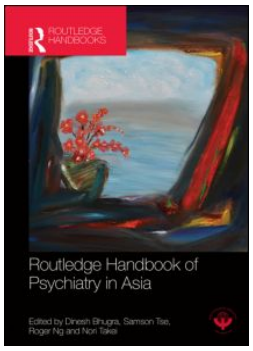

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Russian Federation

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Geographic and general information

The Russian Federation (Russia) is a country with a huge territory, of 17,075,000 km^2, spanning the eastern part of Europe and the northern part of Asia to the Pacific Ocean. Its population as of 2013 was 143.4 million, and country's GDP in 2012 reached US$3,380 billion, i.e. US$23,570 per capita.

Russia has more than 150 ethnic groups, which vary greatly in size, from the 115 million ethnic Russians to minorities numbering only several hundred persons. Between these two extremes come Tatars (5.6 million), Ukrainians (2.9 million), Bashkirs (1.7 million), Chuvashs (1.6 million), Chechens (1.4 million) and Armenians (1.1 million). The indigenous peoples of Siberia, the far east and the far north of the Asian part of Russia constitute about 0.3 per cent of the total population (500,000 persons). Most Russians, Ukrainians and Armenians can formally be described as Christian; Tatars, Bashkirs and most of the people from north Caucasus are Muslims. There are also Buddhist minorities (Kalmyks in the European part of Russia, and Buryats and Tuvinians in Siberia) and a small number of people belonging to the Judaic religion. In addition there are very small groups of pagans in remote parts of Siberia, practising shamanism. Inside Russia, however, people rarely make reference to ethnicity. People abroad use the name 'Russian' for any person speaking Russian, which is the state language in Russia, and the means of communication among the people irrespective of ethnic origin.

The north of Russia includes Siberia, Chukotka and Kamchatka (the last also being the most easterly region of the country). These areas have distinctive small indigenous populations. The far east of Russia includes the Republic of Yakutia, which is the largest administrative unit in the world, in terms of territorial size. Kamchatka is rightly regarded as a place uniquely suited to the ethnocultural investigation of the influence of the environment on the mental health of the native population. At these very high latitudes, even in modern times, with the availability of a wide range of supportive technology, socioeconomic development remains uneasy and even dangerous (Bokhan, 2009)

Siberia and the far east of Russia are home to 65 smaller indigenous groups, including Buryats (about 400,000 persons), Tuvinians and Tofalars (250,000 persons), Khakas (75,000 persons), Altaits and Shorts (92,000 persons). Buryats speak a language in the Mongolian family – whereas the other groups speak languages in the Turk, Tungustic and Samodian groups. Buryats, Tuvinians (Dashieva and Kupriyanova, 2009; Rakhmazova *et al.*, 2012), Khakas (Taliyanova and Korobitsina, 2011) and southern Altaits are representatives of a central-

Asian type of 'Mongoloid' ethnicity. Shorts, northern Altaits and some groups of Khakas belong to a south-Siberian type formed as a mixture of central-Asian Mongoloids and the ancient Caucasian population of Siberia.

Despite differences in culture and anthropomorphological traits, these groups are all experiencing a similar process of acculturation that affects the physiological as well as the social sphere. They have lived together for many years in the same territory and there is no overt discrimination or prejudice among them; indeed, there are many mixed families. However, there is in these regions a trend towards depopulation, which is sometimes viewed as being inevitable (Gumilev, 1993), but medicine and psychology assume measurement of certain parameters that may testify to these objective processes. They have high rates of alcohol and drug abuse.

Mental health policy

According to WHO, total health expenditure in Russia represents 5.2 per cent of GDP (Popovich *et al.*, 2011); this is lower than in other European countries. Care is provided free of charge for people with mental disorders but many people nonetheless make out-of-pocket payments within private and commercial services, partly because of a strong popular prejudice against official psychiatry, as well as a fear of stigmatization.

After the disaggregation of the Soviet Union in 1991, Russia was the first of the former Soviet republics to pass a law on psychiatric care, in 1992 (it came into operation in January 1993). The Russian law guarantees citizens' rights and was commended by international experts. It considerably widened patients' rights and restricted the possibility of unlawful actions in the course of psychiatric treatment. It has been successfully implemented at both federal and regional levels, but the provision of social care is inadequate.

A specific feature and principal defect of inpatient psychiatric care in Russia is its over-centralization. The majority of psychiatric hospitals have more than 500 beds and several large hospitals have more than 1,500 beds. In the past 20 years the total number of beds has decreased by 25 per cent: from 200,192 beds in 1991 to 146,427 in 2012 (see Table 3.1). Now in Russia the number of psychiatric beds per 1,000 population is 1.02 and is still continuing to fall. However, the decrease in the number of psychiatric beds has not always been combined with an increase in extramural forms of psychiatric care.

The task of rebuilding the large hospitals remains, but economic difficulties hinder this. The public health system struggles to provide mentally ill people with suitable employment and adaptation in the setting of a market economy. The number of people registered disabled due to a mental disorder was 1,033,308 in 2011 (Gurovich, 2012); and there are few sheltered jobs for them (only 3.3 per cent). While many appear to live on the streets, most of them are in fact either inpatients of specialized institutions ('internats') for the chronically mentally ill (without active therapy) or live at home under the informal care of their relatives and the formal care of a visiting specialist from a local dispensary. 'Dispensary' is the traditional name for an outpatient clinic.

The unfavourable living conditions in many psychiatric clinics (rooms with many beds, lack of space and equipment) raise serious ethical and legal issues. Moreover, many effective remedies are costly and so remain unavailable to many patients, especially outpatients. Economic difficulties of this transitional period in Russia's social development make it unlikely that these problems will be overcome in the short term. Until recently, psychiatry was not a priority in the state's health care strategy, unlike paediatrics and cardiosurgery.

Table 3.1 Resources available for administration of psychiatric care in Russia[a]

Institutions	*1999*	*2008*	*2012*
Psychiatric dispensaries	164	145	102
Dispensary departments in psychiatric hospitals	122	123	170
Narcological dispensaries (for alcoholics and drug addicts)	171	144	101
Psychotherapeutic units in general outpatient clinics	1,118	1,107	830
Psychiatric hospitals	278	257	224
Narcological hospitals	13	12	11
Total number of beds in psychiatric hospitals (including psychiatric beds in general hospitals)	170,440 (14,015)	155,834 (13,890)	146,427 (13,915)
Number of beds in narcological hospitals	28,700	26,550	24,250

[a] Current statistical data has been taken from the website of the Ministry of Public Health of the Russian Federation

Table 3.2 Specialists rendering psychiatric care in Russia

Specialists	*1999*	*2008*	*2012*
Psychiatrists	15,860	16,184	13,287
(including psychotherapists)	3,248	3,438	1,717
Narcologists (specialists rendering care for people suffering from alcohol and other substance abuse)	4,470	5,012	5,457
Specialists in social work (with higher education)	70	772	911
Social workers	840	1,857	1,606
Clinical psychologists (working in psychiatric and narcological institutions)	1,407	3,050	3,568

The whole system of psychiatric care has shown contradictory tendencies in its development (Table 3.1). On the one hand, taking into account the shortages in state budget allocations, the provision of psychiatric care through local psychiatric dispensaries that are open to the general public and connected to local psychiatric hospitals is a practical expedient. On the other hand, stigma and societal prejudices against psychiatry and psychiatric institutions hinder the development of psychiatric dispensaries. Many psychiatrists, especially psychotherapists, have left the public sector to work in private practice (Table 3.2). Only about 30–35 per cent of all mentally ill patients apply for psychiatric assistance in a dispensary. The prevalence of mental disorders registered in psychiatric institutions reached 2,951.1 per 100,000 population in 2011. In addition, approximately 25–30 per cent of primary-care patients need psychiatric consultations (Krasnov, 2008). The need has arisen to reform outpatient psychiatric care, and the development of alternative forms of care is also required.

Suicide and substance abuse

Suicide statistics vary widely by region within Russia. Siberia has the highest rate. In the Altay Republic the rate is 67.3 per 100,000, in Nenets Autonomous District it is 64.1 and in Buryatia it is 64.0.

The lowest rates of suicide are seen in the north Caucasus. In the Chechen Republic the rate is 0.8 per 100,000 and in Dagestan it is 2.8. This is due to the traditional culture of the predominantly rural Muslim population, as Islam prohibits suicide. The Russian national average rate was 20.1 per 100,000 in 2012. This is one of the highest national rates in the world (Table 3.3). Over the last two decades, though, it has decreased substantially, from 38.7 in 1999. The rate among men is six times higher than among women, probably because of the higher rate of alcohol consumption among men. Across the whole population, alcohol consumption in Russia is the equivalent of approximately 14–15 litres of spirit (primarily vodka) per capita (Nemtsov, 2011).

The prevalence of alcoholism has been more or less stable over last decade, at around 1,792.5 per 100,000 population. The male/female ratio is 5:1. Other addictions appear to have increased in prevalence over recent years, from a total of 252.2 per 100,000 population in 2008 to 382 per 100,000 of population in 2012; among these, opioid dependence is the dominant form of addiction.

Reforms in psychiatric care

Several important changes have been made in the last decade in the development of psychiatric care. First of all, a significant number of psychologists and social workers have been added to the staff of psychiatric institutions, to support a transition from a largely medical to a biopsycho-social model of mental health care and a team approach to its provision (see also Table 3.1).

Table 3.3 Suicide rates per 100,000 by country, year and sex per year (WHO, 2012, data)

Rank	*Country*	*Male*	*Female*	*Average*	*Year*
1	Greenland	116.9	45.0	83.0	2011
2	Lithuania	54.7	10.8	31.0	2012
3	South Korea	38.2	18.0	28.0	2013
4	Guyana	39.0	13.4	26.4	2006
5	Kazakhstan	43.0	9.4	25.6	2008
6	China			22.23	2011
7	Belarus			20.5	2012
8.	Slovenia	34.6	9.4	21.8	2011
9	Hungary	37.4	8.5	21.7	2009
10	Japan			21.7	2012
11	Sri Lanka	34.8	9.24	21.7	2012
12	Latvia			20.8	2010
13	Russia			20.1	2012
13	Ukraine			19.8	2012
14	Croatia			19.7	2002
. . .					
51	Kyrgyzstan	14.1	3.6	8.8	2009
73	Uzbekistan	7.0	1.7	4.3	2005

Second, the structure of the mental health service has changed, with a greater emphasis on the development of care in the community, where a system of psychosocial rehabilitation is organized. In addition, special clinics for people in a first episode of psychosis, hostels and other types of protected housing have been established, and interaction with social services has been facilitated. Assertive treatment teams have been set up and 'hospital at home' – psychoeducation and psychosocial work with families – is now provided. NGOs are not yet sufficiently involved but are now increasingly engaged in mental health provision (Gurovich, 2005, 2012; Krasnov and Gurovich, 2012).

The problem of mental health care for indigenous populations in Siberia and the north requires the development of cross-cultural psychiatry, with an integrated understanding of the role of psychological issues, culture, religion, mythology, traditions and customs. Addiction psychiatry, psychology and psychotherapy are required. In particular, alcohol addiction is a problem. Alcohol use among the indigenous inhabitants of southern Siberia exceeds alcohol use by Caucasians living in the same region, as shown by long-term epidemiological investigations (Nikitin, 2007)

Geographic and ethnic patterns of mental health

The extreme climate, and long dark winters, combined with the low density of population and isolation and remoteness of villages, nevertheless accompanied by the development of large industrial complexes within the high-tempo socioeconomic development of the far northern territories, represent risk factors for the development of mental disorders. This is combined with limited local labour resources and the large-scale immigration of workers from elsewhere in Russia.

Despite their historical and enduring contact with Slavs, most of the indigenous inhabitants of southern Siberia have maintained their traditional culture and have administrative territorial autonomy.

The quality of life and mental health of the smaller ethnic groups of Russia (and especially the circumpolar populations) have been greatly influenced by acculturation, or the 'stress of modernization'.

Ethnocultural factors can influence the clinical manifestation and management of various types of disorder. For instance, Tuvinians and Buryats are highly tolerant of persons with senile psychoses, which is culturally conditioned by their respectful attitude towards the elderly. Among Buryats (continental Mongoloids), explosiveness in a state of alcohol intoxication is common. Arctic Mongoloids are characterized by an absence of vegetative signs of abstinence from alcohol, low rates of alcohol psychoses and a low prevalence of female alcoholism. Interestingly, the frequency of mental pathology in the Buryat Mongol population differs widely across family/tribal groups. Currently more than 270,000 Buryats could be classified as continental Mongoloids and about 660,000 ethnic Russians live in Buryatiya (other groups are much smaller). In a clinical/epidemiological investigation (Dashiyeva and Kupriyanova, 2009) of the population of remote districts of Buryatiya, high rates of alcohol dependence were found in male Buryats (up to 60.8 per cent of those examined) and of neurotic disorders in women (21.1 per cent) (Rakhmazova *et al.*, 2012). In Primorsky Krai, among Udegeans and Nanaits rates of addiction in men were as high as 36.9 per cent, and in women 20.3 per cent. Quickness of formation of a withdrawal syndrome, acts of brutality while intoxicated, acceptance of therapy and a family history of alcoholism are typical (Bokhan *et al.*, 2006; Badyrgy et al., 2012; Artemyev, 2012). Dependence on more than one substance was a trigger for the formation of child/adolescent pathology.

High rates of neuropsychiatric disorders and alcoholism among north-Asian and Arctic Mongoloids (Republics of Sakha/Yakutia, Buryatiya, Tyva), as well as among Mongoloids of Baykal and south-Siberian types, have been described repeatedly but they remain insufficiently studied; nevertheless, these groups do appear to be vulnerable to social stress and the formation of a number of affective and addictive states (Semke and Bokhan, 2008; Semke and Chukhrova, 2009).

Among the more mixed populations typical of the east-Asian part of Russia, the multifactorial concept of mental disorders appears to be more generally applicable. This concept supposes an important role of three basic factors in the aetiology of these diseases: social, psychological and individual/biological (biochemical, genetic, constitutional, morphological). The particular weight and significance of this triad is associated with the peculiarities of populations living under specific conditions and needs distinct ethnocultural investigation.The specific contributions of each of this triad of factors to mental disorders varies.

There are some differences in the symptoms of mental disorders among Caucasian people living in Siberia and some of the small indigenous minorities. For instance, the presentation of schizophrenia and the content of mental disturbances – delusions and hallucinations – in Buryats can reflect religious beliefs: shamanism, Lamaism, Buddhism. Thus, the most frequent delusions concern ideas of supernatural abilities of clairvoyance and healing powers, and patients imagining themselves to be a lama or shaman (Shaman [шаман] – a mediator communicating with spirits, who does aid recovery from mental disorders in some local areas in east Russia). Depressive spectrum disorders in Buryats are characterized by the presence of complaints of a somatic character often themselves attributed to the violation of a taboo.

Psychopharmacological therapy in cases of culture-bound delusion is usually insufficient, and the basic delusional story persists, perhaps because of patients' beliefs in its correctness within their religious frameworks.

In Russia, an area of urgent research interest is the choice of substances of abuse among specific groups, especially Mongoloid peoples. Low tolerance, early loss of situational control, early development of amnesic forms of intoxication and alcohol-related personality changes, notably with brutal behaviour, have been noted. The greatest rates of progression to alcoholism and the greatest rates of resistance to treatment have been observed in the native Arctic population (Semke and Bokhan, 2008). The key may be to understand the problem of their heightened rates of alcoholism.

Thus, for modern Russia a priority is the development of cross-cultural psychiatry and addiction psychiatry services. New forms of psychiatric, psychological and psychotherapeutic help are needed by the indigenous populations of the eastern region of Russia. On the threshold of acceptance of ICD-11, the theoretical significance and practical value of distinguishing different 'risk groups', pre-morbid states, and, for instance, prognostic criteria for borderline personality and addictive disorders have become all the more evident (Bokhan and Ovchinnikov, 2014). In the development of preventive activities by healthcare agencies, a complex of medico-social and sociocultural interventions are required, ones which have a flexible structure and which strive not to violate human rights. The elaboration of cross-cultural aspects of personality disorder represents an important theoretical stimulus connected with the crystallization of a biopsychosocial paradigm and sociotherapeutic preventive measures.

Research activity in the mental health sphere

As there is an urgent need for reforms in mental health care, Russian psychiatrists regard applied clinical–organizational studies as the main scientific task in their work. Epidemiology, the testing

of new models of treatment, especially multidisciplinary teamwork approaches to treatment and rehabilitation, and involvement of NGOs are priorities for most researchers and research groups (Gurovich, 2005, 2012). The recognition and treatment of depressive and anxiety disorders within primary care are also an important focus of scientific and practical effort, as are optimal forms of working relationships and joint research with general practitioners, cardiologists, neurologists and other specialists (Krasnov, 2008, 2011). Socially oriented studies have in recent years been supported by a special federal programme (2007–2011). In particular regions, study of the mental health of populations living for a long time under the strain of a state of emergency, and even during periods of reconstruction and reconciliation, as in the Chechen Republic, has led to the development of appropriate mental health care interventions (Idrissov and Krasnov, 2009).

Russia's multi-ethnic population presents specific problems in relation to psychiatric care in some regions. Recently, new branches of research and clinical psychiatry have emerged in Russia, such as ecological and ethnocultural psychiatry (Semke *et al.*, 1999; Semke and Bokhan, 2008; Bokhan *et al.*, 2013).

Further development of the scientific basis of mental health care in Russia is likely to have a multidisciplinary focus on the ethnic or territorial parameters of the mental health of the population: the epidemiology, pathogenesis, phenomenology, clinical assessment, diagnosis and prevention of mental disorders (including addictions and psychosomatic disorders) across different age and social groups; the ethnocultural assessment of suicidal and aggressive behaviour; gender differences; problems of comorbidity; therapeutic resistance in addictive, borderline, affective and schizophreniform disorders; the contribution of migration, acculturation stress, anthropogenic and extreme geographic factors (principally long winter nights in the far north); medico-social indices and substance abuse; the predictors of the formation, clinical dynamics and prevention of addictive states among indigenous and smaller ethnic groups in Siberia, the far east and far north; the biological, molecular-genetic, neurophysiological and experimental-psychological investigations of mental disorders in different ethnic populations; ethnocultural aspects of the prevention of mental and behavioural disorders in different social groups; and the mental health consequences for ethnic groups of the industrialization of some remote regions of Russia. Indeed, all these issues are being studied at the school of cross-cultural psychiatry in Tomsk (Semke *et al.*,1999; Semke and Bokhan, 2008; Bokhan and Ovchinnikov, 2014).

Education in psychiatry

Postgraduate education for clinical practice (after six years of formal medical education) comprises an additional two-year course termed 'ordinature' and then 500 hours of specialization in forensic psychiatry, narcology or psychotherapy (psychotherapy is possible only after at least three years of practical work in psychiatry). There are also courses on psychogeriatrics, child psychiatry, psychosomatics and the organization of psychiatric services. All doctors have to validate their professional status in certificate confirmation courses, once every five years. There are also a variety of training schemes for clinical psychologists and social workers.

But, taking into consideration the wide differences in socioeconomic and sociocultural conditions across Russia's huge territory, the system of psychiatric education is lacking in certain key regards. For instance, there is no special training course in cross-cultural psychiatry and addiction, where an acquaintance at least, on the part of psychiatrists and psychologists, with the religious notions typical of Buddhism and shamanism, say, and the development of other aspects of professional ethnocultural competence, would help in the elaboration of strategies for prevention, and treatment and rehabilitation within mental health care. In this respect, psychological training in Buddhism might serve as a basis for the elaboration of new

psychotherapeutic methods of treatment for the indigenous population of Siberia, especially for patients with culture-bound disorders.

Conclusion

In 2007–2012 the Federal Programme of Emergency Measures in Socially Important Diseases did help to develop some projects in psychiatry, and to improve conditions in many psychiatric institutions. Several attempts to establish such a programme in previous years failed because of financial difficulties and a conflict of priorities (areas such as cardiology, oncology and paediatrics are generally given primacy). Some mental health problems are being solved with the help of regional programmes for the improvement of psychiatric care, especially the development of psychosocial approaches in mental health care and the transition from the medical model to a more comprehensive biopsychosocial model of care with multidisciplinary working.

In programmes for the prevention of dependence in indigenous populations in Siberia, along with modern psychopharmacological approaches, considerable emphasis is given to traditional methods of treatment, necessary for the treatment of culture-bound mental disorders among Buryats. The development of personalized medicine within a cross-cultural psychiatric approach will help to meet the ethical norms of psychiatry, psychology and prevention. Awareness on the part of psychiatrists and psychologists of the religious notions typical of Buddhism and shamanism will help in the elaboration of preventive and treatment programmes.

Modern Russia is characterized by dynamism and instability. Social psychiatry and the assessment of the psychogenic factors underlying the most common psychopathological disorders of personality, neurotic and addictive disorders, have particular relevance in Russia, especially its eastern regions, with their multiethnic populations and multicultural lifestyles, combined with immigrant labour. Under these conditions the mental health of the population depends on the structure and content of the microsocial and macrosocial environment: each societal stratum has its own social and ethnic characteristics, which determine, for example, responses to stress, and thereby indirectly determine individual and societal well-being. The effective organization of psychiatric help in Russia needs a systemic analysis of the 'inner' and 'outer' space of the individual through the prism of national traditions and customs, but incorporating universal values.

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