History and current condition of Russian psychiatry

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Abstract
Russian psychiatry has a dramatic history, and until now has been at a transitional stage of development. It is facing problems not only common in world psychiatry, but also specific to eastern Europe, in particular Russia. Starting from the beginning of the 1990s, considerable changes have occurred in psychiatry, especially after 1992 when the law on psychiatric care and guarantees of citizens’ rights in its provision was adopted. It became the ideological and legislative basis for reforms. However, there are definite obstacles to structural reforms in psychiatry. They are unfavourable technical conditions in many psychiatric clinics, hypercentralization of psychiatric services, shortage of clinical psychologists and social workers in psychiatry, some difficulties in cooperation between psychiatric and general medical institutions. Economic difficulties in the transition period of Russia’s social development prevent the overcoming of these problems. They are being actively discussed and some of them are being gradually solved, e.g. the organization of team work in mental health services, the increasing number of specialists on social work, and the involvement of non-government organizations in psychosocial rehabilitation.

Background
The Russian Federation is a country with an enormous geographical area of over 17 million km². Its population, as of 1 January 2012, is 143 million people. Over the last twenty years the population of Russia has been declining, especially since the end of the 1990s, with a tendency to stabilization in recent years. The country belongs to the group of countries with an upper-low income (according to the World Bank criteria, http://data.worldbank.org/country/russian-federation). Its gross national product (GNP) by the end of 2010 was US$ 1,480 billion (http://data.worldbank.org/country/russian-federation) which meant a slow production growth despite the world economic crisis.

The healthcare budget during recent years has remained relatively low compared with other countries, both developed and developing ones, and in 2011 constituted about 5.5% of GNP. However, it should be mentioned that federal allocations during the same period had grown from 2.3% to 3.5% of GNP, while the rest of the total budget was provided by the state medical insurance system. There are significant differences between different regions in the degree of financial support for local healthcare from municipal budgets. As for psychiatric care, it is financed from the federal budget and not included in the state medical insurance system.

Life expectancy remains relatively low, though it showed some growth during recent few years, and reached 70 years in the beginning of 2012. For comparison, in 2004 the average life expectancy was 65.3 years (58.9 for men and 72.3 for women).

Historical overview
An early prototype of a psychiatric institution in Russia was created in 1706 as a special department of the general hospital for disabled people in the Novgorod region (later and now Kolmovskaya Psychiatric Hospital). Several special asylums, so called ‘dullhouses’, were opened in the time of the Russian Empress Catherine (Ekaterina) the Great. One of them was opened in 1779 at Obuchovskaya Hospital. During her travels from St Petersburg to Moscow in 1785, Catherine the Great ordered the building of the first psychiatric hospital in Moscow. This still exists today, as the Preobrajenskaya Hospital.

In 1847, Malinovsky published the first original Russian manual on psychiatry. He divided all mental disorders (in tune with his epoch) into monomania,
mania, dementia and idiotism. The first faculty of psychiatry in Russia was organized in 1857 at the St Petersburg Medicosurgical Academy, with Balinsky (1827–1902) as its director. One of the best European clinical departments of psychiatry, with a theatre, greenhouse, and separate occupational therapy premises, was built by Balinsky in 1867 in the Academy. He was also interested in psychopathology and became famous for understanding the 'crystallization of delusions' (Balinsky, 1958).

In 1893 Bekhterev (1857–1927) took up a place at the faculty of psychiatry at the Medical Surgical Academy in St Petersburg. His particular interest was brain structure and he received worldwide acclaim. He also described a number of new neurological symptoms, new reflexes, and developed various research apparatus (Bekhterev, 1911). In the field of psychiatry, he mainly aspired to find anatomical-physiological correlates of abnormal phenomena. He spoke about psychoneurology as a certain approach. His name is associated with Korsakov syndrome (an organic–amnestic syndrome as a result of chronic alcoholism). Korsakov was a brilliant clinician, and taught tenacity in the search for symptoms and disease states, but he also emphasized that the personality required detailed individual description. The Moscow Psychiatric School was mainly represented by Korsakov's pupils and coworkers, for example, Serbsky, Rybakov and Gannushkin.

In the last quarter of the 19th century a network of comfortable psychiatric hospitals was constructed, in which humane patient care was realized. However, new psychiatric hospitals were quickly filled by patients with chronic diseases. It became apparent that hospitals mainly housed patients from nearby districts, but patients from more distant districts continued to stay at home and received less care. It became necessary to reconsider how to make psychiatric care accessible to all the population. After intense discussion, the solution proposed was further decentralization. It implied building smaller hospitals which could admit all patients, instead of one large hospital in the region. Unfortunately, this process was broken by World War I and the Russian Revolution of 1917 and civil war.

Psychiatry of the Soviet period in Russia was constructed on the principles of preventive medicine, the rights of patients to free and qualified psychiatric help, an integrated approach and planning of that help, alongside the introduction of innovations in practice. Frequently these principles remained unrealized. In 1919 in Moscow the beginning of a new section of psychiatric care – outpatient psychiatry – was organized. In this form of help a method was found to bring psychiatric help closer to the population, as originally sought by Zemstvo psychiatry. Outpatient psychiatric services were organized into neuro-psychiatric (later psycho-neurological) dispensaries, which were opened later in all large cities of the Soviet Union (Yudin, 1951). New research institutes were gradually organized, and the number of faculties of psychiatry increased with greater scientific and practice-based developments. In 1920, Rybakov founded the Moscow Institute of Psychiatry, the second research institute of psychiatry in Russia. This institute played an important role in the development of a system of catchment-based psychiatric care facilities. This system was organized around city and regional dispensaries and district psychiatric units with day hospitals. The hospitals were, in the majority of cases, subordinate to dispensaries and they provided care in accordance with territorial principles. Psychiatric care was free. Hospitals and dispensaries set up rehabilitation workshops and some of these provided workplaces for mental patients. At the beginning of the 20th century psychoanalysis, and specifically psychodynamically oriented therapy, was developing fast in Russia, primarily due to the efforts of Ermakov. In contrast, in the early 1930s it was virtually forbidden, and in the period of the 1930s to 1950s it was considered as an antiscientific direction. One must also discuss obstacles to the scientific development of psychiatry in the USSR: persecution of geneticists, and the belief that genetics of mental disorders was not scientific or acceptable, and dramatic restrictions in numbers of clinical psychologists; for example, the famous psychologist Vygotsky was attacked ‘Vygotsky was criticized by official authorities.’

Despite the above mentioned restrictions, psychology remained influential in Russian psychiatry. Melekhov played a major role in the development of the theoretical ground for labour rehabilitation. He used the achievements of the Russian psychological school and especially ‘cultural–historical psychology’ by Vygotsky and the theory of activity by Leontiev. Myasischev (St Petersburg), being a psychologist, developed psychotherapy and rehabilitation.

Period in Russian psychiatry critical to the development of modern legislation and biomedical ethics

The development and practical application of modern ethical principles in Russian psychiatry are rather
edifying from a moral, professional and historic perspective. From an ethical and legal point of view, a serious disadvantage was a lack of a special law on psychiatric care in Soviet psychiatry. Professional instructions which regulated the rights of physicians and patients have always existed.

This system of psychiatric care was based on the principle of paternalism and very far from partnership; the physician had a dominant and patronizing position in all aspects of psychiatric care. Clinical psychologists never took part in therapeutic work and solved only diagnostic problems. The number of clinical psychologists in psychiatric facilities was very low as well as the number of social workers. Also, since the end of the 1950s the system of obligatory registration of everyone seeking help was introduced, even if patients needed just a consultation with a psychiatrist or insignificant psychiatric treatment. For example, it included people with transient, short, neurotic-like disorders and behavioural disturbances.

Registration in a psychiatric dispensary could become a barrier to enter some educational institutions or to find a job in some companies if their administration had the right to make requests about the presence or the absence of a person’s registration in a psychiatric dispensary. One could say that a psychiatrist protected the interests of the state and society, sometimes to the detriment of the patient’s interests (Gurovich, 2005).

In the 1970s to 1980s the psychiatric system in the Soviet Union was used for political purposes. Psychiatric facilities and separate psychiatrists were involved in using their psychiatric expertise leading to involuntary hospitalization and treatment of so-called dissidents; dissidents were those who criticized and opposed the Soviet political system.

The political authorities imposed methods for conducting forensic psychiatric evaluations with individuals who made anti-Soviet statements or had anti-Soviet publications. Psychiatrists were compelled to follow these instructions. So, political persecution was replaced with psychiatric examination and hospitalization in psychiatric clinics. From the point of view of modern diagnostics, in some cases experts’ conclusions were connected with excessive diagnostic patterns for schizophrenia, psychopathy or other mental disorders. Some of these cases were made public and fairly criticized by the whole world. In the Soviet Union this course of action within psychiatric services led to a greater stigmatization of psychiatric services and mental illness, with more fear of psychiatric centres among the public. There were other, less widely publicized violations of patients’ rights. For example, mass ‘prophylactic’ hospitalization of registered patients before major international actions such as international youth festivals, Olympic Games. Many patients with the capacity to make decisions were even deprived of voting rights during elections.

In the early 1980s there was the threat of expulsion of the All-Union Society of Neurologists and Psychiatrists from the World Psychiatric Association because of opposition from international human rights organizations. To avoid the threat, the Society suspended its membership of the World Psychiatric Association. Unfortunately, official representatives of psychiatry who took part in the political abuse of psychiatry never acknowledged the groundlessness of their actions and diagnostics. Such acknowledgment of psychiatric abuse for political purposes would have been understood and highly appreciated by all psychiatrists both inside the country and abroad.

In fact, there had been very few cases of wrong diagnoses. However, the absence of such an acknowledgement and the absence of an analysis of errors committed cast a shadow upon all psychiatrists in the Soviet Union, but specifically in Russia.

At the same time, this painful process had its positive side and led to criticism and growing discontent among the majority of psychiatrists in Russia (Gurovich, 2005; Krasnov, 2002). In the middle of the 1980s there was a more dramatic period of change driven by ‘perestroika’, and so further work on improving the legal status of psychiatric patients began. Discussions in the media and in professional spheres stimulated law-making activities of psychiatrists and lawyers.

In 1991 the Soviet Union fell apart and several other countries were formed (the former Union republics). Russia was the first country where a law on psychiatric care was passed. In 1992 this law was confirmed by parliament and took effect in January 1993. The Russian law for psychiatric care, and guarantees of citizens’ rights in its provision, was accepted and commended by international experts. The law considerably widened patients’ rights and restricted the possibility of unlawful actions in the course of psychiatric treatment.

Modernization of practice and services

The task of the re-building of large hospitals remains, but economic difficulties hinder this aspiration. The number of mentally ill who are disadvantaged in the public health system is growing due to the difficulties of providing employment and adaptation in the setting of the market economy. The number of people disabled due to mental disorders is 1,026,759 (Public health in Russia. Rosstat, Moscow, 2011) for 2010. There are very few sheltered jobs for the mentally ill (only 3.3%). Moreover, the Mental Health Law, in force since 1993, prevents and minimizes the institutionalization of mentally ill patients if their
behaviour does not pose a threat to others. Many mentally ill appear to live on the streets, though most of them are either institutionalized in specialized institutions (‘internats’) for the chronically mentally ill (without active therapy) or stay at home under the care of their relatives.

Unfavourable conditions of living in many psychiatric clinics (rooms with many beds, lack of space and equipment) are serious ethical and legal problems. Costly but effective remedies remain unavailable to many patients, especially outpatients. Economic difficulties of this transition period of Russia’s social development make it unlikely that these difficulties will be overcome in the short term. Until recently, psychiatry was not a priority in the state’s healthcare strategy, unlike paediatrics and cardiosurgery. There are difficulties in the quality of collaboration between psychiatric and general medical institutions when helping people with somatoform disorders, somatized depressions and anxiety disorders. These problems are being actively discussed and some of them are being gradually resolved (Krasnov, 2002, 2008). For example, the rules of informed consent became a norm when new medicines are tested and they gradually spread to all forms of therapeutic activities.

**Psychiatric care system**

In general, the psychiatric care system remains traditional, and it is presented by two main types of facilities. The first is the territorial psychiatric outpatient clinic, so-called dispensary (in rural areas, units in general hospitals) that provides care for the population residing in a specific territory. The second is the psychiatric hospital, which generally provides inpatient treatment for a population within certain catchment areas, i.e. a district or a city, or a region. As a rule, a dispensary district psychiatrist should provide care for 25,000 adults in a catchment area. A child psychiatrist (usually working in a child territorial polyclinic) should provide care for a population of 15,000 children and adolescents. These conditions and standards can be adapted in territories with a lower population density.

Psychiatric dispensaries may be organized along with district psychiatrists’ services and also special services of such specialists as psychotherapists, neurologists, epileptologists, sexologists and gerontopsychiatrists, and may also set up day hospitals. So-called ‘narcology’ services for alcoholics and drug addicts have been organized since the Soviet time, and until now have been mostly separated from regular mental healthcare. More than 5,000 physicians and psychologists are working in narcological institutions – hospitals, narcological dispensaries usually with small toxicological units (Koshkina et al., 2011; Nemtsov, 2011) (see Tables 1, 2 and 3).

The law on psychiatric care adopted in 1992 works successfully enough both at federal and regional levels, and generally provides patients’ rights. However, social provision and a guaranteed volume of care have not been implemented sufficiently. In addition, there were some omissions or errors in routine clinical practice in recent years, but they did not represent a deliberate violation of patients’ rights. In some cases, especially connected with hospitalization, mental health specialists do not give enough attention to delicate and convincing explanations of their actions to patients and relatives. It is not the subject of violation of the legislation, but rather the issue of professional ethics and deontology. All such cases or conflicts occurring within psychiatric care are discussed at meetings of the Russian Society of Psychiatrists or in publications of professional journals.

A specific feature and principle defect of inpatient psychiatric care in Russia is its hypercentralization. The majority of psychiatric hospitals have more than 500 beds and there are several big hospitals with

<table>
<thead>
<tr>
<th>Institutions</th>
<th>1999</th>
<th>2010</th>
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<tbody>
<tr>
<td>Psychiatric dispensaries</td>
<td>164</td>
<td>145</td>
</tr>
<tr>
<td>Dispensary departments in psychiatric hospitals</td>
<td>122</td>
<td>123</td>
</tr>
<tr>
<td>Narcological dispensaries (for alcoholics and drug addicts)</td>
<td>171</td>
<td>144</td>
</tr>
<tr>
<td>Dispensary units in general hospitals (in rural areas)</td>
<td>2,322</td>
<td>2,078</td>
</tr>
<tr>
<td>Psychotherapeutic units in general outpatient clinic</td>
<td>1,118</td>
<td>1,107</td>
</tr>
<tr>
<td>Psychiatric hospitals</td>
<td>278</td>
<td>234</td>
</tr>
<tr>
<td>Narcological hospitals</td>
<td>13</td>
<td>12</td>
</tr>
<tr>
<td>Inpatient departments in psychiatric dispensaries</td>
<td>107</td>
<td>83</td>
</tr>
<tr>
<td>Total number of beds in psychiatric hospitals (including psychiatric beds in general hospitals)</td>
<td>170,440</td>
<td>149,211</td>
</tr>
<tr>
<td>The number of beds in narcological hospitals</td>
<td>28,700</td>
<td>26,550</td>
</tr>
<tr>
<td>The number of openings in day hospitals</td>
<td>13,645</td>
<td>17,289</td>
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Table 2. Mental disorders in Russia (from data of the state psychiatric and narcological dispensaries and psychotherapeutic units) (Public health in Russia. Rosstat, Moscow, 1992 and 2011, in Russian).

<table>
<thead>
<tr>
<th>Patients</th>
<th>1999</th>
<th>2010</th>
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<tbody>
<tr>
<td>Number of people with mental disorders (without substance abuse)</td>
<td>3,813,500</td>
<td>4,187,873</td>
</tr>
<tr>
<td>Number of alcohol abusers</td>
<td>2,230,050</td>
<td>3,178,032</td>
</tr>
<tr>
<td>Number of drug addicts</td>
<td>209,080</td>
<td>550,610</td>
</tr>
</tbody>
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more than 1,500 beds. During the last 20 years, the total number of beds decreased by 25%: from 200,192 beds in 1991 to 149,211 in 2010 (see Table 1) (Public health in Russia. Rosstat, Moscow, 1992 and 2011, in Russian). This process is continuing gradually. However, the decrease of psychiatric beds was not always combined with an increase in extramural forms of psychiatric care.

The system of psychiatric care has shown contradictory tendencies in its development. On the one hand, taking into account the shortages in state budget allocations, psychiatric care on the basis of local psychiatric dispensaries that are open to the general public and connected to local psychiatric hospitals is expedient. On the other hand, psychiatric patients’ stigma and societal prejudices against psychiatry and psychiatric institutions hinder the development of psychiatric dispensaries.

Only about 30–35% of all mentally ill patients applied for psychiatric assistance in the dispensary. However, recently, the number of those patients asking for an initial psychiatric consultation has once again started to increase. The prevalence of mental disorders registered in psychiatric institutions has reached 2,978.7 per 100,000 of population (Public health in Russia. Rosstat, Moscow, 1992 and 2011) (see also Table 2). At the same time, the problem of mental disorders in primary care is becoming more and more serious, due to the fact that approximately 25–30% of primary-care patients need psychiatric consultations (Krasnov, 2008). The need has arisen to reform outpatient psychiatric care, including the development of various forms of care.

The suicide rate in Russia is one of the highest in the world. During recent years the suicide rate has had a slight tendency to decrease: from 38.7 per 100,000 of population in 1999 to 23.7 in 2010. This figure in men is six times higher than in women. One of the explanations for this might be the high alcohol consumption among men. The whole figure of alcohol consumption in Russia in recent years is approximately 14–15 L per capita (Nemtsov, 2011).

The prevalence of alcoholism, including alcohol psychoses, was more or less stable in the last decade, but with a slight tendency to increase, up to 1,922.4 per 100,000 of population in 2008; the male to female ratio was 5:1 (Table 2). Other addictions show more apparent growth in recent years: it was 252.2 per 100,000 population in 2008; opioid dependence was dominant (87.5%) (Koshkina et al., 2011).

Several important changes may be noted in the last decade, which mirror the direction and a sort of intrinsic regularity in the development of psychiatric care. First is the incorporation of a significant number of psychologists, psychotherapists, specialists in social work and social workers into the staff of psychiatric institutions, which created a basis for transition from a largely medical to a biosocial model of mental healthcare and team approach to its provision (Table 3).

During the last few years in a number of regions the introduction of new developments in mental healthcare has led to changes in the structure of the mental health service with a greater emphasis on the development of care in the community, where a system of psychosocial rehabilitation is organized, clinics of first episodes of disease, hostels and other types of protected housing are set up, interaction with social services is developed, assertive treatment departments (teams) are set up, and ‘hospital at home’, psycho-education, psychosocial work with families are provided. Non-government organizations (NGOs) are more and more involved in mental health assistance, although not yet sufficiently so (Gurovich & Neufeldt, 2007; Krasnov et al., 2010).

Table 3. Specialists rendering psychiatric care in Russia

<table>
<thead>
<tr>
<th>Specialists</th>
<th>1999</th>
<th>2010</th>
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<tbody>
<tr>
<td>Psychiatrists (including psychotherapists)</td>
<td>15,860</td>
<td>16,167</td>
</tr>
<tr>
<td>Narcologists (specialists rendering care for people suffering from alcohol and other substance abuses)</td>
<td>4,470</td>
<td>5,329</td>
</tr>
<tr>
<td>Specialists in social work (with higher education)</td>
<td>70</td>
<td>926</td>
</tr>
<tr>
<td>Social workers</td>
<td>840</td>
<td>1,691</td>
</tr>
<tr>
<td>Clinical psychologists (working in psychiatric and narcological institutions)</td>
<td>1,407</td>
<td>3,652</td>
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Research activity in the mental health sphere

According to the urgent need for reforms in mental healthcare, Russian psychiatrists consider the applied clinical-organizational studies as the main scientific task in their work. Epidemiology, formation and trials of new models, new approaches in treatment and rehabilitation on the basis of multiprofessional teamwork, with involvement of NGOs, take priority for most researchers and research groups. The development of
recognition and treatment of depressive and anxiety disorders on a primary care level is also one of the important directions of scientific and practical efforts, alongside seeking the optional forms of interrelationships and joint research with primary care doctors, cardiologists, neurologists and other specialists. Socially orientated studies have been supported in the last few years by a special federal programme. Studying the mental health of the population living for a long time under the strain of an emergency situation and a return to reconstruction and reconciliation processes, such as in Chechen Republic, is also giving experience of developing appropriate mental healthcare in special regions (Idrisov & Krasnov, 2009).

Due to the polyethnicity of the population of the Russian Federation, there are specific problems arising in rendering care in some regions, but the whole system of care remains useful (Krasnov & Gurovich, 2007). Recently new branches of research and practical psychiatry have emerged in Russia, such as ecological psychiatry and ethnocultural aspects of mental health.

Conclusion

Russian psychiatry has both the old system of state mental healthcare and, at the same time, more and more obvious new forms of psychosocial assistance and psychotherapeutic aid. The paternalistic model of care is confronting the biopsychosocial approach and carrying out multiprofessional team work, with the involvement of social workers and other specialists in joint work.

The introduction of internationally recognized legislative standards into mental health service practice has undoubtedly been a positive development. Such standards ensure the protection of human rights during the delivery of mental healthcare and make it easier to organize new forms of care, especially in primary healthcare, and to develop psychosocial methods of treating and rehabilitating people with mental disorders. An increasingly wide range of specialists in clinical psychology and social work, as well as former patients and their relatives, are now involved in providing care to people with mental disorders.

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