



# Mental Health Systems in the Newly Independent States: A Historical View

BY ZOYA SHABAROVA

For many years, psychiatric care in the countries of the former Soviet Union was wrapped in a mantle of isolation. More than any other medical specialty, psychiatry was strongly affected by a society isolated from the rest of the world by the proverbial “iron curtain.” There were no public discussions of mental health issues; people avoided consulting psychiatrists and, if applicable, tried their best to hide the very fact that they had been treated in a mental hospital. Psychiatrists worked in psychoneurological facilities that were also isolated. A journalist or foreign expert was an extremely rare visitor, and ordinary citizens only visited such an institution when trying to obtain a certificate proving they were not on file with a psychiatrist, the most common reason being to obtain a driver’s license. As a rule, people did everything possible to avoid contact with psychiatrists. The reason for this lies in the mental health system of the former Soviet Union.

Asked about the current state of psychiatric care in Ukraine, Semyon Gluzman, executive secretary of the Psychiatrists Association of Ukraine, justifiably stated, “This is still the psychiatry of a nonexistent state. The USSR has been defunct for years, but we still live by its dogmas, and this is a sad paradox.” No doubt, the mental health system has been slowly transforming, and has undergone significant changes for the better (see “The Path to Mental Healthcare Reform in the NIS,” page 43). However, to understand the current situation and the major reforms in mental health in the NIS, we must first consider the mental health system that existed in the former Soviet Union, the major elements of which still form the basis of psychiatric care in the NIS.

## The Traditional Soviet Approach to Mental Health

According to the Soviet Comprehensive Medical Encyclopedia, “psychiatric care . . . includes the prevention of mental illness and comprehensive treatment of the mentally ill.” Accordingly, the mental health system comprised of preventive, diagnostic, and therapeutic components. The diagnostic and therapeutic components of this system were provided at inpatient and outpatient medical institutions. Outpatient psychiatric care was

provided by psychiatrists and nurses in psychoneurological and drug rehabilitation dispensaries (outpatient facilities), psychiatric and drug consulting offices at polyclinics, and medical-sanitary units at workplaces. Inpatient psychiatric care was provided through a network of mental hospitals and mental wards of hospitals. Specialized mental boarding houses maintained by the Ministry of Social Security were set up for those with chronic mental illnesses. People who had broken the law and been ruled incompetent were generally involuntarily committed to locked mental hospitals, which were overseen by the Ministry of Internal Affairs. Psychiatric care for children was provided in special pediatric wards of mental hospitals, and children could also get outpatient care through psychoneurological clinics. Obviously, psychiatric care was strictly specialized, being provided only by psychiatrists on an inpatient or outpatient basis through specialized psychiatric institutions.

### Admission Standards

Because psychiatric dispensaries and mental hospitals provided care to the residents of an assigned district or territory, theoretically a patient could come and consult the district psychiatrist of his or her psychoneurological dispensary and get outpatient care or be referred for admission to an inpatient facility. However, it was rare for people themselves to ask a psychiatrist for help, partly because of the inherent nature of the disease and the person’s uncritical attitude toward his condition, and partly because they feared the social repercussions a request for psychiatric help might generate and the possibility of involuntary treatment. In practice, most often a patient was brought to a doctor by his or her family or by an ambulance.

In the former Soviet Union, the concept of “emergency admission” was defined rather broadly. If a person committed acts “dangerous to society” or to the self, he or she could land in a mental hospital without familial consent, with no easy way out. The requirements for emergency admission were rather vague, inviting abuse of psychiatry for various ends, including political ones. Naturally, there was no legal protection or patients’ rights, and the fear of commitment to a mental hospital was quite justified. The decision to commit was made by a psychiatrist, and had to be approved within 24 hours by a committee of the hospital’s doctors. Having worked for some five years as a psychologist in a mental hospital in Kiev in the late 1980s, I remember how stunned I was in the summer of 1995 when I saw a special court hearing room in the psychiatric ward at Bellevue Hospital in New York where patients could present their cases.

The requirements for emergency admission in Ukraine have now been significantly narrowed. Patients have gained the right



Kiev's Psychiatric Hospital #2.

to legal protection, allowing them to contest emergency admission, and the decision itself must be made by a court. This has been very helpful in reducing fear of psychiatrists and increasing the chances of people voluntarily seeking psychiatric help. Psychiatrists in the NIS are now actively involved in developing and improving psychiatric care laws to clarify the objectives of mental health services and the patients' rights and, in some countries, supervision of locked mental hospitals is now the responsibility of the Ministry of Health.

#### Patient Records

In the former Soviet Union, special records concerning mental patients were kept at the psychoneurological dispensaries, which had to maintain complete lists of mentally ill patients residing in their territories. When someone sought psychiatric help, he or she was listed with the psychoneurological dispensary, and it was very hard to get off this list. Even borderline patients were listed with psychiatric dispensaries for many years and, in cases of schizophrenia, it was practically impossible to get off the list. The social repercussions of these records were bad for a patient and imposed considerable restrictions on his or her life such as certain job limitations and obtaining a driver's license. Very often these limitations were not fully justified. All this created a natural fear of psychiatry.

#### Diagnostic and Treatment Approaches

It should be mentioned that the approaches to the diagnosis and treatment of mental illness practiced in the former Soviet Union differed from Western traditions. As Dr. Gluzman observes, "what we mean by schizophrenia here is something very different [than in the West], and treatment here very often consisted of the administration of unjustifiably high doses of neuroleptic drugs."

The psychoneurological dispensaries set up in the 1930s were intended to fulfill preventive and rehabilitative activities in addition to their primary diagnostic and therapeutic function. However, as Dr. Gluzman explains, "the key to solving all the problems of psychiatry was thought to be the treatment of mental disorders, [and thus] Soviet psychiatry only focused on biological causes." Working toward the prevention of mental illness was rather difficult, again due to the isolation of psychiatric care and the public fear of "the almighty psychiatry." For example, publicizing the fact that depression is one of the five most widespread diseases and does not necessarily imply irreversible mental illness could have enabled many people to seek help, but this information was practically inaccessible to the public, relegating mental institutions to secondary prevention and rehabilitation roles.

Rehabilitation included labor therapy and psychotherapy. Mental hospitals and clinics had workshops where patients learned skills enabling them to perform simple jobs, but the availability of professional psychotherapy was limited, given the detachment of psychology in the former Soviet Union from contemporary world trends and its prolonged development within the framework of a materialistically defined ideology. Furthermore, an infrastructure for the development of social services was nonexistent and so the patient and his or her family were left to struggle alone with all the complex problems accompanying the life of a person suffering from mental illness. Only a psychiatrist could sympathize or help with a kind word.

During the AIHA mental health task force study tour last year, Irina Tikholaz, a psychologist at the Ukrainian Psycho-Diagnostic Center, remarked that "the US mental health system is remarkable for the number of people who help a



Women's ward room at Psychiatric Hospital #2.



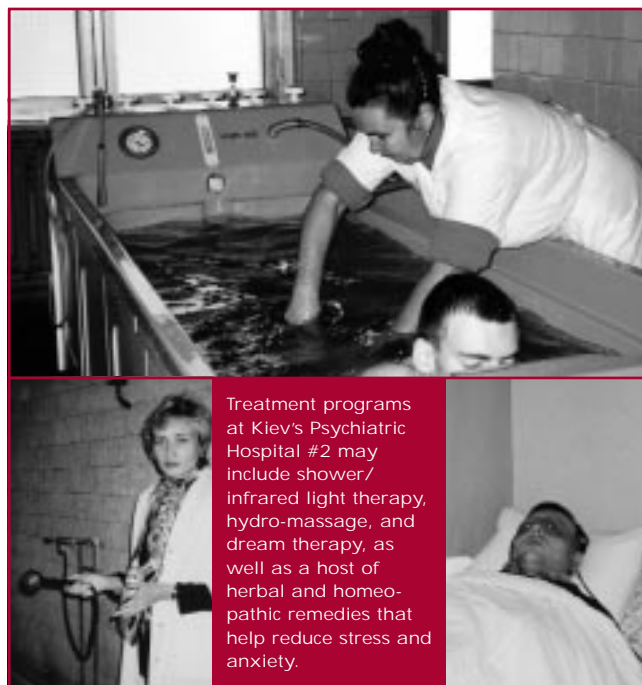
patient in the course of their official duties. Besides the psychiatrist and nurses, there are also family doctors, social workers, psychologists, psychotherapists, and lawyers, as well as numerous support groups for both patients and their families.” For example, when the group toured the Crozer-Chester Medical Center outside Philadelphia, Pennsylvania, participants visited a geropsychiatric department. The experts involved in the geropsychiatric care program included a social worker, a nurse, a primary care physician, a neurologist, a neuropsychologist, consultants, a psychiatrist, and an occupational therapist. In the opinion of Susan K. Ball, director of geriatric psychiatry at the center, this multidisciplinary approach is a necessary condition for providing effective care to the mentally ill elderly.

In the former Soviet Union, the image of psychiatric care at the level of ordinary consciousness often involved a team of muscular keepers who put straitjackets on the patients. Any mental problems were considered a cause for shame. Programs for early prevention of mental disorders were understandably lacking, which significantly hampered mental illness prevention and the provision of care at its early stages. In contrast, the broad public campaigns implemented by former US First Lady Betty Ford and by the vice president’s wife, Tipper Gore, have drawn attention to the problems of alcoholism and depression, which has helped American society overcome the social stigma surrounding mental illness and greatly facilitated its prevention.

What struck many members of the study tour was that the US mental health system functions like the outpatient part of its physical healthcare system and is distinguished by few hospital beds. The system operates in close collaboration with the patient and his or her family, as well as with local community and public organizations.

### Looking Toward the Future

The foremost objectives for the NIS in terms of improving mental health prevention programs are to organize the social worker training system and place social workers on the payroll of psychiatric institutions; to use the mass media to reshape society’s attitudes toward the problems of the mentally ill; to aid the formation of support groups among mental patients and substance abusers; and to develop educational programs for primary care doctors and nurses so they can recognize mental pathology. The first steps in this direction have already been taken in many NIS countries. For instance, within the framework of AIHA’s Kiev/Philadelphia partnership, the partners are developing a model to provide mental health services



Treatment programs at Kiev’s Psychiatric Hospital #2 may include shower/ infrared light therapy, hydro-massage, and dream therapy, as well as a host of herbal and homeopathic remedies that help reduce stress and anxiety.

Photos: Kathryn Ulan.

at the community primary healthcare level (see “Integrating Mental Health Into the Primary Care Model,” page 15). In this model, the family doctor will work together with a psychologist and a social worker on primary mental health issues, bringing psychiatric care significantly closer to the patient and providing the required care at the early stages of mental illness.

In another example, the Dubna/La Crosse partnership has developed and introduced an effective program to prevent alcoholism and drug addiction among teenagers and young adults in Dubna, Russia (see “Reaching Out to Russia’s Youth,” *CommonHealth*, Fall 1999, page 22). According to Olga Vasyutina, chief physician of the Rebirth drug treatment center in Dubna, this program has been successfully implemented in several cities—Dmitrov, Taldom, Zaprudnya, and Klin—north of Moscow. The program actively involves various state and public organizations and encourages schoolchildren to take initiative through a “peer-to-peer” program.

According to a recent study by WHO and the World Bank, mental disorders account for forty percent of disability cases after the age of five. But these figures do not reflect the extreme, endless, and incessant pain and suffering that mental illness brings to the lives of the patient and his or her family. It is obvious that the improvement of the mental health system is a mandatory prerequisite for improvement of public health in general and for the humanization of medicine in particular.

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