

Foreign reports

A week spent working in a psychiatric hospital in Latvia (Part 2)

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(Part 1 appeared in the July 1992 issues of the *Psychiatric Bulletin*).

The main body of Jelgava Psychiatric Hospital, in which I spent my week, consists of 14 or so adult and psychogeriatric and two child psychiatric wards. It was built about ten years ago. An alcohol and drug abuse unit, an out-patient department, and a small day hospital catering mostly for the 'neuroses' are found near-by.

Each ward is made up of a long corridor lined by doctor's and sister's offices and procedures rooms, a communal dining and television room with a nurses' station at one side of it, bedrooms, and a very crowded secure area catering for about 20 patients. The latter is the only room with high windows and it is in here that new patients, the more disturbed, and those suspected of wanting to run away are located during the night. The rest of the rooms are less cramped. The washing facilities are poor but not disgraceful.

Although the wards were kept locked it seemed relatively easy to escape because of faulty design features.

The patients

The inhabitants of my ward consisted of one-third new or relatively well-preserved patients, one-third those with chronic defect states and one-third the 'new-long stay', including those with serious forensic histories. The level of illness leading to admission was a little lower than in England, possibly explained by such circumstances as cramped accommodation at home.

The patients were dressed in night attire and spent their time watching television, reading the paper or trying to find some method of secretly brewing up an intoxicating tea. Expeditions to the hospital shop, which stocked a small variety of assorted groceries, were another diversion.

The ward round was the main event of each day, as the patients knew that this was when they would be noticed, even if only briefly.



The "procedures" nurse.

An individual case

The cases I was specifically asked to see included a man in his late 20s, with a history of both hospital admissions and criminal offences, who had been transferred from a prison, threatening suicide.

Here, he was getting into squabbles with other patients and writing letters of complaint to the medical director. A disrupted early life, a lack of remorse about any of his crimes and prominent tattoo of Stalin, Lenin and Hitler on his chest completed the picture. There was no sign of clinical depression.

I was forced to conclude the he had a personality disorder and that there was nothing much that this hospital could do for him. The prison did not want him back either. I could imagine he might well be a placement problem in England as well.

The hospital's staffing

A ward of 80 patients is covered during the week by two psychiatrists, a ward sister and one or two nurses. On my ward a burly male nursing-assistant, who had just received a broken nose from a patient, and an unenthusiastic 18-year-old youth doing alternative national service were also available at times. At weekends two members of staff are on duty.

The quality of some of the nursing staff left much to be desired. For instance, non-Latvian staff members not speaking Latvian can only make for difficulties with patients and on ward rounds.

Occupational therapy is limited to industrial therapy but even this did not function during my visit. In its place a group of patients was organised to help in the construction of a new building on the hospital campus.

There are no social workers and one psychologist covers the whole hospital.

Compulsory admission

I understand that two psychiatrists, who can be from the same hospital, have to agree for a compulsory admission to occur. This whole area seems in a state of flux and formal protection of individual rights lacking as yet.

Treatment methods

Treatment is almost entirely biological and based on a "hit'em hard" philosophy with the emphasis on "finding a cocktail that suits the patient". Intramuscular (and at times intravenous treatments) were common in circumstances in which we would give oral medication. The explanation for this was "to avoid the oral route as absorption is poor in acute psychosis". In addition various other preparations to improve "blood brain circulations" and to "clean out" the system were given.

Many, though not all patients, were on a combination of several similar drugs. This was explained as follows. Say a patient was given one antipsychotic medication and he developed moderate side-effects which did not respond well to an anti-Parkinsonian drug, another slightly different neuroleptic would be added in and the original one reduced a little.

Chlorpromazine and one depot antipsychotic preparation were regularly obtainable but some drugs such as lithium carbonate were in short supply.

Uncertainty as to which medicines might be available next week also contributed to the giving of a "bit of both" of comparable drugs. Sedation was achieved by using mixtures of barbiturates and benzodiazepines instead of increasing doses of anti-psychotics. One result of all this appeared, at least on my ward, to be an almost complete absence of tremor or tardive dyskinesia, though some stiffness was found, even in long-term illness. Dr Liepina asked me whether our patients didn't complain if they experienced such side-effects.

Many of these treatments were given on the basis of some kind of research, occasionally claimed to have been done in the West, but also because "we find it helps". It was strongly felt that withholding something that was potentially helpful for the lack of expensive research would not be beneficial. An additional comment was – "what about the numerous forms of psychotherapy available in the West, and isn't some of that based on it seeming to help?"

Medication appeared to be reduced during the patient's stay, although in the case of sedation patients were more likely to be left over- than under-sedated.

Placement on discharge

Most patients, after a short period of leave, return to their families. Here they encounter much the same difficulties as our patients but in more impoverished circumstances. The staff of the out-patient department, who deal with follow-up, include a community nurse who sees those who fail to turn up for their depot medication.

The chronic schizophrenic patients are eventually transferred to large long-stay "homes". If they refuse to go or are not quite "good enough", e.g. "the new long-stay", they face spending years on the ward.

The idea of community placement appealed to the psychiatrists; however, they were concerned about the costs and as to whether their patients would be able to tolerate standing in long queues for food.

The benefits of working abroad

Once "inside the system" it became surprisingly difficult to explain fundamentals I normally take for granted. An experience of working abroad may not only be helpful or interesting for the psychiatrists based in that country but it may also raise valuable questions about one's own practice.