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# Practices and Attitudes of Addiction Treatment Providers in the Russian Federation

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## Abstract

The study presented here, the first to collect and analyze data from Russian treatment providers themselves, was undertaken to describe the practices, knowledge, attitudes, and beliefs of working addiction treatment specialists in 10 Russian regions. Open-ended interviews were conducted with drug user treatment service providers (N = 40) in Krasnoyarsk, Moscow Region, Pskov, Saint-Petersburg, Volgograd, Bryansk, Chelyabinsk, Magnitogorsk, Novgorod, and Orenburg in 2008. Treatment practice universally consists of in-patient detoxification and sometimes is supplemented by in-patient or outpatient rehabilitation. Nevertheless, most specialists were skeptical about these practices, which were held to be unsuccessful 95% of the time. They were more accepting of psychotherapy, rehabilitative therapeutic communities (including religious), and use of opioid antagonists even though these methods are not widely enough available in Russia. Treatment providers were generally dismissive of internationally recognized and evidence-based methods of addiction treatment, most especially when it comes to substitution therapy for opioid addiction.

**Keywords:** Russia; Drug treatment; Drug treatment providers; Opioid addiction; Opioid substitution therapy; HIV

**Abbreviations:** OST: Opioid Substitution Therapy; ARV: Antiretroviral Therapy; MLD: Methamphetamine-Like Drugs

## Introduction

Drug abuse, drug injection, and addiction in the Russian Federation have reached epidemic proportions and have spawned a syndemic – a set of parallel, interrelated epidemics – of infectious diseases and non-infectious problems including a growing prison population and fatal drug overdoses. The drugs most common associated with the syndemic are heroin and, to a lesser extent, the methamphetamine-like drugs (MLD). Over the past 15 years, heroin use rose precipitously in the middle years of the 1990's [1, 2] and heroin remains the major drug of abuse, with the vast majority of administrations by injection [3-7]. By the end of 2008 there were nearly 400,000 registered injection drug users in Russia, with estimates for the total of opioid injectors as high as 2.5 million for that year [8].

Users of heroin and MLD in Russia may seek treatment in the state-run narcological system, which operates hospitals, dispensaries (medical facilities with a mix of in-patient and out-patient services), and clinics, that constitutes the only legal addiction treatment system. In 2005 the Russian narcological system consisted of 191 dispensaries, 1989 addiction treatment rooms in local outpatient clinics and 80 drug rehabilitation clinics [9].

Previous studies of addiction treatment in Russia that have appeared in the scientific literature have focused on the experiences and attitudes of those seeking treatment [10,11]. Reports are available detailing Russian law on drugs and the narcology system and the abuse of human rights produced by that system [12,13]. These papers and reports have concluded that narcology as currently practiced in Russia is stigmatizing, generally unsuccessful, and shunned by prospective patients. They also point out the difficulty in providing treatment for heroin addiction in a country where the use of substitution therapy remains illegal. The study presented here is the first that describes from the narcologists' perspective their practices, knowledge, attitudes, and beliefs. It complements an earlier, broader study in which narcologists described their attitudes towards drug users and discussed the moral issues of drug treatment [14].

## Methods

### Participants

Data were collected in January and February 2008. A purposive sample method was used to identify potential respondents. A total of 40 respondents were recruited through local drug user treatment services in 10 cities or regions (Figure 1). In each of 5 regions -- Krasnoyarsk, Moscow Region, Pskov, St. Petersburg, and Volgograd -- the chief narcologist and 6 junior narcologists, recommended by the chief narcologist based on their experience treating opioid addiction and their availability were contacted in person. In these regions, the number of those interviewed made up approximately 20% of all narcologists employed. In Bryansk, Chelyabinsk, Magnitogorsk, Novgorod, and Orenburg only the chief narcologist was contacted by phone. The aims of the study were explained to them, and they were asked whether they would like to participate in the study. Oral consent was received from all those approached. After the interview, participants received a financial incentive. Because the interviews concerned official activities of the study participants, the study was exempt from IRB review.

### Interviews

Interviews lasting on average 60 to 90 minutes were conducted in Russian by a trained interviewer and were tape-recorded. Most interviews (35 of 40) were conducted at respondent's working place; the remainder was conducted by phone. A semi-structured instrument specifically developed for this study included open-ended items that

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**Received** January 29, 2011; **Accepted** March 08, 2011; **Published** March 09, 2011

**Citation:** Torban MN, Heimer R, Ilyuk RD, Krupitsky EM (2011) Practices and Attitudes of Addiction Treatment Providers in the Russian Federation. J Addict Res Ther 2:104. doi:10.4172/2155-6105.1000104

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**Figure 1:** Interviews were conducted with narcologists in ten Russian cities -- 1: Krasnoyarsk; 2: Chelyabinsk; 3: Magnitogorsk; 4: Orenburg; 5: Volgograd; 6: Moscow; 7: Bryansk; 8: St. Petersburg; 9: Novgorod; 10: Pskov.

assessed participant's official status, methods and conditions of drug treatment, availability and barriers for treatment, standards and guidelines used in everyday work, connections with private addiction treatment and rehabilitation clinics, other services addressing drug users' needs, and the respondent's personal attitudes towards drug treatment practices and institutions.

### Data analysis

All responses were typed verbatim into Word files, coded thematically by 2 Russian team members using inductive techniques [15]. Then coded information has been entered into Access database and exported to SPSS version 12.0 for analysis.

## Results

### Patients of Russian drug treatment system

Individuals who seek treatment for drug abuse and addiction through available government-funded programs are officially registered. In 2007, the proportion of the population officially registered countrywide was 274 per 100,000. In the area our study covered, the proportion ranged from a low of 160 per 100,000 in Krasnoyarsk to a high of 430 in Chelyabinsk. Estimates from the narcologists for the actual number of drug users in and out care were 380 for Krasnoyarsk, 920 for Saint-Petersburg, 1040 for Moscow, 2680 for Chelyabinsk, and 4660 for Magnitogorsk. These estimates were generally about 4 times higher than the official data on registered users. Additionally, the narcologists reported a higher estimate for the incidence of drug use in their local populations -- about 5,5% a year -- than official data for Russia (2,2% in 2005) [16].

Studies of drug users in Russia have reported that the vast majority use and inject heroin and, to a lesser extent, other opioids, and that a substantial minority use and inject methamphetamine-type stimulants [6, 17, 18]. Drug users seeking treatment, however, are overwhelmingly (99.4%) opioid abusers. According to UNODC data drawn from treatment statistics, amphetamine misuse prevalence is 0,1-0,3% of Russian population [19], but our data revealed that most stimulant users are not included in drug treatment (only 0,6% of patients on drug treatment are treated for stimulant dependence). Instead, up to 25% of patients in treatment for heroin addiction also abused alcohol.

### Treatment requirements and methods

First and foremost, treatment through official channels is available in each region only to registered residents, who may expect to receive some level of free treatment. In order to receive treatment a patient must present his/her identity document demonstrating local registration. Individuals not registered must pay for treatment. Because the quality of treatment is different across regions and patients are not able to go to the clinic they think is effective if it is situated in different region or city. They remain "chained" to their local clinic.

"Our patients can get treatment free of charge only if they are local residents...that's because drug treatment is funded by local funds, not by federal funds or insurance...that's why. So, if patient wants to receive treatment in Moscow or in other region or anonymous treatment- then he should pay" - narcologist, Moscow Region.

In many regions, there are additional hurdles to those seeking treatment. In 40% of participated regions additional medical tests including and X-ray fluorogram and an HIV test result are needed. In such cases, patients must visit other clinics for tests and often they must pay for them and wait for results. In clinics where patients are not obliged to be tested for HIV prior to treatment, they will be tested upon entry, when blood samples will be drawn and sent to local AIDS center for testing.

"To get free treatment we need passport, syphilis test, HIV test, X-ray fluorogram; to get commercial treatment we need X-ray fluorogram." - narcologist, Krasnoyarsk

The other important factor limiting access to treatment is its cost. Even if the care component of treatment is officially free, patients can be required to pay for medications beyond the minimum needed to complete detoxification. For individuals seeking care outside their region or anonymously within their region, they must pay for their care. In our survey, the proportion of patients seeking anonymous care ranged from 2.3% in Novgorod to 68.6% in Volgograd (SD = 14.4). On average across the regions, 1 day of paid treatment cost 1,600 rubles (about US\$53). In 4 of the 9 regions covered in our survey, patients pay simply for anonymity without receiving any additional services or better treatment. Therefore, the usual treatment -- 1 week of detoxification --

will cost, on average, 11,200 rubles (about US\$373) for the patient or his/her family, not an inconsequential sum in a country with a median per capita income of \$7,059.

“We usually ask our patients to buy extra medicines and bring it to us... if they or their relatives can afford...the official minimum we provide for free is not enough” – narcologist, St. Petersburg

The predominant form of drug treatment reported in our survey was in-patient detoxification, which is the mandatory first step in abstinence-based care practiced throughout Russia. Patients at all participating dispensaries always receive detoxification treatment (from 3 to 15 days, depending on dispensary) in the outset of their treatment course. Detoxification, as practiced in Russia, is a complex of anti-withdrawal measures patients receive in first days of opioid abstinence (Table 1). It may be divided into 2 parts: first 2-3 days when massive infusion and analgesic therapy take place followed by “recovery” period without infusions and with psychotropic medications as a method of “craving suppression” and “psychological normalization”. Treatment standards beyond initial detoxification are not evidence-based [20]. These were issued in 1998 and have not updated since then. In most points, these standards contradict Western standards and guidelines such as British NICE Clinical Guidelines (2008) or U.S. guidelines from NIDA. One of the contradictions of critical importance is that Western guidelines recommend against the use neuroleptics, anticonvulsants and sedatives during detoxification [21] whereas this is recommended in the Russian standards. As a result, this practice is widespread in Russia, and in every participating clinic most of patients receive these classes of medication. However, in some instances the standards may not be rigidly followed; more than half of participating narcologists reported that they either adhere to standards intermittently or follow their own perceptions of good practices.

“Of course they are overloaded with medicines...1000 mg of Phenazepam, standard doses of Tiapridal, Tramal...all prescribed simultaneously” - narcologist, St. Petersburg

“If a patient knows that he will be treated using powerful psychotropic medication – “boiling my brains” as they say-it’s bad, patient will not come to us...” - narcologist, Moscow Region

The other major difference is the illegality of substitution therapy in Russia. This is despite the fact that research on substitution has consistently shown it to be the most effective method of opioid addiction treatment, that the substitution therapeutics methadone and buprenorphine are on the WHO list of essential medicines for treating diseases worldwide, and that WHO, UNODC and UNAIDS hold that substitution therapy is effective in both treating addiction and preventing HIV” [22]. Some Russian narcologists still use so-called “coding”, a placebo treatment that is based on patient’s belief that some medicine (or “code”) has been injected or implanted in his body by doctor and that its interaction with the drug of abuse will cause a harmful or fatal effect [23]. It is widely used for alcohol dependence treatment [24]. However, it has been used much less frequently for treatment of heroin addiction: only 16% of narcologists reported use of this method in their practices. This method of “treatment” has no scientific basis and it is not recommended either in Russian or Western standards and guidelines.

“Opioid substitution therapy? The only reason to use it is if you want drug user to die as soon as possible. I really doubt it will be legalized in Russia... because in that case the destiny of Russia will be not only wide-spread alcohol abuse as now, but also an epidemic drug abuse because it’s easier to start living high on a welfare money...” - narcologist, Krasnoyarsk.

Method or group of medicines	Description	Region(s) where method or group of medicines are in use	Use in international practice
Ultra rapid opioid detoxification	Patient under general anesthesia receives high dose of opioid antagonists (naloxone 10-12.5 mg. or naltrexone 150-200 mg.) in the first hour of procedure. The peak of withdrawal syndrome occurs under the anesthetic effect.	Moscow region, Chelyabinsk, Magnitogorsk.	Not recommended, considered unsafe.
Clofeline detoxification	Patient receives alpha-adrenoreceptor agonist Clofeline to decrease intensity of the withdrawal syndrome. The daily dose depends on severity of withdrawal symptoms and varies from 0.45 to 1.5 mg.	St. Petersburg, Krasnoyarsk, Bryansk, Novgorod, Chelyabinsk, Magnitogorsk	Not recommended for wide use.
Method or group of medicines	Description	Region(s) where method or group of medicines are in use	Use in international practice
Neuroleptics (Chlorprothixene, Thioridazine, Periciazine, Sulpiride, Haloperidol, Chlorpromazine, Trifluoperazine).	Neuroleptics are used to decrease “pathological craving”, seen as mental disorder. Dosage depends on medicine used and symptom severity. The treatment begins at day two or three of detoxification treatment and ends at the end of treatment.	In use in all participated regions. 53.1% of narcologists widely use neuroleptics for detoxification treatment.	Not recommended.
Opioid analgesics (Tramadol).	Weak opioid agonists are used for treatment of withdrawal syndrome. Usual daily dosage is 0.4 g. Treatment begins at the first day of inpatient detoxification.	In use in all participated regions. 88.3% of narcologists use opioid analgesics for detoxification treatment.	Recommended.
Method or group of medicines	Description	Region(s) where method or group of medicines are in use	Use in international practice
Nonopioid analgesics (acetylsalicylic acid, Metamizole sodium, Paracetamol (acetaminophen), Indomethacin).	Non-opioid analgesics are used as nonspecific painkillers. Dosage depends on prescribed medicine and severity of symptoms. Treatment begins at the first day of detoxification.	In use in all participated regions. 90.9% of narcologists use non-opioid analgesics for detoxification treatment.	Recommended.
Anticonvulsants (Carbamazepine).	Anticonvulsants are used as a treatment for “pathological craving” as normothymics. Usual dosage of Carbamazepine is 600 mg. a day. Treatment begins at day two or three of detoxification.	In use in all participated regions. 63.6% of narcologists use Carbamazepine for detoxification treatment.	Not recommended (effectiveness is not proven).
Method or group of medicines	Description	Region(s) where method or group of medicines are in use	Use in international practice
Sedatives (Diazepam, Nitrazepam, Oxazepam, Phenazepam)	Sedatives are used as tranquilizers. Dosage depends on medicine. Treatment begins at the first day of detoxification.	In use in all participated regions. 95.2% of narcologists use sedatives in detoxification treatment.	Not recommended (effectiveness is not proven).

Table 1: Methods of detoxification and medicines used for detoxification treatment in the Russian Federation.

Treatment method	Average Rating <sup>a</sup>	% of specialists rated given method as effective or somewhat effective.
Psychotherapy	4.5	92.1
Detoxification	4.3	84.6
Post-detoxification rehabilitation treatment	4.3	83.3
Religious treatment	4.2	91.9
Opioid antagonist treatment	4.2	87.2
Therapeutic societies	4.03	78.1
12 steps method	3.9	72.2
Placebo treatment	3.2	37.1
Coding treatment	2.5	14.3
Treatment method	Average Rating*	% of specialists rated given method as effective or somewhat effective.
"25-th frame"	2.4	19.2
Plasmopheresis	1.8	40.5
Substitution therapy	1.5	27.8

<sup>a</sup>Narcologists were asked to rate the method on a scale of 1 to 5 where 1 is "does more harm than good", 2 is "not effective", 3 is "a little effective", 4 is "somewhat effective", and 5 is "effective"

**Table 2:** Relative effectiveness of treatment methods as rated by narcologists.

"There are patients who want to be coded...and relatives are ready to pay for absolutely everything...then we do 3 to 5 sessions of coding."  
- narcologist, St. Petersburg.

"12 steps approach - I support it. Put people (patients and their relatives) don't want it. They want a pill- a magic universal pill that treats everything in a second." - narcologist, Pskov

Post-detoxification rehabilitation treatment exists in all participating clinics except in Bryansk. In all participating rehabilitation clinics patients can receive psychotherapy in an in-patient setting in groups or individually. Only in Saint-Petersburg and Podolsk, in the Moscow region is the care sufficiently prolonged such that, according to international guidelines, it is likely to be effective [25]. In these 2 locations (as well as in Krasnoyarsk), rehabilitation applies a 12-steps approach. Elsewhere rehabilitation clinics provide only short-term, uncoordinated, and inconsistent care that is ineffective, and due to insufficient therapists, poor patient motivation, and lack of a clear therapy plan, rehabilitation in these locations has little or no effect in increasing post-detoxification abstinence. In Pskov, Chelyabinsk, Magnitogorsk and Orenburg clinics provide "out-patient rehabilitation" that is a mixture of individual rational psychotherapy, psychotropic medication and, sometimes, opioid antagonists after being discharged from in-patient detoxification treatment.

"I believe that new methods with proved effectiveness should be used...because we don't really treat, don't really help them...an effective treatment is impossible without effective rehabilitation." - narcologist, Karsnoyarsk

"No, we don't have a rehabilitation center...there are some religious ones around, but no "medical" one...I don't know if we need a rehabilitation center. I think that what we need is not to start a rehab but we should change the legislation. Yes, change the legislation. Ban the anonymous treatment." - narcologist, Volgograd

The narcologists we interviewed reported that only 5% of patients who enter detoxification the treatment complete their rehabilitation regimen. Narcologists believe that much of the high failure rate can be attributed to lack of communication between patient and physician. In general, patients and their doctors do not at admission discuss perspectives, length and methods of treatment out-patient specialists don't discuss patients' desires and possibilities of future rehabilitation. Often, doctors mechanically pass patients to each other without any intent to learn the patients' attitudes. At the initiation of detoxification patients receive no consulting or motivational psychotherapy. At discharge from the detoxification clinic patients receive only a brief and formal consultation with the narcologist. The registration of the patient as a drug users does not presuppose any support for patient beyond the chance to return detoxification treatment if the patient relapses. So it

is not surprising that many patients seek to leave treatment as soon as possible and are generally disappointed with it [26,27].

"No, we don't have a discharge conversation with a patient...what do we do? We give them brochures about HIV..." - narcologist, Moscow Region.

Some narcologists try to use the drug user's family as an instrument for control, but no family therapy or consulting services exist in the dispensaries where out-patient care for addiction is delivered. Some rehabilitation centers have family-based services but in general they are poorly organized and no evaluation of their impact has been conducted.

There are a number of negative sequelae of addiction, especially when the drugs are injected. These include the infectious diseases HIV, TB, hepatitis. Our study showed that drug treatment clinics in Russia have limited connection with services to prevent or treat these infections. Connections with local AIDS centers, if they exist, are usually formal and in most cases narcology centers obtain HIV test results but no other feedback from the AIDS center after the patient is registered as HIV-positive. Despite regulations that mandate pre- and post-test counseling, patients are unlikely to receive counseling or antiretroviral therapy for their HIV infection except in St. Petersburg where an AIDS center specialist prescribes and delivers antiviral medications for patients during in-patient rehabilitation treatment. About half of participating narcologists either has no connections with AIDS center about from being engaged in the obligatory HIV testing and reporting -- sending blood samples to the center or reporting HIV-positive patients' names. In other half, either AIDS center staff visit patients in the clinic (e.g., in Saint-Petersburg) or the AIDS center sends patients for drug treatment (e.g., Krasnoyarsk). In some locations (e.g., Volgograd), an adversarial arrangement between patient and physician operates in that narcologists compel newly diagnosed HIV-positive patients to sign a paper that says that if the patient does not show up in AIDS center he will be sued. Only about 11% of narcologists reported any connections with harm reduction services, 63% of narcologists reported an absence of harm reduction programs in their regions even though they exist and 26% of them have no connections with local programs although they know about them.

"My connection with HIV service? I send blood samples to them... that's all about communication activity between me and HIV center." - narcologist, Pskov.

"There was a harm reduction service in Moscow Region - in Mytishi district. This program caused ambiguous reaction...local authorities and medical specialists feared that there will be needle distribution instead of need le exchange. Also were negative towards distribution of condoms. There was a local harm reduction-police-medical community conference. Local authorities closed the program then. Now there's no harm reduction there." - narcologist, Moscow region.



"I'm negative towards harm reduction...drug users are all smart now and they don't use non-sterile needles..." - narcologist, Volgograd.

There is little connection between drug treatment clinics and penitentiary narcology despite the overlap in goals and set of patients; 90% of narcologists have no information about treatment practices and modalities in jails and prisons.

### Effectiveness of drug treatment

A majority of the narcologists we interviewed (72.5%) defined treatment success as absolute abstinence of drugs for as long period of time as possible. Almost half (42%) recognized their patient's social readaptation as necessary part of treatment success, but they held that readaptation is impossible without complete drug abstinence. Narcologists reported low rates of success using their definition: on average, they reported that about 11% of their patients remained drug free a year after end of treatment and about 5% in 5 years. These proportions are very close to those reported by drug users themselves [28]. Narcologists also reported substantial multiple treatment episodes: about a half of their current patients had entered treatment at least once before in the prior year.

Narcologists attributed poor outcomes to low motivation of drug users and to reliance on ineffective methods of treatment. Most blamed the patients, asserting that many drug users seek treatment aiming not to stop drug use but only to reduce their consumption, which the narcologists consider a treatment failure. This statement may be accurate, but it applies mostly to those drug users who have been treated a few times before and have been disappointed with it [28]. Narcologists also cite as a major reason for treatment failure the drug using environment to which the patient will return after treatment. However, a significant minority (n=17, 42.5 %) reported that they felt current methods and practices contributed to ineffective treatment. This did not mean that they favored more evidence-based approaches, n=8 (20% of all respondents and 47% of those attributed failure to ineffective methods) believed that the system should revert to the mandatory treatment of the Soviet times or that Soviet-era labor camps for drug users should be reopened. Only 3 respondents (7.5%) wanted to create more therapeutic communities. These beliefs were based on the opinion that abstinence was the goal and it could be achieved only if their patients were provided a sufficient period of abstinence to adapt to a drug-free life.

"In a month after discharge 2/3 of patients will be sober; in six months - 1/3; in a year - 10%, in 5 years - only few people...the reason for that is unhealthy environment and people we discharge come back and live side by side with active drug users. How can we fight that? We should create rehabilitation centers...normal ones, not as religious centers but based on medical approach. Something like Soviet-time forced labor treatment, most of drug users should be subjects for compulsory treatment." - narcologist, Pskov

Narcologists were given a list of treatment approaches and asked to rate their relative effectiveness (Table 2). They rated psychotherapy, religious treatment, and therapeutic communities highest. Opioid antagonist treatment was rated somewhat lower. Some dissatisfaction with this methods may be because for antagonist treatment to work over the long run, the patient must continue to take the antagonist and this generally means that patients must be supervised by relatives or that there must be a certain level of mutual understanding between doctor and patient [29]. A similar rating was given to 12-step method. Because sustained abstinence is built on mutual help of drug users, narcologists appeared skeptical that drug users could sustain such

efforts. Detoxification was rated lower, in great part because practicing narcologists see the results of its ineffectiveness of a daily basis. The method that received the lowest rating from Russian narcologists, despite its widespread use and international acceptance as evidence-based medicine, was substitution therapy with opioid agonists.

"Methadone treatment is a crutches for a drug user, to use it is to make a patient disabled forever...that is to admit your defeat, helplessness and impotence as a doctor. That's their mentality, a worldview - drug users consider methadone as a drug. And then they are addicted to methadone and use methadone treatment as a possibility to save on street drugs. I tried to be objective towards methadone but I will not support, don't want to support this treatment until I see a group of successfully treated methadone patients." - narcologist, Pskov.

"That's a delusion [substitution therapy] - we are just changing one drug to another...let Brits have fun with that!" - narcologist, Volgograd.

"I don't like this method [12-step method] at all...it's not our style... and patients don't want to participate - sponsors are former drug users themselves, with their mental health issues...so our patients say "it's a sect and they are all retards there", that's what they say". - narcologist, St. Petersburg.

### Discussion

This study reveals a cognitive dissonance between the results of addiction treatment practice and practitioners' beliefs and attitudes. The currently employed treatment practices such as detoxification, psychotherapy, post-detoxification rehabilitation and religious treatment narcologists rate as effective methods but narcologists' assessment of the results finds these ineffective. Their failure to take responsibility for the ineffectiveness of accepted methods is justified by choosing instead to blame patients. Despite the existence of regulation that call for post-detoxification rehabilitation programs, few of the established programs we encountered met an evidence-based criterion of being effective [25]. The failure of the current approaches, then, may be attributed to the lack of both effective rehabilitation programs and an extended system of social services and aftercare. Such a lack creates major barriers to providing quality care. Without an effective rehabilitation system, treatment is reduced to detoxification. Approval of these approaches may reflect the sense of futility narcologists feel about the methods they do control.

At the same time Russian narcologists insist that internationally proven approaches to treatment, most notably opioid substitution therapy, are not effective. This may be related to ignorance of positive aspects of OST and to the official position of Russian medical and civil authorities who voice extremely negative attitudes about OST. We must, however, take into account the notion held by many Russians (not just Russian narcologists) that Western experience is not applicable to the Russian mentality.

One of the pressing issues for Russian narcological system is insufficient cross-institutional communication. Cooperation of narcology clinics and AIDS centers is often limited and in some of Russian regions is not productive enough. As an example, the need for better HIV consulting in the narcology clinics is clear. Advocacy campaigns for coupling antiretroviral (ARV) and addiction treatment during detoxification and rehabilitation is needed.

There are several limitations to this study. First, the sample size is small and drawn by purposive convenience. Sampling was designed to cover a range of Russian regions, and participants came from 6 of the 7 geographic regions of the Russian Federation. The 10 cities or regions

have widely divergent populations, from 6.6 million in the Moscow region to 194,000 in Pskov; 3 locations have more than 1 million inhabitants and 4 have less than 0.5 million. Because the sample was small, the analysis was restricted to descriptive statistics and no attempt was made to find associations between practices and attitudes. A second limitation was related to the nature of the study instrument. No attempt was made to pilot the survey before it was used to collect data from narcologists and none of the measures could be truly validated. However, all but one of the authors are practicing Russian narcologists; their intimate knowledge of the Russian addiction treatment system allowed for the generation of a survey instrument that could capture the wide range of actual and potential treatment options. Indeed, the survey was administered by a narcologist, which we believe should contribute to getting candid answers from the participants. A third limitation was 2 interviewing modalities were employed: 35 of the interviews were conducted in person and 5 were conducted by phone. However, all interviews were conducted by the same individual.

In conclusion, this study, the first undertaken of Russian addiction treatment specialists, reveals the gap between their attitudes and their desired treatment outcomes. The findings highlight the need for a revamping of the medical curriculum and post-graduate training to provide a wider range of information on evidence-based practices in addiction treatment. Practically speaking, since all Russian medical practitioners are required to take periodic post-graduate educational courses in their specialty, modernization of the post-graduate training for narcologists would seem to be the quickest and most efficient way to introduce evidence-based methods into the Russian addiction treatment system.

#### Acknowledgements

This project was supported by a grant from the Open Society Institute and the Canadian International Development Agency. Dr. Torban received additional support from an AIDS/TB International Clinical, Operational, and Health Services Research and Training Award (5U2RTW006893) from the Fogarty International Center at the US National Institutes of Health.

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