Mental health reform in the Russian Federation: an integrated approach to achieve social inclusion and recovery

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Objective To facilitate mental health reform in one Russian oblast (region) using systematic approaches to policy design and implementation.

Methods The authors undertook a three-year action-research programme across three pilot sites, comprising a multifaceted set of interventions combining situation appraisal to inform planning, sustained policy dialogue at federal and regional levels to catalyse change, introduction of multidisciplinary and intersectoral-working at all levels, skills-based training for professionals, and support for nongovernmental organizations (NGOs) to develop new care models.

Findings Training programmes developed in this process have been adopted into routine curricula with measurable changes in staff skills. Approaches to care improved through multidisciplinary and multisectoral service delivery, with an increase in NGO activities, user involvement in care planning and delivery in all pilot sites. Hospital admissions at start and end of the study fell in two pilot sites, while the rate of readmissions in all three pilot sites by 2006 was below that for the region as a whole. Lessons learned have informed the development of regional and federal mental health policies.

Conclusion A multifaceted and comprehensive programme can be effective in overcoming organizational barriers to the introduction of evidence-based multisectoral interventions in one Russian region. This can help facilitate significant and sustainable changes in policy and reduce institutionalization.

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Une traduction en français de ce résumé figure à la fin de l'article. Al final del artículo se facilita una traducción al español. الترجمة العربية لهذه الخلاصة في نهاية النص الكامل لهذه المقالة.

Introduction

Mental illness is a major global health burden[1] with substantial societal and economic consequences.[2] In developed countries, around 66% of people with mental disorders do not receive treatment, but in developing countries this figure reaches 90%.[3,4]

In Europe, after cardiovascular illness, mental disorders account for the second-highest burden of disease.[5] This is particularly the case in the Russian Federation and the countries in economic and social transition around them. Following the collapse of the Soviet Union, this region experienced increased mental illness and high suicide rates along with widened socioeconomic inequalities, high mortality from alcohol and tobacco-related diseases, rapidly rising HIV incidence and declines in life expectancy.[6–10]

The WHO Global Burden of Disease study – which used limited data from the Russian Federation[11] – estimated unipolar depression to account for 4% of the country's total burden of disease in 2002.[12] The suicide rate peaked in the mid-1990s, when for men aged 50–54 years this was over six times that seen in the United States of America: 139 and 22.5 deaths per 100 000 population, respectively.[13] In 2002, Russian men had the second-highest rates of suicide in WHO European Region, with rates of 69.3 per 100 000 males and 97.2 per 100 000 in the 45–54 year old age group.[13,14] Between 1990 and 2000, the number of individuals registered as disabled because of mental illness increased by 17.4% to reach 861 650. This accounts for 20% of all people registered as disabled in the Russian Federation.[15,16]

The isolation of Russian psychiatry during Soviet times and limited funding of mental health services severely curtailed access to new evidence.[17,18] Consequently, most practitioners lack the knowledge and skills required to deliver a range of effective medical and psychosocial treatments necessary for community-based care.

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Moreover, despite the high burden of mental illness globally, the Millennium Development Goals do not directly include targets for mental disorders; thus these illnesses attract meagre investment by international donors.[19] Consequently, donor investment to reform mental health services in eastern Europe, when available, has been sparse, short-term and unisectoral.[20]

Although a Declaration and Action Plan endorsed by all WHO European Member States prioritized mental health in Helsinki in 2005,[21,22] the Russian Federation and post-communist countries have yet to introduce reforms to enable innovative treatments to be embedded in routine care.[23,24]

We summarize the main interventions employed and outcomes achieved by a research project funded by the United Kingdom (UK) Department for International Development. This project adopted an integrated and multifaceted approach to mental health reform in the Russian Federation that aimed to promote social inclusion of people with mental illness.

Methods

The study was implemented between 2002 and 2004 in Sverdlovsk oblast (available at: http://www.iop.kcl.ac.uk/departments/?locator=430&project=10256) in three pilot areas: urban, semi-urban and rural. It was directed by a multidisciplinary group of UK-based and Russian professionals led by the Institute of Psychiatry in London and the government of the Sverdlovsk oblast,[1] in collaboration with the Russian Federal Government, WHO, and local municipalities and universities.

We employed action research,[25] using qualitative and quantitative methods of enquiry in three interlinked stages. We paid particular attention throughout to participation of local researchers and stakeholders, and to reflexivity and methodological relativism to avoid cultural bias and understand behaviours and practices in the Russian context.[26,27] Data emerging from the study were regularly discussed at individual meetings and workshops with local collaborators and key stakeholders to reinforce our inductive approach and triangulate findings.

In stage one, published data and documents on mental health issues in the Russian Federation were analysed to understand the local context. In stage two, we undertook a rapid situational assessment, an approach tailored from previous similar work in mental health (for example, see www.mental-neurological-health.net) and communicable diseases,[28–31] which included site visits, discussions with key stakeholders and key informant interviews to explore contextual and health system barriers to change and care delivery, especially those factors which hindered intersectoral approaches and the engagement of users and nongovernmental organizations (NGOs) in the planning and delivery of care. These were augmented by focus groups, direct observation of clinical practice, and further examination of documents and routine data.

The data emerging from the second stage informed the third stage of the study, which lasted two years and included the design and implementation of three major organizational and operational interventions aimed at: developing new structures to enhance intersectoral working, strengthening interagency collaboration, developing community-based services as alternatives to institution-based treatment and care, increasing the availability of social rehabilitation, and fostering meaningful involvement of users and NGOs in care processes. First, we developed federal- and oblast-level policy dialogues and created intersectoral steering committees (ISCs) at oblast and municipal levels to coordinate access to health, social care, housing, employment and other support services for clients with mental illness. Second, we established and trained multidisciplinary specialist teams (available at: http://www.iop.kcl.ac.uk/departments/?locator=430&project=10256) at each pilot site, and trained social workers (available at: http://www.iop.kcl.ac.uk/departments/?locator=430&project=10256) and generalist doctors to recognise and manage mental disorders. Training programmes, which included contemporary training materials and WHO mental illness guidelines,[32–34] were iteratively refined through ongoing analyses, participant feedback, and emerging needs articulated by local collaborators and trainers. Third, through training and technical support, we enhanced the capacity of NGOs in advocacy, service delivery and governance (available at: http://www.iop.kcl.ac.uk/departments/?locator=430&project=10256). We used interviews, focus group discussions, direct observations of clinical practice, teamwork and intersectoral liaison to understand how our interventions influenced policy and practice.

We assessed the effectiveness of training using validated questionnaires comparing pre- and immediate post-course assessment of knowledge, followed by interviews and focus group discussions to ascertain if knowledge and skills gained were applied when planning and delivering services.

We used routinely collected data from the regional Health and Social Protection ministries to measure service utilization by mentally ill clients, the number of dedicated beds for treating patients with mental illness, and admission/readmission rates. There were no routinely collected patient-level data on outcomes.

Results

The health system context

Mental health has traditionally been a low priority within the Russian health system. While landmark legislation in 1992 guaranteed the rights of individuals with mental health problems, resources to support the system's modernization have been insufficient. In the mid-1990s, the federal Urgent Measures for Improving Psychiatric Care programme received only 0.2% of gross domestic product (GDP) in funding and could not be implemented, while it has been contended that in some institutions in the late 1990s there were insufficient funds to provide adequate nutrition for inpatients.[35] The need to further improve mental health services was recognized in the federal Psychiatric Care Network Reorganization programme for 2003–2008. This initiative set objectives of improving access to services and conditions in mental health hospitals; expanding outpatient services, day-care facilities and sheltered workshops; and bringing psychiatric dispensaries closer to patients' homes.

The federal health ministry develops legal and regulatory frameworks, strategies and policy guidance for delivery of all specialist health programmes, including mental health, which are used by oblasts to develop local strategies. They, along with municipal administrations, are responsible for most mental health services.

Care remains predominantly institution-based, provided in 2004 through 279 psychiatric hospitals and 110 inpatient departments within 171 psychiatric dispensaries,[36] each serving a population of approximately 25 000. Specialist psychiatric units serve people who also have tuberculosis. Care can be provided in psychiatric departments within general hospitals as well. The Russian Federation continues to have one of the highest levels of psychiatric beds per capita in Europe at 113.2 per 100 000 population, or more than 161 000 beds in 2005.[37] Ambulatory care is provided through 171 psychiatric dispensaries, 2271 psychoneurological doctors' offices, 12 psychotherapeutic centres and 1117 psychotherapeutic offices. There are 15 287 places in day-care hospitals, but community-based treatment and care facilities are very limited. While psychiatrists are numerous (13.3 per 100 000), there are few social workers (1.2 per 100 000).[38]

Individuals who do not respond well to treatment at dispensaries may be admitted to long-term social care institutions (internats), where they remain indefinitely. These internats, managed by oblast Social Protection ministries, provide places for approximately 125 000 people.[38]

Mental health services are predominantly funded through government budget transfers and allocated by oblast finance ministries, largely on the basis of historical expenditure and available infrastructure rather than according to population need or the burden of mental illness. Psychiatric hospitals absorb a high proportion of this budget but meet a relatively small proportion of population need. Funds are "locked" within these long-stay institutions, which have perverse incentives to maintain high bed-occupancy levels as they are paid by bed-days. Regulations prevent resource transfers or budget-pooling to coordinate provision across sectors, for example to invest in social housing, supported employment or vocational rehabilitation services. These regulations prevent interaction between different specialist health-care programmes, general health services and social protection sectors,[39–41] and constrain NGOs from playing roles in planning and care delivery.

Absence of contemporary training materials and evidence-based guidelines hinder effective care. The lack of multidisciplinary teams prevents individualized multi-axial assessment and treatment. Intersectoral collaboration between health, social protection, employment and housing agencies is limited not by explicit government prohibitions, but rather because agency staff members are wary of interdepartmental or intersectoral communication that might be construed as political. Civil society resources are few, and family care-givers are isolated from wider networks of support. This encourages families to accept their relatives' placement in internats, particularly as they then bear no financial responsibility for long-term care costs.

Impact of interventions

Organization, regulation and service delivery

The situational analysis identified several attitudes and beliefs likely to impede change. The first of these is reliance on a narrow model of mental disorders that focuses primarily on the medical treatment of psychiatric symptoms and underestimates psychological and environmental factors' effect on illness course and outcome. The second factor is therapeutic pessimism concerning the possibility of recovery from severe and enduring mental illness, and an associated belief in the necessity for long-term protective institutional care for most patients. The third impediment is a hierarchical approach to clinical decision-making where the psychiatrist assumes responsibility for directing assessment and treatment activities, limiting input from other disciplines. Finally, there is an incorrect belief that proposed changes to the service structure and clinical practice would contravene existing legal or regulatory guidelines, that treating mental health problems in primary care is not allowed, and that community social workers are forbidden to care for people with mental illness. Analysis of regulatory and legal documents and subsequent clarification with Russian lawyers revealed no such legal or regulatory barriers. Communicating these findings to key stakeholders was a critical step in dispelling myths about barriers to reform and in securing support.

The project established intersectoral collaboration at strategic and operational levels. At the strategic level, intersectoral collaboration and coordination was achieved through the ISCs – now well-established with high-level political support, chaired by the health minister at oblast level and by mayors at the municipal level. At the operational level, multidisciplinary specialist teams that include psychiatrists, social workers, nurses, psychologists and occupational therapists have been established at the three pilot sites. They undertake multi-axial assessments, develop care plans, initiate treatment and rehabilitation programmes for clients to ensure community-based care with minimal hospitalization, regularly review progress of clients and revise treatment programmes, and intensively work at the start of an illness episode to prevent social exclusion, job loss and adverse affects on families.

The ISCs, which meet at least once every three months, analyse problems to inform policy. They have established hostels and social housing, created sheltered work opportunities and fostered close working links between multidisciplinary specialist teams and medical, social and educational assessment committees.[2] They also have assisted in developing social services for people with mental illness living in the community, and encouraged the inclusion of NGOs as an integral part of service delivery.

Return to employment is a critical component of social inclusion. The project worked with federal- and regional-level officials to establish return-to-work programmes. For example, the Federal Employment Service has set up a federation-wide programme to encourage people with disabilities back to work. Hitherto, in Sverdlovsk at least, this programme had largely ignored people with mental illness, so the project worked with the oblast Ministry of Social Protection and the Federal Employment Service in Sverdlovsk to establish an initiative to help people with mental illness return to work. At regional level, municipal employment officers are now invited to participate in municipal and oblast ISCs and to share job vacancies with mental health teams, and employment centres collaborate with mental health services to provide ongoing support to clients.

The project has strengthened vertical links between the federal and oblast health ministries in relation to mental health. Joint meetings in Sverdlovsk and Moscow were held to discuss project implementation, mental health policy and broader social, employment and

housing policy issues affecting mental health care. These meetings led to a federal mental health policy within the Prevention of and Struggle Against Socially Significant Diseases 2007–2011 framework. Collaboration with the Ministry of Social Protection has led to the appointment of municipal social workers to aid people with mental illness.

Impact of training and development

Forty-six generalist physicians completed the training course on mental health offered by the project, with a further 204 physicians trained by local staff. By 2012, another 927 physicians (223 general practitioners and 704 polyclinic-based district physicians) in the oblast will receive this training.

Ninety-three mental health workers completed the project specialist training programmes with significant resulting knowledge gains (Table 1). While the UK-based trainers instructed cohorts 1 and 2, cohort 3 was taught by Russian trainers selected from previous cohorts. The Russian-trained cohort achieved knowledge gains comparable to those achieved by previous cohorts, indicating that they were able to effectively reproduce the training. Key informant interviews and focus groups demonstrated that the specialist training programme has helped foster enduring changes in practice. It did this by creating a critical mass of practitioners capable of delivering multidisciplinary assessment and treatment as routine care, and by training members of the local clinical and academic workforce to replicate the training programme, enabling wider knowledge of novel treatment approaches.

This training programme has been incorporated into the curricula of the oblast medical college and oblast medical academy, which train nurses, psychiatric nurses, general doctors, psychiatrists, social workers and psychologists. The programme has particularly influenced the advanced training course developed by the oblast medical college for retraining nurses as social workers, which is now used throughout the Russian Federation. The fifty-three municipal social workers trained by the project (http://www.iop.kcl.ac.uk/departments/?locator=430&project=10256) were subsequently integrated with local intersectoral and multidisciplinary teams.

Table 1. **Group mean knowledge test scores, pre- and post-training, of specialist mental health professionals**[a]

Group	Pre-training	Post-training	95% CI of difference	2 tailed significance
Cohort 1 ***N*** **= 21**	36.0%	59.8%	20.1–27.5	0.000
Cohort 2 ***N*** **= 25**	37.0%	53.6%	13.6–19.6	0.000
Cohort 3 ***N*** **= 31**	34.9%	52.1%	14.3–20.0	0.000
Combined ***N*** **= 77**	35.9%	54.7%	16.9–20.7	0.000

CI, confidence interval.

[a] Full data were available for 77 out of a total of 93 participants.

These training initiatives succeeded in part because senior officials at ministerial level gave prior approval and because intensive efforts were made to facilitate dialogue between the ministries. Workshops with the federal Ministry of Health and Social Protection and three conferences with the Russian Psychiatric Association showcasing the Sverdlovsk project transferred the experience in Sverdlovsk to other Russian oblasts. Human resource development undertaken by the project is summarized in Table 2.

Service utilization, efficiency and access

Service delivery approaches are shifting towards community-based care in all pilot sites, giving patients improved access to social rehabilitation programmes and industrial rehabilitation workshops, as well as to hostels for formerly institutionalized patients. Establishing supported housing proved particularly difficult, with only one pilot site creating a small number of places. Self-help groups have been established in all the pilot sites. In pilot sites 2 and 3, the number of individuals with psychosis who have obtained employment has substantially increased. These two pilot sites now routinely gather client satisfaction data, and more clients receive multi-axial care plans. (Table 3).

Table 4 shows admissions and readmissions levels in the pilot sites and Sverdlovsk oblast from 2001 through to 2006, two years after the project ended. While there has been little change in the number of beds available, admission rates between 2001 and 2004 fell in all pilot sites. These data must be treated with caution, partly because of the availability of new population census data for the Russian Federation from 2002 and changed municipal catchment areas, which in pilot site 3 artificially reduced the admission rate. Pilot site 1 merged with another facility during the project, meaning that the full impact of reduction in bed use cannot be identified.

Nonetheless, the number of admissions in pilot site 1 fell from 2323 to 988, a 57% decrease, while in pilot site 2 these decreased from 3358 to 3178, a 5.3% decrease. Moreover, reductions in admissions were maintained in two subsequent years. In the entire oblast, between 2001 and 2004 admissions increased from 26 501 to 27 197 before declining to 24 636 by 2006. By 2006 rates of readmission in all three pilot sites were below the readmission rate observed in the oblast as a whole.

Impact on NGO involvement

Training and capacity building of eight NGOs enabled their further development and integration as care providers. Seven of these had established self-help groups, and all had developed employment programmes or programmes that offered people more meaningful activity, even if they were not able to earn a real income. NGOs successfully implemented grant funded projects to create eight new employment and housing projects across the oblast.

By the project's end two new NGOs were established. The ISCs also involved both NGO activists and users, acknowledging their importance and raising their profile as care providers; this was a fundamental shift from the deep-rooted suspicion about NGOs revealed in the initial situation analysis.

Table 2. **Human resource training developments**

Cadre	Numbers trained directly by the project	Sustainability
Generalist physicians (GPs)	46 of 927 (223 GPs plus 704 polyclinic-based physicians)	The local trainer, a lecturer in Sverdlovsk Oblast Medical Academy's family medicine department, has trained a further 74, and the entire oblast will be trained by 2012.
Specialist mental health workers (psychiatrists, nurses, social workers, psychologists, occupational therapists)	93 of 289	The course materials have been adopted into basic, post-basic, and continuing professional development training curricula for these cadres; the 4 local trainers are senior lecturers in the oblast's medical college and medical academy.
Municipal social workers	53 out of 495 in the pilot municipalities	These social workers are now assigned to mental health care in the community.
Employment agency workers	3[a]	There are as yet no plans to undertake further training of these workers.
MSEC officers	4[a]	There are as yet no plans to undertake further training of these workers.
Oblast medical college trainers	2 of 2	These trainers are leading courses for nurses, social workers and occupational therapists.
Oblast medical academy trainers	9 of 9	These trainers are leading medical students' basic training and psychiatrists' postgraduate training and continuing professional development.
University department of family practice trainers	2 of 2	One of these two trainers is leading the mental health continuing education of all oblast generalist physicians, developing a cadre of trained family practice physicians.

MSEC, Medical and Social Assessment Committee.
[a] Total number unavailable.

Discussion

Implementing the study was challenging and required iterative and sustained engagement with local stakeholders. This process developed a holistic vision for the evolution of services and helped stakeholders perceive that change was feasible and that multiple interventions were possible and realistic. Despite perceived legal, structural and financing barriers that prevent flexible use of financial and human resources, it is possible in the Russian Federation to develop intersectoral and multidisciplinary approaches to manage mental illness.

We show that demonstrable improvements in pilot projects can be used to disseminate good practice and to inform policy at regional and federal levels. For example, while the regional government in Sverdlovsk has indicated its commitment to scale up the project from pilot sites to cover the whole region, the Russian government has arranged for wider dissemination of project outcomes and materials across the federation, including project guidelines for developing mental health policy and for treating mental illness in a primary-care setting.

The study has shown that within existing regulations and organizational structures in the Russian Federation it is possible to establish ISCs to encourage intersectoral planning, modify care approaches to develop alternative community-based service models delivered by multidisciplinary teams, improve social rehabilitation coverage, and extend employment and housing opportunities for people with mental illness.

Replicating this progress across all 89 regional divisions in the Russian Federation will be challenging, but the High Level Working Group for Tuberculosis Control in the Russian Federation convened by WHO has demonstrated that cross-learning among regions and between the regional and federal levels is possible.[42]

The long-term impact of mental health training will be influenced by the extent to which the trained physicians remain in primary care, which needs strenghening.[43] Yet the pilot sites' experiences show that primary health care and community-based approaches are possible.[44]

In spite of these achievements, five key barriers need to be addressed if the Russian Federation is to shift away from

Table 3. **Number of clients with multi-axial care plans, accessing sheltered work and obtaining employment**

Indicator		2001	2002	2003	2004	2005
Sheltered work						
Hospital 29	Pilot site 1	0	0	2	6	12
Nizhny-Tagil	Pilot site 2	90	90	90	135	135
Pervouralsk	Pilot site 3	0	0	0	35	35
People with psychosis obtaining employment						
Hospital 29	Pilot site 1	0	1	2	3	3
Nizhny-Tagil	Pilot site 2	0	0	45	62	39
Pervouralsk	Pilot site 3	1	7	4	51	17
Number of clients with multi-axial care plans						
Hospital 29	Pilot site 1	0	4	6	6	9
Nizhny-Tagil	Pilot site 2	0	0	52	166	262
Pervouralsk	Pilot site 3	0	0	26	44	39

Table 4. **Psychiatric beds, admissions and readmissions in the three pilot sites and the Sverdlovsk Region, 2001–2006**

	2001		2002		2003		2004		2005		2006	
Catchment area adult population	**Population**		**Population**		**Population**		**Population**		**Population**		**Population**	
Hospital 29 (pilot site 1)	187 500		187 500		187 500		187 500		187 500		187 500	
Nizhny-Tagil (pilot site 2)	668 421		672 619		708 791		708 791		768 750		768 750	
Pervouralsk[a] (pilot site 3)	126 984		216 216		216 216		216 216		210 526		210 526	
Sverdlovsk oblast	4 563 810		4 509 524		4 363 208		4 376 190		4 482 178		4 492 000	
Russian Federation[b]	144 386 752		143 525 696		143 452 528		143 821 216		143 113 888			
Beds per 10 000 pop	**Rate**	**Beds**	**Rate**	**Beds**	**Rate**	**Beds**	**Rate**	**Beds**	**Rate**	**Beds**	**Rate**	**Beds**
Hospital 29 (pilot site 1)	8	150	4.8	90	4.8	90	4.8	90	4.8	90	4.8	90
Nizhny-Tagil (pilot site 2)	9.5	635	8.4	565	9.1	645	9.1	645	8.0	615	8.0	615
Pervouralsk[a] (pilot site 3)	12.6	160	7.4	160	7.4	160	7.4	160	7.6	160	7.6	160
Sverdlovsk oblast	10.5	4 792	10.5	4 735	10.6	4 625	10.5	4 595	10.1	4 527	10.0	4 492
Russian Federation[b]	11.7	168 693	11.6	166 194	11.5	164 752	11.4	163 384	11.3	161 748		
Admissions per 10 000 pop	**Rate**	**Admissions**	**Rate**	**Admissions**	**Rate**	**Admissions**	**Rate**	**Admissions**	**Rate**	**Admissions**	**Rate**	**Admissions**
Hospital 29 (pilot site 1)	123.9	2 323	43.2	810	60.1	1 127	52.7	988	61.3	1 150	43.7	820
Nizhny-Tagil (pilot site 2)	50.2	3 358	46.0	3 095	44.0	3 121	44.8	3 178	40.2	3 087	38.8	2 983
Pervouralsk[a] (pilot site 3)	80.3	1 020	46.0	995	47.4	1 024	49.5	1 070	51.1	1 075	50.4	1 061
Sverdlovsk oblast	58.1	26 501	57.4	25 898	60.6	26 454	62.1	27 197	55.7	24 949	54.8	24 636
Russian Federation[b]	47		46.8		47.2		46.9					
Readmissions as % of all admissions	**%**	**Readmissions**	**%**	**Readmissions**	**%**	**Readmissions**	**%**	**Readmissions**	**%**	**Readmissions**	**%**	**Readmissions**
Hospital 29 (pilot site 1)	11.0	256	19.6	159	19.9	224	19.3	191	18.3	211	17.8	146
Nizhny-Tagil (pilot site 2)	28.9	970	16.4	507	24.8	774	28.0	889	20.5	632	18.6	556
Pervouralsk[a] (pilot site 3)	26.6	271	17.3	172	15.3	157	12.2	131	11.5	124	9.0	96
Sverdlovsk oblast	22.6	5 976	19.4	5 012	22.3	5 905	21.8	5 921	22.2	5 538	20.3	4 999
Russian Federation[b]	21.6		21.7		21.8		21.5					

[a] Two municipalities were added to the catchment area for Pervouralsk in 2002.
[b] Bed numbers and population for Russian Federation from WHO Health For All Database 2007.

hospital-centred mental health services emphasizing institutionalization and towards multisectoral approaches that foster community-based services supported by multidisciplinary teams.

First, funding of mental health services is based on the existing number of hospital beds and bed occupancy rate, which in turn determine staff levels and other inputs. This provides perverse incentives for health-care providers to maintain existing beds and hospitalize patients with mental illness. Existing resource allocation and provider payment systems should be changed to ensure efficient providers are not penalized for downsizing capacity.

Second, the Russian regulations stipulate periods of hospitalization for patients with mental illness. These need revising, combined with economic incentives to discourage undue delays in discharging individuals from inpatient care.[45]

Third, downsizing the hospital sector and shifting to community-based care require reducing or redeploying staff. This is politically difficult to achieve and requires carefully designed human resource policies.

Fourth, because community-based services for mentally ill patients and social support for the unemployed majority of these patients are underdeveloped, it is difficult to rapidly implement lower-cost and therapeutically more effective alternatives to inpatient care. Investment is needed to develop these sectors.

Fifth, financing regulations in the Russian Federation prevent pooling of sectoral budgets and shifting funds from health sectors to social protection sectors. Revision is required in regulations that discourage multisectoral policies and co-financed community-based interventions that encourage deinsitutionalization and develop community-based supports.

The Russian Federation has declared its commitment to mental health reform.[21,46] The recent merger of the federal ministries of health, labour and social protection facilitates coordinated planning, resource pooling and integration of health and social protection services to address the complex needs of people with mental illness. In the short term, the constraints identified above pose a challenge to attaining rapid and substantial improvements, but with strong leadership these changes are feasible.

Current policies that focus on population health[47] need to embrace mental health along with the more visible factors that have contributed to the demographic crisis in the Russian Federation.[10,48] Embedding mental health in primary health care services creates the opportunity to benefit from the Presidential Priority Health Project, which is injecting approximately US$ 4 billion per year to the primary health care system over three years.[49]

We tried to address our study's limitations. We were unable to measure outcomes, because our sponsor's changing priorities reduced funding in the final year these studies were planned. We used routinely available data to assess results instead. We used qualitative research with theoretical rather than random sampling of stakeholders.

Our findings nonetheless have important implications for mental health care in the Russian Federation and the wider region where similar systems exist. Introducing community-based care and using existing resources more efficiently require reform of health system standards and of regulations related to planning, financing and clinical care. Such changes take time, and reforms should focus on carefully developed medium- to long-term system improvements rather than short-term fixes that cannot be sustained. ■

Competing interests: None declared.

Résumé

Réforme de la santé mentale dans la Fédération de Russie : démarche intégrée favorisant l'intégration sociale et le rétablissement des malades

Objectif Faciliter la réforme de la santé mentale dans une région (oblast) russe par une approche systématique de la conception et de la mise en œuvre des politiques dans ce domaine.

Méthodes Les auteurs ont entrepris un programme de recherche pragmatique sur trois ans, couvrant trois sites pilotes et comprenant une série d'interventions selon plusieurs axes : évaluation de la situation pour fournir une base à la planification, maintien d'un dialogue politique aux niveaux fédéral et régional pour catalyser le changement, introduction d'une collaboration multidisciplinaire et intersectorielle à tous les niveaux, organisation de formations pour améliorer les compétences des professionnels et aide aux organisations non gouvernementales (ONG) dans la mise au point de nouveaux modèles de soins.

Résultats Les programmes de formation développés dans le cadre de ce processus ont été intégrés aux programmes de formation classiques, avec comme conséquence une amélioration mesurable des compétences du personnel. Les démarches thérapeutiques se sont aussi améliorées à travers la délivrance de services multidisciplinaires et multisectoriels, le développement des activités des ONG et l'implication plus poussée des usagers dans la planification et la délivrance des soins dans tous les sites pilotes. Entre le début et la fin de l'étude, le nombre des hospitalisations a chuté dans deux des sites pilotes et dans les trois, le taux de réadmission a atteint en 2006 un niveau plus faible que dans l'ensemble de la région. Les enseignements tirés de ce programme ont servi de base à l'élaboration de politiques de santé mentale aux niveau régional et fédéral.

Conclusion Il est possible, dans une région russe, de venir à bout des obstacles organisationnels à l'introduction d'interventions multisectorielles développées à partir d'éléments factuels par un programme complet et pluridimensionnel. Un tel programme pourrait aussi faciliter des changements notables et durables de politique et réduire la bureaucratie.

Resumen

Reforma de la atención de salud mental en la Federación de Rusia: enfoque integrado para propiciar la inserción social y la recuperación

Objetivo Facilitar la reforma de la atención de salud mental en un *oblast* (región) de Rusia utilizando métodos sistemáticos para formular y aplicar las políticas.

Métodos Los autores emprendieron en tres sitios piloto un programa de acción-investigación de tres años que abarcaba un conjunto multifacético de intervenciones como la evaluación de la situación para fundamentar la planificación, un diálogo de política sostenido a nivel federal y regional para catalizar los cambios, la acción multidisciplinaria e intersectorial a todos los niveles, medidas de formación práctica para los profesionales y el apoyo a organizaciones no gubernamentales (ONG) para desarrollar nuevos modelos de asistencia.

Resultados Los programas de capacitación desarrollados a lo largo este proceso han sido incorporados en los programas de estudios habituales, con cambios cuantificables en las aptitudes del personal. La asistencia mejoró gracias a la prestación de servicios multidisciplinarios y multisectoriales, con un aumento de las actividades de ONG y la participación de los usuarios en la planificación y prestación de la asistencia en todos los sitios piloto. Los ingresos hospitalarios, determinados al comienzo y al final del estudio, disminuyeron en dos sitios piloto, mientras que la tasa de reingresos en los tres sitios piloto en 2006 fue inferior a la del conjunto de la región. Las enseñanzas extraídas han fundamentado el desarrollo de las políticas de salud mental regionales y federales.

Conclusión Un programa multifacético e integral puede ayudar a superar eficazmente las barreras organizacionales a la aplicación de intervenciones multisectoriales basadas en la evidencia en una región de Rusia, y ello puede facilitar la introducción de cambios considerables y sostenibles en las políticas y reducir los internamientos.

ملخص

إصلاح الصحة النفسية في الاتحاد الروسي: أسلوب متكامل لتحقيق الاندماج في المجتمع والشفاء

الهدف: تسهيل إصلاح الصحة النفسية في إحدى المقاطعات الروسية باستخدام أساليب منهجية لتصميم السياسات وتنفيذها.

الطريقة: نفَّذ الباحثون برنامجاً للبحوث ذات التوجه الإجرائي استغرق ثلاث سنوات، وشمل ثلاثة مواقع ارتيادية، يتألَّف من مجموعة متعدِّدة الجوانب من التدخلات واشتمل على تقييم للوضع وتقديم المعلومات للتخطيط والحوار الدائم حول السياسات على مستوى المقاطعة والمستوى الفيدرالي لتحفيز التغيير، ولإدخال العمل وفق نُظُم مختلفة وبين قطاعات مختلفة على جميع المستويات، إلى جانب التدريب الذي يستند على المهارات لدى المهنيِّين، ولتقديم الدعم للمنظمات غير الحكومية لإعداد نماذج جديدة للرعاية.

الموجودات: تم اعتماد البرامج التدريبية المعدَّة في هذه العملية وأدخلت ضمن المنهج الدراسي الروتيني وفق تغييرات قابلة للقياس في مهارات العاملين. وتحسنت أساليب الرعاية من خلال إيتاء الخدمات المتعددة القطاعات والمتعددة النظم، مع ازدياد في أنشطة المنظمات غير الحكومية، ومشاركة المستخدمين في تخطيط الرعاية وفي إيتائها في جميع المواقع الارتيادية. وقد انخفض عدد الحالات التي أدخلت للمستشفيات في نهاية الدراسة عما كانت عليه في بدئها في موقعَيْن ارتياديَّيْن، فيما انخفض معدل اعادة إدخال الحالات للمستشفيات في جميع المواقع الثلاثة حتى عام 2006 دون معدل المقاطعة الإجمالي. وقد أدت الدروس المستفادة إلى إعداد سياسات صحية نفسية على المستوى الفيدرالي وعلى مستوى المقاطعات تستند على المعلومات.

الاستنتاج: يمكن لبرنامج متعدد الجوانب وشامل أن يكون فعالاً في التغلب على الحواجز التنظيمية التي تعيق إدخال التدخلات المتعددة القطاعات المُسْنَدة بالبيِّنات في إحدى المقاطعات الروسية، ويمكن لهذا البرنامج أن يساعد في تسهيل إحداث التغييرات الهامة والمضمونة الاستمرار في السياسات وتقليص الهيمنة المؤسساتية.

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