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Oleg Goncharov, Olga Stackelberg, Sakari Kainulainen, Teela Pakkasvirta, Minna Suomi, P.Telpis & Pekka Tuomola

Promoting substance abuse care in Saint Petersburg

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PROMOTING SUBSTANCE ABUSE CARE IN SAINT PETERSBURG

Diakonia-ammattikorkeakoulu
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ABSTRACT

Oleg Goncharov, Olga Stackelberg, Sakari Kainulainen, Teela Pakkasvirta, Minna Suomi P. Telpis & Pekka Tuomola

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Project Addiction Problems and Health in Saint Petersburg and in the Karelian Republic started in 2008 and continued until spring 2011. The project consisted of two sub-projects, one in Karelia and the other in St Petersburg. In this report the results from St Petersburg are being presented. Project was funded by the Ministry for Foreign Affairs of Finland.

Diaconia University of Applied Sciences was the grant holder and coordinator of the project. Two units of A-Clinic Foundation were involved in the project: Järvenpää Addiction hospital and Kymi A-Clinic as well as Helsinki Deaconess Institute and City of Kotka. From St Petersburg the Medical Academy of Postgraduate Studies and the city Addiction Hospital were the Russian partners in the sub-project.

The aim of this sub-project was to increase the knowledge and know-how of staff on motivational guidance and develop a supporting chain of care within the Addiction hospital and its units. The target group, patients, were HIV positive drug addicts and people with substance misuse problems.

During the project period three different groups, 15 experts in one group, were trained. Altogether there were 45 physicians specialized in addictions,

psychologists, nursing professionals, and volunteer social workers trained. The trainings took place in St. Petersburg and in Finland. The training consisted of seminars, practice training, individual work between training sessions and visits to Finnish addiction treatment institutions. Main topics in the training were principles of care of a HIV+ patient, consultancy of HIV testing, facing challenging patients, multiprofessional team-work, motivational interviewing, constructing of trust in the care relationship, and phases of change, basics of substitution treatment and working with networks as well.

According to feedback discussions, feedback questionnaires and self-evaluation of the trainees the project succeeded to achieve the main aims. Through the educational process new usable working methods and principles of addiction care were adopted to everyday work in the institutions involved.

Keywords:
HIV infection, substance abuse, substance abuse work, projects,
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TIIVISTELMÄ

Oleg Goncharov, Olga Stackelberg, Sakari Kainulainen, Teela Pakkasvirta, Minna Suomi P. Telpis & Pekka Tuomola

Pietarin päihdehuoltoa uudistamassa

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”Päihdeongelmat ja terveys Pietarissa ja Karjalan tasavallassa” hanke toteutettiin vuosina 2008 – 2011. Hanke koostui kahdesta osahankkeesta, joista tässä raportoidaan tuloksia Pietarin osalta. Hanketta rahoitti Suomen ulkoasiainministeriö lähialueyhteistyövaroin.

Hanketta hallinnoi Diakonia-ammattikorkeakoulu. Hankkeeseen osallistuivat A-klinikka säätiön Kymen A-klinikkatoimi ja Järvenpään sosiaalisairaala, Helsingin Diakonissalaitos ja Kotkan kaupungin sosiaalitoimi. Pietarissa hankkeeseen osallistuivat Lääketieteellinen jatkokoulutusakatemia ja kaupungin päihdesairaala.

Hankkeen tavoitteena oli lisätä henkilöstön osaamista HIV+ ja päihdeasiakkaiden hoitoon hakeutumiselle ja hoitoon motivoimiselle sekä kehittää kannustavaa päihdehuollon hoitoketjua kaupungin päihdesairaalassa ja sen alaisuuteen kuuluvissa päihdehoito- ja kuntoutuslaitoksissa.

Hankkeessa koulutettiin kolme 15 henkilön asiantuntijaryhmää (päihdelääkäreitä, psykologeja, sairaanhoitajia, vapaaehtoisia), yhteensä 45 pietarilaista asiantuntijaa. Pietarissa toteutettu koulutus koostui seminaareista, harjoituksista, välitehtävistä ja tutustumiskäynneistä

suomalaisiin päihdehoitolaitoksiin. Koulutuksen keskeiset teemat olivat HIV+ asiakkaan hoidon periaatteet, HIV -testauksen konsultaatio ja haastavien potilaiden kohtaaminen, moniammatillinen tiimi, asiakkaan kohtaaminen ja hoitosuhteen luominen, motivoiva haastattelu ja muutoksen vaiheittaisuus, korvaushoidon periaatteet ja perusteet sekä verkostotyö.

Palautekeskustelujen ja -kyselyn perusteella hanke onnistui antamaan Pietarin päihdehuollon työntekijöille käyttökelpoisia heille uusia työmenetelmiä. Koulutetut mainitsivat käyttävänsä jokapäiväisessä työssään useita koulutuksen aikana harjoiteltuja menetelmiä.

Asiasanat:
HIV-tartunta, päihdeongelmat, päihdetyö, hankkeet, Pietari

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1 Reasons for new way of thinking

Situation of substance abuse and challenges in its evaluation

The problem of narcotics and psychoactive substances in Russia is very complicated. This is because we still do not have an effective and accurate mechanism to evaluate the situation. This is maybe due to the fact that the Soviet Union collapsed already more than 20 years ago but the IDEOLOGY and attitudes towards substance abusers and also the support methods for them have stayed the same as they were in the Soviet Union. We did not have any meaningful changes in our policies or campaigns against the illegal psychoactive substances distribution in our society.

"Dispensary observation" is one of those old mechanisms of practice from the Soviet times which is still being used in Russian narcology. The term "Dispensary observation" means that the client is registered in a medical institution. By doing this, the patient also loses a part of his/her civil rights, for example the right to have a driver´s license. This means that instead of having an adequate treatment, the patient becomes socially stigmatized and his civil rights are violated. Many Russian narcologists have written about the negative effects of this kind of approach, comparing it with irrevocable conviction. In both cases the person loses a part of his/her civil rights, but in the case of a substance abuse patient, this is done without the person actually being committed by the court of any crime.

We could of course discuss the reasons of such a situation in the Russian narcology, but the goal here is to have a survey of the substance abuse situation in Russia. As mentioned already before, in Russia we have a lack of studies that could correctly evaluate the epidemiology of distribution of any psychoactive substances. Studies usually emphasize only those patients that are registered for this so called dispensary observation. In reality these persons have been suffering from drug abuse already for a longer period of

time, they have serious social problems and because of limited resources (mental and physical) they do not have a significant role in the social environment. The rest of the patients, a fairly big group of people with addictions, prefer not to have any contacts with the public sector. They approach private centers or doctors, which do not keep such records. This is why the national statistics show us only the situation of those patients approaching public health care institutions. This is also the reason why we have to operate only with official statistics, which as we well know, show only the tip of the iceberg when it comes to the Russian narcology.

So, we can start with the information received from the report of Mrs. Golikova, minister of health care and social development of the Russian federation. In 2009 as a result of psychoactive substance abuse, there were 3 250 664 persons with mental and behavioral disorders registered in the Russian federation. From these persons 82.2% (or 2 658 302 persons) were alcoholics, 16.6% (or 555 272) abusers of substances considered as drugs and 1.2% (or 37 090 persons) abusers of substances that are not considered as drugs from the juridical point of view.

In Russia, alcohol use consists of 15 liter per person. From the year 2000 to 2008 the alcohol use grew by 1.8 times. One year ago the president of the Russian federation, D.A. Medvedev told us even more dramatic figures: the use of 18 liter of pure alcohol to each citizen of the federation, including old people and babies. The world health organization has counted that if the alcohol use is more than 8 liters, it is already dangerous for the health of the population and each added liter above this limit will take 11 months away from the life of men and 4 months from the life of women. During one year the alcohol use becomes the reason of the death of 2 million people and represents 4% of all sicknesses in the whole world. This is the answer to the question of the relative safety of legal drugs. In Russia the situation however is even worse. To count the amount of alcohol being used in the country is a very complicated task, because of the huge amount of alcohol being produced at the factories off the books, not to mention the countryside, where the alcohol is mainly made at homes.

The Russian federation in practice has a lack of distinct alcohol policy. Alcohol is sold on a 24-hour basis, and it can be sold in many different places: in big supermarkets, in thousands of kiosks around the metro stations, at residential areas, sometimes not far from the schools. At the mo-

ment ministry acknowledges the fact that 80% of the alcohol being used is beer. This being said, we understand that it is the alcohol drink that has the biggest popularity among young people. It is not a coincidence that young people are getting more and more drawn into uncontrolled use of this particular alcohol drink, thus creating an addiction.

One of the current problems is heroin addiction as well. The number of patients with heroin addiction is not decreasing and these patients represent the absolute majority of all dispensary observation patients. For an example we can look at the situation of the Leningrad region which surrounds the city of Saint Petersburg. The number of citizens is 1 631 thousand people, which is 3 times less than the population of the northern capital (St. Petersburg). As we can use only the information of official statistics that count only those patients that use the public health services at their own place of residence, the conclusion about the prevalence of drug pathologies at this specific region will be very relative. Anyway, there is one specific key figure that has a practical value. If we talk about opiate addiction, the percent of patients being registered is 93.4. 2.3% of patients have an addiction of psycho stimulants and 1% is cannabis addicted. These numbers show us that the patients suffering from one of these 3 mentioned addictions approach the help of a narcologist very seldom. The main reason for visiting a narcologist is to cope with the withdrawal symptoms, but this is not shown when it comes to these above mentioned addictions. Now then, for the beginning we shall look at the official indicators of Russian narcology.

Firstly – it is the key figure for the incidence of diseases or the amount of patients with opiat addiction newly diagnosed within one year for 100 000 of citizens. In 2009 this figure was 26.4.The dynamics was as followed: a considerable increase of the key figure from the year 2000 to 2006, after which it has stayed on the same level. The other key figure was for the prevalence rate or the occurrence of this same addiction for 100 000 citizens. In the Leningrad region this figure in total was 316.9, in addition with a yearly growth of 3-5%. Unfortunately these figures give us only little of information, as it is based only on the information of the small part of population that apply for the state health care institutions, and does not include the information about those patients that are getting treated in the private sector or public organizations.

Significantly more informative is the figure which shows the number or

patients with alcoholic psychosis, as far as practically all who suffered from this are being treated in specialized clinics. In the Leningrad region the amount of alcoholic psychosis consistently decreases, and from the year 2006 it has in practice fell by a half. A reason for this can be that the quality of alcohol being used became better and also the fact that the average age of patients with alcoholic addiction has also decreased.

Also one important objective figure: the amount of patients with opiat addiction, HIV -infected, that are registered for dispensary observation. From the year 2001 to 2010 the HIV -infection in this category of patients grew by 2.5 times. The reason for this could be the inadequate drug policy of authorities, the absence of substitution therapy, the denial of the needle exchange program, the absence of social support for addicted patients, an emphasis on denying the pharmacological help during the period of abstinent syndrome. It is no coincidence that some of the Russian patients with heroin addiction take their case to the European court of human rights with the claim of inadequate medical support for patients from this category in Russia. A typical example: one of the most popular opiates in Russia is desomorphine, a substance which you get when you add different chemicals with legal drugs which contain codein. Codein is a plant-based opiate used in complex drugs against cough and also in analgesics. Desomorphine is used intravenously to get, besides the narcotic effect, also numerous badly healing limb ulcers. The question of the permission to sell these substances at the drug stores without any prescription, which is happening at the moment, has been discussed many times in the press and also at the federal court as a reaction to illegal drug trafficking. However, the Ministry of Health Care by far has not taken any actions.

As a result, the situation with psychoactive substances in the Russian federation remains very complicated. There is an absence of exact information of the amount of users with well-known drug addictions. In practice we do not have any information about new drugs like “oxybutyrate” and “smoking blends” and many others.

The term “remission” is quite contradictory in Russian narcology. If the patient together with the family consults the doctor and his/her main objective is to overcome drug addiction, for instance alcohol, most commonly it means that the doctor is to recover the patient’s mental and physical health and refresh social relations. Let’s take alcohol addiction and consider

further treatment stages. The patient's treatment motivation can be different, for instance it can be a full termination of the process of becoming an alcoholic. He may say: "Doctor, please help me to overcome my alcohol addiction so that I could resist alcohol in any real-life experiences" or he/she can consider a possibility of standardized alcohol consumption: "Doctor, I want to drink on occasion, but I do not want to feel I need alcohol the next day or experience any abstinence symptoms". The patient's relatives most commonly support the first variant, putting forward additional social-psychological requirements: a positive change of behavior, the absence of irritation, bursts of anger which is quite typical for the patients upon of the termination of the process of becoming an alcoholic. Apart from that there are several social requirements: a refreshment of occupational skills, a development of family relations and communication skills, participation in the upbringing process of children. The latter seems to be quite unrealistic, as frequently our patients had numerous personal disorders before the alcohol dependence formation, so well-balanced relations with the society seems to be quite vague and problematical. On the ground of the aforementioned information we can conclude that the expectations of patients and their relatives are often based on some unclear concepts of present-day Russian narcology, with well-developed scientifically decorated shamanism. The essence of this approach is infusion/suggestion. E.M. Krupitsky **(1)** more specifically considers the basic principles and phenomenology of this fact.

Namely there are numerous advantages:

- it works in certain cases;
- the treatment cost value is quite low;
- the narcologists' unearned income needs can be easily satisfied.

However there are a lot of negative aspects, which can be divided into two groups: ethical and medical. Let's consider the ethical side.

- the doctor deliberately deceives the patient, and the patient pays for it;
- the patient has the right to file a lawsuit against the narcologist for deliberate deception in order to have commercial benefits;
- the patient does not get true information on his/her disease and approved possible treatment methods.

Apart from ethic there are several negative medical aspects:

- the patient is not responsible for his/her health and future;
- during the treatment he/she goes in a wrong way of overcoming addiction: the patient changes doctors searching for the immediate "real cure", in the meantime the disease develops;
- the dependence becomes chronic and the patient loses faith in treatment efficiency.

In order to estimate the efficiency of such an approach we need to consider with care the type of pathology. Today the Russian narcology uses the following efficiency rates of dependence syndrome treatment: resistance, time duration and remission quality. Dependence syndrome, like any other chronic mental progressive drug addiction, is followed by dreadful changes in personal, family, professional, economical and other spheres of patient's life, determining the quality of his/her life. In this regard the estimation of such a clinical rate as remission quality can be directly connected with such a personal and social phenomenon as the quality of life. This aspect is covered in numerous research papers, proving that the stability of remission, its duration and the absence of morbid attraction to psychoactive substances (psychoactive substances addiction) are directly connected with the patient's life quality improvement. On the ground of the aforementioned fact we can conclude that the main objective of therapy is the stabilization of remission and the prevention of early relapses. The scientific resources comprise such terms as "remission formation", "remission stabilization", "stage of remission development", "long-term remission" etc., but the definition of the term, stage and duration are interpreted according to the author's preferences, which means they are quite provisional and there are neither clear terms or definitions, nor single methodological approach scientific research system. Currently we have scientific proof that all addictions have common pathogenesis links which correspond to the laws of course and development of a disease.

To describe the dynamics and results of disease scientists use the following terms: "remission, partial remission, full remission, incomplete remission, practical recovery". In spite of numerous scientific sources comprising information or the term "remission", its development stabilization etc., there is no such clear term or definition as "remission", just some information

covering possible gradation and stages. Psychiatric sources define remission (lat. remitto – to release, to relinquish) as a stage of disease with a temporary decrease of degree of manifestation or a decrease of psychopathologic symptomatology. Remission is defined as a considerable mitigation and diminution of symptoms, followed by a compensatory mechanisms development. Talking about remission in the process of alcoholic addiction treatment, there is a number of extended definitions: remission is a stage of chronic disease treatment, when the symptoms are considerably or fully diminished, but still exist in a latent form and can arise under certain conditions.

Eryshev O.F. (**2**) defines alcohol remission as a dynamic state with a recidive risk degree as the main phenomenon at all the stages of course of a disease, depending on clinical, personal and social-psychological factors. In addition in his fundamental work the author determines the stages of remission formation and their clinical variants. The majority of scientists share this viewpoint, as they consider remission as a dynamic state with the corresponding features.

The most important issue is remission start diagnostics. This question cannot be expressly interpreted from a clinical point of view, as the problem of duration, terms of remission start, transition from one stage to another (brand new stage), has always been quite controversial, and until the moment there are still many opinions about it.

The following view point has been quite popular in narcology: the evaluation of remission can be started not earlier than in 1 month of the patient's temperance, when all intoxication symptoms are over and the patient's physical and neurological state *is normal.*

Russian researchers still seem to distinguish at least two stages of disease - withdrawal (WS) and transitional syndrome, which has numerous definitions and terms (including delayed WS presentation to post-abstinent state and unstable balance state). Such a variety of definitions is caused both by clinical and quality differences, covering the formation of "new homeostasis", and most probably changes of neurochemical brain functions, which affects the course of disease. At present it is proved that the remission process of physical dependence is followed by a typical fluctuation of the dopamine level: at the initial stage the level is quite high, then as a rule it falls below the standard level. It is obvious that lack of dopamine in

supporting brain structures is the basis of the preserved morbid attraction to drugs and the high probability of recidive within this very period. The aforementioned neurobiology information speaks of qualitative differences between the withdrawal syndrome (increase of dopamine level) and the subsequent period (decrease of dopamine level).

The remission state is correspondently defined as a state of stable clinical compensation, the start of remission is the period after the post-intoxication symptomatology (not earlier than 3-4 weeks after the termination of alcohol consumption).

Kaplan H.I. and others **(3**) estimate the stability and duration of remission from the retrospective point of view, distinguishing between full and partial remission. Partial remission: if within the last 6 months there was an occasional use of psychoactive substances with the corresponding drug dependence symptoms. Full remission: if within the last 6 months there was experienced full withdrawal or administration of psychoactive substances in the absence of drug dependence symptoms.

Consequently we can conclude that the “full remission” presupposes absence symptomatology, physical and mental rehabilitation, a re-adaptation of the patient in the social environment (family and professional). However, in this case the phenomenon “full remission” does not differ from the term “absolute recovery” or “practical recovery”. The only difference is that in the case of dependence syndrome, being considered as a chronic disease, there is no guarantee (even theoretically) of long-term psychophysical state stability. In this regard the treatment based on theoretical approaches, which are not considered to be evidence based medicine approaches, are based mainly on the patient’s belief in various scientific like myths and do not presuppose any obstinate efforts on overcoming the dependence, cannot be considered successful in the longer term.

Sharing Ideas

The aim of the seminar that was organized within the frames of the Finnish – Russian co-operation project “Addiction problems and Health in Saint Petersburg and in the Karelian Republic” was to train narcologists, psychologists, social workers and nurses to the current approaches and to the methods of addiction treatments. The project also had the aim to introduce

participants to the Finnish substance abuse treatment institutions and to the treatment practice in Finland. The training part consisted of 3 seminars and of a visit to Finnish health care organizations treating substance addictions.

Main topics of the training were:

- Establishing confidential relations with the patients
- Multi-professional team work.
- Consulting drug addicted HIV+ patients/ patients with Hepatitis.
- Motivational interviewing and working with different stages of changes.
- Working in networks.
- Principles of substitution treatment.

Main goals of the study program were:

- To increase the knowledge and know-how of participants in preventive care and treatment of addictions.
- To introduce narcologists to multi-professional teamwork and to conduct trainings about it.
- To conduct trainings of motivational interviewing and working with changes.
- To introduce participants to the principles of organizing and realizing substitution treatment.
- To compare Finnish and Russian methods of addiction treatments with the aim to work out the optimal model for drug addict treatments.

The need for this training program arose from the fact that Russian drug addiction treatment differs from the European model. Reasons for this can possibly be found in the field of sociology, more specifically in the construction of Russian society during the soviet and post-soviet period. The idea of democracy and humanity are not yet stabilized enough for the awareness of human life being the main value of a developed society. Not by accident, discussions about the compulsory treatment of drug abusers are held in Russia at the same time. Moreover, the discussions are about persons who have not committed crimes. Unfortunately the negative historical experiences of compulsory treatment for persons suffering from alcoholism, has

not brought an understanding of the fact that a successful treatment cannot be a forced one. The main goal of any treatment has to be based on the rehabilitation and integration of the addicted person into society.

It is worth noting some main Russian features of substance abusers' treatment:

- Biologically orientated approach to the therapy of addictions, use of medicines from different pharmacological groups. Many of officially recommended medicines are not being examined from the point of view of evidence based medicine.
- Absence of multi-professional group work. As a general rule the biggest part of work is done by narcologists.
- Absence of social workers and also of legal framework of their actions.
- Absence of substitution treatment.
- Small role of psychotherapeutic treatment.

Taking into account these above mentioned features, it is hard to expect any effectiveness of such an approach: the amount of patients, not using drugs for a longer period of time (a year or more) usually represent a small percentage of all patients. A much bigger group of patients go only through the first step of detoxification after which they will again return to using drugs. Naturally such an ineffective model causes serious criticism within the community concerning the addiction treatments and give rise to the wish to change the principles of support, to approach those standards used in the whole civilized world. This is why the offer of getting to know the Finnish addiction treatments seemed to us extremely interesting.

The cooperation of specialists from St. Petersburg Medical Academy of Postgraduate Studies (MAPS), St. Petersburg Addiction Hospital and Finnish colleagues started in 1995, when different projects were carried out, in which took part many doctors, psychologists and other specialists of the narcology field around the north-west areas of Russia. This cooperation was supported by different organizations, including the Ministry of Foreign Affairs of Finland. This support was probably received not only because of the humanitarian aspect of our project but also because of the fact that drug addictions, alcoholism and HIV do not know national boundaries.

The project "Alcohol problems and health in St. Petersburg and in the Karelian Republic" was started in April 2008. During the project with Finn-

ish colleagues we were able to carry out a comparative analysis of preventive treatments in Russia and in Finland. Various appearances of different drug related diseases showed us the necessity of a complex therapy program. This principle proposes the combination of biological, psychotherapeutic, therapeutic and methods of rehabilitation at all stages of treatment. This is because the remodeling has to pay attention not only to drug-abuse but also to psychological, physical and social disorders. Therefore, in the treatment of drug addicted patients, the following concrete actions are necessary.

That is, an on-time diagnosis of psychoactive substances use, and to offer patients both social and medical treatment, to train social workers and volunteers for the work in the environment of drug-abusers with the help of emotional and informative psychological support.

The main attention in this project was to train social workers and volunteers, to create multi professional teams together with narcologists carrying out social-psychological monitoring for patients in the frame of aftercare.

Together with the Finnish colleges we aimed to create a study program for all specialists taking part in substance abuse treatment. Creating such an integrated program was not possible without first introducing Russian specialists to the Finnish approach to addiction treatment. Only after this a training course was held at the department of St. Petersburg Medical Academy of Postgraduate Studies (MAPS) with the study material.

During the project nearly 45 persons from different regions of Russia (Yakutia, Dalnij Vostok, Kavkas, Severo-Zapad) took part in the training in one of the 3 groups consisting of 15 participants each. All of these groups did the full program of seminars and visits to Finnish Addiction Clinics. Besides this, nearly 20 persons, narcologists, who were at the moment studying at the department of Narcology (MAPS) took part in the seminars which were held in Russia. The biggest number of specialists came from St. Petersburg. These specialists represented different professions within the field of drug abuse treatment. Most of the participants were doctors, but there were psychologists, social workers and nurses as well. Many of these work at drug abuse clinics or at dispensaries. The participants of the seminar already had theoretical and practical knowledge of preventive care and treatment of drug addicts and among them it was possible to find those ones able to stand out as the leaders of medical centers and to organize the work according to international principles.

One of this project's goals was to get integrated with the global experience of substance abuse treatments, to review specialties of different approaches towards aftercare: social, psychological and biological. This was an attempt to collect and combine all the useful information of important practical experiences that were received in seminars and at the meetings that were held.

Our material is based on strict scientific facts, received through methods of evidence based medicine. In many ways this material differs from those approaches that are used in Russia. However, the integration of global experiences, the wish to work by the regulations of the whole civilized world and also the absence of contentment of already existing results of practices, from our point of view, makes it useful to publish the material of the seminars. Thus, it is about the different stages of the remission process and also about those methods of treatment that are used by drug abuse clinics world-wide.

2 Main stages of substance abuse care system

Stages of stabilizing remission in substance abuse care practice

Detoxification - stage of stabilization. The remedial measure of detoxification stabilization is for those patients suffering from withdrawal symptoms because of long-term drug abuse. Detoxification can be determined as a process where the patient is given medical treatment and pharmacotherapeutic care, in order to assure the patient's abstention from substances and the organism´s functionality, with only minimal physical and emotional disorders.

Pharmacotherapy provides a suitable agonist which is gradually decreased to reduce into a minimum the amount of painful withdrawal symptoms of opioid, barbiturate and benzodiazepine addictions. With these addictions the withdrawal symptoms of physical and emotional disorders typically appear within 8-12 hours after the last doze of narcotics. Those persons that have used amphetamine or cocaine can also experience significant emotional and physical disorders that will need remedial measures of stabilization.

The main task of this stage is to have a secure treatment against complications, to assure the patient's abstention from drugs and to form facilities for the patient for the realization of a strategy for implementing cognitive and behavioral changes, which give the base for the next stages of rehabilitation. Detoxification alone probably won't bring about a total recovery of the patient. This stage of treatment has to be considered as the beginning stage for a long-lasting treatment, which aims to assure the patient´s abstention from substances and to support the patient's rehabilitation. This is why the practice in Russia, where the treatment often consists only of this first stage, is incorrect and needs to be updated.

Pharmacotherapy. By the information available to us we know that detoxification during heroine and other opiates abuse can be done with a kill-

ing doze of agonist opiate receptors (mainly with methadone), or partially with antagonist buprenorphine and 2 non opioid drugs – clonidine and lofexidine (which are agonist a2 – adrenergic receptors). However evaluating the relative advantages of these components is complicated because of different ways of implementing the treatment and because of different approaches to the clinical evaluation of the withdrawal's seriousness.

Taking into account these circumstances, Gowing and others [4] carried out a Cochrane survey of 218 international detoxification researches, which shows that the mean value of terminating the course of opioid detoxification using methadone in institutional and non-institutional conditions formed, respectively, 75 and 35 per cent. The same indicant in the use of agonist a2-adrenergic, reached, respectively, 72 and 53 per cent. The number of randomized tests was conducted in controlled environments for comparison of buprenorphine and clonidine. The results showed us that buprenorphine more effectively cuts down the effects of withdrawal symptoms and causes less side-effects (5).

Length of the treatment. Strong symptoms of withdrawal usually decrease within 3-5 days, but the treatment might be increased for a patient with psychosomatic disorders or because of physical dependence on a benzodiazepine and other sedatives. As Gowing's group's survey showed, if the detoxification with the use of methadone is more than 21 days, the average rate of those terminating the treatment is 31%. The same rate is 58% in those cases where detoxification does not exceed 21 days. Authors note that to some extent the effectiveness can be explained by the conditions of the treatment, as 89% of the researches with an extended treatment of detoxification were carried out at communities.

Conditions for carrying out the treatment. The question of effectiveness is very actively discussed when it comes to the measures of detoxification at hospitals and in non-institutional care [6, 7]. It is usually considered that hospital treatment achieves better results. However, in most countries measures of stabilization to all patients, except to those ones in the very worst conditions, are carried out in non-institutional conditions. For example, there abounds material on cocaine addicted patients with facts of an early termination of the treatment during the first 14-21 days of outpatient care, and during the first weeks of the treatment this drop rate reaches 27-47% [8, 9, 10].

It is thought that detoxification is especially justified for those patients with apparent psychosomatic disorders (especially for those who have in their medical history epileptic seizures and depression) and also to persons with a significant accompanying alcohol problem.

The research of short-term outpatient anti-drug programs usually brings unpromising results: a high rate of early terminations of treatment is noted and only a few patients in the end stay away from drugs. Nevertheless patients with less significant disorders and difficulties who live in stabile and more favorable environment can accomplish the detoxification in community. The question of adequate conditions for the treatment of physical and psychical disorders, connected with the abuse of psycho stimulants, was studied only in a few researches, yet usually treatment for patients with significant symptoms of psychical disorders and emotional distress is carried out in hospitals.

We are well aware that the possibility of detoxification with the help of agonist opioid receptors (Methadon, LAAM) or partial agonist (Buprenorphine) does not exist. This is why the question of carrying out an adequate therapy at this stage is complicated and often causes the use of medical substances without prescription. For example, the use of different neuroleptics in order to repress the addiction of psychoactive substances, or to remodel the patient's behavior with their help at the hospital care.

Rehabilitation and anti-relapsing stage of treatment. Rehabilitative measures are oriented to those patients who already do not have significantly strong physical or emotional after-effects of recent psychoactive substances abuse. The main goal of this stage of treatment is to prevent the patient from returning to the active abuse of psychoactive substances, to help the patient to control his/her urge to drug abuse and to help the patient to get back or to make his/her health and social status better.

Specialists´ opinions differ when it comes to the loss of control over alcohol or/and drugs of patients taking part in the treatment. As an explanation we can find various possible reasons, for example:

- Genetic predilection.
- Acquired metabolic deviation.
- Acquired negative forms of behavior.
- Deep feeling of own insignificance.
- Self-treatment of original psychical or psychological disorder.
- Lack of family or other social support which would support positive

motivation.

- But there is just as wide a range of strategies and methods of treatment which can be used for correcting or smoothening out these main disruptions and to give the patient continuous support to achieve the planned changes.
- To use medication for psychological disorders.
- To use medication against drug craving.
- To use substitutive pharmacotherapy to rehabilitate the patient.
- To have psychological consulting individually and in groups.
- To have therapeutic conversations in order to ensure the understanding of the problem.
- To offer and recommend and assist in behavioral changes.
- To take part in peer support groups (such as "anonymous drug addicts") with the aim to give continuous support to those patients abstaining from drugs.

In Russia the only pharmacological possibility to stabilize remission is to use opiate receptor-antagonists of naltrexone: antaxon and long-acting form prodetoxon and vivitrol. However because of big financial costs, these can be widely used only by those clients who are actively supported by their wealthy family members.

Duration of the treatment. Short-term hospital rehabilitation programs are usually counted to continue 30-90 days. The length of the treatment in therapeutic communities is usually from 3 months to one year. Outpatient programs of psychological consulting for the purpose of keeping the patient away from the drugs are counted to last 30-120 days. In the end, the program of supportive treatment with methadone cannot have strict time limits. Many more intensive forms of outpatient treatments (for example, intensive outpatient care and daytime hospital) begin with practices which continue during the full day or part of the day, not less than five times per week and approximately for one month. As far as the treatment continues, the intensiveness of it decreases and shorter practices of 1-2 hours continue few times per week, and after this one time per week. The final stage of outpatient care is usually called "follow-up" or "follow up after the treatment". In these practices once per two weeks or once per month a support group gathers (in coordination with parallel measures of self-aid). The length of

this stage is up to 2 years.

Psychological counseling. The possibility for a regular psychological counseling in the case of psychoactive substances addiction can meaningfully help patients for a successful termination of the treatment program. For example in a randomized study one of two patient groups of the treatment with methadone had psychological counseling added to their course [11]. The results show us that 68% of those patients who were not given psychological counseling had no notable changes at the level of their drug addiction, and one third of these patients had at least once had a need for acute medical help. At the same time, from the group that received psychological counseling, 63% of the patients were noted with stable abstinence from the use of opiates and 41% of the patients had stable abstinence from the use of cocaine.

The positive effect of individual or group psychological counseling and taking part in the series of 12 steps program are studied in another research. This research showed that by raising the amount of participation in such events for those patients from the group that was given psychological counseling and from the group of self-aid, the chance of relapses reduced within the following 6 months (12).

Factors of rehabilitation and anti-relapsing stage of treatment. As the results showed us, having a course of psychotherapy had more notable improvements when it comes to the patient´s health, the refusal of illegal drugs and criminal activities, if compared with those patients who had the standard course of psychological counseling.

Within a framework of another study, Crits-Cristoph and others [13], patients with cocaine addiction were voluntarily assigned to a course of psychological group counseling “12 steps” or to this course and to one of three forms of additional individual psychological counseling (according to 12 steps program, cognitive psychotherapy, or supportive expressive therapy). The results showed us that the biggest reduction in the level of cocaine use was noted within those patients who took part both in the group and in the individual psychological counseling of the 12 steps program. Those patients who participated in the additional course of cognitive psychotherapy had the same results as those patients who only took part in the group counseling.

W. Miller and S. Rollnick [14] developed a method of short-term therapeutic interventions, called “motivational interviewing”, which are created

in order to increase the inner motivation of the patient to correct his/her behavior. This method was used with heroine-users.

In Australia B. Saunders and others [15] reported results from a one hour long motivational interviewing tested in controlled conditions, compared with patients taking part in supporting treatment with methadone. The control results show us that within 6 months after the beginning of the research, those patients, taking part in motivational interviewing, were using illegal drugs in a smaller extent and no longer gave up the treatment and also did not continue to use heroine as fast, when compared to those patients of the control group. Methods of short motivational interviewing were used also to disorders associated with the use of cannabis. Positive results were received in 2 tests which were done in the USA.

Cognitive behavioral therapy

From all methods of psychosocial counseling the most actively studied one is the method of anti-relapsing therapy. Wide ranges of studies were done in order to evaluate the effectiveness of cognitive behavioral therapy relating to patients suffering from alcoholism. In addition, main attention was given to developing social-communicative skills in order to release emotional stress and to correct the patient's temper.

Resent research shows us that when it comes to addictions, cognitive behavioral intervention (therapy, CB) is the most effective and the main form of psychotherapy. It is a complex of methods, which are used in changing the patient's behavior, in connection with the psychoactive substances use. This includes motivational intervention, self-control, control of one's own way of life and methods of relapse prevention. Using this complex of methods means that the change in behavior will go through these following stages: preliminary analysis of one's own behavior – effect – decision – maintaining the change and relapse prevention.

Basic protocol of taking "CBT into use (structural approach for leading the patient) contains 5 stages:

A. **Evaluating** and choosing clients/patients for the treatment with CBT methods (by using a scale of grades showing the addictions' seriousness. For example, ASI scale, which helps to evaluate also the occurrence of associated health problems and the stage of social integration).

B. **Motivating** patients to change the behavior and strengthen the motivation.
C. **Managing** the changes (control of behavior).
D.Relapse **prevention.**
E. **Maintaining** changes in the behavior.

Motivational interviewing is a targeted, dynamic, cyclic process of work and a way to communicate with the client, in the course of which the balance of arguments "for" and "against" change when it comes to the use of psychoactive drugs. In the course of motivational interviewing the predominance of negative consequences of the addiction over positive ones arises as well as the need to change the behavior and the requirements for the change, the motivation of the client, strengthens.

In order to evaluate the stage of motivation, to estimate the patient's level of motivation for the moment, clinical methods or a psychological test can be used. We produced one such test which is easy to use for the evaluation.

Questionnaire of evaluating the patient's readiness towards his/her own behavioral change

Surname: ____________ Date: ____________

Please answer the following questions by making a circle around the appropriate choice

Completely agree	I agree	Not sure	I disagree	Completely disagree
1	2	3	4	5

1. I do not think that I drink too much 1 2 3 4 5
2. At the moment I try to drink less than usual 1 2 3 4 5
3. I get pleasure from drinking but sometimes I drink too much 1 2 3 4 5
4. Sometimes I think that I have to stop drinking 1 2 3 4 5
5. There is no use to think about my drinking 1 2 3 4 5
6. Only not long time ago I changed my drinking habits 1 2 3 4 5
7. Anyone can tell as much as they want about their wishes to do something with their drinking habits, but I am actually doing something 1 2 3 4 5
8. At the moment I am in such a state where I have to start

thinking about changing the way I use alcohol 1 2 3 4 5
9. My use of alcohol sometime creates problems 1 2 3 4 5
10. It is necessary for me to think about how to change alcohol use 1 2 3 4 5
12. It is meaningless to me if I drink less 1 2 3 4 5

Calculating the points

To estimate the stage of the patient's readiness to refuse from his/her harmful habits, mark the points for all 3 phases. The phase with the highest amount of points will be considered as the phase of change. If it so happens that there is more than one phase having the same amount of points, please choose the phase which has the biggest gap with the first phase of change.

preliminary consideration		**consideration**		**realization**	
question #	points	question #	points	question #	points
question 1		question 3		question 2	
question 5		question 4		question 6	
question10		question 8		question 7	
question12		question 9		question 11	
total		total		total	

After finding out our patient's current stage of motivation begins the psychotherapeutic conversation depending on the phase of readiness for changes.

Phase of preconscious

Ask for permission to start the conversation
Establish confidential relations
Talk about doubts and about details that cause worries
Show that you are interested
Keep the door open

Phase of consciousness

Make uncertainty/ambivalence evident
Help the client to stay in balance
Sort out and summarize self-motivating statements of the client

("discussions of changes")
Sort out the client's opinion about self-containment, expectations

Phase of commitment

Clear up the client's own goals
Agree with the client about the plans of change and therapy
Analyze and try to lower the barriers which need to be overcome
Help the client to obtain social support
Formulate the patient's goals in accordance with the SMART instructions

Phase of realization

Make a plan of concrete steps
Take part in finding alternative strategies of coping
Remain in supportive contact
Achieve an agreement of home work

Phase of support

Support the changed lifestyle
Determine the situations entailing a big risk
Determine alerting signs
Work out a plan of actions in the case of emergency situations

Relapse

React empathetically
Help the client to stay in the course of change
Relapse is normal
Relapse is one part of learning
Analyze the meaning of relapse
Confirm the determined changes
Study different coping reactions
Study the effect of failure

3 New way of thinking – carrying out the training

The project started in April 2008 and ended in May 2011. The project was funded by the Finnish Ministry of Foreign Affairs and was administered by Diaconia University of Applied Sciences. Participants of the project were: Kymen A-klinikkatoimi (the A-Clinic foundation), the Järvenpää city Addiction Hospital, the Helsinki Deaconess Institute, the Social Service Department of the city of Kotka, St. Petersburg Medical Academy of Postgraduate Studies (MAPS) and St. Petersburg Addiction Hospital. 45 specialists working for substance abuse care in St. Petersburg studied within the project. Besides this, narcologists from different parts of Russia and doing their postgraduate education at MAPS, took part in the education in random order. The educational part was mostly held in St. Petersburg. Each year from 2008 to 2010 a group of 15 persons underwent the training. Three 3 day long seminars in St. Petersburg and one 4 day long study trip to Finland were organized for all the participants. The participants of training represented different organizations of institutional and non-institutional treatment for addiction patients of St. Petersburg. Important criteria when selecting the participants was to get multi professional groups. This means that there had to be doctors, nurses, psychologists, and social workers within one group. Besides this, the aim was to get such people in the group working together. St. Petersburg's coordinating group took care of the participants' selection.

Marja Hannula, a teacher, coordinator, psychotherapist, and a specialized family therapist from the A-Clinic Foundation of Kyme, took part as a teacher. Other teachers from the A-Clinic Kyme were Minna Suomi, a nurse, teacher and art therapists and also Pekka Tuomola, Drug Addiction and Mental Health Work Director from the Helsinki Deaconess Institute. Marja Hannula had the main responsibility for the educational part. The education was interactive and consisted of many practical trainings. Each

year the seminar structure was the following:

First seminar:

- Principles of working with HIV positive patients, consultation of HIV testing and encounters with difficult patients (patients with less motivation for the treatment)
- Multi professional group, the ideology of the treatment, group works and practical applications

Second seminar:

- Meeting with the client and establishing therapeutic relations
- Carrying out a motivational interview
- Phases of changes

Third seminar:

- Principles and basics of substitution therapy
- Networking: map of nets, creation, explanation and use of the map. The meaning of networks, working in nets depending on the client's needs
- Network between persons from different responsibilities

Fourth seminar:

- A study visit to Finland.

During the visit the participants became aware of the daycare and hospital care of the A-Clinic Kyme, including the principles of helping under aged and old aged clients with addiction to psychoactive substances. Colleagues of the clinic told about their work. At the Järvenpää city Addiction Hospital the participants were given information about the current substance addiction situation in Finland. Besides this, during all visits the group took part in a therapeutic session of a patient suffering from drug or alcohol addiction. In Helsinki the group found more about working with HIV positive clients and about the practice of substitution therapy at the care centre for drug addicted patients.

Between the seminars the listeners did their intermediate assignments. After the first seminar the assignment was to describe the meeting with difficult clients (carrying out a motivational interview). These assignments

were reviewed in the second seminar. Before the seminar of networking, there was an assignment connected with this theme. After the visit to Finland the participants of training groups analyzed the difference between the Russian and Finnish substance abuse care systems and tried to evaluate which of the studied things they could use in their own work. Further follows the introduction of the main contents of each seminar as well as some of the participants' intermediate assignments.

Multi professional work team

GOAL: To propose to organize a time to have regular forums once per week for 1.5 hrs. This would bring about a time and possibility to communicate, to have a dialog between different specialists. The main goal of communication is to improve the process of treatment given to different patients, families and groups. During the conversation the group tries to analyze the situation of the current patient/family/group widely and from different points of view.

The goal is not to find the final answer to a given question but to train specialists and to give the foundation for their future work.

The goal of the multi professional team is also to evaluate the stage of the care system and its effectiveness. At the same time the team has to regularly analyze their own work at least when the group gets a new member or when a partner who has worked within the group for a longer time leaves the group. Each time a new member comes into to team, or an old member leaves, the team changes.

TASKS: The task of the multi professional team is to provide equal experience for each member in the team, regardless of qualification and experience. It is useful for the team to bear in mind special skills of all workers without emphasizing anyone separately.

HOW: In the team the participants respect each other and pay attention to each other. Each participant has own ideas and feelings related to the care work. Sarcasm towards caring and depressed feelings is unacceptable in the group. Team work is analogical to the work with the client. How can the workers achieve equal and respectful relations with the client if they cannot achieve it with their colleagues? Some of the issues are very complicated for a discussion. For example, the love/crush of a patient towards the specialist, and also aggressive expressions as another opposite, are a difficult situation. Both of these cases need special skills

and honesty. Honest and straight conversation often helps in such cases.

DIFFICULTIES: The team has to recognize the situation, where a specialist is not able to receive the team's help. The worker might be depressed with his work responsibilities or with the current personal life situation. Each has to be encouraged to talk. One cannot be forced to talk. One might talk only face to face with a worker alike. The head of the group has the main responsibility. The head of the group is responsible for an equal interaction within the group, for professionalism and also he/she has to take care that the group concentrates on work with the current task. A professional attitude does not mean a complete absence of happiness and humor.

IMPORTANT DETAILS TO PAY ATTENTION TO IN THE GROUP WORK

- Equal interaction, each member can, each member is permitted, and no one fears to talk.
- Braveness to bring difficult questions to be discussed in the group.
- Worker cannot make use of the group, if not trusting or daring.
- Personal life problems affect work.
- Stress, bad health or feelings, illnesses.
- Mental tiredness of the worker.
- Mental problems of the worker.
- Substance abuse problems of the specialist him/herself.

PRACTISE OF GROUP WORK

In Finland a multi professional group usually consists of a nurse, a social worker, a doctor, a psychologist and an office worker. The structure of the group may vary, depending for example on the institution's size and of its employees. Anyone of the group members can carry out these following responsibilities:

- To establish contacts with the client and others in contact with the client, for example family members, close friends.
- To collect background information about the use of psychological substances.
- To motivate in giving up psychoactive drugs, to engage close to patient people with the process, and when needed to send the patient to get treatment from other members of the group.

- To tell about the principles of treatment: confidence, non-disclosure of information received during the treatment, joint efforts, group work.

The nurse in the group usually realizes the outpatient detoxification, which for many patients is the beginning for the whole treatment process. The nurse delivers evaluation of the situation – evaluates the health situation of the patient (both physical and psychical), does follow ups, measures the arterial pressure and the amount of alcohol in blood and makes drug tests. The nurse also talks with the client about the need of treatment and its expectations and gives possible "Dispensary detoxification medicines" and conducts the therapy with medicines in accordance with the doctor's prescriptions. The nurse consults other specialists.

The social therapist together with the client evaluates the social situation (family, relations with other people, accommodation and economic situation). Discusses about the need of a treatment, about expectations and goals. The social therapist begins and carries out the treatment selected together with the client (individual treatment, family treatment, group treatment). The social therapist consults other specialists about the current case.

The doctor together with the worker responsible for primary care (nurse, social therapist, coordinator and psychologist) creates a contact with the client and listens to his/her story. The doctor also listens to the report of the worker responsible for primary care. Doctor determines the possible medical treatment, for example, evaluates the stage of depression and gives a medical evaluation of the patient's condition. This means that the doctor is responsible for the moments which need examination and medical treatment. He finds out what kind of treatment was done in other places, and coordinates the treatment of drug or alcohol abuse. The doctor also has the task to motivate the patient to take part in individual, family or group treatment. The doctor consults other specialists.

The psychologist carries out tests that aim to find out the patient's personal peculiarities and evaluates his working ability. The psychologist plans and realizes the treatment (individual, family). The psychologist consults other specialists.

The office worker is responsible for the first contact with the client, for example, by telephone or at the place of treatment. The office worker is also responsible for coordinating and consulting in general questions and

informing the client about the person responsible for the primary care.

Anyone from the group can be the first one to meet with the client although not often the first one is the doctor. The office worker tells to other members of the group about the current patient. The office worker asks for consulting from other members of the group face to face or in group meetings when appropriate possibilities and methods of treatment are being discussed. Other members of the group taking part in the treatment process will consult about organizing and taking into use these methods, when needed.

Meeting with the client and building therapeutic relations, motivational interviewing and stages of change

We will meet with absolutely different kinds of persons: we come across with lonely people, with middle aged people, with women, with pensioners, with alcoholics, with the divorced, with creative persons, with criminals, with decent people, with depressed people, with demented persons, with strong men, with people who have lost their wish to live, with lazy people, with the pedantic, with twisted people, with the dependent, with the homeless, with secret alcoholics, with the motivated, with sensitive persons, with people with families, with persons who periodically collapse to drink, with sick persons, with persons with a sense of humor, and with the arguing, with the aggressive, with the dreaming, with the self-contained, with self-assured and egoistic people.

During the meeting the ability for cooperation is important. Abilities to use open questions, an ability to confirm what is said, reflective listening and making the conclusions after hearing the client are such abilities that will help to create confidential relations between the client and the specialist.

During the meeting and conversation with the client, it is important to pay attention to many factors. In the following section some moments are introduced, which help the worker to hold a conversation with the client and to avoid dead-end situations. It is good to use open questions and to avoid closed ones, paying attention to the signals coming from the client.

Closed questions

Question why:

- These are such questions which require a wide explanation about earlier life before answering the actual question (to this question children often answer “just because”).

Questions that can be answered with only one word:

- Such questions hold a closed signal within, which usually is not known to the person talking
- Listener hears it through his/her feelings
- Suffocates the conversation

Open questions

- Starts with an interrogative
- The answerer has to think before answering
- Closed signals are justifiable
- Opens the conversation
- Gives space for different ideas, opinions, feelings

The manner of giving information can reflect a reduced, increased or personal level of responsibility.

Reduced level of responsibility

- The patient does not talk in the name of anybody
- The patient talks from the point of view of an undefined person, meaning him/herself
- Patients says “you” meaning him/herself
- Information received is not precise
- Pose is slightly closed
- The patient’s glance is searching for an own strong channel for information giving. Specialist should not take the responsibility for the given information and actions.
- Some irritation

Increased level of responsibility

- The patient talks on behalf of everybody
- The patients uses words like: all, everybody, surely, nobody, always

- Pose is straightened, sometimes unnecessarily
- Glance directed towards the listener
- The listener starts to have a feeling of resistance
- Some clients get irritated
- The listener might get the feeling that there is no point in saying something
- Pose may give a feeling that the person talking is proud of him/herself

Personal level of responsibility

- Patient talks on behalf of him/herself
- Patient uses signals "you" and "I" depending on who he/she directs the responsibility to. This means that the **responsibility is directed correctly**
- The patient's pose is straight and stabile
- Glance matches with the situation of interaction
- Therapeutic can ponder freely

In following we can see some typical situations when **mistakes in discussion are possible, and ways to overcome them.**

1. Trap question – answer
   - Remedy: open questions
   - Reflective listening
2. Confrontation - trap of denial
   - Remedy: reflective listening
3. Expert's trap
   - Remedy: to underline knowledge, raising the client's meaning, his/her activity and things he/she does
4. Mistake of stigmatization
   - Remedy: to pay attention to concrete problems and to their management
5. Premature concentration on the problem of addiction
   - Remedy: Start with the client's worries
6. Trap of accusation
   - Remedy: Don't look for the guilty ones: concentrate on the problem and on its management
7. Frequent unsuccessful attempts to change

- Remedy: If this happens, help can be searched for!

8. Interest towards the change varies during the process
   - Remedy: Be ready for this!

Listen with empathy

Listening quiet

- Door openers; use short words to encourage the client: aha, hmm, so
- Keep your pose open
- Listen to the words – clarifying and specification of the patient's words (important meaning), feedback
- To listen and hear the whole meaning of what the other person is saying (confirming)
- Technique of sorting: feelings and emotional condition!

Empathy and listening – Reflective listening

- Repeat the patient's sayings
- Reformulate
- Summarize the client's sayings
- Search for new meanings (pos. connotation)
- Make phrases: I think that.... I feel that.... I sense that... I felt that...

In the role of mediator

- Don't look for guilty ones
- Observe the emotions
- Help both sides to talk with each other (in such a case where the subject is a person who is not present at the psychotherapy session but is emotionally meaningful to it)
- Don't solve and don't agree to act as a judge
- Don't RESCUE

Evaluating the conversation

- Motivational meeting
- Damage and worries
- Chronological passage to the future
- Pointing out contradictions
- Neutrality

- Variants; the client's choice
- Do not stigmatize, give labels, or show prejudice

Evaluating the conversation

The strategy:

- Eliminating barriers in order to achieve goals
- Free choice and wish
- Empathy
- To offer feedback
- Clearing up the goals
- Active help

In substance abuse care work it is always about motivation and motivating the client. The following comparisons are about 2 different ways to approach the client's problems: a motivational interview and a way of approach which is based on breaking the negative perceptions.

Motivational interviewing	**Breaking the refusal of the treatment**
Recognition of stigmatization "alcoholic" is irrelevant.	To make the patient acknowledge that he/she is an alcoholic.
Emphasizing the patient's own possibilities to choose	Alcoholism is seen as a disease which reduces the possibilities of individual choice.
The individual is not seen as helpless towards alcohol	Individual is seen as helpless towards alcohol
The goal of the treatment agrees upon the information available and other requests.	The goal of the treatment is a complete and lifelong refusal of alcohol.
A possible goal of the treatment can be controlled alcohol use, although this variant is not suitable for everybody.	Controlled alcohol use is not possible
The person conducting the conversation tries to grow the patient's own concern of alcoholism.	The person conducting the conversations shows the evidence of alcoholism.

Refusal of therapy is seen as a problem of interaction.	Refusal of therapy is seen as a part of an alcoholic's character.
Refusal of therapy is faced ref-lecting the situation	Refusal of therapy is followed with corrections of the patient's position.
Information about the harm of psychoactive substances is shown to the client so that he/she can make his/her own con-clusions.	Information about the harm is pre-sented as an evidence of a progressive disease which shows the need of full abstention.

In the following the basic features of the motivational interviewing will be presented. About the motivational interviewing you can also read more at: www.motivationalinterview.org. **Key skills to be used in the motivational interviewing:** Empathy; open questions; reflective listening.

Main ideas of the motivational interviewing: No accent of stigmatization; personal responsibility; inner self-determination; a consciousness of discrepancy.

Key principles of the motivational interviewing: The motivation comes from the client, it cannot come from outside; the patient, not the specialist, has to find and resolve ambivalence; attempts to persuade directly is not an effective way to solve ambivalence; Conversation style should be listening and expectative.

Strategy of the motivational interviewing: Confirming; Awareness; Alternatives.

Carrying out the strategy of the motivational interviewing, motivatio-nal discussion:

- Presentation of self motivational statements
- Objective evaluation
- Increasing the amount of information
- Short quotations of discussed matters
- Drive from motivation stages
- Discussing the variants
- Specialist guides the client, helping him/her to examine and solve the ambivalence
- The readiness for changes is the result of cooperation
- Therapeutic relations equal to a partnership between the specialist and the client

How to carry out a motivational interviewing:

- Show empathy
- Encourage the client´s capabilities, support the client´s trust for his own capabilities to change
- Avoid resisting, roll with resistance when the client resists, don´t argue with the client
- Make the difference between the current situation and the aimed situation significant, make the contrast between “reality” and “desired”

Meeting with the client in the context of his situation – Thesis of M. Hannula

- Everybody is interested in something
- Everyone has someone most important to him/her
- If you don´t know, ask!
- If you don´t understand, don´t try to act as if you did, be surprised
- Open questions and respectful supposition
- Anyone is capable of almost anything
- Complicated things can be done at once
- Impossible things take just a bit more time
- Sometimes yes will sometimes become no / curability

Studying motivational interviewing; intermediate exercises

During the seminar listeners made different exercises about patients´ motivation in the city´s different substance abuse care centers. As an outcome, these cases were gathered together and analyzed which was, without a doubt, good for the professional growth of our specialists. In the following we can see 3 most interesting works of participants.

1. Patient N, 17 years old, approached the reception of St. Petersburg Addiction Hospital with his father, because of father´s insistence. Father suspects that his son is using psychoactive substances and wishes to get consultation and a confirmation or retraction about son’s drug addiction.
Conversation with the patient´s father (patient absent):
Specialist: Tell me about the reasons for your worries. Why do you think that your son is taking drugs? Did he tell about it himself?

Father: No, he categorically denies drug addiction, but for the past half a year he changed a lot. He became reserved, irritated, skips lessons, comes home late at night, and in the mornings can be in an inadequate condition: weird smile, unclear voice, "glassy" eyes. He explains that has been in a disco with friends and has drunk beer, but I don´t smell the alcohol.
Specialist: How did your son's interests and forms of entertainment change. Does he have a girlfriend?
Father: Before he was interested in sports, he went to the gym every day, got ready for the entering exams of his institute, read a lot, but now he is not interested in anything. He had a girl-friend, but she broke up with him.
Specialist: Thank you, please ask your son to come in.
Patient comes with evident marks of light drug intoxication: constricted pupils, unclear speech, and a blithely euphoric face expression.
Specialist: Hello, sit down please I am a doctor in psychology and specialized in substance abuse care. Please tell me, what problem brought you here? If there is a problem, I will try to help you to solve it. I ask you to be open with me, as it is your own best interest.
Patient: I do not have any problems. Father thinks that I am using drugs, but it is not so.
Specialist: Tell me, how do you spend your free time, please
Patient: I go to night clubs with my friends; we dance and listen to music
Specialist: And to up-grade your mood, do you take something for this?
Patient: We drink 1-2 bottles of beer
Specialist: You were never offered to take drugs? I heard that it is trendy now in the clubs.
Patient: I was offered to try amphetamine. I tried maybe 2-3 times.
Specialist: And what about heroin?
Patient: Never tried
Specialist: As you are under aged, I will do you a drug test from your blood with your father's permission. The test will show a positive result when you have opiates in your blood.
Test shows positive results for opiates in blood.
Specialist: How do you explain the opiates in your blood?
Patient: So I sniffed up few times, and what?
Specialist: And when was the last time?
Patient: Well, this morning a bit

Specialist: With the permission of your father I will now give you an injection, after which we will continue this conversation.
Patient is given an antagonist of opiate receptors intravenously.
After the injection, the patient´s condition strongly changes. His mood changes into depressive, hypochondriac and there are tears in his eyes.
Specialist: Let´s try to talk once again, ok?
Patient: ok
Specialist: How often do you use heroin?
Patient: Almost every day, up to 0,5g per day, but I do not consider myself as being sick, and I do not see the problem.
Specialist: And for how long?
Patient: For about 4 months
Specialist: And what kind of plans do you have for your future? Soon you should have final exams
Patient: I am planning to enter the institute
Specialist: For this one needs to have a lot of strength, desire, ability to work, knowledge, do you agree?
Patient: Yes, I agree
Specialist: So tell me, how do you usually feel in the mornings?
Patient: Not always so good, sometimes I have a bad mood, I feel weak.
Specialist: Were there some cases when you missed your lesson because of feeling not good?
Patient: Yes, there were
Specialist: I guess it is hard to work and learn in such a condition, you agree?
Patient: Yes, but I did not connect this with the drug use, I thought it is just tiredness.
Specialist: You never thought to make you feel better with the help of drugs?
Patient: Sometimes
Specialist: It is called the rush of withdrawal symptoms or "sweats".
Tell me, after taking drugs, do you feel like working or studying? What do you do after taking drugs?
Patient: I don´t have any special wishes to do anything. I get the high.
Specialist: So let´s make a short summary: almost for a half a year everyday your life has been divided into 2 parts. In one of these you feel bad, and in the other one you are intoxicated. In both of these circumstances you are not willing or able to study or work. How in this current situation do you think

about your chances to enter the institute?
Patient: It will be a bit hard
Specialist: And because of what?
Patient: Heroin
Specialist: Good that you understood. And did you try to stop using drugs?
Patient: I always thought that I can stop whenever I want to, but I continued to use
Specialist: in the future it will get only worse. Your portion will get bigger and you will take them more often, the withdrawal will get harder. It will be harder to handle the addiction even with the doctor's help. At the moment you still have the possibility to recover. By the way, why did you break up with your girl-friend?
Patient: She broke up with me when I started to sniff a lot and did not walk her home.
Specialist: This way she showed the relations of any normal woman to drug addicted men. By the way, addiction leads to impotency.
Patient: I understood you. I have what to think about. Thank you, doctor.
Specialist: I am sorry to say but at the current moment you have your addiction at the beginning stage and without the help of a specialist you will find it hard to manage. Think about this and come again when I have my reception time. We will solve how to help you.
Father: Thank you, we will come on Monday at 10:00
Patient: Thank you
Specialist: I will be waiting for you

2. **Patient**: Hello
Specialist: Hello, please come in, get seated. Tell me what reason brings you here.
Patient: I don´t actually have any reasons, but my wife thinks that I am misusing alcohol and that it is necessary for me to get treated.
Specialist: If I understood you right, you don´t think the same way. Let´s try together to understand this situation, if, of course you will help me and try to be open. Are you ready for a confidential discussion?
Patient: Actually not, but I can try
Specialist: Then tell me, what is your wife worried about? And what is the reality?

Patient: Sometimes I really drink with friends or in celebrations, but not more than others drink.
Specialist: How often has this happened to you lately? Let´s say, during a month or two?
Patient: Well, of course lately I have been drinking more because I am temporarily not working and I have more time to meet with my friends.
Specialist: Anyway, let´s be more specific, how often has this been?
Patient: Maybe 2-3 times per week, not more.
Specialist: Do you think this is not often?
Patient: At the moment I have time, it does not bother anyone, so I don´t see anything bad in it.
Specialist: It seems to be that your wife has another opinion about this, because she sent you to a doctor.
Patient: That´s the thing, the problem is not my drinking but our relations. She is all the time not happy with something; she starts to make scandals out of nonsense.
Specialist: Tell me about this nonsense.
Patient: First of all, she thinks that I don't give enough effort on finding a new work, but I am all the time occupied with it, just at the moment it has not been successful. The work itself is boring or they pay too little.
Specialist: Tell me in more detail, how do you search for work?
Patient: I look at the papers with announcements; I search for vacancies on the internet, sometimes I call and ask for more information about the work, I send my resume, and if they offer, I go to the interview.
Specialist: How often have you been in interviews?
Patient: Altogether twice, I didn´t like it, it was like in school exams, I felt like running away and drinking, a very unpleasant feeling.
Specialist: and now you don´t have any unpleasant feelings?
Patient: no, I don´t need anything from you, I´m just telling.
Specialist: What other "nonsense" makes your wife not happy?
Patient: What else…yes! I give children too little attention
Specialist: Tell me how much time you spend with your children?
Patient: Well, all the free time
Specialist: What things did you do with your children lately?
Patient: Well, on birthday we went with my wife and children to our friends.
Specialist: Did you spend time with the kids or adults there?

Patient: Well, of course I was more with my friends, we hadn't seen each other for a long time, and kids had things to do even without me.
Specialist: But did you spend time separately just with the kids, maybe something special for them?
Patient: well, at home we are together, I don´t like hanging out. When I worked, there was not enough time, I am not used to.
Specialist: What other claims does your wife have?
Patient: She is not satisfied with our sexual relations. But she is guilty herself because she is nagging all the time and that is why I have no wishes. She is also tired because of her work and home work and kids, it´s all to her.
Specialist: And you wouldn´t like to help her?
Patient: I will not work for her.
Specialist: And at home, with the kids?
Patient: Well that is not for men, and actually day time when I get up, they are not at home and in the evenings I will go somewhere as my friends are free only during the evenings. So this means that when I have time they are not at home and when they come back, I am somewhere else.
Specialist: And how do you spend your time with your friends?
Patient: The usual way, we drink, everybody feel tired in the evenings, we sit, talk, we drink and I feel happier. The whole day at home makes me depressed.
Specialist: So, on the average how much do you drink?
Patient: it differs, sometimes easily some 5 bottles of beer, sometimes we drink vodka.
Specialist: How much of vodka?
Patient: It happens sometimes that a whole bottle, but then to be honest, I will be at home feeling sick the whole next day, my health gets bad. Earlier I still went to work but now, God bless me, at home.
Specialist: And for how long have you been having these problems with your health after using alcohol?
Patient: Maybe for a year, at the moment I am not working so it is not that bad to feel sick
Specialist: Tell me please, did you ever try to plan your day so that there would be time for your wife and kids, looking for a work, beforehand planning?
Patient: well I think this way is also normal, you get up, you see how you feel and then you plan.
Specialist: Divide please, if you can, your day in percentages, how much and

what do you do?
Patient: I don´t look for work every day. With the kids, well I don´t know, maybe some 20 percent, with my wife, well she starts to scream so often so we don´t talk at all, well and with my friends some 40 percent.
Specialist: And what do you think, is this a normal distribution of time?
Patient: Well, somehow it is not coming out right.
Specialist: And could you give more time to your family, to look for work, to work at home, to be with your wife and children?
Patient: Without problems, at the cottage I can work every day, with the kids I can go somewhere for example every day. By the way, I have to call my old friends and search for a vacancy, I don´t like asking but how long can I live with my wife only working
Specialist: Maybe you will plan your week more concretely, and then it will be easier to do everything
Patient: Yes, maybe I will talk with my wife, about how it would be best to plan. She is kind, she will help.
Specialist: And how do you feel, if you limit your alcohol use, you will have more time to do everything planned?
Patient: Yes, I think a lot more, my evenings will be free, maybe my relations with the family will get better, I ´d like to have my life the way it used to be, with good relations, peaceful, I loved my wife.
Specialist: And at the moment?
Patient: And currently,…currently I also love her
Specialist: Good. Maybe you are tired of this discussion?
Patient: Well no, actually I started to feel better, things got clearer.
Specialist: What became clearer?
Patient: That I was not doing what I was supposed to do, and my life got messed up. To be truthful, I am already tired, something had to be changed. I didn´t know what exactly so I drank with my friends, spent some time.
Specialist: And now do you know what to do?
Patient: To make a plan and to limit my drinking.
Specialist: You need to be aware that it is a long process to give up alcohol, and it will take ascertaining efforts. You have to understand yourself, that alcohol is the main reason if your life gets ruined. But if you really decide to go this way, you can solve the problem which has appeared. You can always turn to me for consultation and help.

Patient: Thank you, I think I understood the reasons for my problems.
Specialist: Good, let´s agree that next time you will tell me what you succeeded to accomplish from your plans?
Patients: Certainly, see you
Specialist: You can come to me during the next week. If possible let me know about your visit beforehand. Thank you for this conversation, Good bye.

3. Patient A. 26 years old, entered the center 03.05.2009 with the diagnosis: Syndrome of opiate addiction in mid-range seriousness. In medical background we can see that: period of use about 8 years. Has used heroin, methadone and ephedrine. Currently using heroin. Doze is up to 5g per day. Starting from the year 2002 sick with hepatitis B and C and from the year 2006 HIV positive. Has been sentenced twice. The first time he was on probation and the second time he was sentenced for two years. During the imprisonment the patient did not stop using drugs. The remission times are not long, in maximum 1 month when he went to the country side. During this time he misused alcohol. Was treated at our stationary more than once. Stayed only for the period of detoxification, and then signed out. Did not participate in the rehabilitation even once.

It is complicated to motivate this client as he had no understanding of the rehabilitation process. He has not been sober during his history of drug use, has a lowered intellectual level and a low self-critic to his own condition (it´s possible to say that no criticism at all), and also is seriously sick with diseases like hepatitis and HIV.

Nevertheless during the conversation the patient said that he wants to stop using drugs because he “no longer has the energy”, because he is “tired of how one by one his friends that used drugs with him pass away”. He is afraid to be the next one. He said that he has seen people who stopped using drugs and returned to normal life and he wants to do the same.

I asked him to explain what makes him to return back to drugs every time. He explained that he all the time returns back to the group of previous users. I asked him to tell about his family. He told that his father died when he was 16 years old and that his mother raised him. He has an older brother who has already for a long time been living separately, has his own business, family, and who tries not to stay in contact with him or with the mother. Mother is working in 2 different places. They live in a two room apartment, one room

they are renting to visitors. The patient himself does not work, most of his time he is looking for money and searching for drugs.

He tells that he doubts that can get cured. I explained to him that drug addiction is a chronic disease and that there still are no “medicines” to cure it, but that he can reach the level where he can spend more time being sober, to gain peaceful remission which will allow him to return to his previous life where he can practice socially accepted things, to be a part of society. But this would not happen just like that, this needs to be earned by working long and hard and by wanting it. Although, first he needs to accept that he is seriously ill without the possibility of being fully cured, but against which he can successfully fight. Detoxification is only the top of the mountain, only the beginning of a long and hard road. Furthermore it is necessary to work with his feelings, to start talking about them. After this he will learn to live in a community, with rules, to have some role and responsibility (which he did not have, already starting from his childhood because of the features of the upbringing) most of all for himself and for his own actions. He will start to create his own limits and stop breaking limits of other people. Also we need to understand that a relapse during the rehabilitation is not a failure, it is just one part of the fight against this disease.

I made him a scheme were I showed how the treatment goes through several stages: understanding the problem on the level of feelings, forming the motivation to be sober, changing the system of values, sober period, relapse, starting from the beginning…And these normal steps which are the components of a more successful fight are (3): to break the link with the previous group of acquaintances, to solve the family conflict, to start to make normal agreements with close people and to teach them to communicate with you properly, this means that we do not only solve the problems of addiction but also of codependences. If possible, then to try living by yourself, independently, to find work and to take care of yourself alone. And, in the end, to form a new system of values.

The life of a drug addict is like a ring. Everything in this ring is wrapped around one and only value which is drugs. The very second that the drug is taken away from this ring, the ring starts to collapse. In order to close this ring again, we need a new value. This means that drugs come back to the picture in order to fill the emptiness starting to appear, this “hole”. In order not to let this happen, we need to fill this gap with something else, with something

socially acceptable. It might be some new occupation, work, an important relationship, religion and God…I explained that it is necessary as soon as possible to get away from drugs, in spite of the concomitant complications, like sleeping disorders and affective disorders, since he has to start to live with a sober mind. You cannot use alcohol or other psychoactive substances because that would only mean that you change one addiction to another, which does not let you objectively evaluate the world around you and let you solve the existing problems effectively.

At the moment this patient is going through rehabilitation at our department, he does his exercises, goes to NA groups, takes part in psychotherapy, has a free exit from the ward and is busy looking for work.

Working with the stages of change

Changes in the client´s behavior happen gradually, not suddenly. In the following is shown the five-step circular model of Prohachaska, DiCLemente and Norcross. Changes are not to happen at one stage after another, the client can whenever and more than once return to any of the previous stages or come off the circular. The crisis opens doors of the system and creates the road to changes.

STAGES OF CHANGE (Model by Prochaska, DiClemente and Norcross)

1. PRELIMINARY REASONING: The person does not think that his behavior is problematic or does not see it as problematic as others see it.
Characteristic: reluctant, resistant to change and towards philosophizing.
Intervention: Empathy, motivational discussion, increasing the level of acknowledge, sense of after-effects, changing the company, surroundings.

2. REASONING: The client accepts information and is ready talk about the change.
Characteristic: ambivalence, fear and interest of change (but still not interested).
Intervention: The same as in the preliminary reasoning, but besides this also a repeated self-evaluation about how the patient feels and thinks about himself regarding the problem.

3. PREPARATIONS: The client has seriously decided to try to change.
Characteristic: It is typical that the levels of interest and ambivalence differ.
Intervention: A technique that helps to increase the interest, a distinction between plusses and minuses of changes, to think out different variants of fulfilling the change, making the plan, evaluating realistic and meaningful goals.

4. PRACTISE: taking the plan into practice.
Characteristic: The client is using the therapy, which helps him to gain his goals and looks for support; the client´s feeling of own competence grows.
Intervention: Positive affirmation of actions' effectiveness, strengthening the support of social networks, searching for alternatives when problematic behavior occurs, changing the environment and everyday actions, teaching the mind to feel that all efforts will be rewarded.

5. SUPPORTING: A new model of behavior strengthens.
Characteristic: Getting ready to support the result of the happened change but evaluating the situations, in which the problems can appear again
Intervention: A preventative technique against failure. For example, by uncovering critical situations and by making a plan of recovery for the situation after the failure.

How the specialist supports the process of change with the help of motivational conversation.

STAGE OF PRELIMINARY UNDERSTANDING/REASONING:
- Unwilling to stop
- Strengthening the patient's doubts and supporting the client's observation of risks and problems of present behavior, to make the client's awareness grow

STAGE OF UNDERSTANDING/REASONING:
- Tries to shift balance to the direction of wanted change
- Awakens the reasons to change
- Offers to look at the risks of the present situation
- Strengthens the patient's discomfort, but acting still with empathy
- Strengthens the effectiveness of the patient's feeling of individual "I", in

order to change the patient's current behavior
- Can have a bit skeptical or paradoxical way of approach

MAKING THE DECISSION/ READINESS TO STOP:

- Helps the client to choose which direction of actions is the best one, but does not make the decision for the patient
- Shows what he/she believes in the patient's possibilities
- Finds out examples of success in the client's personal history

PRACTISE:

- Helps the client to make rights steps in the direction of change
- Removes barriers, supports, encourages and gives positive feedback

SUPPORTING:

- Strengthens the already happened changes
- The most difficult stage
- Helps the client to recognize risky situations and to use the strategy of preventing relapses
- Gives positive feedback, based on the evaluation of the already happened progress
- It is possible to decrease the amount of visits, and to loosen the contact
- Last contacts can be made for example by the phone, 3-6 months between each other
- When needed, the holding of contact can continue for a few years

END OF ADDICTION:

- The specialist might get a temptation to proceed faster than the client, to stop or to go further to the stage of practice, which might harm the patient
- The changes do not happen against the understanding/ subconscious belief, values and relations of the person

RELAPSE:

- The client returns to one of the earlier stages
- For both, to the client and to the specialist, it is important to have the right attitude to the relapse. Relapse = lesson
- The specialist, without accusing or moralizing, helps the client to get back to the process of change

Studying the stages of change: intermediate excercises

Further we will see two works from the participants of the seminar about the stages of change in the patient's behavior.

1. Stage of change in the patient's behavior during the motivational work within the frames of the rehabilitation program of 5th ward, City's Addiction Hospital.

Preconscious: At the first visit the patient yet has no awareness that there is a need to have any serious changes in his/her behavior. A subconscious feeling of uneasiness, concerns, psychological discomfort appear (The patient has got positive results from the HIV test). We find out where and when the patient gave the analyses and if the patient had any consulting. Did anything change in his awareness of behavior?

The main goal of the consult at this stage is to create a contact and confidential relations, also it is possible to have a conversation with the patient about the patient's doubts and about other things making him/her worry. The consultant must show interest to the patient's personality, to his life, especially to those ideas and meanings that the patient confers. It is necessary to "keep the door open", even if not managing to create the needed contact with the client, it is necessary to foresee his/her possibilities in the future and to invite the patient to come for the next visit.

Recognition: at this stage the patient feels worried, has concerns, which are growing. It happens a gradual understanding of the correlation between the reasons (HIV infections, use of psychoactive substances) and the results (appearing psychological, social and medical problems). It appears an arising need to do something, to change something in life. It is necessary to explain to the patient to get registered to the clinic. Did some changes happen in the patient's awareness of the problem.

The specialist's task is to evidently show the difference between the real life situation and the situation in wanted life; and to reach the awareness of the correlation with the existing problems and the occurrence of the HIV-infection because of substance use. It is necessary to help the patient to balance the scale: on the one hand, the wish to live as previously, and on the other hand, to live with the growing problems and the need to change. Self-motivational statements of the patient can be separated

(when talking about changes): I feel that I am at the end of the road, I cannot go on like this anymore, and so on.

Making the decision: At this stage the patient starts to question, to be doubtful, and worries reach the apogee. The need to make final decisions about the change starts to formulate. Conversation about the problems if needed, with relevant persons.

At this stage it is necessary for the consultant to clear up the personal goals of the patient, to agree about the plan of changes and about therapy. The specialist also needs to foresee factors of risk in forming the commitment, to see the risks of relapse and the way of coping with it. Also it is possible to try to lower the barriers, which have to be conquered, to obtain social support, to formulate the client's goals according with the instructions of KIPRS, concrete/measurable/acceptable for the client/realistic/time structured.

Practice: Starting to work in order to accomplish the made decision. At this moment the patient feels worried, restless anxiety, or even the opposite. The patient might feel euphoric because finally he gets to "start doing" – an effect of recency. The consultant should act in a way to find constructive strategies to win over the stressful situations with the client. The most important thing is not to lose the supportive relationship, and to reach the mutual understanding of doing the home exercises (to increase the growth of independence, self-efficacy and responsibility).

Supporting the changes: At this stage the patient starts to experience changes which will take a special place in the patient's everyday life, and which will become a part of his/her normal routine. During this stage boredom or stress can become reasons for relapse, sometimes a very bad mood or psychological condition. During this stage it is important to find out if the client had ideas or possibilities concerning the relapse and what helped him/her to resist it, does the patient take part in supportive groups, groups of secondary prevention.

Furthermore, the specialist will support the patient's success in having positive changes in his life style, evaluate situations which are linked with high risks of relapse, evaluate together with the client alerting elements and warning signs of the relapse, give support, to recognize the patient's efforts and to reason their value. The specialist also works out together with the patient a plan of actions for emergency situations (threat of relapse,

a relapse already happened): who to contact, where, when and with what coordinates.

2. Throughout the whole cycle of rehabilitation, the patient's social card (Social card of "new generation") gets filled by the patient him/herself or under the control of the specialist. The goal for this is: to get information, to see information about persons important in the patient's life, and their relations, and to use the chance to create a constructive contact with the client by filling in the card information together.

With the help of this it is possible to do the planning and controlling the dynamics of the patient's changes regarding his/her social relations in the direction of strengthening the development of natural social connections (relatives, friend, colleagues). To carry out continuing diagnostics and corrections (discussed with the patient) a micro set of natural social connections and cooperation with the specialists involved in the treatment

The reason of current patient's primary consulting.

	Goals	**Principles**	**Examples**
Motivation	Creating and strengthening the consultative extent. Demonstrating the interest. Arousing the patient to continue to tell about him/herself.	Kindness, unconditional acceptance of the client, which is heard in the tone of voice and behavior.	"I understand.." "yeah.." "yes.." "that's interesting" "Anyone can come across with these"
Reflecting the feelings	To help the patient to tell, to work out, to acknowledge his/her own feelings which means to relieve distress. To help the patient in identifying his/her own feelings and to show emphatic understanding to client.	To choose words which reflect the patient's feelings, to concentrate on the patient's current feelings. To keep it short, clear and concrete, to use positive wording and to be confident.	"Do you feel that…" " were you strongly worried about this?.." "Are you angry?"
Repetition/ reformulating	To show that we are listening and are interested. To show that we recapture the facts. We clarify facts to ourselves.	Briefness, as it is. To concentrate on the actual for the patient content. To use the conceptual framework of the patient. To repeat the patient's main ideas and to underline important facts.	"If I understood you correctly…" "In other words you decided to…" "So this means that you.." To literally repeat

Interpretation	To help to clear up the real meaning of things said or the reasons and goals of what the patient has said. Interpretation has to be done very carefully because exact interpretation might evoke strong defense, or even worse, it can deprive it and leave the person vulnerable and broken. Not accurate interpretation can lead to big damage as it is hard when you are taken for someone you are not. This evokes anger.	Make clarifying questions. Use the technique of trial questions or conventional hypothesis.	"I suppose you mean that…" "You are saying this probably because…" "It seems that you would like that….." "But maybe it is so that you wanted that…."
Effective asking of: Open questions like "How", "What" and others. Of closed questions those that allow the client to answer with only one syllable word (for example: "Yes", "No", "I Don't know" and others)	To help to establish and deepen the contact, encouraging the patient to be actively involved in the consulting. To get information of the patient's situation and to discuss patient's feelings. Allows to concretize and specify the situation without giving the word to the person talking.	Use open questions. Don't give many questions at once. Questions like "Who?", "What?" are more oriented to facts. Question "How" is more oriented to the person him/herself, to his behavior and inner world. Question "Why" often provokes the defensive response.	"And what did you do when you understood this?" "How would you like…" "And how did you before solve similar situations" "Do you want to go through the treatment?" "Was it hard for you to talk about…."
Structuring	Engaging the patient to take part in planning the process of consulting. To help to determine priorities, if the patient talks not clearly. To motivate to open one story more thoroughly before changing to another.	Happens through the whole process of consulting	"What is the most important thing for you in this situation", "Is there something you would like to start with, in the thing that you were talking about?"
Summarizing Debriefing	To assure the mutual understanding of the patient and consultant. To help to appreciate what happened during the process of consulting: the path that the patient and consult together walked through, and the logic of the patient's decision making.	To repeat the main moments of the conversation. To underline the made decisions.	"Today we talked with you about…, discussed…., and we made the decision that…."

At the entry the patient complains about her brittle mood, yearning for drugs, and thinks that her relatives are interested in her treatment (thinking that she can be saved) when is not. At the appointment she arrives with her mother and sister.

Background: heredity tainted, father and grandfather (from father's side) with alcohol problems. Father is kind, liberal, wanting in initiative, fairly calm. Mother is active, powerful, and emotionally unstable. Older sister is hyper responsible and conceptual. The girl was born from her mother's second pregnancy, in time without abnormalities. Until the age of 6 months, she grew up without any abnormalities. When she was 6 months old she caught the cold, which then lead to bronchial asthma, which continued until she was 7 years old. Before school she went to the day-care and kindergarten. Grew up to be a fairly calm child but was also very vivid, active, and over-excitable with other kids. Games with sister and other kids were often noisy, which provoked the asthma to appear. Because of this, the girl got more attention than usual and noisier and active games were not allowed. When she was 7 years old she started the school in an Italian language group, she studied well but the best results she always got from lessons of humanistic arts. She started to play the flute when she was 6 years old, her talents were noticed but already at the age of 10 years she started to skip the lessons. She did not tell her parents that she does not like to play solfeggio. At school it was easy for her to make contacts with other kids, but mostly she spent her time with boys. With boys she felt that she was the center of attention and then she felt that girls envied her for something. At home she was loved and got a lot of attention. When they had lots of guests, the parents used to show people her talents (to sing, to play the flute, to dance). At school teachers were not complaining about her behavior, but she was able to get class mates to skip uninteresting lessons. She finished the 11th class with mostly good grades like 4 and 5 and with few 3 grades. After school she entered the Herzen Pedagogical Institute's initial class, after a year she gave up those studies since she had no interest to continue (she entered the institute because of her parents recommended her to do so, but she had no own wishes for getting such knowledge and profession). After this, through an acquaintance, she entered the faculty on foreign languages (Italian) at University, but gave up those studies as fast as the first one, because there she should have regularly participated in all the lessons, to eagerly study, many of the subjects were difficult, and the patient was more interested in

cool night clubs, discos. At this same time she started to have promiscuous sexual relationships, and she often disappeared from home. The patient points out that she spent her time with a group off high-class people where she was the center of attention and got attention from other young people. She tried to study in the Saint-Petersburg University of Humanities and Social Sciences but gave up as fast as before, since she was already using psychoactive drugs.

She is communicative, but apparently she has never made close friends. According to her mother all relations were quite superficial, without any affection and were, so to say, quite "consuming". Within this period things were being stolen from home and from the houses of her relatives. At 23 she went to Italy to undergo a treatment in a rehabilitation center (manual work turned out to be for me the most difficult part), and after a 5.5 years' stay in the center she decided to stay in Milano (her sister also lives there). Soon after she got acquainted with an Italian and they started to live together. At that time she worked as a translator in restaurant business. Her husband was quite dominant, emotional and jealous; he controlled her life suspecting her of abusing psychoactive substance. She gave birth to a son who is at the moment 1,5 years old. Currently her husband is imprisoned in Italy. According to the patient she started abusing psychoactive substances because of the problems with her common-law husband. However the patient's mother thinks that she started drug taking long before, and now hides the truth. In December the mother took the patient and her son back to Russia and within this period (December-April) the patient was abusing psychoactive substances followed by numerous thefts from her relatives; according to her mother she could just leave her baby and go somewhere to take drugs, and the mother is absolutely sure she did not have any scruples.

Medical history: The patient has been abusing drugs since she turned 17 (cannabinoids, LSD – on an occasional basis (not more than once a week) within 6 months. She tried opiates (poppy straw) intravenously, from 2.0 ml.—also on an occasional basis, but 3 months later it turned to be systematic and the non responsiveness raised to 10.0 ml of solution per day. At 18 she suffered from psychophysical dependence and the abstinence symptom caused by opioids. Within the period of 1992 - 1997 she tried to undergo anonymous treatment followed by short remission periods (1-2 months.) In 1996 she tried heroin dose of 0.5- 1.0 g/day. In 1997 she went to Italy by invitation of her sister to undergo treatment in a rehabilitation center "Comuna" where she stayed up

to 2003 (5 years of remission). In October 2005 she had a breakdown – she turned to heroin (0.5-2 g/day). Her last heroine abuse was more than 1 month ago, the abstinence syndrome was cut short at V.M. Bekhterev Institute, after which she started the rehabilitation treatment at NRC No1. Currently she follows her individual program in the center, resulting in additional dynamics in behavioral stabilization, she has a mind set to stop taking psychoactive substances, and problem of addiction is not acute at the moment.

Mental state: the mental state is not confused, she has a good sense of orientation, expressive mimic and gestures. Her speech is well-formed and expressive. She does not present any claims, looks younger than actually is. She has few manners, she is thoughtful and kind. She is communicative, keeps to the point while answering the questions, tries to make a good impression, she is quite shallow in her statements. When remembering about her past life and bad times, she has tears in her eyes, her face blushes with shame. Her thought is sequential, creative. The intellect and memory are in a good state.

Allergic anamnesis: normal state.

Previous diseases: Bronchial asthma in childhood before she turned 7. Hepatitis “B” and “C” -1994. Syphilis -1994. Denies tuberculosis and HIV.

Physical state: satisfactory condition, no skin rash, harsh breathing, rhythmic and clear heart tones. Arterial pressure 130/85 Mmhg, pulse -75 BPM. The tongue is moist and pink, belly is soft, w/w. Liver+1 cm., w/w. No oedema.

Neurological state: pupils D=S, tendon jerk - normal. No focal symptoms. No shivering. The walk is steady.

Psychologist’s opinion: In general her intellectual and mnestic activity is normal. Loss of stability and attention selectivity is not revealed. The memory state corresponds to a middle age norm. A decrease of generalization, a possibility to accentuate essential differences and impairment in the ability of making simple logic connections is not revealed. The personal mentality component is preserved (no cognitive slippage, philosophizing or many-sidedness revealed).

We revealed a hysteroid type of character accentuation (egoism, an attention-seeking personality, pandering desires and moods, indifference to problems of other people, individualism, overestimated self-esteem and a self-conceit negation of authority, represented nonconformity and imaginativeness).

We point out dissatisfaction with the current situation, expressed with inner discomfort, social integration disorders. One should note intensive work of almost all forms of adaptive processes and a human response to the stress envi-

ronment mainly by more primitive defense mechanisms, preventing the access of conflicting and traumatic information. The highest points were received on such psychological defense mechanisms as “regression”, “compensation”, “suppression” and “negation”.

The rates of trait anxiety are quite high; this is preventing an open presentation of arising aggression signals and leads to the expression of aggression through negation and irritation.

High rates of trait anxiety can be related to the use of a not very adaptive coping strategy (“compensation”), despite the adaptivity of cognitive and emotional coping strategies. In general with temporary and insignificant difficulties such behavior can be considered as adaptive, helping to overcome difficulties successfully, but in the case of long-term and considerable stress situations it can be estimated as de-adaptive, contributing to psychic tension caused by such circumstances.

Substantiation of diagnosis: the diagnosis considers a hereditary load of alcohol abuse by the father and grandfather and mother’s unbalanced character. The patient developed her personality traits from childhood, namely: a combustible character, deceit, the absence of permanent habits, change of behavior depending on external factors, the absence of affection, the absence of friends, the shallow nature of statements. The lack of will is caused by a differential leveling of such components as the control of motives, alternatives and decision making and a decrease of analytic level. The absence of self-consistency, the pursuit of the state of excitement, egocentricity, uncontrolled sexual behavior since she turned 17, the strive for attention, a loss of moral and ethical principles and a well-formed dependence and a well-shaped abstinence syndrome is caused by opioids abuse since she turned 18. On the ground of anamnesis, the patient’s state and psychological opinion, the patient can be diagnosed as follows: the opioids dependence syndrome of personality with histrionic personality disorders. Treatment - full withdrawal from drugs.

Recommendations: a long-term SRC rehabilitation treatment (up to 12 months) for qualitative dynamics of her psychological state.

The following section of the text considers rehabilitation. It is made by a participant of the project training and presented in the final seminar of the project.

According to the Order M3 dated November 22, 2003 No 500 the Healthcare Committee of St. Petersburg Government established numerous rehabilitation centers under the auspices of **Interregional Drug Abuse Clinic No 1**. Five **Drug Rehabilitation Centers (DRC)** provide day patient facility services and cover the drug abusers who could not get comprehensive medical assistance before.

DRC comprises: 1) Department of social and medical rehabilitation for adults (a day patient facility for 25 beds) and 2) Outpatient rehabilitation department (25 people). The main work principle is a team approach, which helps to provide comprehensive assistance to patients: medical (psychiatrist-narcologist, psychotherapeutic, physician, neurologist, nurses), psychologic-psychotherapeutic and social (medical psychologists, social service specialists). The patient undergoes rehabilitation stage by stage with the corresponding objections reached at each stage (adaptation, integration, stabilization).

A semi-closed rehabilitation environment, including a day patient facility, has a number of advantages, namely: the patient can live in his/her usual environment, continue his/her studies or work; apart from that he/she receives complex help from various specialists. This approach raises recovery motivation.

The center mainly works with chemical addiction patients (drug dependence, alcohol addiction, toxicomania, tobacco addiction) however the majority are opium and alcohol addiction patients. Apart from addiction issues the center also covers the problems of personal, interpersonal, family relationship problems; the center provides occupational guidance services, skill refreshment, employment assistance, leisure activities. Rehabilitation can be performed on either a group or individual basis, which makes it possible for the patient to visit the Center at any time. The rehabilitation process also covers the important work with the addicts' relatives (both group and individual). Depending on stage, group rehabilitation events comprise: motivational groups, training analysis, art-therapeutic classes; psychodynamic, existential groups; cinema- and bibliotherapy; occupational therapy.

Rehabilitation work is based on a complex humanistic rehabilitation program, covering the following major concepts: rehabilitation and treatment, the patients' rehabilitation potential, the rehabilitation environment and the rehabilitation field.

Overall goals and missions of rehabilitation

- A complex of pharmacotherapeutic and other events focused on the suppression of morbid attraction to psychoactive substances.
- Communication skills refreshment.
- Assessment of asthenic, affective, behavioral and intellectual-mnestic disorders, caused by psychoactive substances addiction.
- Analysis and estimation of self-destructive behavior.
- Development of stress suppression skills and antidrug attitude.
- Neutralization of drug sub-personality and its general influence on personality, an awareness and development of healthy personality constructional parts
- Development of the patient's responsibility for his/her behavior and healthy life-style.
- Development (or refreshment) of systematical labor and studies skills.
- Stabilization of a professional relationship, revival of positive social contacts.
- Formation and consolidation of a standard system of values and positive moral and ethical motivation.
- Development of a real life perspective.
- Recovery and normalization of the family relationship.
- Development of motivation for participation in rehabilitation programs, strive for living without psychoactive substances addiction.
- Development of purposeful activities and raising standard aspiration and social interests' levels.
- Development of emotional adequacy, skills, helping to differentiate between positive and negative emotions, emphasizing the positive attitude in the resolution of personal or social issues.
- Improvement of the life quality of patients who want to complete the rehabilitation program and avoid a relapse of the disease.
- Psychotherapeutic work with the patient's relatives, to give them more wider education and awareness of medical and social consequences of drug addiction and alcohol abuse, development of psychological support skills and a control of their state in order to avoid a relapse of the disease and overcome the co-dependence syndrome.

Rehabilitation units.
Medical, psychological and social assistance.

I period: pre-rehabilitation; realized on an out-patient basis.
The goal: estimation of subacute disorders, pre-treatment work with patients to prepare them for the rehabilitation programme.
Task:
Diacritical: clinical evaluation of postabstinent, postpsychotic disorders. Physical examination.
Therapeutic: normalization of postabstinent, postpsychotic physical disorders.
Psychotherapeutic and psychological: creating the contact, formation and stabilization of rehabilitation treatment motivation.

II period: rehabilitation
Stages: Adaptation, Integration, Stabilization

Adaptation
Objective: the patient's adaptation to the day hospital conditions.
EXAMINATION
MOTIVATION
COOPERATION
Examination: The patient's examination and clinicopathologic assessment –the initial stage upon the patient's registration in day hospital by psychiatrist-narcologist.
- Blood test (markers of hepatitis B and C, RW, Φ50). Before Φ50 pretest consulting is required, followed by after-test consulting, irrespective of the result. Following further indications there can be made biochemical blood assay, clinical blood analysis etc.
Medicinal treatment (branches): A correction of affective, intellectual-mnestic and behavioral disorders; an anti-relapse treatment; a correction of physical and neurological disorders.
Motivational psychology: a disclosure of psychoactive substances addiction motives; a disclosure of rehabilitation motives and external motivation transfer (relatives' wish, infectious diseases, pecuniary burdens, problems with law etc.) to a supraliminal desire of drugs withdrawal; depreciation of

psychoactive substances addiction; support of the patient during the period of fighting the drug withdrawal syndrome and addiction activation; work with the patient's family members, aimed at establishing an appropriate communication strategy with the addicts.

Integration:
The goal: To work with psychotherapeutic and psychological issues; group and individual psychotherapy (an integration of psychodynamic, cognitive, role-divided psychotherapy approaches, etc.); trainings (communication, personal, existential training**);** art therapy groups (cinema therapy, bibliotherapy, painting); task-oriented groups; a dynamic examination of a medical psychologist; the organization of leisure activities; religion therapy; group and individual mental psychological work with the relatives of drug abusers; work with critical states (the acceptance of HIV diagnosis, counseling on the structure and work of St. Petersburg AIDS service centers).
Social work: assistance in **employment:** cooperation with social offices for drug abusers, expirees "Roko", cooperation with job centers. Counseling on social protection issues, the accuracy of paper work for the registration at job centers; social work in **small groups** and workshops; the **maintenance of contacts with discharged out-patients**, an accumulation of follow-up information; **educational work and the organization of leisure activities** (theaters, library, cinemas, museums, public sport events - skiing, skating) - for instance DRC-4 organized table tennis competitions among the rehabilitation programs participants, entertainment events; **social surveys of patients and their relatives** with the purpose of raising the quality and efficiency of social assistance, involvement of patients in labor and therapeutic activity, labor skill refreshment.

Stabilization:
The goal: the rehabilitation, the correction or formation of standard personal and social features, further life in the family and social environment; an emphasis on the psychosocial aspect; occupation guidance; the provision of employment to patients; the establishment of family relations; the establishment of a standard value system; the correction of physical and neurological disorders; forming an adequate system of important priorities; motivation for requesting the corresponding assistance of HIV and hepatitis patients

Program of individual psychological and social rehabilitation of chemical dependants

The following tasks are to be resolved at all the stages: **drugs withdrawal motivation, the development of long-term psychological and social rehabilitation support motivation; the** perception of the disease (psychological dependence) and its evidence, counseling on the family communication process; psychodiagnosis, career guidance; the encouragement of old and new interests and leisure activities.

The program comprises several main topics of individual meetings: *anosognosia; personality; deconditioning factors and description of emotional response; interpersonal relationships; health; career - guidance and consulting; value system; stress and crisis; time perspective.*

Form of work - individual topical discussions with the medical psychologist and/or social service specialist.

III period: post-rehabilitation *(preventive)*
in outpatient department

Goals:

Diacritical: clinical recognition of the basic disease and intercurrent diseases.
Therapeutic: supporting therapy and physical disorder therapy.
Psychotherapeutic: supporting and correctional therapy.
As a rule at this stage the patient is employed or undergoes treatment according to the individual rehabilitation plan.

Substitution therapy and network infrastructure

The author of the substitution therapy report, Head of Detoxication and Psychiatrical Department, Pekka Tuomola**.**

Substitution therapy

Illegal drug abuse causes numerous social problems, social life is limited to the drug abuser's circle, drug consumption can be followed by criminality, drug traffic, illegal import and prostitution — these are the major ways of getting drugs. We also have to mention the bad sanitary conditions and the use of non-sterile needles and syringes, which can lead to numerous health problems like HIV, hepatitis and tuberculosis.

Earlier the addict treatment was limited to coping with the withdrawal syndrome and further rehabilitation treatment, resulted in full withdrawal from drugs. After the rehabilitation treatment the drug addict gets back to his social life, breaks away from the drug environment, obtains employment, has a possibility to study, opens new social contacts outside the drug addict environment. Unfortunately the overall performance of addicts after the treatment is very bad, particularly of opioid abusers: 90% of former addicts start using drugs after the rehabilitation treatment irrespective of the nature and program.

Substitution therapy is based on the concept that the addict officially takes a medicine replacing heroine (methadone or buprenorphine), which helps him to integrate into society without any substantial consequences of illegal drug use. After the patient gets back to normal life, he studies or works, he has his own apartment, sober friends, the substitution therapy can be terminated. But the duration of the therapy is not the main point: the main point is to prevent the patient from drug consumption. The results of the substitution therapy are higher than these of the traditional treatment.

Methadone is an extremely effective substitutive medicine. It can be taken orally, and if taken properly, it is not somnolescent, there is no risk of intoxication, it does not affect memory, senses and physical sensation. Methadone decreases addiction, a state of euphoria happens only seldom, and it is quite safe from the medical point of view. Methadone is a long-acting substance (duration of action is 24 hours).

Munkkisaari service-center has been practicing Methadone substitutive treatment on an outpatient basis for more than 10 years. There are 62 patients and methadone doses vary from 20-245 mg per day. The illegal use of buprenorphine of methadone patients was fully stopped, the rates of criminality decreased. The patients raised their social status, some of them have their own home (before the treatment they were homeless). Only two patients terminated the treatment, the majority is very satisfied with it.

The treatment is started on an outpatient basis with very small doses 10-20 mg/day. The dose is increased by 5 mg in two days up to 30 mg per day, after which follows a longer period. It should be noted that the methadone treatment therapy has some drawbacks: inexplicable, not dose-dependent fatal cases were reported within the first two weeks of treatment, therefore one should monitor the patients' state very carefully within the first two

weeks of treatment. Methadone dose should be prescribed individually so that the patient has no withdrawal syndrome symptoms and to avoid somnolence. When choosing the dose the withdrawal syndrome symptom intensity rate and the content of methadone in blood is used as auxiliary. If used in a right way methadone is a safe substitutive medicine, it is more effective and cheaper than buprenorphine. On very rare occasions it is used illegally (as a drug). According to Finnish legislation after a strong therapeutic contact the patient can take an 8-day dose of methadone with him/her, and at the beginning of the treatment the patients come to the center every day to take their dose. In **Munkkisaari** the patients regularly get their dose for the weekend if therapeutic relations are appropriate and it causes no further problems (for example, that these doses would be sold to anyone else or would be used in the wrong way).

Methadone treatment is an effective and safe remedy for opiate abusers, whose lives often used to be connected with law violations, prostitution and often followed by serious infectious diseases. The majority of the patients are satisfied with their treatment. **Munkkisaari** supports harm reduction policy aimed at the prevention of law violation and infectious disease. The treatment helps the patients to adapt to normal social life, to increase the quality of life and thus get a chance to start a completely new decent life even in very hard cases.

Network environment

In order to provide reasonable help to the client one should use all resources available, including the social network. The client's problems often concern a number of other people, from relatives to officials.

A network map is often used in works based on network use. Such a map can be used for various purposes, for example it can help to determine the list of people whose assistance can be used to get the corresponding results or people who can take part in social work. Using the card one can have a clear view of support potential and make a list of "negative" people from the point of view of the client. Sometimes it is worth determining a central figure of the nexus, i. e. the person who can act as major support source for the client. Sometimes a person, who acts as a transmitter of information from one person to another, turns out to be the major figure. If the central figure loses his/her support potential or stimulating energy it can be followed

by a personal crisis. Within such a period a social worker can replace this figure on a temporary basis.

Sometimes one can see that there are very few notes on the map. In such circumstances a social worker has to work out another support network together with the client, or think of possible measures to be taken if human relations in the network are unstable or problematic.

The network program presupposes about the meetings with the client:

- presence of the client/family/close friends at the meetings: relatives, friends, neighbors
- the goal is to unify disintegrated methods and assistants
- different persons are present at one time

The below mentioned list explains the network principle from the point of view of the social worker and the client and the situations that need attention.

SOCIAL WORKERS	CLIENTS
A number of problems	Too much of support people
Assignment of work is essential	I should "remain faithful to…"?
Common goals	Whose goals?
Respect	Will I have time for my own life?
Respectful estimation	What to tell and to whom?
Information sharing	Can it break the family?
Agreements	

PERSONALITY – FAMILY - NETWORK

- The assistance provided to an individual is not sufficient, for example drug treatment, personal therapy, crisis therapy etc.
- work with everyone related to this situation; it is needed to reveal the problem and to be concerned about it.
- exchange of opinions and communication of the aforementioned persons
- team-work of separate parts of the system can be unified using personal or family therapy, and the work with the client's relatives.

SPECIALISTS' NETWORK

- common issues of concern, for instance, drug abuse or any other problems
- limits of personal community

- limits of own professional group
- discussions about the quality and scope of the partnership, as well as about different levels of interests towards it
- establishment of a collective plan, conclusion of an agreement

Social network map

Make a map: A map may take a lot of time and efforts. In the beginning you can, for instance, depict people, in the second map you can add the remaining forgotten people and then start to consider the relations. Before drawing, identify the symbols being used (usually a circle means "a female" and triangle means "a male") and explain that the most important figures should remain as close to the patient as possible. Also try to explain that you want to see his/her immediate decision, in the course of time the map can change (state the date!). Do not draw attention to the quality of the picture, just make sure that both of you understand and interpret the drawing in the same way. The map can include dead people or animals, if their personality or image influenced the client. Make additional questions.

First draw a central circle with the name and age. If it seems to be difficult, make your own map (think out anything that you would like to tell about yourself!). The best way is to start from the family and friends. Ask the patient to put your name or symbol also on to the map!

If your map comprises relations, choose symbols, colors or types of lines and put them under the map for reference. See the most common symbols below:

________ = good, permanent relations
(Instead of lines you can use marks + and - !)

----------- = good, distant relations

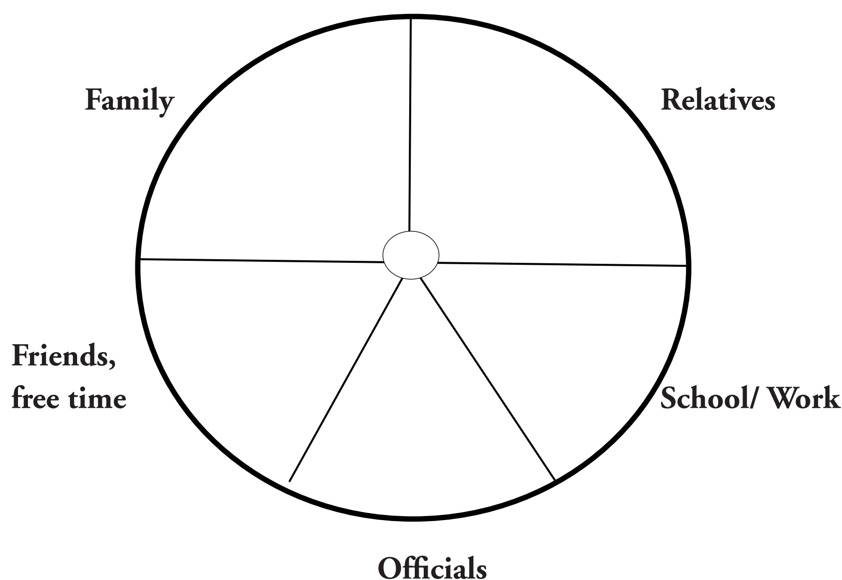
= on-off relationship

= ended relations

= hostile relations

You may use a template (A4 format) or make it yourself. It's up to you if you want to use the separating lines for blocks or not, but you'd better use

the idea of separating. Sometimes the drawing board is quite inspiring, anyway, you should use something that really works.



The below mentioned information covers three reports of network neighborhood workshop participants

1. As a Head of Drug Rehabilitation Center I used to work with the administration of Interregional Drug Abuse Clinic (I was accountable to this institution), with various units of city district administrations (mainly on promotion of our center in the district mass media, organization of lectures and small school conferences touching upon drug abuse prevention issues), with heads of higher education establishments (drug prevention lectures and conferences for students and teachers), with heads of departments and doctors of City Drug Rehabilitation Hospital and district outpatient drug rehabilitation departments (on the questions of referral to treatment), with the social bureau of the city (as some of our patients are in ward of the social bureau), with penalty institutions (if the patients undergo compulsory treatment).

In this regard I can conclude that the city's drug rehabilitation service lacks a unified structure and single work scheme with patients. Thus we

always have to remind hospital doctors and employees of outpatient drug rehabilitation departments that they are to motivate their patients for further rehabilitation in our center (or at least they should provide them with the information required). But actually it does not work, and is not an effective strategy, as during the treatment the doctors just forget to inform the patients about our center.

I do not have such problems with other institutions (however there are still too many time-consuming issues to be discussed, I wish I could use this time for the treatment of my patients).

I am a very sociable person and communicate much with my colleagues and so do they; it helps to resolve these issues somehow.

2. Currently two institutions provide drug rehabilitation services to St. Petersburg citizens: St. Petersburg Addiction Hospital and Interregional Drug Abuse Clinic No 1 (IDC -1). St. Petersburg Addiction Hospital has an in-patient department for 510 beds and 8 district offices for substance abuse patients. IDC -1 comprises 11 out-patient departments, a Day patient facility, 5 Drug Rehabilitation Centers, an Expert department and a Chemical-toxicological laboratory.

When the patient contacts his regional out-patient department and he/she is diagnosed with drug abuse pathology for the first time in his/her life, he/she is automatically registered in this institution after the corresponding HIV infection and hepatitis tests. All St. Petersburg district out-patient departments provide numerous services for their patients: consulting with a psychiatrist-narcologist, psychotherapists, a medical psychologist and social service specialists. In order to undergo a treatment at the department, doctors need the patient's consent for monitoring and examination in compliance with the active legislation. Apart from this the doctors provide supportive counseling services both before and after the examination (called before- and after- examination counseling). In the case of positive hepatitis antigens examination results the patient undergoes further examination, a specification (or clearing of hepatitis suspicion) of the diagnosis and its confirmation by the infection disease specialist domiciliary. After the diagnosis is confirmed the patient is registered according to hepatitis type and gets a personal registration number reported to the department.

If the patient is diagnosed as HIV-positive, he/she undergoes post-test

counseling and afterwards is examined by the specialists of St. Petersburg AIDS Center. In AIDS Center he/she undergoes further examination (with a subsequent confirmation or clearing of HIV suspicion) and HIV-positive diagnosis clarification. After this the disease is registered with its registration number assigned and reported to the department.

The drug rehabilitation patient can undergo comorbidity treatment (HIV infection, hepatitis) either as an outpatient or in hospital (in AIDS Center or Municipal Hospital of infectious Diseases No. 30 named after P.A.Botkin).

But there arise several problems in the abovementioned process, including:

Difficulties related to the type of patients, namely:

- not every drug addict will contact the infection disease doctor domiciliary or AIDS Center in order to complete the examination and confirm the diagnosis, which can be made only by the infection disease doctor;
- still if the patient undergoes complete examination and his/her diagnosis is confirmed, in order to complete the full course of treatment he/she has to focus on the stimulus attitude to the comorbidity treatment course, in other words compliance motivation; at this stage the patient can consult the doctor or medical psychologist, as this type of treatment is physically demanding and not all patients undergo the complete treatment course.

Difficulties related to the communication and co-operation of employees of various institutions (or one institution) in order to handle problems at this or that stage, namely:

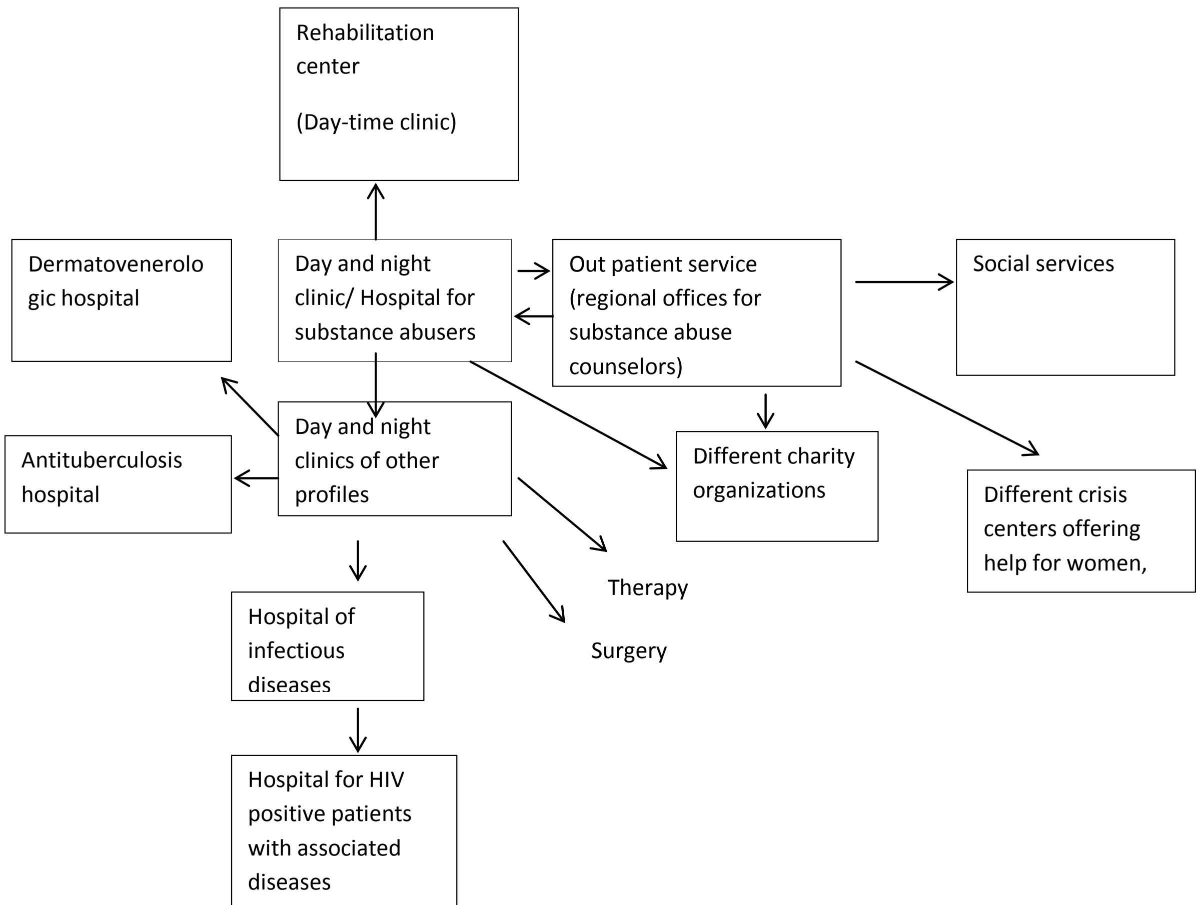
- the medical records are not always provided to doctors after the patient's in-patient hospital treatment course is over.
- narcologists sometimes do not organize patients' appointments with a medical psychologist for further psychological examination and psycho correction, as many narcologists have an additional education background or psychological therapy certificates, so they are entitled to perform this type of examination and psychological therapy course, but anyway they cannot fully replace the medical psychologist. It can be followed by the doctor's emotional burnout on the one hand and by the absence of a review on the patient's problems and possible solutions on the other.

- weak motivation for the rehabilitation treatment course in Drug Rehabilitation Center (outpatient or in-patient treatment).

3. Network cooperation will provide a clear picture of drug rehabilitation hospital communications. Such a form of cooperation can help the patient to use both full medical and social assistance services. The successions scheme of in-patient hospital and outpatient service is followed by good results.

Drawbacks:
Non-acceptance of substance dependence patients, particularly it relates to somatic in-patient clinics.
Competition between commercial and state institutions.

SCHEME OF NETWORK COOPERATION



4 General concepts of finnish drug monitoring system

Interest in the Finnish drug monitoring system was mainly caused by substitution therapy, particularly non-medical therapy and the attention paid to the patient. The doctors were surprised to estimate the role of other professional groups in direct care. Social workers and psychologists were fascinated with the accessibility of treatment and client-oriented approach and also with the calming, homey atmosphere of the medical treatment facilities. They also paid attention to a limited list of drugs used and the importance and relevance of psychological connection. Positive feedback was given to the co-working of various institutions and the conciliatory atmosphere during treatment mainly due to its location in a so-called "rural area".

Estimating the differences between the countries, the attention was drawn to the differences in resources and practical work. In Finland the personnel does not have too many duties and therefore can concentrate on work with patients. To some extent it is explained by the lack of bureaucracy in Finland as compared to Russia, where record-keeping takes too much of time. The level of co-work of various institutions and systems in Finland is on a completely different higher level. The scope of social support is evident; thus in Finland it is possible to extend the therapy treatment period and case management turns out to be more effective. There are more variants for a treatment available and the choice of treatments is mainly based on the client's demands, which can be explained by the freedom of choice of your recovery process and regime. The doctors also distinguish the different attitude to substitution therapy.

It goes without saying that individual efforts aimed at changing the drug rehabilitation system are limited. But the professional community can make considerable changes in certain decrees and legislations. Qualified specialists are ready to use new and efficient treatment methods and principles. The doctors supported the idea of trying non-drug therapy and various

types of social support, including co-work with other professional groups, multi professionalism and a more effective use of social workers' skills. This presupposes a more active participation of the patient's family in direct care and a desire to use network facilities and additional inspiration methods."

Basic and possible skills to be applied in St. Petersburg institutions:

- Change of the record-keeping system (less bureaucracy), with more time for work with the patient.
- Use of breath alcohol testers.
- The knowledge gained will contribute to a more effective teamwork of the Department.
- To increase the number of social workers, to interact more efficiently with municipal social structures (employment services, half-way houses etc.).
- Teamwork. It is worth having a supervisor, a high level specialist, such as Maria Hannula, in order to get the advice required.
- Application of the motivational interview approach in the patient's work.
- Application of "empowerment" philosophy principles, as a key to the patient's identity formation.
- Firstly it is teamwork: narcologist, psychologist, nurse, social worker in different interaction groups.
- Secondly, less of concentration on drug therapy, paying more attention to the psychotherapeutic side, which turns out to be more difficult.
- Thirdly, making the motivational interview to be a part of practice as well.
- Thank you for sharing your experience, for your hospitality and warm atmosphere.
- I fully support your work with patients; in my work I also try to apply cognitive psychological therapy. I would like to take a close look at your working methods.
- Thank you for interesting workshops.
- I will apply the motivating interview method and the teamwork approach.
- A very useful scale 0 ____________ 10.
- Art therapy elements (post cards, pictures, toys).
- How to talk with the unwilling patient.

Finnish drug monitoring system as viewed by the Russians

- We really liked very much the rehabilitation center in Kotka, the A -Clinic Foundation. Is differs from all the rest by its cozy and almost like at **home atmosphere**, a possibility to get all the required assistance during hard times and the necessary help in order to start an individual life. Rehabilitation program does not impose any ready-made ideology, is not based on some religious views or any other philosophy, so it is useful for a bigger community.

- We were surprised to see that the patients **take very few drugs**, there are no serious drugs, which contributes to deep psychological work with patients from the very start of the therapy and motivates their comprehensive approach to the treatment. Another thing is that **social workers** are not secondary employees even in the treatment process.

- We were interested in the concept of rehabilitation centers **for the underage** "Stoppari" and work with teenagers, the effectiveness of withdraw from drugs at the **earliest stage** of dependence is obvious.

- I've totally changed my mind about **substitution therapy**, especially after what I have seen at the Helsinki Deaconess Institute. Before going to Finland I felt negative towards substitution therapy. Once there was held a conference with a certain interview of narcologists on the relevance of substitution therapy in Russia: we all together answered: no, not possible, inhuman. But now, my answer would be "Yes". It was made clear to me that this is an individual treatment method, upon availability of indications for such a treatment with minimal harm to the patient and maximum benefits for the society. I deeply appreciate the efforts and the results of work with HIV positive drug users at the Helsinki Deaconess Institute.

- I am impressed by what I have seen. I was glad to see that the specialists had an opportunity of **ranging** the drug users **according to their personal treatment needs**. I appreciated the clear stage-by-stage treatment process: detoxification centre, detoxification, rehabilitation, presupposing territorial division of facilities. I think that it is wise to locate treatment facilities for teenagers and old-age patients in the countryside. I was surprised by the **important role of paramedical workers** in the treatment process and patients' rehabilitation.

- I was deeply surprised by the facility for the life-long residence of **old-aged patients** with alcohol addiction.

- I was impressed by the fact that drug rehabilitation assistance is available

for all population groups, the workers are very **friendly**, the atmosphere is calm and the interior is quite pleasant. I liked the wonderful facility for elderly people with different addictions, located in a very picturesque place. There is no such institution in Saint Petersburg. I was surprised to see the **family department**; we do not have such services although there are a lot of problematic couples who have underage children.

- The structure of the Multi-profile drug rehabilitation institutions of the A-clinic Foundation was thoroughly introduced to us and I noted comprehensive **interaction between drug rehabilitation institutions**. I was surprised to hear about the HIV infection problem of injection drug users in Finland. Then I was astonished to see the results of **work on HIV harm reduction** among the population, reached due to the use of the organization's appropriate work strategy and enormous efforts and positive motivation of each and every specialist.

- I was surprised by the living conditions of the patients; practically all centers are located on the outskirts in very picturesque places. There are **no window grids** and **no narcologists**, all the work is performed by nurses and social workers.

- I am engaged in rehabilitation treatment and therefore concentrated mainly on its **psychological part** and I asked a number of questions about the techniques on working with patients. I got a lot of information during the seminars about the motivational interview, art therapy (demonstration of work with postcards), and behavior therapy (the example with the Russian girl with alcohol addiction).

Comparison of drug monitoring systems

A patient in Finland has a **number of opportunities for treatment and rehabilitation**. The drug rehabilitation system clearly determines the rights and possibilities of a patient. In Russia such a patient can be admitted to hospital several times, which is quite a big budget expense and is not always rational.

In Finland one can use substitution therapy. This has decreased the rate of HIV infection and the crime rate among drug users.

The Russian rehabilitation system is highly bureaucratic; one doctor and a nurse can have up to 25 patients at once, and one social worker supervises at least 30 patients. This system does not allow enough attention to all patients.

In Finland there is a clear interaction mechanism between law-enforcement, social and medical services.
The differences are:
- availability of "detoxification centers" of drug rehabilitation institutions in Finland.
- work with "drunk drivers" is carried out after such cases are revealed and in our service we have preventive work included in the process of medical examinations.
- In Finland there is a **wider infrastructure of family treatment services** with specialized multi-profile institutions; in our country the family work is performed on an outpatient basis.
- In Finland the patients can be treated by a **number of multi-profile specialists**, in our system one doctor is responsible for the outcome of the treatment.
- In Russia the strategy of giving clean equipment is not developed enough. There is also no substitution therapy.

One big difference between the Finnish and Russian drug rehabilitation systems is that in Finland there are no "records" of drug users, which in my opinion provides an opportunity for any person to get **medical aid without restrictions.** Another difference is the major role of **medicated treatment in Russia**. Our patients think that the more injections they receive, the better they are treated, and this is why they prefer to stay in the hospital. Perhaps this is mostly predetermined by the patients' types. The majority of patients are heroin addicts with 6 (or more) years of dependence and a high daily heroin dose, with complicated comorbidity (on average every patient has at least 2 somatic diagnoses), and therefore they need the medicated aid to feel better. Sometimes their life is already in danger.

As far as I understood, the Finnish rehabilitation systems is strongly based on **psychotherapeutic aid** and well-developed **social aid** as a contrast to our services. One of the major differences is the introduction of **substitution therapy**, which makes it possible to provide medical aid to drug addicts with long-term addiction and HIV infection. Russian narcologists can only dream about substitution therapy while giving recommendations to patients with 20 years of addiction, HIV infection, etc.

There is a big difference in our rehabilitation service systems, first of all

it relates to the material and working conditions for both the personnel and patients. The doctors and nurses have to spend much time **keeping case-records** and various documents instead of working with the patients. We cannot use substitution therapy, and this causes troubles as a big part of the patients with ten years of heroin addiction cannot go through the rehabilitation program, they break the treatment and go back to hospital 10-15 times per year.

Being a social worker I see the difference between the Russian and Finnish rehabilitation systems on the level of **interaction between various drugs-related institutions**. In Finland a patient has a doctor and the **schedule** of his treatment, the rehabilitation and adaptation is carefully considered and monitored. Here several people may be responsible for the patient's treatment without any clear system, although similar tasks can also be resolved with common efforts. In Finland psychoactive substance abusers can use **a wider range of social support services**: (Stoppers for the underage, detoxification centers, senior centers for addicts, rehabilitation centers with residence places, social apartments with supervision, detoxification clinics for HIV positive patients), and the majority of addicts really need this kind of support. For example, we could see that in such rehabilitation infrastructure in Finland, the work is evidently effective not only for drug addicts but for the rest of the population as well.

The major difference is the non-availability of substitution therapy in Russian rehabilitation systems and the **number of employees**, monitoring the state of one patient. In Russia 2-3 nurses can work 24 hours a day with 50 patients and in Finland 3 nurses work 12 hours with 10-18 patients.

I was astonished by the difference in the **amount of medical record-keeping system** and the amount of patients and personnel at the department. If we talk about the approach to rehabilitation in a therapeutic community, for example my institution concentrates on self-analysis, psychological self-help and to a bit lesser extent on social issues. In our system the patient has more activities during the day, written tasks, the leisure activities are not very diverse, there are too many rules and a well-developed system of sanctions and awards, less occupational therapy). It seems to me that the rehabilitation system in Finland is mainly based **on resolving social issues**.

5 Conclusion

Looking through the project we can see that we managed to reach our main targets. Three groups of Russian specialists (narcologists, psychologists, nurses and volunteers) had the change not only to get to know the principles of the support given to substance addicted patients in Finland, but also to take part in the trainings, to discuss professional questions and challenges with foreign colleagues and to try to formulate own opinions of the substance addiction care situation in Russia and measures for optimizing it. As many of the participants noted, the most interesting part of the project was visiting substance abuse centers in Finland. Our specialists got the chance to see the detoxification center, the rehabilitation center for young people called "Stoppari", the center for elderly people with psychedelic drug problems, the Support center for HIV positive drug addicts and also the Social Hospital of Järvenpää city. Each of these centers was really interesting to the Russian colleagues. The openness of the Finnish specialists, who were trying to tell about their work in detail, left an indelible mark among the Russian specialists. Special attention was given to conversations with the clients of these centers, which gave the possibility to evaluate the results of already held treatments and to compare different approaches to the treatment of patients with difficult addictions. It is known that in the Russian Federation it is illegal to treat drug addicts with the methods of substitution treatment. This is why it was so useful for our specialists to visit such substance abuse centers where these methods are widely and successfully used.

In reality, using the method of substitution treatment has led to a situation where there are significantly less HIV positive drug addiction patients in Finland than in Russia. Besides this, with the help of substitution treatment the patient can more effectively take part in the rehabilitation, keep his social status and in a longer period of time stay committed to the therapeutic program.

One very important detail that received our specialists' full attention was

the usage of multi professional teamwork, where each member, besides their own responsibilities, shared their effort with the other specialists in the group. It makes sense that there is a group from different specialists approaching the problem, as the reasons for the origins and for the development of the addiction problems are also multi complex.

And as a last thing, we would like to remember about the trainings of the motivational interviewing and the acquisition of experience in working with the changes. The motivation is one of the most important aspects in working with substance abusers. Working with the patients that are moving from one stage of motivation to another, building up their stable motivation to stay away from any drugs and at the same time cumulating positive changes in the social life of the patient, is the task for all specialists helping substance abusers.

When summarizing all the things mentioned above, it is evident to us all how useful this project has been to us. This is the general opinion of the participants, which was said aloud not only once already during the seminar and after it, when all the experience and new knowledge turned out to be useful in everyday work practices.

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