for Mental Health Care (RIMCH). In these we find:

intramural (General Psychiatric Hospitals [GPHs], PDGHs, Psychiatric University Clinics [PUCs] and Specialised Psychiatric Hospitals)
semi-institutionalised (day-treatment in Psychiatric Hospitals, PDGHs, PUCs, sheltered residence units and crisis intervention centres) and
extramural facilities (Regional Institutes for Ambulant Mental Health Care [RIAMHCs], psychiatric out-patient departments of Psychiatric Hospitals, PDGHs and PUCs as well as independently established psychiatrists and psychotherapists.