Pergamon

Alcohol & Alcoholism, Vol. 29, No 4, pp 357–362, 1994
Elsevier Science Ltd

0735-0414/94 $26.00 + 0.00

0735-0414(93)E0017-6

INVITED REVIEW

ALCOHOL TREATMENT SERVICES IN RUSSIA: A WORSENING CRISIS

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Abstract — This paper reviews the state of alcohol treatment services in Russia. There have been some recent improvements, for example the introduction of confidentiality in treatment, the closure of correctional centres, and the payment of state benefits to in-patients. However, there remains a considerable stigma attached to a diagnosis of alcoholism. Although new approaches to treatment have been promulgated, in practice Russian treatment methods remain idiosyncratic with little in the way of psychotherapy. Many techniques utilise placebos and persuasion, with the patient as a passive recipient. Services are generally of a poor quality, and underfunded and medical specialists are poorly trained. To improve matters it is suggested that there will need to be: (1) changes in knowledge and attitude among the general population and within the specialist services; and (2) a continuing exchange of ideas and specialists between Russia and the West.

As a group of English and Russian specialists we have worked together since 1988 studying the state of alcohol and drug services in the former U.S.S.R. (Feltham and Meyroyan, 1991; Fleming, 1991; Fleming *et al.*, 1992; Poling, 1992). Our experience is that it has been very difficult to describe what is happening, especially following the major upheavals that have occurred in all aspects of life in the former Soviet Republic. Nevertheless it is possible to pick out some general problems in the structure of substance misuse services.

One of the main issues was the lack of confidentiality. For many years this had been one of the principal obstacles to patients attending for either in-patient or out-patient treatment. A diagnosis of alcoholism (and even more so of drug addiction) would in practical terms mean the end of a career for leaders of the Communist Party, and for top officials in the executive; similarly for the military, the police, KGB officials, pilots, drivers and railway workers. However, heavy drinking was the accepted cultural norm in these groups, and not to go along with this risked ostracism by the group, so the culture virtually enforced heavy drinking but proscribed treatment.

Another peculiarity of that time was the paradox that to be in treatment for alcoholism, to have the stigma of being an alcoholic, even for those who had completely abstained from alcohol, was seen as a disgrace in the public's eyes. This paradox had a legislative basis; for example, professional drivers who had undergone treatment in alcohol clinics were no longer able to drive (Guzikov and Meyroyan, 1986, p. 73). Another example of this rejection by society of the medical diagnosis of both 'alcoholism' and 'drug addiction' is that this group of patients did not get a medical certificate after treatment. This document ensures that the recipient receives financial compensation for days spent as an in-patient. In all other cases this certificate is obligatory after any period of in-patient medical treatment. Thus, although alcoholics and drug addicts were considered officially as patients by doctors and the medical care system, public opinion considered that they were victims of their own actions and that they had to pay for this in a literal sense.

It was in general too costly for anyone with social status to protect to seek treatment. This was even more of a problem for women alcoholics, on whom public opinion is even harsher. Those women who did come for treatment cared little for what others thought, and not surprisingly, treatment outcome in this group was poor. As a result it came to be accepted by most of the

population, and indeed specialists themselves, that alcoholism in women is an incurable disease (Guzikov and Meyroyan, 1988). The courts resorted with increasing frequency to the practice of sending men and women to specialised correctional centres for 1 or 2 years. These establishments, run by the Ministry of the Interior, were in effect, prisons. They strengthened the image of alcoholics in the public mind as asocial individuals, even criminals.

The public stigma towards drug addicts was even more manifest. They had to be registered by the police department immediately after coming for help to a clinic, and they were much more likely to be imprisoned or sent to a specialised correctional centre (Guzikov and Meyroyan, 1990). Unfortunately, these negative attitudes towards patients with drug and alcohol problems was also deep-seated for a significant number of medical staff, particularly nurses, which further depressed treatment outcomes (Guzikov and Meyroyan, 1990).

Nevertheless, in the 1980s, different approaches to rehabilitating alcoholics and drug addicts were being studied in a number of research centres: in Leningrad at the Bekhterev Psycho-Neurological Institute, and the Kirov Institute of Advanced Medical Studies, and in Moscow at the Institute of Psychology attached to the Academy of Science (Schikherev, 1988) and at Moscow University. A number of textbooks have been published, whose titles reveal the tenor of the new rehabilitation approaches: *Group and Family Psychotherapy* (Guzikov *et al.*, 1980), *Special Features in Psychotherapy of Women Alcoholics* (Guzikov and Meyroyan, 1980), and *The Work of a Clinical Psychologist in the Addictions* (Guzikov *et al.*, 1987).

The period of glasnost and perestroika has accelerated the process of humanising society's attitude towards alcoholics and drug addicts. The practice of confidentiality in treatment is more widespread; patients are now reimbursed for days spent in the clinic. The system of specialised correctional centres has now largely been abolished.

More optimistic prognoses on the treatment of alcoholics and drug addicts are being promulgated in a number of scientific and popular publications, as well as in the mass media. Patients can choose from a wide range of services which they can obtain, not only in state clinics but in private clinics as well. The latter often offer home detoxification.

However, in such a short period of time, long-standing negative social attitudes towards alcoholics and drug addicts cannot be overcome easily. The official medical establishment treats addiction services as a poor relation. Funding is much worse than in other medical specialities. Many of the addiction clinics look like shelters for homeless people. It is now possible to get treatment on a confidential basis at these clinics, but for many patients it is an emotional shock having to identify themselves with people receiving treatment there, and this is itself a further obstacle to recovery. Insufficient funds are available for private addiction treatment, and it cannot seriously compete with the state clinics.

To illustrate the poor conditions of the addiction service network, we describe one unit in the St Petersburg City addiction clinic. There are 70 beds in the unit. The establishment is for two-and-half specialist psychiatrists, but in reality only one doctor works in the unit, and he also acts as the head of the unit. There are twelve qualified nurses and nine unqualified staff. The average length of stay in the unit is no more than 3 weeks.

Most patients are voluntary, and have the right to confidential treatment. They can be divided into two groups: 50% are self-referred and are people of no fixed abode, with a criminal history, who are mainly seeking accommodation. The other 50% are referred by doctors, usually as a result of pressure by their families. When a patient decides to go for treatment he/she signs a contract with the head of the unit.

There is a staged treatment programme. For the first 3 days patients undergo physical examination, and investigation. For the next 10 days they remain in the unit. During the following 2 weeks, patients may have periods off the unit, and may have weekend leave. The final stage is a day programme, after which patients are supposed to attend the unit every 2 weeks for supportive psychotherapy, whilst working during the day.

Although there are supposed to be psychotherapy sessions in the unit's regime, these are not in fact taking place. There is not a therapeutic atmosphere in this and other such units. They look more like long-stay psychiatric institutions; patients do not have much to do, and

are not involved in any intensive treatment process (Poling, 1992).

We will discuss some of the treatment methods that have and are currently being used in this and other clinics to demonstrate how antiquated they are and explain the obstacles that exist to improving addiction services in Russia.

After detoxification, which lasts about 2 weeks, depending on the person's condition, the main 'alcoholism treatment' takes place. As quoted in a textbook for medical students published in 1987 (Babayan and Gonopolskiy, 1987), this consists of aversion therapy, treatment with Antabuse, combined therapy (several techniques together) and psychotherapy. In a postgraduate textbook published in 1983 the authors emphasise medical treatments in alcoholism: vitamins, drugs which cause hyperthermia, Antabuse, and metronidazole to increase sensitivity to alcohol; apomorphine (a form of aversion therapy) and neuroleptics (Morozov and Ivanets, 1983). Only seven pages are devoted to psychological treatments in a book of 432 pages, and this describes mainly methods of hypnotherapy, and a brief explanation of group therapy (Morozov and Ivanets, 1983). Nowadays these treatments are used less often. They have been replaced not so much by psychotherapeutic approaches as by the use of placebos and suggestion as the main therapeutic interventions.

Disulfiram implantation has been used in the former U.S.S.R. since the beginning of the 1980s as one of the methods of treatment most favoured by alcoholics and their families. The use of implanted disulfiram to increase sensitivity to alcohol is described in a textbook on addiction (Entin, 1990), using a French preparation of disulfiram, 'Esperal'. As the author notes: 'Disulfiram implantation is an undoubtedly effective and promising method of treatment for alcoholism' which 'reduces the activity of aldehyde dehydrogenase during the first month, recovery to pre-treatment levels taking six months' (Entin, 1990, pp. 218–219). Soon after starting to work with implantation Russian specialists began to use it as placebo therapy. Patients were asked to sign an official document warning them of the possible adverse effects of taking alcohol for a period of 5 years after the implantation. The adverse effects claimed were: paralysis of the upper and lower limbs, blindness and death. There was no open debate among Russian specialists about the acceptability of such 'psychotherapy'. Behind the scenes conversations took place at scientific conferences. Views varied on how many years of sobriety it is better to recommend to patients after implantation. Usually, as already noted 5 years was advised, but in the textbook quoted above, it was suggested the time be reduced to 3 years (Entin, 1990).

The present shortage of disulfiram for implantation makes this treatment 'special' in both state and private clinics. The cost of the treatment reflects its popularity: 25,000 to 40,000 roubles (the minimum salary is 20,000 to 25,000 roubles a month; June 1993).

In the early years of working with disulfiram 80% of patients had remissions of longer than 1 year. Patients believe that they will not drink alcohol for several years. The length of that sobriety is determined by the specialist telling the patient they cannot drink for 3 or 5 years (clinics have different treatment schedules).

Now in the second decade of its use, the initial good results with Esperal have established, in the minds of patients and their relatives, the belief that this treatment is one of the most effective. In spite of subsequent failures in the method, implantation is still the most popular treatment with the patients. The belief in its effectiveness has become part of the conventional wisdom. It has directed attention away from more progressive psychological approaches and has weakened patients' confidence in their ability to overcome dependency by becoming aware of the problem and mobilising their own will and intelligence.

Unfortunately, not only was the placebo effect of disulfiram implantation accepted uncritically by professionals and the public, but it in turn led to other forms such as the 'capsule'. This consists of an outer gelatine skin filled with a neutral substance, e.g. vitamins. The capsule is given to a patient with the explanation from a doctor or a nurse that for a certain period after taking the medication (1, 3, or 6 months), drinking alcohol will cause unpleasant physical effects. The effectiveness of such a suggestion depends on the therapeutic ability of those who dispense the capsule as well as the patients' and their relatives belief in miracle cures, just as in the case of disulfiram implantation. Sometimes in attempting to make the placebo effect even stronger, specialists make absurd claims for the effects of

the 'capsule' on the body, which are easily refuted by patients, and which only serve to compromise the specialist and his/her clinic. In spite of the capsule's worsening results, it is still widely used in practice.

There is one further version of placebo therapy, the 'torpedo'. In this treatment the patient has an injection of a mixture of substances: magnesium sulphate, nicotinic acid, and methylene blue (to produce a fear reaction). The patient then experiences a number of physical symptoms: dizziness, feeling hot, rapid breathing. In this state the patient is told he/she cannot drink alcohol for 6 to 12 months. This treatment is as ineffective as the capsule. It is nevertheless surprising that some patients manage to abstain for a few months after receiving it. Both these methods are recommended as supportive treatment (Entin, 1990), and are used on selected patients (those who are more motivated and abstinence orientated), as in the implantation treatment.

Perhaps too ready both to anticipate and expect change, many foreign specialists now assume that the dark ages of Soviet addiction treatment must be at an end. This may be the case once the attitudes and assumptions of professional staff at all levels, and perhaps even the beliefs of patients and their relatives and public opinion in general, have all changed. However, some of us are not so hopeful. Current therapeutic practice is still based on people's ignorance, and a neglect by specialists of their professional duty. This is made worse by a form of treatment graced with the name 'placebo therapy' which is based on suggestion, fear and deception.

Finding further evidence of this backwardness is not difficult. Another widespread treatment method which is very popular with alcoholics and their families is 'encoding' or stress psychotherapy; it was developed by a Ukrainian alcohologist, A. R. Dovzhenko (Dovzhenko *et al.*, 1988). The method has been widely promulgated in the media from orthodox newspapers such as *Pravda*, to the democratic journal *Ogonyok*. Many television and radio broadcasts have devoted time to this technique, which is probably the most popular treatment approach at the present time. The method has several stages.

The first stage is the preparation, during which patients are selected for treatment. There are only a few centres where specialists use the method, and these centres are usually in large cities, and thus patients often have to travel hundreds or even thousands of kilometres to obtain the help they are seeking.

The second stage is group suggestion during which the doctor tells the patients that it is not the patients themselves, but the doctor's will power that will save them from alcoholism. As the author of the method says, during contact with the patient, a 'personality cult' is being formed. If we remember that historically the term 'personality cult' referred to the Stalin era, then the requirement by the specialist that the patient believes unconditionally in the effectiveness of this treatment, is comprehensible. In addition to being given information about the adverse effects of drinking alcohol, the patients are told about the unique abilities of the specialist leading the session. The main explanation of the treatment unfortunately bears no relation to any scientific truth (Borodkin and Grekova, 1987). Patients are told during the session that the doctor creates in the patient's brain a 'stable centre of excited nerve cells' which blocks the craving for alcohol. The specialist 'encodes' the duration of action of the centre for the required period of time. The patient himself chooses the 'code' for the length of time (1, 3, 5, 10, 25 or more years of sobriety) — this is the critical moment, as patients in fact programme their sobriety according to their motivation. This is reinforced by the doctors suggestion that drinking alcohol before the code lapses will result in death.

The third state is the individual treatment. Patients go to a separate room and are asked for how long they would like the code to last. The encoding then takes place. The doctor closes the patient's eyes with his hand, and pushes the patient's head back with his other hand. For 2–5 sec he presses on the supraorbital region until pain is produced, and then he sprays ethyl chloride into the patient's mouth, producing various somatic symptoms. After this procedure, the patient signs a form to say that they understand that if they take a drink they will die (Entin, 1990).

Descriptions of other 'therapies' for alcoholics used in the former Soviet Union will have to await a further paper. However, we would like to consider the following questions: (1) Why is it that in Russian alcohol clinics, group and family therapy is so rarely used? (2) Why are there not self-help groups such as Alcoholics Anonymous?

(3) Why do doctors have such poor psychotherapeutic training? (4) Why is funding so limited, and the physical condition of clinics so bad?

Addiction clinics' dependence on bureaucratic organisations such as the Ministry of Health, and the medical departments of local government responsible for the implementation of addiction treatment programmes impedes improvement. These organisations have been resistant to the establishment of more therapeutic rehabilitation programmes, as developed by some of the scientific institutes. They required that long-established guidelines on the organisation of treatment services be followed, and therefore appointed as chiefs of services those who followed these orthodox approaches.

Perestroika enabled two sorts of changes in addiction treatment services. The first was the development of private independent, self-financing clinics. However, this has not occurred; directors of private centres could not provide any serious competition for the state services because of the absence of adequate finance. Levels of poverty amongst the population at large and people with alcohol problems in particular have meant that individuals paying for their own treatment is not a real option. There is no other source of finance. The bureaucracy did not want to support an alternative treatment service, and the new commercial organisations were not ready to invest in this field. An insurance-based system could facilitate the setting up of such alternative independent centres. There has been talk of creating an insurance-based system since the start of perestroika, and nothing yet has happened.

Another possible way of improving official services has been by the exchange of ideas and specialists in addiction between Russia and Western countries. As a result of such exchanges modern approaches in addiction therapy and rehabilitation have been described in publications by Russian specialists (Guzikov and Meyroyan, 1986, 1990). In addition to this many have visited clinics abroad. In Moscow and Vladimir (a city near Moscow), Russian specialists have set up new treatment programmes based completely on Western approaches, but the dominant, antiquated methods of treatment of alcoholics and drug addicts are still very much alive. Another cause of this is the 'poor quality of specialist training' (Meyroyan, 1990). Lisicin and Sidorov (1990) note that the Russian Ministry of Health, over the last few years, has undertaken several inspections of regional addiction units. As a result of this they discovered: 'a picture of many incompetent psychiatrists and addiction specialists'. These doctors treated patients with structured conventional regimes in their clinics. They rarely used psychotherapeutic methods, there was 'an absence of ethical principles, and no creative attitude to their work; there was no desire to acquire new methods of treatment, and a lack of interest in specialist medical publications'.

We see two possible ways of helping post-Soviet addiction services to find a way out of this crisis: to improve the level of knowledge in alcoholism and drug addiction among both specialists and the general population, and to cooperate with groups of enthusiasts and addiction clinics in setting up joint programmes of treatment and rehabilitation. In an attempt to help this process the authors, together with colleagues in the U.K., have set up an organisation FFD (Freedom From Dependency) which aims to integrate the efforts of English and Russian specialists by setting up an international centre in St Petersburg. We intend to develop a detoxification/treatment unit run on more psychotherapeutic lines with community-based follow-up, and encourage the setting-up of more self-help groups. Training will be an important part of the work of the centre, and this, together with research, will be undertaken jointly with local academic and training institutes. We hope this centre will help the development of addiction services not only in St Petersburg but also in north-west Russia.

Contacts with Russian institutions have been maintained by U.K. workers since the start of this collaboration. The U.K. side notes a growing recognition by the state sector of the need to change and offer a service more appropriate to those with alcohol problems. This change of view in itself represents a real step forward. Less well understood by Russian specialists are both the nature of the change demanded and consequently the means of implementing any new strategy. Foreign partners may be able to offer some alternative service options, appropriately modified for Russian circumstances, but the problems of modernising this fundamentally conservative

profession in what are indisputably hostile economic and political circumstances are not inconsiderable.

Acknowledgements — The authors wish to thank Ann Feltham of the Department of Language and Linguistics at the University of Essex, and Michael Poling of the Wessex Regional Drug Problem Team for helpful comments on an earlier draft of this paper. A grant from the Foreign and Commonwealth Office has contributed to the funding of this project.

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