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Mental Healthcare Reforms in Post-Soviet Russia

Negotiating new ideas and values

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ABSTRACT

This thesis provides insights into the process of mental healthcare reform in post-Soviet Russia. The reforms started in Russia in the early 1990s, following the collapse of the Soviet Union. They were triggered by a desire to conform to international standards for patients' rights within a mental healthcare system that had previously been sharply criticized for ineffectiveness and political abuse. In this study, the development of Russia's mental health policy is considered in its social and historical context and with reference to the World Health Organization's guiding principles. The thesis provides a historical review of Soviet psychiatry in order to gain a greater sense of the significance of mental healthcare reforms in post-Soviet Russia. The thesis focuses on policy issues such as patients' rights, deinstitutionalization, service users' inclusion and participation, and the prevention of stigmatization. These internationally recognized principles have provided the basis for the development of mental health policy in many countries, and could be deemed central to the analysis of the reforms in Russia.

Methodologically the study is based on interpretive policy analysis (Yanow 2000), which focuses on the meanings that policies have for a broad range of policy-relevant publics. This research started from the premise that the meanings that different interpretive communities attach to mental health policy are important for its development and implementation. In this thesis, policymakers, the media, mental healthcare staff, and the relatives of people with mental illness are considered key interpretive communities. Each study (article) provides insights into how policy principles were interpreted by a particular interpretive community. For the conceptual basis, I drew on social constructionist theory, which claims that discourses (such as those on mental healthcare reform) are tied to the cultural, social and political contexts of the particular society. I also used the concept of path dependency to analyse whether and how the Soviet background has influenced mental healthcare development.

The research aimed to answer the following questions. What kinds of similarities and differences appear in different interpretive communities' interpretations of the new mental health policy principles, and how do these interpretations relate to either support for or opposition to mental healthcare

reforms? How do different interpretive communities see the role of various actors (such as policymakers, the mass media, state institutions, non-governmental organizations, service users and their caregivers) in the reforms? How are interpretations of mental health policy constructed in terms of distinctions from and links to the Soviet historical background?

The study methods were qualitative, consisting of qualitative content analysis and thematic analysis. The research material included mental health policy documents, mass media texts from selected newspapers, and interviews with mental health professionals and family caregivers of people with mental disabilities.

The results of the study revealed that the policy discussion on patients' rights and the reorganization of mental healthcare was a significant advance over the Soviet past. However, the policy documents did not pay attention to the issues of stigmatization or users' empowerment. The media response to the new policies was largely ambivalent. Support for patients' rights was accompanied by fears about the detrimental effects of the liberalization of psychiatry on public safety. The research revealed that negative media responses to the reforms preceded the policy programme for deinstitutionalization, creating an unfavourable climate for its implementation. There were also multiple gaps between policy planning and practice in Russia. The way the policy was introduced by the government and represented by the mass media contributed to a distrust of the reforms among citizens affected by the policy. Deinstitutionalization met with little support from professionals or family caregivers. The professionals criticized the new policies and were suspicious of reform, arguing for the preservation of the existing system. They perceived psychiatric institutions as a means for the social control and protection of people with mental illness and their families. Simultaneously, caregivers were strongly concerned about the high risk of losing the support they received from existing services.

In sum, the results of this study demonstrate that transferring mental health policy ideas across national boundaries is a complex process. This underlines the importance of seeking balance between internationally driven initiatives and the readiness and willingness of the receiving country to accept the proposed changes.

TIIVISTELMÄ

Väitöskirjassa tarkastellaan mielenterveyspalvelujen reformien prosessia, joka alkoi Venäjällä 1990-luvun alussa Neuvostoliiton hajoamisen jälkeen. Reformien taustalla oli pyrkimys saattaa potilaiden oikeuksien turvaaminen kansainvälisten suositusten mukaiseksi palvelujärjestelmässä, jota oli aiemmin kritisoitu voimakkaasti tehottomuudesta ja psykiatrisen hoidon väärinkäyttämisestä poliittisiin tarkoituksiin. Tässä tutkimuksessa Venäjän mielenterveyspolitiikan kehitystä tarkastellaan sekä sosiaalisessa ja historiallisessa kontekstissaan että suhteessa Maailman terveysjärjestön (WHO) suosituksiin. Tutkielmassa luodaan katsaus neuvosto-psykiatrian historiaan, minkä pohjalta voidaan arvioida mielenterveyspalvelujen reformien tärkeyttä nyky-Venäjällä. Tutkimus keskittyy potilaiden oikeuksiin, laitoshoidon purkamiseen, palvelujen käyttäjien osallistamiseen sekä stigmatisoitumisen ehkäisyyn politiikan tavoitteina. Nämä kansainvälisesti tunnustetut periaatteet ovat toimineet mielenterveyspolitiikan kehittämisen perustana monissa maissa, ja ovat siten keskeisessä asemassa myös analysoitaessa reformeja Venäjällä.

Metodologialtaan tutkimus perustuu tulkinnalliseen politiikka-analyysiin (interpretive policy analysis, Yanow 2000), jossa keskitytään siihen, millaisia merkityksiä politiikalla on erilaisille ryhmille. Tutkimuksen lähtökohtaisena oletuksena on, että erilaisten politiikkaa tulkitsevien yhteisöjen (interpretive communities) mielenterveyspolitiikkaan liittämillä merkityksillä on tärkeä sijansa politiikan kehittämisessä ja toimeenpanossa. Politiikan suunnittelijat ja päättäjät, media, mielenterveyspalvelujen henkilöstö sekä mielenterveysongelmista kärsivien läheiset nähdään tässä tutkimuksessa tärkeimpinä tulkintoja tuottavina yhteisöinä. Osatöissä (artikkelit) tutkitaan eri toimijoiden tapoja ymmärtää politiikan suuntaviivoja. Käsitteiden osalta tukeudutaan konstruktionistiseen teoriaan, jonka mukaan esimerkiksi mielenterveyspalvelujen reformeja koskevat diskurssit ovat sidoksissa yhteiskunnan kulttuuriseen, sosiaaliseen ja poliittiseen kontekstiin. Polkuriippuvuuden käsitettä käytetään analysoitaessa sitä, miten neuvostoajan perintö on vaikuttanut mielenterveyspalvelujen kehitykseen.

Tutkimuksen tarkoituksena on vastata seuraaviin kysymyksiin. Miten eri tulkinnan yhteisöjen käsitykset uudesta mielenterveyspolitiikasta eroavat toisistaan

tai vastaavat toisiaan, ja kuinka nämä tulkinnat tukevat tai vastustavat reformeja? Kuinka tulkinnan yhteisöt näkevät eri toimijoiden (kuten politiikan suunnittelijat, päättäjät, media, valtion laitokset, kansalaisjärjestöt, palveluiden käyttäjät ja heidän hoitajansa) roolin reformien toteuttamisessa? Millä tavoin mielenterveyspolitiikan tulkinnat rakentuvat suhteessa neuvosto-menneisyyteen? Tutkimuksessa käytettiin menetelminä laadullista sisällön analyysiä ja teema-analyysiä. Aineisto koostui mielenterveyspolitiikkaa käsittelevästä asiakirja-aineistosta, sanomalehtiaineistosta sekä mielenterveysalan ammattilaisten ja omaishoitajien haastatteluista.

Tutkimuksen mukaan mielenterveyspoliittisessa keskustelussa on edetty merkittävästi potilaiden oikeuksien ja mielenterveyspalveluiden uudelleenorganisoinnissa. Politiikkaa koskevissa asiakirjoissa ei sen sijaan ole kiinnitetty huomiota palveluiden käyttäjien kokemaan stigmaan tai heidän voimaannuttamiseensa. Median tapa käsitellä uutta politiikkaa oli suurelta osin ristiriitainen. Potilaiden oikeuksia puolustavan näkemyksen rinnalla tuotiin esiin pelko psykiatrisen hoidon vapautumisen aiheuttamasta vahingollisesta vaikutuksesta yleiselle turvallisuudelle. Analyysi paljasti, että laitoshoidon purkua koskevan toimenpideohjelman toteuttamista edelsi aiheen saama negatiivinen mediajulkisuus. Tästä seurasi epäsuotuisa mielipideilmapiiri, joka vaikeutti toimenpideohjelman toteuttamista. Tutkimuksessa kävi myös ilmi, että politiikan suunnittelu ja toteuttaminen eivät aina vastanneet toisiaan. Tavat, joilla hallinto esitteli politiikan tavoitteet, ja joilla media aiheesta uutisoi, oli omiaan lisäämään politiikan kohteina olevien ihmisten kokemaa epäluuloa reformeja kohtaan. Laitoshoidon purkaminen sai mielenterveysalan ammattilaisilta ja mielenterveyden häiriöistä kärsiviä omaisiaan hoitavilta ihmisiltä niukasti tukea. Ammattilaiset kritisoivat uusia ohjelmia, suhtautuivat epäluuloisesti reformeihin ja puolustivat olemassa olevan järjestelmän säilyttämistä. Psykiatriset hoitolaitokset edustivat heille keinoa sosiaalisen kontrollin säilyttämiseen sekä potilaiden ja heidän perheidensä suojeluun. Omaisiaan hoitavat olivat hyvin huolissaan mahdollisuudesta menettää nykyisistä palveluista saamansa tuki.

Kaiken kaikkiaan tutkimuksen tulokset osoittavat, että mielenterveyspoliittisten ideoiden siirtäminen kansallisten rajojen yli on monimutkainen prosessi. Tämän vuoksi on tärkeää sopeuttaa kansainväliset aloitteet vastaanottavan maan valmiuksiin ja halukkuuteen hyväksyä ehdotetut muutokset.

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List of original pubications

1: Shek O., Pietila I., Graeser S. & Aarva P. (2010) Redesigning mental health policy in post-Soviet Russia: a qualitative analysis of health policy documents (1992-2006), International Journal of Mental Health, 39 (4), 16-39.

2: Shek O., Lumme-Sandt K. & Pietilä I. (2016) Mental Healthcare Reforms in post-Soviet Russian Media: Negotiating New Ideas and Values, European Journal of Mental Health, 11(1-2), 60-78.

3: Shek O. & Pietilä I.(2016) The limits for deinstitutionalization of psychiatry in Russia: perspectives of professionals working in out-patient mental health services, International Journal of Mental Health, 45(2), 118-134.

4: Shek O. & Pietilä I.(2017) Family Caregivers' Views on the Deinstitutionalisation of Psychiatry in Russia, The Journal of Social Policy Studies,15 (1),143-156.

Abbreviations

WHO: World Health Organization
RF: Russian Federation
USSR: Union of Soviet Socialist Republics
NGO: non-governmental organization
I: newspaper Izvestia
T: newspaper Trud
AiF: newspaper Argumenty i Fakty
RG: newspaper Rossiiskaya Gazeta
KP: newspaper Komsomolskaya Pravda

1 INTRODUCTION

Mental health policy in the RF has undergone substantial changes aimed at reforming mental health services after the fall of the Soviet Union. From the late 1980s and early 1990s onwards, democratic principles began to enter different branches of Russian social and health policy. In the post-Soviet period, Russia's aspirations to enter the world community as a state that respects the rights of all citizens has led to an intention to develop new mental health policies based on approaches consonant with the principles of the World Health Organization (WHO 2003, 2005a, 2005b). The development of mental health policy in post-socialist countries was to a large degree instigated by international organizations such as the Council of Europe and the WHO, with mandates covering human rights and the reorganization of mental healthcare services (Petrea 2013). These prestigious international organizations are influential drivers of international knowledge transfer in the field of mental health. An important challenge in the transfer of new ideas is to account for the specific socio-cultural context of the receiving society. This study aims to increase the understanding of mental health policy developments in post-Soviet Russia in their political, social and historical context, using the WHO guiding principles on mental health policy as a starting point.

Although post-socialist countries including the RF have declared their commitment to mental healthcare reform, the policy changes in many respects have been very limited and slow (Petrea 2013). While each country has a unique profile, there are some common features inherited from the socialist system, leading to similar tendencies in mental health policy development (Rose & Lucas 2006). We can observe that know-how about modern mental healthcare and the direction of needed reforms is available in policy programmes, but this does not necessarily lead to their actual implementation (Dlouhy 2014). There is a lack of research providing systematic understanding of the reasons for the gap between policy aspirations and the way people with mental illness are treated and integrated into society. According to the WHO (2005c) definition, mental health policy is an organized set of values, principles and objectives for improving mental health and reducing the burden of mental disorders in a population. These values and principles are the basis on which governments establish the aims of their own policy and develop programmes as well

as courses of action. As Thornicroft and Tansella (1999) note, reforms in mental healthcare policies are based on ideas regarding "good care" that are often not made explicit or discussed. These underlying values should be made more transparent, so that opposing views, hidden assumptions and unintended consequences can become known.

Before presenting the background of the research, I will briefly describe the methodological approach used in this study, which has led to the use of certain terminology throughout the paper. The study uses interpretive policy analysis (Yanow 1996, 2000, 2007) as its methodology. The interpretive approach is based on the idea that our social world is characterized by the possibility of multiple interpretations (Yanow 2002). In this analytic framework, the notion of policy, whether as legislative document or political intention, is implicitly or explicitly replaced by the multiple interpretations of various policy-relevant publics. Policy-relevant groups become interpretive communities by sharing thoughts, speech, practices and meanings (Yanow 2000). In this study, policymakers, the mass media, mental health professionals and the family caregivers of people with mental disabilities are considered interpretive communities with their own opinions of mental healthcare reforms. Although these interpretive communities have different degrees of influence and power, I suggest that each of them plays a particular role in supporting or opposing mental healthcare reforms. In my discussion, I draw conclusions about the possible influence of their interpretations of mental health policy implementation and development.

This doctoral thesis consists of four articles published in international refereed scientific journals. At the first stage of the study (the first and second articles), the analysis focused on aspects of mental health policy that dealt with issues related to the key principles articulated in WHO documents (WHO 2003, 2005a, 2005b). These were patients' rights; an integrative approach suggesting attention to the social determinants of mental health and illness; the reorganization of mental health services to foster deinstitutionalization; activities preventing stigmatization; and the empowerment of people with mental illness and their caregivers. These principles provide the basis for the development of mental health policy, and could be considered central to the analysis of post-Soviet Russian mental health policy's distinctiveness from and links to its Soviet background. In the third and fourth articles, the research topic narrowed to focus on deinstitutionalization. The data collection for the third and fourth articles took place in one of the largest cities in the RF. The city in question plays an important role in innovation processes in Russia; I was therefore interested to see whether the changes in the mental healthcare system were supported there.

2 BACKGROUND OF THE RESEARCH

2.1 Soviet mental health policy

Soviet mental health policy has a complex history with both positive and negative features. The development of mental health policy in the USSR was strongly influenced by Soviet political ideology (Korolenko & Kensin 2002). The main vision proclaimed by Communist ideology was universal access to health services (Romanov 2003). The USSR was the first state in principle to promise universal free access to healthcare services, including mental health services (McDaid et al. 2006). Although mental healthcare was mainly provided in psychiatric hospitals, a system of outpatient services existed as well. The first psychiatric outpatient clinic, called a *dispanser*, opened in Moscow in 1923. The organization of *dispansers* marked the beginning of a national system of outpatient mental healthcare across the country (Polozhij & Saposhnikova 2001). However, seeking help from a *dispanser* involved being listed on a psychiatric case register (*uchet*). Registered patients were not permitted to travel abroad, take up certain types of employment, or in some cases drive a car. Furthermore, the *uchet* was associated with negative social attitudes towards registered patients (Kotsjubinsky, Butoma & Erichev 2013). The *dispanser* also played a role in preventing patients from avoiding treatment. The *dispanser*'s staff supervised the circumstances of the patient's personal life and work (Luse & Kamerade 2014). The idea behind this system of control was to ensure that patients could participate in productive labour between periods of illness (Luse & Kamerade 2014).

The Soviet welfare state regime was based on a guarantee of full employment in society (Novak 2001). Therefore, the system of "work therapy" for people with mental disabilities was well organized in the Soviet Union (Polozhij & Saposhnikova 2001; Tiganov1999). It began in the USSR in the 1920s and continued its development throughout the Soviet period, especially after the 1960s (Tiganov 1999). Work therapy units (*lechebno-trudovyi masterskii*) for people with mental disabilities existed in outpatient and inpatient psychiatric clinics. There were also special workplaces for people with mental illnesses in industry and agriculture. However, the critical view claims that work therapy served to mask the labour exploitation of people with mental illness (Korolenko & Kensin 2002).

In the 1930s, after Stalin's rise to power, Soviet medical sciences started to become isolated from the international scientific community (Segal 1975; Vlassov & Danishevskiy 2008). Disability and illness were mainly seen in a narrow medical way as physiologically based deficiencies (Luse & Kamerade 2014). Correspondingly, it was mainly professionals with a medical education, such as psychiatrists and psychiatric nurses, who worked in mental health services at that time. There were no psychologists or social workers (Polozhij & Saposhnikova 2001). The government closed down university departments and research laboratories in psychology, and the only officially accepted "scientific" psychology was Pavlov's theory (Balachova, Levy, Isurina & Wasserman 2001; Windholz 1999). The Khrushchev era, after the death of Stalin in the 1950s, led to some positive changes in mental health policy – for example, the reopening of departments of psychology in Moscow and Leningrad (Balachova, Levy, Isurina & Wasserman 2001).

Nevertheless, the late 1950s and early 1960s witnessed the beginning of a campaign to label political opponents as mentally ill and incarcerate them in psychiatric hospitals. In a speech published in the state newspaper *Pravda* on 24 May 1959, Khrushchev declared: "Of those who might start calling for opposition to Communism… we can say that clearly their mental state is not normal" (Tomov, Van Voren, Keukens & Puras 2006: 402). When Brezhnev took power in 1964, repression increased once again, and criticism of the Soviet regime was considered a "destructive activity" that had to be restrained (Tomov, Van Voren, Keukens & Puras 2006). The absence of any specific mental health legislation made it possible to use psychiatry for political purposes and to neglect patients' rights (Appelbaum 1998). This political abuse constituted an infringement of human rights when psychiatric diagnoses were used to suppress behaviour considered political dissidence. Thus, for example, a number of political dissidents were committed to compulsory psychiatric treatment (Korolenko & Kensin 2002). High doses of antipsychotic drugs were administered by injection to punish violators of hospital rules and to treat "anti-Soviet thoughts" (Bonnie 2002). Patients were afraid to complain about their treatment, abusive staff conduct or hospital practices (McDaid et al. 2006). Thus patients' rights were severely restricted, and the dominant approach to treatment took a paternalistic orientation (Polubinskaya 2000). Cockerham, Snead and DeWaal (2002) also argue that Soviet-style socialism suppressed individuality and individual initiative, leading to the development of a passive orientation to personal health. The practice of political abuse resulted in the expulsion of Soviet psychiatry from the World Psychiatric Association in 1982 (Polozhij & Saposhnikova 2001).

During the Soviet period, the very existence of mental health problems in society was officially denied or described as a relic of the old class society. The absence of social conditions for the development of mental health problems in the USSR was proclaimed as a basic assumption (Korolenko & Kensin 2002). This claim was supported by the constant falsification of statistical data on mental illness in the USSR (Korolenko & Kensin 2002). The Communist Party-controlled media was broadly used to promote images of the prosperity of socialist society (De Smaele 2007). In this way the Soviet state attempted to demonstrate the USSR's prosperity compared with the rest of the world. In 1980 at the Moscow Olympics, when a Western journalist asked a Soviet official whether the USSR would participate in the Paralympic Games, the official stated: "There are no invalids in the USSR!" (Fefelov 1986). This incident illustrates the policy regarding people with any kind of disability during the Soviet period (Luse & Kamerade 2014). In the USSR, it was common to isolate people with disabilities by placing them in specialized residential institutions called *internats* (Phillips 2009). The system of *internats* did not offer recovery or social integration, but rather served to hide those who had become a nuisance to the Soviet state (Tomov et al. 2006).

The democratic reforms of the late 1980s and early 1990s had a significant impact on the country's mental health policy. The 1980s Gorbachev era of perestroika was characterized by "openness" (glasnost), and many new democratic principles began to appear. In the late 1980s the USSR openly admitted that psychiatry had been abused for political purposes, and this facilitated the return of Russian psychiatry to the World Psychiatric Association in 1989 (Polozhij & Saposhnikova 2001). The recognition of political abuses in psychiatry was accompanied by an anti-psychiatric campaign in Russia at the end of the 1980s; this was a difficult period for mental health professionals, who had to face accusations from patients, patients' relatives, journalists and the public at large (Polozhij & Saposhnikova 2001).

It is noteworthy that some changes had already been made to mental health services in the 1980s. During that period, mental health services were extended beyond the traditional structure based on hospitals and *dispansers*. Mental health services ("psychotherapeutic cabinets") were organized in regional general community health centres (polyclinics) (Gurovich 2007). In the beginning of the 1990s, the RF formulated new policies for mental healthcare, taking international developments into account. At the same time, the democratic reforms influenced the mass media. Becker (2004) notes that democratic media began to emerge in Russia under Mikhail Gorbachev at the end of the 1980s, and this development continued in the 1990s under Russia's first president, Boris Yeltsin. In this period the media received

substantial freedom compared with the pre-glasnost period. The democratic reforms gave journalists an opportunity to openly discuss different kinds of health and social problems in Russia. However, in Putin's Russia control over the mass media has increased again (Lipman & McFaul 2005; Becker 2014).

2.2   Burden of mental diseases in post-Soviet Russia

One of the underlying reasons for the mental healthcare reforms in post-Soviet Russia was the population health crises of the early 1990s (Polozhij 1996; Poliwuk 2005). Considerable societal changes created conditions of instability, which caused negative trends in the population's mental health (Rutz 2001; Fryers, Melzer & Jenkins 2003; Jenkins, Klein & Parker 2005). These public health crises were attributed to the upheaval in values, status and social cohesion, along with difficulties experienced by a significant number of citizens in coping with prolonged psychosocial stress (Tomov et al. 2006; Pietilä & Shek 2008). Researchers have pointed out that the early post-Soviet period was characterized by unemployment, financial difficulties, and a loss of personal identity and meaningfulness in life, all of which had a negative impact on the population's mental health (Polozhij 1996; Poliwuk & Baranskaja 2001). Varnik (cited in Tomov et al. 2006) noted that in the late 1990s, nine of the 10 countries with the highest suicide rates in the world were former socialist countries. The suicide rate in Russia doubled after 1991, reaching 44.8 per 100,000 of the total population in 1999 (Poloshij & Saposhnikova 2001), significantly higher than most European countries (WHO 2004). In 2011 the suicide rate for males was 53.9 per 100,000 and for females 9.5 per 100,000 (WHO 2011). According to a Russian study on the rate of mental disorders in general health services, a mental disorder (of any kind) was diagnosed for 57 per cent of patients in a multidisciplinary hospital, and for 80 per cent of patients in a district polyclinic (Drobizhev 2002). Another study reported that the rate of patients with depressive disorders in district polyclinics was 50–60 per cent (Tabeeva & Vejn 2000).

Between 1990 and 2000, the number of individuals registered as disabled because of mental disorders increased by 17.4 per cent, reaching 861,650 (Jenkins et al. 2007). The RF government reported that during the 10-year period from 1985 to 1995, registered disabilities due to mental illness increased by 31 per cent (Government of RF 1995). The reduction of social protection for people with mental disabilities at the beginning of the 1990s took place in the context of a general and progressive worsening of standards of living. Official documents noted an increase in the number

of mentally ill people with no means of subsistence, housing or social relations (Government of RF 1995: chapter 1). From 1991 to 2013, the rate of mental health disorders continued to rise from 2,366.8 to 2,802.4 per 100,000 of the population (Limankin 2016).

2.3   Contemporary Russian mental health system

It has been claimed that the Soviet legacy persists in the Russian mental healthcare system: the system is based mainly on institutional care, with little focus on community services or social work (Jenkins et al. 2001, 2007). Although 46,500 psychiatric beds have been cut across Russia since the 1990s – almost a quarter of the total national bed capacity – the Russian mental healthcare system is still largely based on institutional care (Kotsjubinsky, Butoma & Erichev 2013). In 2011, the number of psychiatric beds was 109.53 per 100,000 people (WHO 2011), which is notably higher than the European median of 39.4 per 100,000 of the population (Petrea 2013). A substantial proportion of patients (22 per cent) stay in hospital for more than a year, and a significant number for up to five years (Gurovich 2012). It should also be kept in mind that the average hospital stay for all causes is higher in Russia than in most European countries (Organization for Economic Cooperation and Development 2011). In Russia, patients with non-psychotic disorders, who could be treated in outpatient services, are often hospitalized in psychiatric hospitals (Lovett-Scott & Prather 2012). According to McDaid et al. (2006), the funding mechanism is the key barrier to any downsizing of institutional care in Russia, because this mechanism provides very strong incentives for institutions to maintain large numbers of beds. Jenkins et al. (2007) point to organizational barriers that block sustainable changes, because the shift to community-based care requires the reduction or redeployment of staff.

Alongside mental health hospitals, another similar type of care institution in Russia is the *internat*. The *internat* is a large psychoneurological inpatient facility, often containing more than 500 beds, in which people with mental disabilities generally remain for life (Krivoshei 2001). *Internats* are managed by the Ministry of Social Protection, while psychiatric hospitals are managed by the Ministry of Health. The mental healthcare reforms still do not extend to *internats*, and people with mental disabilities continue to receive care in the *internats* similar to that given in the Soviet period (Petrea 2013). Gurovich (2012) points out that in Russia the number of people with mental illnesses living in *internats* is 85.5 per 100,000 of the population – more

than any other European country for equivalent facilities. As Tiganov (1999) notes, there were 442 *internats* with 124,600 beds in 1999. According to the Civic Chamber of the Russian Federation (2014), there were 505 *internats* with 145,191 beds in Russia in 2013. This data indicates that a decrease in the number of psychiatric beds in hospitals has been accompanied by an increasing number of beds in *internats*. Similarly, Petrea (2013) claims that the old Soviet practice of hiding people deemed disabled translates nowadays into the practice of relocating them from mental health hospitals to *internats*.

The mental health system in Russia is also traditionally characterized by a widely developed network of outpatient clinics, such as psychoneurological *dispansers*. These services are typically a person's first point of contact with the mental healthcare system. Access to appointments in a *dispanser* is not limited by referrals from general physicians or mediated by other specialists, but is usually open, immediate and direct (Gurovich 2007). According to the WHO (2003a), the key features of community-based care are the accessibility of services and a reduced level of stigma associated with seeking help for mental disorders. As Kotsjubinsky, Butoma and Erichev (2013) note, a visit to the *dispanser* carries a lot of stigma due to the stigmatized Soviet practice of *uchet*. Additionally, in most Russian regions, *dispansers* cover large areas and large numbers of people, which does not promote the idea that people have a mental health facility nearby. In large Russian cities, a *dispanser* may be responsible for populations of over a million.

The *dispanser* falls into the WHO's (2003a) definition of stand-alone mental health services that function in isolation and do not have strong links with the rest of the healthcare system (Kotsjubinsky, Butoma & Erichev 2013). As Bartenev (2005) claims, the organizational structure of services in Russia does not allow any community-based alternative to the *dispansers*. The role of primary care staff (polyclinic staff) in providing mental health services is very limited in Russia. General practitioners are not allowed to treat mental disorders, and have to refer patients with mental health problems to specialist mental health facilities (Petrea 2013). Additionally, general practitioners are overloaded with work, and therefore they are not eager to take on new responsibilities for the treatment of people with mental health problems (Graeser & Shek 2006).

Gurovich (2007) has pointed to a number of positive changes in the organization of mental health services in the post-Soviet period. New positions were established in psychiatric services for psychologists, psychotherapists and social workers. In addition, as he observed, there was a tendency towards a broader integration of mental health services into general healthcare facilities, which could be seen in the increasing number of psychotherapeutic cabinets in polyclinics. However, in a later publication Gurovich (2012) reported a negative trend in mental healthcare reforms in Russia: the further

reduction in the number of hospital beds was not accompanied by the development of new forms of care to replace inpatient care. On the contrary, the number of services and staff available in outpatient services decreased during the period of the reforms. He noted that the number of psychotherapeutic cabinets in general healthcare services had decreased since 2009. The number of *dispansers* has also decreased, from 154 to 98 (Limankin 2016). The system of vocational rehabilitation created in the Soviet period has been completely eliminated (Gurovich 2012). The living conditions in many psychiatric hospitals remain poor (Petrea 2013). Researchers have pointed out the chronic underfunding of psychiatric care (Savenko & Perekhov 2014) and corruption in Russian psychiatry (Savenko & Bartenev 2010). On average, mental healthcare staff in the public sector receive a salary of US$200–500 per month (Savenko & Perekhov 2014).

2.4 WHO mental health policy as a guide for national policies

One of the key international stakeholders with an important role in fostering the development of national mental health policies is the WHO, a global organization that sets standards and provides guidelines (Jenkins et al. 2011). The aim of the WHO is the achievement by all peoples of the highest possible level of health. According to the WHO's constitution, health is a state of complete physical, mental and social well-being, and not only the absence of disease or infirmity (WHO 1948). The Mental Health Division of the WHO has developed a wide range of consultative documents for governments and other stakeholders (Jenkins & Baingana 2001).

In this study, the approach to the analysis of Russian mental healthcare reforms is based on key European documents such as the Mental Health Policy and Service Guidance Package (WHO 2003), the Helsinki Declaration on Mental Health for Europe (WHO 2005a) and the related Mental Health Action Plan (WHO 2005b). These documents integrate the contributions of professionals, NGOs and service users' organizations. The documents are pivotal to mental health policy development in Europe during the period covered by this study. The Helsinki declaration and plan are based on the recognition of the importance of policy development to overcome differences in mental health policies and practices, especially between Western and Eastern countries in the European region (Thornicraft & Rose 2005). Their shared past has had an impact on the development of mental health policies in former socialist countries in Central and East Europe. The years of isolation from the rest of the world resulted in the underdevelopment of essential components of mental health

policy (Tomov 2001). The declaration aimed to build a platform for modernization in the WHO European region, learning from countries with positive experiences (WHO 2005a).

The purpose of the guidance package (WHO 2003) is to help governments to develop comprehensive policies and strategies for improving the mental health of populations, to provide effective services to those in need, and to ensure the integration of people with mental disorders into the community, thereby improving their overall quality of life. The Helsinki declaration (WHO 2005a) encourages countries to develop mental health legislation and programmes which are based on current knowledge and consider human rights a central component of mental health policy. The declaration puts the focus on the transformation of mental health services in the European region, with the aim to achieve equality and social inclusion for people living with mental illness. According to the declaration, mental health policies should be extended to the promotion of mental well-being and the prevention of mental health problems. The declaration and action plan demand the development of comprehensive and effective services, underlining that services should be provided in a wide range of community-based settings and no longer exclusively in isolated large institutions. The documents emphasize the inclusion in society of those who have experienced mental health problems, tackling stigma and discrimination (WHO 2005a, 2005b). They also encourage involvement and choice for people with mental illness and their caregivers, supporting service users' organizations in the field of mental health.

The Helsinki Declaration on Mental Health for Europe (WHO 2005a) and the related Mental Health Action Plan (WHO 2005b) were endorsed by the ministers of health of the 52 member states in the WHO European region, including the RF. Therefore, I started my research with the assumption that the key ideas and values of the WHO's mental health policies played an important role in post-Soviet Russian mental healthcare reforms. I was interested to find out how the WHO principles were interpreted by the different interpretive communities, and how these interpretations might influence the implementation and further development of mental health policy.

3 MENTAL HEALTHCARE REFORMS IN POST-SOCIALIST COUNTRIES: A LITERATURE REVIEW

Mental healthcare care systems have undergone significant changes in recent decades in many countries. Therefore, the scope of the literature covering mental healthcare reforms is rather broad. This literature review mainly focuses on previous studies of mental healthcare reforms in post-socialist countries. After the collapse of Communist ideology at the end of the1980s and beginning of the 1990s, these countries went through similar political and socio-economic changes, e.g. from a centrally planned to a market economy, and from a one-party political system towards democracy (Safaei 2012). The countries of Central and East Europe, including those of the former USSR, are often considered together, because despite their cultural and historical differences, they share the legacy of a Soviet-model healthcare system (Ho & Ali-Zade 2001). During the Communist era the Soviet Union, as well as Communist countries in Central and East Europe, had no statutes that ruled their mental health systems, and therefore patients' rights were severely restricted. After the collapse of the Soviet system, human and patients' rights in post-socialist countries were under scrutiny. Starting from the late 1990s, many researchers pointed to significant progress in the development of mental health legislation and the protection of patients' rights in former socialist countries (Appelbaum 1998; Tomov 1999; Polubinskaya 2000; Poloshij & Saposhnikova 2001; Bonnie 2002; Bartenev 2005; McDaid et al. 2006).

3.1 Studies based on statistical data and experts' reports: how reliable are the findings?

While access to information about the performance of the mental healthcare system was highly restricted during the Soviet period, the situation changed with the collapse of the Soviet system, and studies using statistical data on the mental healthcare systems in post-socialist countries began to appear. Becker and Vazquez-Barquero (2001) analysed mental healthcare reform across Europe, including in former socialist

countries, using statistical data. Based on a summary of quantitative indices and expert ratings of broad aspects of mental healthcare systems, the study concluded that all countries intended to move away from an institutional model of mental healthcare. Rutz (2001) analysed mental healthcare needs and challenges across the WHO European region of 51 nations, using the Health for All statistical database and the Health21 Programme. The study concluded that in Central and East European countries, one of the biggest obstacles to the downsizing of mental institutions was the lack of economic and social support to sustain independent living in the community, along with the stigma associated with mental illness. A more recent study by Mundt et al. (2012) reported on the provision of mental healthcare in post-socialist countries: Azerbaijan, Belarus, Croatia, Czech Republic, East Germany, Hungary, Kazakhstan, Latvia, Poland, Romania, Russia and Slovenia. Analysing the countries' statistical data and experts' reports, the study found uniform trends over the past two decades of decreasing psychiatric hospital bed numbers.

Krupchanka and Winkler (2014) examined the current state of mental healthcare systems in East Europe (Belarus, Bulgaria, Czech Republic, Hungary, Republic of Moldova, Poland, Romania, RF, Slovakia and Ukraine), using statistics available from the WHO's Mental Health Atlas (WHO 2005d, 2011, 2014a). The study reported that mental healthcare systems in these countries continued to rely on institutional care. It was found that between 2011 and 2014, despite a decrease in the number of hospitals, the number of beds in institutional care facilities increased. The largest average number of beds per hospital was found in Moldova, followed by the RF. The study concluded that despite slight progress in some post-socialist countries, the development of mental healthcare in the region remained slow, with insufficient resources allocated to mental health, and a lack of involvement of service users in policymaking.

The authors of publications based on the analysis of statistical data point to a number of limitations of their studies. Becker and Vaazquez-Barquero (2001), recognizing that their approach is rather descriptive, suggest additional data collection. Mundt et al. (2012) point to incomplete and missing data from the countries in question, and the difficulty of assessing the data quality. Krupchanka and Winkler (2014) refer to the insufficient standardization of country reports and definitions, along with the absence of quality control in data collection. They also note that databases hardly allow an assessment of the quality of the indicators. For example, although legislation reportedly exists in the majority of countries, they are unable to assess its quality. The authors conclude that the limitations they have faced reflect a

general situation of insufficient data on the functioning and development of mental healthcare systems in the region.

3.2   International collaborative projects as a main source of information on mental healthcare reforms in the region

Studies conducted in the framework of international collaborative projects present more detailed accounts of mental healthcare reforms in post-socialist countries. Many organizations work on mental health reforms in post-socialist countries, including the WHO Regional Office for Europe, the Geneva Initiative on Psychiatry, the Association of Reformers in Psychiatry in Eastern Europe, the Hamlet Trust, the Open Society Institute, the United Kingdom Department for International Development, the International Consortium for Mental Health Policy and Services, the Swiss Agency for Development and Cooperation, the Stability Pact and others. The studies conducted in the framework of such projects are the main sources of information on mental healthcare reforms in post-socialist countries available in the international literature. The participants in these projects employ action research paradigms (McCutcheon & Jung 1990; Jenkins et al. 2001, 2007; Tomov et al. 2006).

The publications of Jenkins et al. (2001, 2005) were based on statistical data and information gained through such collaborative projects. The authors claimed that mental health services in post-socialist countries continued to be heavily institutional. Hospitals were old, and there was a lack of funds for even the necessities of food and warmth. The quality of care was poor and staff morale was low. It was claimed that hospital directors were keen to admit more patients in order to increase their hospital budgets. There was a lack of funding for community care, because ministries blocked deinstitutionalization out of a concern that it would generate additional costs. The study also reported extremely limited NGO development in the field of mental health, with no culture of collaboration between the state and voluntary sectors. The new community-based services run as demonstration projects were not sustainable if the donor pulled out (Jenkins et al. 2001, 2005).

Tomov (2001) described the results of the international collaborative project "Attitudes and Needs Assessment in Psychiatry" carried out in six countries (Azerbaijan, Bulgaria, Hungary, Kirghizia, Lithuania and Ukraine). The study aimed to investigate beliefs, attitudes and needs related to mental health reform in this part of Europe. A number of focus groups were conducted within the framework of this project. The groups consisted of directors of medical services, patients who had

become activists in the human rights movement, and graduates of medicine who were about to begin specialization in psychiatry. The study found that participants in the focus groups did not question the ethics of institutional psychiatry. Professionals and users alike shared negative expectations of and attitudes towards reform, expressing helplessness and alienation. They did not regard their personal position as potentially capable of making a difference, and they pointed to the low responsiveness and open-mindedness of psychiatry, and to the community's inability to accept people with mental illness. Tomov (2001) expected that future health administrations would take on board the buzzwords of reform from countries in West Europe, in order to present themselves as belonging to the "new wave" and benefit from the financial support of demonstration projects.

A later publication by Tomov et al. (2006) draws on official country statistics from six countries (Azerbaijan, Bulgaria, Georgia, Lithuania, Russia and Ukraine) and the reports of international teams established for two collaborative projects: the abovementioned "Attitudes and Needs Assessment in Psychiatry" project (Tomov 2001), and the project "Analytic Studies of Mental Health Policies and Services", which produced descriptions of countries from all WHO regions, including East Europe. These projects found that mental healthcare reforms in post-socialist countries were often orchestrated by regional administrations and compromised by corruption. Furthermore, "state administration employees appear to hate their work, which in democratic countries would normally involve mental health policymaking and implementation" (Tomov et al. 2006: 401). This alienation from work was reportedly a salient feature of the workplace ethos in the region's state administrations. The study also pointed to a lack of involvement of mental health service staff and NGOs in policy development (Tomov et al. 2006).

The more recent publication of Petrea (2013) used a comparative analysis of data collected for the 2011 WHO Mental Health Atlas on the structures of mental health systems in Russian Commonwealth countries, along with data available in other WHO papers and international projects' reports. For the purposes of the paper, the group of countries referred to as "former Soviet countries" included Azerbaijan, Armenia, Belarus, Georgia, Kazakhstan, Kyrgyzstan, Republic of Moldova, RF, Tajikistan, Turkmenistan, Uzbekistan and Ukraine. In the framework of collaborative projects, pilot community mental health centres had been set up in some of the countries, including Armenia, Moldova, RF and Ukraine. Similarly to previous studies, Petrea (2013) claimed that besides the development of policy and legislation, progress in implementing reform could be traced mainly to projects that benefited from expert and financial support from international donors. The expectation that the new centres

would be taken over by local authorities and integrated into the existing system was not realized. The pilot centres, rather than becoming examples of good practice, were perceived as unfair competition by professionals working in traditional services. Petrea (2013) suggested that in reforming their mental health systems, Russian Commonwealth countries needed to find solutions that were feasible within their cultural, financial and organizational contexts. She recommended taking a closer look at the dynamics within mental health systems, paying special attention to the impact of the Soviet past on current services.

There are also publications based on international projects delivered in Russia. In international journals, I found three publications derived from a project conducted in 2002–2004 in the Sverdlovsk region of the RF (McDaid et al. 2006; Jenkins et al. 2007, 2011). The project was directed by a multidisciplinary group of United Kingdom-based and Russian professionals led by the Institute of Psychiatry in London and the government of the Sverdlovsk region. The authors noted that implementing the study was challenging and required iterative and sustained engagement with local stakeholders (Jenkins et al. 2007). There were key informant interviews, and an analysis of legal and regulatory documents, ministerial orders and reports conducted in the framework of the project (McDaid et al. 2006). It was found that although the need for community-based services was recognized in Russia, mental healthcare was still largely provided in institutions (McDaid et al. 2006). Five key barriers were identified that needed to be addressed if Russia was to shift from hospital-centred to community-based care. First, the funding of mental health services was based on the existing number of hospital beds and bed occupancy rate, and this provided incentives for healthcare providers to maintain existing beds (Jenkins et al.2007). Second, the regulations stipulated periods of hospitalization for patients with mental illness (Jenkins et al. 2007). Third, there were difficulties in reducing or redeploying hospital staff, which required carefully designed human resource policies. Fourth, community-based social services and human resources were limited, especially in the areas of social work, housing support and vocational rehabilitation (McDaid et al. 2006). Fifth, financing regulations prevent the shifting of funds from the health sector to social protection sectors (Jenkins et al.2007).

There were also country-specific studies on mental healthcare reforms in other post-socialist countries. Fernezelyi, Eröss and Tamasi (2009) conducted research in 2008–2009 within the framework of an international project (funded by the European Union) in Hungary. The study was based on semi-structured interviews with national mental health authorities, and on an analysis of key national documents. It was found that Hungary's authorities faced a dilemma in terms of policymaking: on the one hand,

Hungary was trying to conform to "European expectations"; on the other hand, the existing structures, established mechanisms and economic constraints often frustrated the reception of policies. The authors also noted that they faced severe difficulties accessing the field, due to rejection by both the Ministry of Health and psychiatric professionals.

Klein (2014) described the findings of a collaborative project in Croatia (funded by the Open Society Foundation) that aimed to replace hospitals with community-based care. Klein claimed that Croatia's process of accession to the European Union created new incentives for the government to adopt progressive policies, and opened a new window of opportunity for deinstitutionalization. The study reported strong government support for the reforms, but resistance from hospital staff and the relatives of people with mental illness. Similar resistance to deinstitutionalization reforms among hospital staff was also reported by a collaboration project in Georgia (Makhashvili & Voren 2013). This study noted that resistance to mental healthcare reforms is widespread throughout the former republics of the USSR (Makhashvili & Voren 2013).

3.3   Russian mental healthcare experts' views on the reforms

According to Litvinova (2010), the 2007 Russian mental health programme, which underlined the importance of deinstitutionalization, met strong criticism from mental health professionals and human rights activists, who pointed to the unpreparedness of psychiatric services for the reforms. Articles published in international journals by leading Russian psychiatrists (Gurovich 2007; Krasnov & Gurovich 2012) reflected on the obstacles to psychiatric reform in Russia, such as the unfavourable technical conditions in many psychiatric clinics, economic difficulties, and the shortage of clinical psychologists and social workers. Similarly, studies in Russian-language publications pointed to a lack of economic resources, and to funding mechanisms that encouraged the maintenance of a large number of psychiatric beds (Shevcheno 2004, Limankin 2013a), along with a deterioration of the outpatient mental healthcare system during the deinstitutionalization reforms (Gurovich 2012; Limmakin 2013a). Savenko and Perekhov (2014) provide the Russian Independent Psychiatric Association's view of the reforms. The authors claim that Russian psychiatry, which is seriously underfunded, is going through a severe crisis, and the rights of people with mental illness are openly ignored (Savenko & Perekhov 2014). However, the articles by Russian experts in the mental health field provide very limited details about their

data sources, or about their data collection and analysis process. They are based primarily on the expert knowledge and experience of the authors, and lack any explicit explanatory focus.

3.4   Anthropological studies on the reforms

Anthropological studies conducted in some post-socialist countries provide us with a deeper understanding of not only what has happened in mental health services but also why it happened. Friedman (2009) presents the results of anthropological fieldwork conducted in Romanian psychiatric services in 2005–2007. The methods of anthropological observation and patient interviews were used in the study. The author considers the deinstitutionalization policy in Hungary an extension of the global neoliberal policies forced on post-socialist countries by international organizations (the International Monetary Fund, World Bank, WHO and European Union). The study found that Romanian psychiatrists are resisting deinstitutionalization by introducing an unofficial diagnostic category, the "social case". Patients who fall into the category of "social case" receive long-term psychiatric care, remaining hospitalized because psychiatrists perceive them as too poor, "unfit" to survive without the welfare assistance provided by institutionalization. This category of patients emerged in post-Soviet Romanian psychiatry at the intersection of state plans for deinstitutionalization, the rise of a new class of downwardly mobile and increasingly poor formerly working-class people, and the desire of psychiatrists to protect their patients. These "social cases" concerns most psychiatrists, who worry about the impact of deinstitutionalization on the country.

An anthropological study conducted in 2008–2010 explored how mental health reforms in Ukraine, specifically the push for community mental health services, were seen from professionals' and patients' perspectives (Yankovsky 2011). The study argued that the international agenda being promoted in Ukraine, which pushed for Western-style neoliberal political and economic reform, had produced cultural and structural discrepancies and tensions which could be seen in the mental health field. These anthropological studies present an interesting perspective on mental healthcare reforms in post-socialist countries. However, there are no similar studies on mental healthcare reforms in Russia.

3.5 Missing voices of family caregivers of people with mental illness

A number of studies from West Europe and the United States have reported that families of people with mental health problems express opposition to institutional closures (Heller, Bond & Braddock 1988; Larson & Lakin 1991; Tossebro 1996; Tabatabani 2013). However, publications representing the opinions of family caregivers of people with mental illness in post-socialist countries are lacking in the international literature. The European Federation of Associations of Families of Mentally Ill People attempted to conduct questionnaire surveys in order to reveal the shortcomings in mental healthcare from a caregiver's perspective (Brand 2001). The researchers regretted that there were no replies from associations in East European countries.

Russian researcher Limankin (2013) points to a lack of studies on carers' opinions about mental health services in Russia, explaining this in terms of the prevalence of the paternalistic approach in Russian psychiatry. The studies published in Russia have been based on quantitative methodology, e.g. surveys (e.g. Solohina 2004; Levina & Lubov 2009; Bylim & Lubov 2010; Limankin 2016). These studies report that carers do not support the development of new types of service, demanding instead better funding for existing services (Levina & Lubov 2009; Limankin 2016). However, their reasons for this position are not explained in these studies.

3.6 Literature on mass media representations of mental illness

Many studies of the reforms in post-socialist countries point to the high level of stigma associated with mental illness as an obstacle to reform (Rutz 2001; Tomov 2001; Jenkins et al. 2001, 2005).Media representations of mental illness can have a significant effect on public images of people who experience mental health problems. Mass representations of mental illness have been broadly studied in the United Kingdom (Philo et al. 1994; Cutcliffe & Hannigan 2001; Anderson 2003; Cross 2004), United States (Wahl 1995; Thornton & Wahl 1996), Canada (Olstead 2002) and New Zealand (Coverdale, Nairn & Claasen 2002). However, there are very few publications analysing the role of mass media in mental healthcare reform in post-socialist countries.

Bilic and Georgaca (2007) studied representations of mental illness in Serbian newspapers from 2003 to 2004. Three broad discourses were identified: (1) the discourse of the dangerousness of people with mental illness; (2) the discourse of biomedicalization, constructing psychiatrists as responsible for managing medical disorders and patients as passive sufferers of their condition; (3) the discourse of socio-political transition as accounting for the recently increased incidence of mental disorders in Serbia.

Kamerade (2005), analysing Latvia's mass media from 2004, found that people with mental illness were mainly represented as criminals, strangers, irresponsible, weak and pitiable. Luse and Kamerade (2014) compared representations of mental illness from 2004 and 2008, and found encouraging signs of positive change in the way mental health issues were portrayed in Latvia's print media. While in 2004 information on mental health issues had been very scarce, in 2008 the reporting on mental disorders, their possible causes and treatment was more precise and coherent. Stories about people with mental health issues had become more frequent, and encompassed the barriers such people met in their lives. The authors even found an article based on an interview with a person with mental illness, and took this as a sign that the voices of such people were being heard. They explained these positive changes by the fact that Latvia had joined the European Union in May 2004 and therefore was increasingly exposed to inclusive approaches to mental health and illness. However, the authors also noted that articles with negative representations of mental illness were very common in both periods.

There are a number of Russian publications analysing the representation of mental illness in the mass media (Rukavishnikov, Rukavishnikova & Bil'zho 1990; Yastrebov, Balabanova, Serebrijskaja, Mihajlov & Stepanova 2004; Yastrebov & Trushcheelev 2009). All these studies report negative representations of mentally ill people and psychiatry. Yastrebov and Trushcheelev (2009) studied images of psychiatry in print media, using the method of content analysis. They compared newspaper articles from three periods: 1987–1989, 1995–2002 and 2003–2007. It was found that the number of publications on the topic of psychiatry had increased during those 20 years. However, the mass media persistently published articles representing people with mental illness as dangerous and aggressive or as helpless victims, ignoring the possibility of recovery. It was concluded that in spite of the development of legislation and mental healthcare reforms, the image of people with mental illness, and of mental health services and staff, continued to be negative.

3.7 Concluding remarks

The literature review demonstrates that different types of publication on mental healthcare reforms in post-socialist countries are available in the international and Russian literature: comparisons of reforms in different countries using statistical data; publications derived from international collaborative projects; reflections by mental health professionals on the reforms; and anthropological studies from some countries. While these publications often rely on statistical data, the analysis of national policy documents, or authorities' and professionals' views of the reforms, the opinions of service users and their caregivers remain under-represented. Similarly, there is a lack of reflection on the role of mass media in the reforms.

Authors often point to problems with the reliability of the statistical data. For example, Tomov (2001) noted that in the collaborative project, the problem regarding the validity of official data in the post-socialist countries became obvious. There was a systematic bias in the reporting of statistical data in many locations. The information gained through international projects provides a broader picture of the situation in the region. However, such studies also have some limitations. The authors do not describe in a systematic way how their materials were collected and analysed. Furthermore, it seems that the findings of most of the projects were gained through communications with the authorities and mental health service staff in leading positions who were mainly involved in such projects. For example, Tomov (2001) reflected concern about the ways such research is actually conducted in the region. Of the six local teams (Azerbaijani, Bulgarian, Hungarian, Kyrgyz, Lithuanian and Ukrainian), three were composed on the basis of family links between the members; the rest listed prior friendships or other relationships of trust as a leading criterion for selecting partners in the research. Additionally, many projects report difficulties in engaging with national authorities, which I consider might well also affect the results.

A review of previous literature thus shows that there is a need for a deeper understanding of mental healthcare reforms in post-socialist countries, including Russia. My study aimed to enrich our knowledge of this topic. To the best of my knowledge, no studies have been conducted in post-socialist countries which attempt to integrate the views of different actors (such as politicians, mass media, professionals and caregivers) on the reforms, or to analyse how these combinations of opinions might affect policy development.

4 THEORETICAL FRAMEWORK OF THE RESEARCH

4.1 Health policy and systems research: looking for new analytical approaches

Health policy and systems research is a field that seeks to understand and improve how societies organize themselves to achieve collective health goals, and how different actors interact in policy and implementation processes to contribute to policy outcomes (Alliance for Health Policy and Systems Research 2011).

Starting from the early 1990s, several researchers (Walt 1994; Walt & Gilson 1994; Reich 1995; Barker 1996) called for a new approach to health policy analysis, claiming that analysis had hitherto largely focused on technical content and design, neglecting the actors and processes involved in developing and implementing policies, and paying little attention to the contexts. This type of analysis failed to explain how and why certain policies succeeded and others failed (Gilson & Raphaely 2008). Health policies were commonly understood as the formal documents and guidelines that present policymakers' decisions about what actions are legitimate to strengthen health systems and improve health (Sheikh et al. 2011). However, these formal documents are translated through the activities of policy actors (such as health workers and patients). These daily practices become health policy as it is experienced, and this may differ from the intentions of the formal documents (Sheikh et al. 2011). Therefore, health policy can be seen not only as formal statements of intent, but also as informal, unwritten practices (Buse, Mays & Walt 2005). There is an emerging recognition that health systems and policies are human creations, embedded in social and political reality and shaped by particular, culturally determined ways of framing problems and solutions (Lambert 2006; Sheikh et al. 2011).

In my research, mental health policy is considered as a complex social and political phenomenon, constructed and brought alive by social actors through the meanings they attach to (their interpretations of) their experiences (Gilson et al. 2011). Based on this definition, I have chosen an interpretive approach to the analysis of mental healthcare reforms in Russia.

4.2 Interpretive approach to the analysis of Russian mental health policy

This study used the methodology of interpretive policy analysis, as proposed by Yanow (1996, 2000, 2007). This approach was also developed in a number of other works, including Healy (1986), Torgerson (1986), Fischer and Forester (1993), Hawkesworth (1988), Yanow and Schwartz-Shea (2006), Fischer (2003), Hajer and Wagenaar (2003) and Wagenaar (2011). In contrast to traditional policy analysis, which addresses the numerical analysis of policy facts, the interpretive approach focuses on underlying meanings in the policy process (Yanow 1996; Hendricks 2007). In this analytical framework, the focus is on the meanings that policies have for a broad range of policy-relevant publics. Collectives of actors belonging to the same groups may share cognitive styles and use similar language to discuss policy problems, thus forming interpretive communities (Sheikh & Porter 2010).

Interpretive policy analysis is derived from a constructivist epistemology in social research (Burr 2003) which aims to "include multiple voices and views in their rendering of lived experience" (Charmaz 2000: 525; Sheikh & Porter 2010). The social constructionist approach is based on the idea that reality is not "self evident, stable and waiting to be discovered, but instead it is a product of human activity" (Pilgrim and Rogers 1999: 18). From this perspective, terms such as "mental health" and "mental illness" are considered socially relative categories that are subject to contestation, and whose precise boundaries and meanings vary by time and place (Busfield 2001). Discourses on "good care", and hence the views on mental health policy of different interpretive communities, can also be seen as socially constructed. They are tied to the cultural, social and political contexts of their particular society. The focus of interpretive policy analysis is on "local knowledge", that is, the mundane, expert understanding of and practical reasoning about local conditions derived from lived experience (Yanow 2002).

Policy analysts working with interpretive methodology study how representatives of interpretive communities construct their realities, and how they define policy problems and solutions (Yanow 2000; Sheikh & Porter 2010). Policy processes are seen as discursive struggles over the definition of problems, the boundaries of categories used to describe them, the criteria for their assessment, and the meanings of ideals that guide actions (Fischer 2003). The interpretive approach suggests that researchers should attempt to understand the values, feelings or beliefs actors express when discussing policy problems (Yanow 2000).

In the last years, there has been a growing interest in using interpretive policy analysis in health policy research. This approach has been applied to the gaps in the implementation of standardized public health practice guidelines in India (Sheikh & Porter 2010), young adults' participation in health policy in Scotland (Stewart 2015), migrants' interpretations of the Affordable Care Act and related health polices in the United States (McElfish 2016), and the implementation of mental health policy in Australia (Smith-Merry & Gillespie 2016). However, there is still a lack of studies subjecting mental healthcare reforms in post-socialist countries to interpretive policy analysis. To the best of my knowledge, there have been no such studies on mental health policy in Russia.

4.3 The concept of "path dependency" in understanding post-Soviet reforms

Another component of the theoretical orientation of my research is the concept of "path dependency". This concept is frequently used as an explanatory tool in social sciences in general (see for example Mahoney 2000; Pierson 2000; Beyer, 2010) and in relation to healthcare reforms in particular (Tuohy 1999; Haeder 2012). According to the theory of path dependency, the historical background plays a significant role in explaining why certain policies exist today, and why they are so difficult to change (Kupers 2009). The concept proclaims the historicity of institutions, suggesting that approaches used in the past, established ways of thinking and everyday practices have an impact on the present (Beyer 2010). According to this theory, "path dependency" restrains possible new actions, and thereby decisively impacts on the trajectories of development (Inglehart & Baker 2000). A number of researchers consider socio-political background to be a crucial explanatory factor in understanding why mental health policy in the former socialist countries lags behind the developments achieved by other countries (Korolenko & Kensin 2002; Tomov et al. 2006). Tuohy (1999) claims that changes in the political system can lead to a paradigmatic shift and new trajectories of policy development. The collapse of the Soviet Union and Communist ideology opened a window of opportunity for changes in mental health policy in Russia. Inglehart and Baker (2000) claim that cultural values can change, but they also continue to reflect a society's cultural heritage. Therefore, my interest lay in analysing the influence of both new international ideas and the Soviet historical background on different actors' interpretations of mental healthcare reforms in Russia.

5 STUDY DESIGN

The study design was developed in accordance with Yanow's (2000) methodology of interpretive policy analysis. Yanow (2000) describes the following steps in interpretive policy analysis:

1.   Identifying the policy issues to be analysed
2.   Deciding who can be considered policy-relevant groups, i.e. interpretive communities
3.   Identifying the discourses and meanings that appear in discussions of the policy issues
4.   Discovering points of conflict that reflect different interpretations of the issue by different interpretive communities
5.   Demonstrating the implications of different meanings for policy formation

In my research, I followed these stages. At the first stage I identified the issues of post-Soviet mental healthcare policy to be analysed. The key WHO principles – patients' rights in mental healthcare, attention to the social determinants of mental health/illness, the reorganization of mental health services toward deinstitutionalization, the prevention of the stigmatization of people with mental illness, and the empowerment of such people – were considered the policy issues for analysis. I chose these policy principles because according to my literature review they had been neglected during the Soviet period, and therefore could be deemed important for the analysis of the new Russian mental health policy from the perspective of its differentiation from and links to its Soviet historical background.

Yanow (2000) states that there are at least three interpretive communities in any policy situation: the policymakers, the agency personnel who implement the policy, and the citizens who are affected. In this study, in addition to these communities, the mass media was considered another policy-relevant group that reflected and created public opinion on mental health policy reforms. Therefore, four interpretive communities were considered relevant for the analysis of post-Soviet mental health policy:

1. Policymakers

The opinions of policymakers were analysed through the analysis of policy documents. Political discourse is closely bound up with culture in a particular society (Chilton & Schäffner 2002). I considered policy documents as socially constructed texts, created by policymakers in certain historical, social and cultural circumstances.

2. Mass media

Fairclough (2003) argues that the media, as a cultural industry, is increasingly important because it reflects, constructs and circulates representations and values that form the substance of society. The mass media is frequently named as a source of information on mental illness for the general public (Cross 2004; Harper 2005). The media thus creates cultural attitudes and values that could have an effect on mental health policies (Cutcliffe & Hannigan 2001). The views on mental healthcare expressed in popular Russian newspapers were analysed.

3. Mental health professionals

The transformation of mental health systems is associated not only with changing programmes and policies, but also with changing beliefs of the people involved (Marlett 2007). The professionals working with people with mental illness play a vital social role in translating policy directives into practical work; they play a key role in the network of social constructive processes through which contemporary social representations of mental illness evolve (Morant 2006). The opinions of mental healthcare staff in the most typical Russian mental health outpatient services (*dispansers*) were analysed in this study.

4. Family caregivers of people with mental disabilities

Family members' active engagement remains at the heart of the social and cultural reforms needed for people with mental illness to live in the community (Hughson 2007). In this study, caregiving was defined as a set of activities involved in meeting the physical and emotional requirements of dependent people with mental illnesses in the normative, economic and social contexts within which the care is assigned and carried out (Daly & Lewis 2000). I demonstrated how various processes and factors were involved in the construction of caregivers' discourses on the reforms.

Yanow's (2000) third step suggests the identification of communities' discourses: in this case, how they talked about the mental health policy issues in question. The goal

of this step was to discover the meanings – e.g. values, beliefs and feelings – that were important to each interpretive community. At the next stage, conflicting interpretations were identified and analysed. Finally, the implications of different meanings for mental health policy formation in Russia were demonstrated.

6   RESEARCH OBJECTIVES

The purpose of this study was to explore how mental health policy developments in Russia were seen from the perspectives of various interpretive communities, and how these interpretations might contribute to policy implementation and further development. The study revealed the mental health policy interpretations appeared in policy documents and newspaper articles, as well as in interviews with mental health service staff and caregivers of people with mental disabilities. The focus was on the analysis of mental health policy interpretations with reference to the WHO mental health policy principles and the historical, political and socio-cultural contexts of the RF.

The **research questions** were:

1. What similarities and differences appeared in different communities' interpretations of the new mental health policy principles, and how did these interpretations relate to either support for or opposition to mental healthcare reforms?

2. How did different interpretive communities see the role of various actors (policymakers, mass media, state institutions, NGOs etc.) in the reforms?

3. How were the interpretations of mental health policy constructed in terms of distinctions from and links to the Soviet historical background?

7 RESEARCH DATA AND METHODS

7.1 Research data

Data were collected in different ways from each interpretive community. The research material consists of health policy documents that discuss mental health issues, mass media texts from selected newspapers, and interviews with mental health professionals and family caregivers of people with mental disabilities

7.1.1 Policy documents

The collection of the policy documents took place in 2006. The research material consisted of health policy documents issued in the RF during the period 1992–2006. The documents were collected using two online databases, Integrum (www.integrum.ru) and Garant (www.garant.ru), which are among Russia's leading information companies supplying users with specialized databases on all branches of federal legislation.

The main principles of healthcare reform in the RF are stated in high-level policy documents called "conceptions", prepared by the RF government and the Ministry of Health. A conception is a document written as part of the legislative process preceding a draft law or regulation. It presents the key principles and views which serve as the basis for the policy. The conceptions outlined the main directions for the development and implementation of various national health programmes that aimed to protect and promote the physical and mental health of the population. Three health conceptions were prepared in Russia between 1992 and 2006. In addition to these, I included in the research material the federal law (Supreme Soviet of RF 1993) that laid down the key principles for health legislation after the collapse of the Soviet Union. This law served as the basis for the development of health policy in the post-Soviet period. Thus four key health policy documents were included in the research material. At the second stage, I collected from the Integrum and Garant databases all federal policy documents with titles containing the words "psychic" (mental), "psychiatric" and "psychotherapeutic" issued in the RF during 1992–2006. To ensure that I had

covered the most important policy documents, I consulted collaborators working in the mental healthcare field in Russia, who helped me to include additional documents in the research material. The important criterion for including documents in the data was that mental health/illness was among the main topics in the document. In total, 16 special laws and orders regulating the scope and quality of mental health services in Russia, and two mental health programmes, were included in the research material. Thus altogether 22 documents, including four key health policy documents, were selected for study 1. The list of research materials appears in the appendix of article 1. An official version of the latest RF mental health programme (MoH 2007) was not available at the time the policy documents were collected in 2006; it was therefore not included in study 1. The programme was included in the analysis at a later stage of research during the implementation of studies 2, 3 and 4.

7.1.2   Newspaper articles

The collection of newspaper articles took place in 2008 and 2013. In order to examine the interpretations of mental healthcare reforms in the mass media, key national newspapers were chosen for analysis. The newspapers were selected on the basis of their circulation and popularity. The data comprised articles published in the following newspapers: Известия (Izvestia, I), Труд (Trud, T), Аргументы и Факты (Argumenty i Fakty, AiF), Российская газета (Rossiiskaya Gazeta, RG) and Комсомольская Правда (Komsomolskaya Pravda, KP). Although the main research interest was in the post-Soviet period, I considered it necessary to start with newspapers from the late Soviet period in order to find out how the discussion of mental health issues had developed. Newspaper samples were collected for the years 1982, 1987, 1992, 1997, 2002, 2007 and 2012, for the periods 7–20 March, June, September and December of each year. Altogether 883 individual newspaper issues were covered by the search for articles on mental health issues. The materials from post-Soviet newspapers (the 1990s and 2000s) were gathered using the electronic database Integrum, which is one of the leading Russian information companies providing users with specialized databases of media materials. The materials from Soviet newspapers, and some of the materials from the 1990s, which were not available on Integrum, were collected from the Russian library.

The research started with a search for articles that covered mental illness topics. In this search, the keywords were: "психич*" (psychic*, i.e. mental), "психиатр*" (psychiatr*), "психопат*" (psychopat*) and "психотерап*" (psychotherap*). The

word "психол*" (psychol*) was not used as a search term because articles with this word could be found in abundance in discussions of mental health promotion to the general population, while the focus of my research was mainly on mental healthcare and rehabilitation. Nevertheless, references to psychology were analysed when they appeared in discussions of the WHO principles in question. The research material included news stories, articles, short reports and editorials. Commercial advertisements, TV programmes and short descriptions of films were not included in the research material, because these materials were not the journalistic products of the newspapers themselves. I also excluded publications that included the keywords but did not refer to mentally ill people or mental health services/specialists. For example, articles in which the keywords were used figuratively (e.g. "mental attack on the opponent"; T, 10 September 1997) or appeared in astrological predictions ("these cosmic factors can lead to strong mental tension"; RG, 18 September 2007) were not included in the analysis. After this selection procedure, a total of 364 articles were considered for analysis.

7.1.3   Interviews with mental health professionals

The study was conducted in a large city in the RF which tends to play an important role in leading innovation programmes nationally. I was interested in the degree to which the reforms of the mental healthcare system would be supported in this supposedly "vanguard" milieu. The data for the study consisted of 33 qualitative semi-structured interviews undertaken with mental healthcare professionals from psychoneurological dispansers for adults. Respondents from five dispansers participated in the study. The main professional groups were represented as follows: psychiatrists (14), psychotherapists (one), clinical psychologists (seven), social workers (three), speech therapists (two) and psychiatric nurses (six). In selecting the participants, I aimed to involve professionals with both medical (psychiatrists, psychotherapists, nurses – 21 interviews) and non-medical backgrounds (psychologists, social workers, speech therapists – 12 interviews). Specialists with medical backgrounds traditionally predominate in Russian mental healthcare, and therefore the sample reflected this tendency. The duration of the interviews (30–90 minutes) was dependent upon the respondents' willingness to share information and the availability of their time. The study was conducted according to the principles of informed consent, confidentiality and anonymity of participants. The respondents

were informed of their right to freely decide whether to participate in the study, and the right to withdraw at any time.

The series of semi-structured interviews was conducted in 2010 (12 interviews) and 2013–2014 (21 interviews). During the first stages of data collection in 2010, respondents were asked about post-Soviet psychiatric reforms from a rather broad perspective. The interviews focused on the topics I used for the analysis of policy documents and mass media materials. The question guide covered aspects of mental health policy such as the improvement of patients' rights, the reorganization of mental healthcare services, activities preventing stigmatization, and the empowerment of service users. As mentioned above, these topics could be deemed the most important for understanding Russian mental health policy in relation to its Soviet historical background. The respondents also had opportunities to discuss other aspects of the reforms they considered important for understanding post-Soviet changes in mental healthcare.

The process of qualitative data analysis can begin during the early stages of data collection (Braun & Clarke 2006). This early involvement in the analysis phase helps the researcher to move back and forth between concept development and data collection in order to direct the subsequent research (Miles & Huberman 1994; Zhang & Wildemuth 2005). After preliminary analysis of the first part of the interviews, I discovered that reform towards the deinstitutionalization of psychiatry was one of the most contested topics in the respondents' accounts. Therefore, to cover this topic in detail, I focused the further data collection on deinstitutionalization. I asked the professionals their opinions on aspects of the reforms such as the downsizing of institution-based care, the decentralization of psychiatric services, the reduction of periods of hospitalization, the decrease in numbers of repeated hospitalizations, the integration of mental healthcare into general healthcare services, and the development of community-based care. At the second stage, in 2013–2014, the interviewing strategy was more structured than at the initial stage, although there was still quite a lot of flexibility in its composition. Therefore, some unexpected topics, such as the Soviet system of vocational rehabilitation, became emphasized in the respondents' narratives. Three respondents interviewed during the earlier stages of the research (in 2010) were contacted again in 2014, in order to clarify their opinions and ask additional questions.

7.1.4   Interviews with family caregivers

The study participants were recruited at a psychoneurological dispanser in a large city in the RF in 2014. Access to the field was based on previous research collaborations with the dispanser's staff. I had an opportunity to interview family caregivers who attended the dispanser while accompanying their relatives with mental disabilities. Additionally, several participants were recruited using the snowball method, in which the interviewed family caregivers assisted the researcher in identifying other potential respondents. Although some caregivers declined to participate in the study, explaining this mainly by lack of time, most participants were quite enthusiastic about the opportunity to express their views on mental healthcare in Russia.

The study participants were chosen in accordance with the definition of family caregivers used by Quah (2014) and Perlick et al. (2008). The interviewees were recruited according to the following criteria: (1) they were immediate family members of the care recipient; (2) they supported the care recipient financially; (3) they were the most frequent collaborators in treatment; (4) they served as the main contact in cases of emergency. In total, 20 semi-structured interviews were conducted with family caregivers of adults with mental disabilities. Most caregivers who met the chosen criteria were mothers aged between 40 and 73 (17 interviews). The interviewees also included one sister (aged 30), one father (aged 53) and one grandfather (aged 65). All participants consented to be interviewed and for their anonymous data to be used for reporting purposes.

I asked the caregivers' opinions about existing mental health services, both inpatient and outpatient, and how from their point of view the services should be improved. The question guide also covered aspects of mental health policy such as the downsizing of institution-based care, the reduction in the number and length of hospitalizations, the integration of psychiatric services into general healthcare, and the development of community-based services. The interview strategy was semi-structured, offering flexibility in its composition. I formulated the questions in a way that would be simple and understandable for the caregivers. Open-ended questions encouraged the respondents to give elaborative answers, and gave us an opportunity to identify new ways of understanding the topic.

7.2 Reflections on my position in the research field and the ethics of the research

7.2.1 Position in the research field

My position in the research field resulted in some limitations, and simultaneously in some advantages for the collection of the data. During my fieldwork, I introduced myself as a researcher from the University of Tampere. I suggest that my affiliation with a Western university encouraged respondents to speak about the influence of international ideas on the reforms in the post-Soviet mental healthcare system. Simultaneously, I suspect that my affiliation sometimes also provoked superficial answers or even outright refusal to participate in the research. The attitudes of mental health professionals to researchers from the West were probably cautious, due to the history of Soviet psychiatry followed by broad international critiques and public anti-psychiatry campaigns. This tendency was particularly evident in the interviews with professionals who had worked during the Soviet era. I had the impression that some of them thought that this Western researcher was probably looking for violations of patients' rights in current Russian psychiatry. I have noticed increasingly negative attitudes towards the adoption of Western approaches and to researchers from the West since 2014. This might be associated with recent political tensions between Russia and Western countries. This tendency was evident in the way respondents reacted to my invitation to participate in the research, as well as in their comments about "Western" and "Russian" approaches.

To at least partly overcome this barrier, I informed the respondents not only about my affiliation to a Western university, but also about my previous work experience as a clinical psychologist in mental health services in Russia. My previous affiliation gave me better access to the research field, as it increased trust among some respondents. However, this particularity of my position raised additional ethical considerations

7.2.2 Ethical considerations in the interviews with professionals and caregivers

Participation in the research by both professionals and family caregivers was voluntary and based on the principle of informed consent. I informed the respondents about aims of the research and treated all information confidentially. During the interviews with mental health professionals, I faced ethical dilemmas when the respondents

provided me with information on mental health service work that they did not want to be disclosed in reports or publications. Although I emphasized that every effort would be made to exclude details that might enable the interviewees to be identified, some respondents refused to be recorded when speaking about unofficial practices in mental health service work. Sometimes it was not even possible to take notes. I illustrate this situation with the following extract from an interview with a psychiatrist who worked in a part-time position in a general hospital.

Interviewer (I): Is there any psychotherapy or psychological support?
Respondent (R): There are no such services in general hospitals.
I: But they could be useful?
R: Such professionals are not supposed to work in the hospital.
I: But many diseases...
R: No, of course, a patient can ask for paid service. For example, in our hospital a patient can pay ₽600 (US$18) for psychotherapy. But I receive only ₽110 (US$3.50) of this ₽600. Do I need this?
I: So, there is no regulation that such professionals should work in the hospital?
R: Unfortunately, no. Although it is a controversial question, because if such vacancies were in the hospital, they would be filled by some corrupt persons. They will not do anything and just take money. Do you understand what I'm talking about? In hospital N, there are positions for psychotherapists. Do not record.

When I turned off the recorder, the psychiatrist explained to me some unofficial practices in this psychiatric hospital. Although I understood that such unrecorded information could contribute to the understanding of mental health service work, the participant did not agree to the practice being disclosed. Wiles, Crow et al. (2008) suggest that unless a participant gives permission for information to be disclosed, researchers should not do so. In cases involving public safety, researchers might be expected to break the confidence of a participant (Gregory 2003). Researchers may also feel a moral duty to disclose information if a study participant reports being a victim of a crime, or is perceived as being at risk of harm (Wiles, Crow et al. 2008). However, information provided by the respondents about unofficial practices in psychiatric services did not fall into any of these categories.

I should note that in informal conversations the professionals pointed to certain existing unofficial practices as adaptive strategies in relation to low salaries in the mental healthcare system. They also openly criticized the government's mental health

policy and corruption in psychiatry. However, I was not able to use a recorder or make notes during these information-rich informal talks. Due to the specificity of the research field as described above, I was especially careful to preserve the respondents' anonymity, and did not indicate the city where the fieldwork was conducted in publications.

While planning and conducting the interviews with family caregivers, I kept in mind the ethical concerns that arise during research with potentially vulnerable people. My ethical considerations took into account the potential burdens caused by the interview. The principle of "protection from harm" is included in professional guidelines for the ethical conduct of research (World Medical Association 2014). I realized that some of the caregivers might experience mental strain while talking about their relative's history of mental illness or their difficulties in social life. I used my psychological knowledge to avoid causing negative feelings in respondents, formulating my questions carefully and sensitively. Research ethics is concerned with ensuring that research is conducted in a manner that not only protects but also enhances the participants' lives (O'Brien 2001). Therefore, I tried to prepare the interviews in such a way that the caregivers could focus on the positive sides of their life experience, and on their resources to cope with problems.

There is a growing emphasis on more inclusive and participatory approaches to research, and this would suggest the involvement not only of caregivers but also of people with mental health problems (Beresford 2002). Their experiences could offer nuanced and subtle understandings that would enhance the research. At the initial stage of the research, I planned to include interviews with mental health service users. However, I met significant difficulties in the preparation of the interviews with this potential group of respondents. This included potential difficulties in obtaining genuine informed consent from people with mental disabilities. This problem of consent has been most discussed in respect of difficulties arising from the patient's mental illness (Gupta & Kharawala 2012). I had no access to any patients' medical information, and therefore I did not know whether a particular patient was capable of giving informed consent. Due to potential ethical concerns in the interviewing of patients with mental illnesses, and problems with getting approval from directors of Russian psychiatric services, I decided not to include this group of respondents in the research.

7.3 Analysis of the data: qualitative research methods

Interpretive policy analysis relies on in-depth qualitative research methods, which help us understand people's motives, attitudes and values (Charmaz 2000; Sheikh & Porter 2010). Qualitative methods reveal not only what people think, but also why they think so and how they justify their views (Denzin & Lincoln 2011). According to Streubert, Speziale and Carpenter (2007), the main characteristics of the qualitative approach are a belief in the possibility of multiple interpretations of reality, respect for participants' views, a commitment to seek a detailed understanding of the studied phenomena, and the reporting of findings in a literary style enriched by participants' comments.

The data was analysed using qualitative content analysis (Mayring 2000) and thematic analysis (Braun & Clarke 2006). The policy documents and mass media articles were analysed using qualitative content analysis, and the interviews with professionals and caregivers by thematic analysis.

7.3.1 Qualitative content analysis

The method of qualitative content analysis is appropriate for the systematic analysis of documents; its strength is in organizing written materials such as reports, articles or policy documents (Solin 2011). Qualitative content analysis allows more than just counting words or expressions with the aim to classify large amounts of research material into categories that reflect similar meanings (Weber 1990). By using qualitative content analysis, it is possible not only to quantify the data, but also to analyse it qualitatively (Gbrich 2007). This method focuses on the characteristics of language as communication, paying special attention to the contextual meanings expressed in the text (McTavish & Pirro 1990; Tesch 1990). According to Hsieh and Shannon (2005), qualitative content analysis can be defined as a research method for interpreting the content of textual data through a systematic classification process of coding and identifying patterns.

Qualitative content analysis can be based on an inductive or a deductive approach (Mayring 2000). The researcher's decision as to which type of content analysis to use depends on the theoretical orientation and the topic to be studied (Weber 1990). An inductive strategy is usually recommended when previous theory and research on a studied topic is limited. Researchers avoid using preconceived categories, instead deriving them from the data. Researchers immerse themselves in the data to allow new insights to emerge (Kondracki & Wellman 2002). In a study based on a deductive

approach, a researcher works with previously developed categories, connecting them to the text. The analysis process consists in the methodologically controlled assignment of these categories to passages of text (Mayring 2000). In the course of analysis, additional categories are developed, and the initial coding scheme is revised (Hsiu-Fang & Shannon 2005).

7.3.2   Qualitative content analysis of the data (studies 1 and 2)

The research presented in studies 1 and 2 was based on a deductive strategy of qualitative content analysis. For the conceptualization of how mental health principles are interpreted in the health policy documents and newspapers, we (my co-authors and I) elaborated a special framework based on the priorities reflected in the WHO documents (WHO 2003, 2005a, 2005b). In line with this theoretical background, we identified keywords, expressions and ideas related to different aspects of mental health policy. The analysis focused on the question whether the WHO principles were reflected in modern Russian policy documents (study 1) and newspaper articles (study 2), and how they were discussed. The text units identified were analysed using a coding table with reference to the selected categories.

The categories for analysis reflected the following aspects of WHO mental health policy:

1.   *Protection of patients' rights,* including key empowerment rights (such as information, consent, freedom of choice, privacy and confidentiality); the right to be protected from cruel, inhuman and degrading treatment; and the provision of a safe and hygienic environment (WHO 2003, 2005a, 2005b)

2.   *Integrative model of mental health and illness,* which suggests attention to the social determinants of mental health/illness as a precondition for the reorganization of mental health services

3.   *Reorganization of mental healthcare services*, entailing the accessibility, comprehensiveness, coordination and effectiveness of mental health services; the integration of mental health services into general healthcare; and deinstitutionalization and community-based activity

4.   *Activities preventing stigmatization*, implying the promotion of positive images of people with mental illness, with a focus on recovery from mental disorders and social integration; the debunking of myths and prejudices about mental illness; and increasing public awareness of mental health issues

5.   *Participation and involvement* of people with mental illness and their caregivers in care planning and development of services

In study 1, the references to all the above-mentioned categories were analysed. In study 2, the analysis was narrowed to the issues of patients' rights, the reorganization of mental healthcare services, and activities preventing stigmatization. Widening the scope of the research to include other aspects would have significantly increased the amount of research work and the size of the article.

Different ways of reading the material were used: first, we analysed what was said (which of the chosen principles were discussed in the materials); second, we analysed what was not said (which of the principles were not discussed); and third, we analysed what was said differently (which of the principles were discussed differently, and the key differences between formulations). As Sandelowski (2010) notes, qualitative analysis can start with a theoretically driven framework for collecting and analysing data, but that does not suggest a commitment to stay within the originally chosen framework (Vaismoradi, Turunen & Bondas 2013). Therefore, following the qualitative approach of staying as close as possible to the text, the categories were revised on the basis of the research material. The central interest in our analysis was to develop the proposed categories as closely as possible to the material, and to reformulate them in terms of the material itself. The style of the discussion of the modern principles revealed to us the hidden features of modern mental health policy legislation and mass media materials. At the final stage of the research, we formulated the main ideas (core concepts) reflected in the documents and mass media. The main results of the analysis are presented in publications 1 and 2.

7.3.3   Thematic analysis

Thematic analysis offers a useful, flexible approach to analysing qualitative data (Braun & Clarke 2006). It is a method for identifying, analysing and reporting themes within data (Boyatzis 1998). There is some degree of similarity between thematic analysis and qualitative content analysis in terms of methods, procedures and techniques. These methods follow similar procedures of working with text by breaking it into small units of content and submitting these units to further analysis (Sparker 2005). While content analysis makes it possible to quantify the data, thematic analysis is a purely qualitative, nuanced and detailed method of analysing data (Braun & Clarke 2006). The categories a researcher develops during qualitative content analysis mainly reflect the manifest content of the text, whereas the themes reflect the deeper latent content of the data

(Vaismoradi, Turunen & Bondas 2013; Graneheim & Lundman 2004). The significance of a theme is not always dependent on how often it appears in the data, but rather on whether it provides some important insight in relation to the topic of study (Spencer et al. 2003; Braun & Clarke 2006). This differs from the presuppositions of content analysis, where topics are identified on the basis of their frequency in the text (Vaismoradi, Turunen & Bondas 2013). For example, in study 2, which was based on the qualitative content analysis of newspaper articles, I compared the numbers of articles discussing mental health issues in the Soviet and post-Soviet periods. Although the sample of newspapers did not allow me to make generalizations based on statistical analysis, it indicated a significant increase in the number of published articles discussing mental health problems during the period covered by the study. While in the samples from the 1980s I found only two articles discussing mental illness, from the 1990s onwards the number of articles gradually increased. Based on the number of publications, I drew conclusions about the opening up of public discussion of mental health issues in post-Soviet Russia and the growing interest in this topic in post-Soviet media. In study 4, on family caregivers' views of the reforms, the data was subjected to thematic analysis. Although distrust of NGOs was mentioned by only two of the 20 caregivers, I considered this finding important for understanding the caregivers' views of the reforms.

7.3.4 Thematic analysis of the data (studies 3 and 4)

The initial stage of the analysis consisted of reading all the interviews and selecting the parts that were relevant to our focus of interest: reforms towards the deinstitutionalization of mental health care. The next phase involved the production of initial codes. Coding identifies characteristics of the data that appear interesting to the analyst, and refers to the most basic segment of the data that can be assessed in a meaningful way regarding the phenomenon (Boyatzis 1998). Codes were developed by considering each phrase or paragraph of the data set in order to summarize arguments for or against deinstitutionalization. As a result, we had a list of different codes identified in the materials. The next phase involved sorting the codes into potential themes, and allocating all coded data extracts within the relevant themes. Each theme reflected some important and patterned way of argumentation by which the respondents approached the issue of deinstitutionalization reforms. The formulation of a theme involved summarizing different parts of the research materials, with the aim to reveal the key interpretations of mental healthcare reforms that appeared in the

data. Themes can be identified at two "levels": the semantic or explicit level, and the latent or interpretive level (Boyatzis 1998). The latter tends to come from a constructionist paradigm, where broader assumptions, structures and meanings are theorized as underpinning what is articulated in the data (Braun & Clarke 2006). In our research, the development of the themes involved interpretive work in an attempt to understand the structural conditions and socio-cultural contexts that enabled the professionals' and caregivers' interpretations. At the subsequent stage of the research, all the interviews were reread to ascertain whether the themes "worked" in relation to the whole data corpus. The revised themes were also enriched with additional data which had not seemed relevant to deinstitutionalization in earlier coding stages, but which appeared to be important for the understanding of the topic during further analysis. The final stage of the analysis consisted of summarizing and conceptualizing the key themes in order to arrive at the main conclusions. The results of the analysis are presented in articles 3 and 4.

7.4   Division of work between the co-authors and the contribution of the doctoral candidate

The aim and the structure of all the articles included in the thesis were developed by the doctoral candidate. I collected all the research materials: policy documents, newspaper articles, and interviews with professionals and caregivers in Russia. I analysed the data and drafted the first version of the manuscripts. During the subsequent work on the articles, I regularly discussed the categorization procedure and findings with my co-authors. The revisions to the manuscripts during the submission process were made in collaboration with the co-authors.

8   RESULTS

8.1   Supportive and oppositional views of the new mental health policy principles

The first subsection of the results section summarizes how each of the chosen aspects of mental health policy were considered from the perspectives of different interpretive communities. It demonstrates how these opinions were similar to or different from each other, and how these interpretations related to either support for or opposition to mental healthcare reforms.

8.1.1   Patients' rights: political discussion without mass media support as a shaky basis for the reforms (studies 1 and 2)

The discourse on patients' rights was one of the key topics in the policy documents. The 1992 legislation that took a stand on patients' rights in psychiatry served as a basis for mental health policy in post-Soviet Russia This document claimed that "the absence of proper laws on psychiatric care leads to the use of psychiatry with non-medical intentions, violates personal dignity and human rights, and by this damages the country's international prestige" (Supreme Soviet of RF 1992: introduction). In this law, human rights together with the country's international prestige were used as an argument for mental healthcare reform. The documents emphasized patients' rights in the field of mental healthcare regarding e.g. examinations, admission and discharge procedures, as well as the general right to social protection of people with mental illness. Thereafter, a number of special laws, orders and programmes were approved to regulate the scope and quality of mental healthcare in accordance with this basic law. The discourse on patients' rights was found in most of the documents analysed in the study. The broad political discussion of patients' rights can be considered a basis for the reforms. Given that the USSR was sharply criticized for abusing psychiatry for political purposes and violating patients' rights, it is understandable that patients' rights were heavily emphasized in policy documents, particularly right after the collapse of the Soviet Union.

At the beginning of the 1990s, discussions of patients' rights appeared in the mass media as well. Patients' rights were discussed with reference to the Soviet period, e.g. the use of psychiatry for political purposes. The mass media often represented people with mental illnesses as victims of Soviet psychiatry and its denial of patients' rights. Articles used expressions such as "patients are behind bars" (I, 17 September 1992) and "patients are tortured by injections" (KP, 7 December 2002). While such critical discussions might be regarded as creating negative images of psychiatry, at the same they promoted the recognition of problems, and in this way opened a window of opportunity for changes in this area. However, journalists simultaneously questioned some aspects of the new policy, such as the consensual nature of diagnosis, hospitalization and treatment. Articles noted that patients' willingness to seek help, which the new law designated a prerequisite of psychiatric treatment, might lead to negative results such as delayed visits to psychiatrists. Recognizing the importance of the liberty and autonomy of service users, the media at the same time represented them as avoiding visits to mental health services, and as lacking knowledge about mental illness and its treatment.

The mass media also criticized the consensual nature of hospitalization, pointing to a risk of dangerous activities and crimes committed by people with mental illness. The articles connected patients' rights under the new policy regarding hospital admission and treatment with an increase in violent crime in the country. Such discussions opposed the reforms, representing the liberalization of psychiatry as a source of public danger. Distancing themselves from the Soviet past, and supporting patients' rights as democratic principles, the newspaper articles simultaneously suggested that maintaining security in society should be the priority.

It is also important to note that the media discussion of patients' rights during all study periods centred mainly on voluntary/involuntary care, whereas other rights – such as the right to have access to information, to communicate with other people and to participate in social life – received marginal attention in the post-Soviet media. To conclude, our research demonstrates that in Russia a negative media response to the new mental health policy appeared even at the initial stage of the reforms. Preceding the policy actions for deinstitutionalization, this created an unfavourable basis for the reforms.

8.1.2 Lack of attention to the issue of stigmatization (studies 1, 2, 3 and 4)

Although the policy papers called for the social integration of people with mental illness, no particular actions against the stigmatization of such people at the community level were recommended in the documents. It thus seems that policymakers did not consider negative attitudes to mental illness an important obstacle to the social integration of people with mental illness. Moreover, some of the documents implicitly linked mental illness to drug abuse and crime, thereby contributing to negative images. This lack of attention to the problem of stigmatization could be considered a shortcoming of the reforms, taking into account that the representations of mental illness across the analysed mass media materials were mostly negative. Newspaper articles often represented people with mental illness as dangerous or unpredictable, particularly in the context of crime stories. Arguments against the stigmatization of people with mental illness did appear in mass media. However, in many cases articles that ostensibly sought to change negative attitudes to people with mental illness also included statements and images that might increase their stigmatization. There were very few articles referring to the positive social adaptation and rehabilitation of mentally ill people. Most of the articles with positive images of people with mental illness were based on interviews with mental health specialists, which demonstrates the significance of such specialists' support for anti-stigmatization activity.

It is important to note that the professionals interviewed in our study said that their own perceptions of mental illness had changed as a result of working in psychiatric services. They had become more tolerant and had lost their fear of people with mental illness. However, these professionals were quite pessimistic about the possibility of changing the negative public attitude towards mental illness. Several professionals discussed the leading role of the mass media in the creation of negative representations of people with mental illness. Interviewees complained that the mass media not only portrayed people with mental illness in a negative way, but were also not interested in publishing the opinions of mental health professionals who wanted to change social attitudes.

Although the professionals and caregivers were not asked directly about the issue of stigmatization, this topic appeared regularly in their talk about the deinstitutionalization reforms. Both caregivers and professionals pointed to the existence of negative social attitudes towards people with mental illness and their relatives. Unlike the policy documents and mass media, they actively emphasized that

such attitudes formed one of the biggest obstacles to reform. The professionals and caregivers' talk about the issue of stigmatization will be discussed in more detail in the next subsection.

8.1.3 Deinstitutionalization reforms: from support in theory to resistance in practice (studies 1, 2, 3 and 4)

The studied policy documents called for the reform of mental health services to overcome old approaches inherited from the Soviet period. The first national mental health programme of the RF (civilF 1995) aimed primarily to improve conditions of care within psychiatric hospitals. It noted that poor material conditions and inadequate equipment in mental health hospitals did not allow the provision of satisfactory psychiatric care. Criticizing conditions in psychiatric services, the document pointed out that a considerable number of buildings lacked regular energy and water supplies (Government of the RF 1995: chapter 1). The next programme (MoH of the RF 2002) called for the improvement of psychiatric services by arranging cheaper and more effective outpatient services than those provided by hospitals. The latest programme (MoH of the RF 2007) proposed further measures to reduce the role of hospitals in mental healthcare, such as reducing the period of hospitalization in psychiatric facilities, decreasing the number of repeated hospitalizations, and creating a system of community-based mental health services. The policy documents called for the integration of mental health services into general services to help overcome patients' social exclusion (MoH 2003b). This policy discourse reflects the international tendency towards the deinstitutionalization of psychiatric care (Litvinova 2010).

However, the discussion of deinstitutionalization received very limited support from other interpretive communities. Although the media portrayed Western mental health policies towards deinstitutionalization in quite a positive way, it also noted that such practices might be premature and challenging to implement in Russia, due to the particularities of the RF's current socio-economic situation and historical background. The interviews with professionals reflected similar doubts regarding the success of the reforms. When talking about deinstitutionalization with reference to experiences in Western countries or in abstract terms, the professionals pointed to both positive and negative sides of the reforms. Nevertheless, the tone of their discussions of deinstitutionalization became more negative when they were talking about potential changes in this direction in Russia. Most of the interviewed caregivers lacked knowledge about deinstitutionalization and alternative ways of organizing the mental healthcare system. The fragmentary information that they received from the media,

professionals and informal sources made them suspect that possible reform in the direction of deinstitutionalization would be for the worse. The lines of argumentation against deinstitutionalization that appeared in talk among different interpretive communities touched upon two key themes: (1) low expectations of the reforms and sticking to tradition; (2) the controlling and protective role of psychiatry.

8.1.4 Low expectations of the reforms and sticking to tradition (studies 2, 3 and 4)

The newspaper articles, as well as professionals and caregivers, criticized the conditions in mental health facilities in Russia, claiming that the situation needed significant improvement and that this should be the priority for the reforms. Most professionals had negative opinions about state mental health policy, pointing to the low priority given to mental health issues, the poor implementation of policy declarations in practice, and insufficient funding. Arguing against the reforms proposed by the authorities, the professionals mentioned the high levels of perceived corruption in the country. They were suspicious that ideas about deinstitutionalization, which originally aimed to improve the life situations of people with mental illness, might be being used as a cover for other, hidden intentions associated with financial benefits. Some professionals thought that somebody was interested in hospital buildings and was hiding these personal interests behind deinstitutionalization reforms. Therefore, they were not sure that deinstitutionalization reforms in the name of the social integration of people with mental illness were appropriate for contemporary Russia. One newspaper article (I, 17 September 2007) also suspected that certain people had commercial interests in psychiatric hospitals' land and buildings.

Similarly to professionals, the interviewed caregivers also did not trust the reforms. They were concerned that reforms might make mental health services less accessible, and thus leave people with mental illness and their families without care or support. It is important to note that there were examples of coalitions between professionals and caregivers against deinstitutionalization. One of the interviewed mothers remembered how she was frightened by the possible closure of the hospital: "When I was told that the hospital would be closed, I thought that's it, it will be the end for all the patients" (woman, aged 73). She was proud to say that she had signed a petition proposed by mental health professionals against the closure of the hospital, and that the hospital still existed.

The interviewed professionals acknowledged negative features of Soviet mental healthcare, such as the violation of patients' rights. Despite this, they argued that many post-Soviet changes in the organization of psychiatric services had been for the worse. The lament about the destruction of the Soviet system of vocational rehabilitation for people with mental disabilities sounded in the mass media as well. The interviewed professionals were suspicious that the idea of deinstitutionalization could be used to destroy the system of psychiatric services, similarly to what had happened with work therapy units, and that nothing new would replace the "good" old practice. In their opinion, work therapy in dispansers and hospitals had been useful not only for the provision of labour activity, but also for the social rehabilitation of people with mental illness. They mentioned that work therapy units had been a good means to support the patients' relatives. Several of the caregivers I interviewed had heard about the Soviet system of vocational workshops in hospitals and dispansers, and regretted their disappearance. They reported that people with mental health problems could not find jobs due to negative social attitudes. They wanted vocational workshops to be organized in dispansers and hospitals again.

The discussion above demonstrates that there were many similarities in how interpretive communities expressed their distrust of deinstitutionalization reforms in Russia. In light of the particularities of Russia's current political and socio-economic situation, as well as its historical context, they were concerned that the restructuring of mental health services would be for the worse.

8.1.5   Controlling and protective role of psychiatry (studies 1, 2, 3 and 4)

Another line of the argumentation opposing deinstitutionalization reforms was based on discourses about the controlling and protective roles of stand-alone psychiatric services. Images of people with mental illness as asocial or dangerous, and therefore as requiring control by psychiatric institutions, appeared throughout all the data sets. If the policy documents only implicitly connected mental illness with crime, such associations were stronger in professionals' talk, and were obvious in newspaper articles. As mentioned above, negative images of people with mental illness were abundant in the mass media materials. Simultaneously, the professionals also considered hospitalization a means to protect public safety, which could be disturbed by asocial people with mental illness. They claimed that some people with mental health problems "terrorized" neighbours or relatives. The caregivers also acknowledged that relatives' inadequate or aggressive behaviour could be difficult for

themselves and those around them. One of the mothers, recalling the hospitalization of her son, said:

Hospital has disciplined him. He had a feeling of licence: if I want, I can break a window. This feeling of licence is a rather dangerous tendency. So he ended up in the hospital. He realized that there were bars on the windows, there was no outdoor activity. Because of this he understood that there is such a thing as restraint. This feeling of licence started to disappear. (Woman, aged 51)

From this mother's point of view, frightening conditions in the hospital had an unintended positive consequence, serving as a punishment for "bad" and "irresponsible" behaviour, and disciplining her son. She claimed that after his hospitalization she could discipline her son just by reminding him of the possibility of hospitalization. Another mother (aged 47) also confirmed that after five months' hospitalization her daughter had become more responsible. She explained this not in terms of any positive results of the treatment, but rather by the daughter's fear of being hospitalized in such a "terrible" hospital again.

Although people with mental illness were often depicted as potential threats to social safety, many professionals and relatives claimed that it was not so much society as people with mental illness themselves that needed protection. The existing stand-alone mental health services, such as psychiatric hospitals and dispansers, were perceived as playing this protective role. Criticizing the current conditions in mental health hospitals, such as huge wards and poor nutrition, professionals claimed that many patients would face even worse situations in their homes or "on the street". The professionals reported that some chronically mentally ill people had no sufficient livelihood in the community, and would themselves therefore apply for admission to a psychiatric hospital. Professionals also perceived hospitalization as a means to help relatives to care for people with mental disabilities. Simultaneously, the relatives recognized that hospitalization provided them with some respite from their caring role. They pointed to their own tiredness, and complained about the lack of any financial or social support from the state. Eighteen of the 20 interviewees were women. Many of them were retired or close to retirement age. Because of their age they found it increasingly difficult to care for their relatives. From the caregivers' point of view, the only existing alternative to hospital was the internat. Their views on internats were extremely negative. One of the mothers said: "Internat is the end of everything, they do not receive any treatment there. They [internat staff] say honestly that in six months they [patients] will die" (woman, aged 71).

Pointing to negative social attitudes towards people with mental illness, both professionals and caregivers claimed that stand-alone psychiatric services provided a protective environment away from the hostile outside world. Instead of integrating mental healthcare into mainstream services, professionals and caregivers argued in favour of special health and social services for people with mental health problems. Although they recognized that some specialists from mental health services, especially hospital nursing staff, also had negative attitudes to mentally ill people, they still thought that attitudes were better in psychiatry than in society in general. The caregivers also pointed out that attitudes towards people with mental disabilities and their families were better in the dispansers than in general health clinics. The dispanser, from their point of view, was a place where they could get support from staff and other caregivers; it also provided an opportunity for people with mental disabilities to communicate with each other. However, some of the caregivers preferred the people they cared for to also communicate with healthy people, because they thought this would help them learn new social skills and be better integrated into society.

In sum, while newspapers saw stand-alone psychiatric services mainly as a means to protect the public from "dangerous" mentally ill people, the professionals and caregivers rather interpreted the role of psychiatric institutions in the opposite way: hospitals and dispansers were thought to protect people with mental illness from "normal" people.

8.2 Who is considered responsible? Views of different interpretive communities on the role of various actors in the reforms

The analyses of the policy documents revealed that state authorities, administrators and staff of mental healthcare services were described as the main actors initiating and implementing the reforms. There was a lack of attention in mental health policy programmes to the role of other possible actors such as private organizations, NGOs, patients and caregivers. Nor did the policy documents consider the media as important actors that could either support or oppose the social integration of people with mental disabilities.

A paternalistic approach to policy planning and development was predominant in the policy documents. A paternalistic policy approach suggests that the government decides what is best for the people and enforces those judgements (Sunstein and

Thaler 2003). There was a lack of attention in the policy documents to the empowerment of people with mental health problems and their carers. The policymakers did not recognize the knowledge and experience of service users and their caregivers as an important basis for developing mental health services, as proposed by the WHO (2005b). It is important to note that not only mentally ill people but all citizens were sometimes presented as irresponsible and lacking the necessary knowledge. Health policy, for instance, claims that "individuals do not have a personal sense of responsibility for the care and promotion of their own health" (MoH 2003: chapter 1, section 4). Therefore, citizens are represented as objects of change and supportive measures. Their role as active participants is limited, while state organizations and authorities remain the key actors in the development of mental health policies and services. Moreover, even professionals in the state mental health services, who are described in the policy documents as important actors in the implementation of the reforms, feel that they are not listened to by authorities. The interviewed professionals felt subordinated to authoritarian state power, which from their point of view often neglected the needs of both mental health professionals and patients. They complained that policymakers lacked competence and did not take professionals' opinions about mental healthcare reform into account. This situation reinforced professionals' distrust of the reforms.

In many newspaper articles, people with mental health problems were represented as strange, inadequate or dangerous. They were also seen as children who needed care and support. For example, one article (RG, 19 September 2007) stated that people with mental illness were taught how to live, "like small children", and were controlled by a social worker, "a babysitter". In the context of such views, the experiences, opinions and knowledge of people with mental illness could hardly be represented as a resource for the development of the mental healthcare system. The voices of people with mental health problems or their relatives were missing from the newspaper articles. All stories were told by mental health specialists or journalists on behalf of service users. Similarly to the policy documents, newspaper articles pointed to a lack of knowledge and an avoidance of mental health services due to the "low level of mental health culture" typical of post-Soviet citizens.

In their considerations of mental healthcare reforms, professionals spoke about people with mental health problems as passive, and primarily as objects of care and protection. Paternalism can be defined as an intention to access and address the needs of individuals or groups in the same way as a caring parent who nurtures and protects a child without asking for permission (Breeze 1998). One of the psychiatrists (man, aged 45) mentioned that mental health professionals should have a "sense of

responsibility", as parents do for their children. This psychiatrist thought that such a "sense of responsibility" was typical of the Soviet period and that it had been lost nowadays. He argued against the rise of the post-Soviet consumerist model of medical care, which suggests a shift of responsibility from health professionals to patients who are increasingly perceived as equal partners in care.

Most of the caregivers for people with mental disabilities did not consider carers' opinions to be important for the reform of the mental healthcare system. They did not regard their personal experience as offering valuable insights that could be taken into account by policymakers. A father of a man with a mental disability explained his acceptance of his son's illness, the hospital's problems, and his own passive attitude to the reforms with reference to the religious sentiment of humble acceptance:

There is question here: "do I deserve this kind of treatment or not?" I have done a lot of bad things in my life. […] I do not think that my opinion is important. I don't think about this [reform], I take it as it is. […] Do you remember the film Heart of a Dog? In this film, somebody said that as soon as the cleaners find their way into government then everything would fall apart. (Man, aged 53)

This father aligned the relatives of people with mental disabilities with cleaners, and he thought they should not be involved in the decision-making process about psychiatric reforms, since only professionals could decide how the system should be organized. It is interesting to note that although the caregivers complained about psychiatry, they were not eager to support initiatives that criticized psychiatry. For example, one interviewee said:

I have extremely negative attitudes to those who give out such leaflets: "If your relative had a bad experience in psychiatric services, you should complain." There is an international tendency to leave people alone, not to treat patients, to close hospitals. I do not know what their aim is. But of course there are many problems in our hospitals. (Woman, aged over 40)

Although this woman complained about psychiatric hospitals, she interpreted initiatives to criticize psychiatric care in a negative way. She was suspicious about such activity, associating it with an anti-psychiatric movement. The woman suggested that "somebody must be paying these people" to argue against psychiatric care. One plausible reason for her negative interpretation of these activities is the influence of broader processes in Russian society, such as the state policy to promote suspicious attitudes to NGOs, especially those funded from abroad. This woman was concerned that the reforms would damage a previously stable psychiatric system, bringing uncertainly and risk.

To conclude, the study revealed that mental healthcare reform was perceived by all interpretive communities as a primarily state-driven endeavour, in which other actors – such as NGOs, the private sector, patients and their relatives – had no role.

Correspondingly, the authorities were seen as responsible for the success or failure of the reforms. Throughout the research material, the authorities were criticized for the groundlessness of the reforms or for their poor implementation.

8.3 Distinctions from and links to the Soviet historical background in interpretations of mental health policy

According to mental health policy documents, the psychiatric reforms were necessary because the regulations issued during the Soviet period were not in line with international mental health policy principles, and this was damaging the prestige of the country (Supreme Soviet of RF 1992). Post-Soviet rhetoric advocated international standards in mental healthcare: "Diagnosis should be made in accordance with international standards and must not be based only on non-accordance with socially recognized moral, cultural, political or religious values" (Supreme Soviet of RF 1992: article 10). This document implicitly refers to the Soviet period, and could be considered a distancing from the Soviet period in terms of human rights. The policy documents introduce the new mental health policy principles as an attempt to overcome the low quality and ineffectiveness of the old Soviet mental healthcare system. The RF's first national mental health programme, published in 1995, emphasizes that "a further organization of mental health services in the buildings of old monasteries and prisons is unacceptable" (Government of the RF: chapter 1, section 7).

Similarly to policy documents, newspaper articles often reported that during the Soviet period patients' rights had been violated and psychiatry had been used for political purposes. In the context of this critical representation of psychiatry, people with mental illness and their caregivers were represented as victims. Other studies have also highlighted anti-psychiatric public attitudes during the early post-Soviet period (Poloshi & Saposhnikova 2001). While this critical discussion contributed to negative images of psychiatry, at the same time it also increased awareness of the importance of patients' rights, and hence opened a window of opportunity for reform in this area. The interviewed professionals recognized that patients' rights had been violated in the Soviet period, and they supported the reforms in this area. The broad post-Soviet discussion of patient's rights may be seen as a reaction to the broader social changes underlying the new democratic principles, and as a simultaneous distancing from the Soviet past.

However, the study revealed that interpretations of the Soviet period were not so straightforward. Positive comments about some aspects of Soviet psychiatry appeared in mass media, as well as in professionals' and relatives' interviews. Although the newspapers pointed to such positive post-Soviet innovations as the appearance of psychotherapy and rehabilitation programmes (I, 17 September 1992; KP, 19 March 1997), they also lamented the destruction of the Soviet system of vocational workshops (RG, 19 September 1997) and regular check-ups on children's mental health (I, 11 September 1997). The interviewed professionals, especially those who had worked during the Soviet period, often used expressions such as "we have managed to save the Soviet system of psychiatric services" or "the Soviet services were destroyed," reflecting an apparent nostalgia about the "good old (Soviet) days" – i.e. traditions – in the face of the perceived risks of post-Soviet reforms. These ideas also reflected implicit tensions between "us" (mental health specialists) and "them" (the authorities).

Although the policy papers and media represented Western mental healthcare in a mainly positive way, the opinions of professionals were quite different. While discussing psychiatric reforms in Russia, the professionals mentioned both "our traditional way" (Russian and Soviet) and supposedly "new" ideas perceived as originating from the West. Some professionals viewed these ideas as premature and difficult to implement in today's Russia. Other interviewees were more doubtful, and pointed to the differences between Russia and Western societies. According to these lines of argumentation, new models cannot be borrowed from the West, and the development of the Russian mental healthcare system should follow "our traditional way".

References to the positive elements of the Soviet mental healthcare system appeared in interviews with caregivers as well. For example, one of the caregivers said: "There is an old regime in the dispensary, they phone and ask about a patient's health, whereas the polyclinic cares less" (woman, aged 73). By "old regime" she meant the Soviet period. Although these check-up practices were reminiscent of the Soviet uchet, the woman thought that such attitudes were better than the indifference she encountered in polyclinics. Taking into account caregivers' social isolation, it seems that the caregivers felt supported when somebody other than themselves was interested in their relatives' well-being. It is interesting to note that the caregiver associated this supportive approach with Soviet practices.

Simultaneously, some professionals also claimed that relatives of people with mental illness had received more support during the Soviet period due to the ability to transfer part of their caring responsibilities to the staff of vocational workshops. A

psychiatric nurse who had been working in a dispanser since the Soviet period described the work therapy unit in the dispanser in the following way:

I should say that vocational workshops – as I need to say and not only me – all our staff, from the height of age and time we remember and really regret that we do not have such vocational workshops any more. […] It was helpful because, first of all, their relatives felt calm. They brought the patient here in the morning and took him away at 4 p.m. The patients received medicine and food during the day. We fed them breakfast and they went to their workplaces. They hung out with each other and the staff. We also tried to educate them morally. If they had appointments, a nurse escorted them there in the evening. So, if they needed a doctor, it was not necessary for the relatives to run here and worry. We escorted them to the ground floor and they had their appointments. We had our own psychiatrist. [...] These vocational workshops were like nursery school for kids.

This quotation demonstrates that the nurse misses not only the vocational workshop itself, but also the comprehensive organization of care, when staff could take care of various patients' needs, and as a result the relatives of people with mental illness received some respite from their caring responsibilities.

The interpretations of mental healthcare reforms described in this section demonstrate how the images of current Russian psychiatry and its possible development paths were constructed on the basis of comparisons with the West and the Soviet past. The policy documents reflected policymakers' intentions to improve the international prestige of the country by distancing it from Soviet psychiatry and urging psychiatric service staff and administrators to follow Western standards of mental healthcare. By contrast, the attitudes of other interpretive communities towards the "old Soviet" and "new Western" practices were not so straightforward. The mass media generally described Western approaches in rather positive ways, but simultaneously noted that their adoption might be premature for modern Russia. The media also pointed to some positive elements of the Soviet mental healthcare system. Professionals – especially those who had been active in the Soviet period – in many cases did not regard Western approaches as a model to which Russian psychiatry should aspire. Associating the Soviet period with a well-organized and stable system, and post-Soviet changes with uncertainty and the decreasing protection of patients, they argued against "Western" reforms. Although there were only a few explicit references to the Soviet past in the interviews with caregivers, the latter also missed some elements of the Soviet mental healthcare system and were suspicious about the reforms. However, it is noteworthy that there were professionals and caregivers who referred to Western practices in quite positive ways. To conclude, there was no common understanding within or between interpretive communities of the possible pathways for development of the mental healthcare system in Russia. The current

situation in Russian psychiatry was perceived as stuck between the lost Soviet stability and unclear "Western" reforms.

9   DISCUSSION

9.1   Assessment of the research methodology and methods

When we consider the results of this study, a number of important issues related to the research methodology and materials have to be taken into account. Sometimes the relevance of qualitative research methods is questioned by referring to the "subjective" nature of the data interpretations. According to Yanow (2000), when producing a report, the analyst is engaged in interpretive acts. Furthermore, the reader of this report also makes interpretations. Thus we have not only the immediacy of first-level interpretations (made by actors in the situation) and the less proximate characteristic of second-level interpretations (made by the researcher), but also the reader's even more distant third level. Therefore, I recognize that interpretive policy analysis cannot lead to universal or objective claims. In spite of this limitation, I think that the interpretive approach has given us the possibility of a deeper understanding of the views of different interpretive communities in Russia on mental healthcare reforms. I would also like to point out that the research was based on systematic and rigorous methods, such as qualitative content analysis and thematic analysis. To increase the validity of the findings, the hypotheses, categorization process and results were regularly discussed in the research group (study 1) or between the co-authors of the articles (studies 2, 3 and 4). The findings were also reviewed by outside experts on mental health policy, who were consulted regarding their adequacy and relevance.

The WHO recommendations were taken as a starting point of the analysis, since these areas and principles for action are broadly respected worldwide and reflect opinions generally accepted by the international scientific community. This does not, however, mean that they were considered "perfect" ideals to be adopted without question or (as this research has suggested) socio-cultural adaptation. Rather, in this study, WHO principles were taken as a point of comparison with the Soviet background, with the aim to outline the key developments in post-Soviet mental health policies.

Mental health policy is a complex and multidimensional phenomenon that poses the research challenge of focusing on certain policy aspects while excluding others. At the initial stage of the study, I chose several mental health policy principles that could

be considered central to the analysis of the new Russian mental health policy regarding its differentiation from and links to the Soviet historical background. Several principles were included in the analysis to demonstrate their interconnection. However, while conducting the study, I gradually realized that the research focus needed be narrowed, due to the limited availability of time and resources. The narrower focus gave more opportunities for deeper analysis. In studies 3 and 4 I focused my attention exclusively on the issue of deinstitutionalization. The interviewing strategy was semi-structured, which gave the respondents an opportunity to discuss the issues they considered important for understanding the mental healthcare reforms in Russia. As it turned out, topics excluded from the question guide, such as activities against stigmatization, appeared regularly in the respondents' talk on deinstitutionalization reforms. Additionally, some new topics, such as the system of vocational rehabilitation in the Soviet Union, were emphasized in the respondents' talk. This dynamic in the research process demonstrated the existence of complex links between different aspects of mental health policy, which I tried to capture in my research. Although I aimed to cover several aspects of mental health policy, I had to limit my study in order to make its implementation possible. I suggest that the study of interpretations of other mental health policy areas, such as preventive actions (for example, suicide prevention) or mental health promotion, would be a fruitful topic for further research.

An important characteristic of the materials in study 1 was that it focused on legislative documents issued at the federal level. My primary interest in documents issued at the federal level was to analyse upper-level processes, which may be considered the first steps for mental healthcare reform and the basis of its value in post-Soviet Russia. According to Adams, Daniels and Compagni (2009), policies and plans issued at the national level serve as guidelines for the whole system of mental healthcare, providing models that are available for adoption and implementation at the local level.

A similar restriction applied to the newspaper articles as well. Although I studied interpretations of mental healthcare reforms only in national-level mass media, the chosen newspapers enjoyed large circulations and popularity in most regions of the RF. Furthermore, I analysed mass media representations only on the basis of newspaper articles. I realize that representations of the reforms in other types of media, such as television or the Internet, might be different. I suggest that a study of the views reflected in other media sources would similarly be an interesting topic for further research.

I also recognize that studies 3 and 4, based on interviews with professionals and caregivers, have certain limitations typical of qualitative studies, such as small sample sizes and all the interviewees being from one city in the RF. The views of mental health professionals and family caregivers from other Russian regions might have been different. It would be interesting to explore in further research whether there are differences between Russian regions and cities with regard to opinions about the deinstitutionalization of mental health services. In interviews with professionals it might be useful to take into account the interviewees' educational backgrounds in e.g. psychiatry, psychology, social work etc. Further research might also explore the views of other relevant interpretive communities, such as professionals from psychiatric hospitals or general healthcare services. Our understanding of mental healthcare reform would definitely benefit from a study of the opinions of people with mental health problems.

9.2   How do different interpretive communities shape mental health policy and its implementation in Russia?

This section summarizes and discusses what the results tell us about the meanings of the reforms for the different interpretive communities, and how these interpretations might influence further mental health policy development and implementation. The research started from an assumption that the Soviet historical background influenced the discourses of different interpretive communities on the reforms. In this section I also discuss whether and how the concept of "path dependency" can help us to understand mental health policy development in post-Soviet Russia and demonstrate possible alternative ways of interpreting the findings.

9.2.1   The policymakers' views: what were the driving forces and style of the reforms?

Major political and ideological changes in society, such as the collapse of Communist ideology, can lead to a paradigmatic change, a process where deep social values are altered and reconsidered (Howlett 2009). Thus they also open a window of opportunity for new trajectories of policy development. While Soviet psychiatry was strongly criticized for its violations of patients' rights, a number of studies have reported that the principle of human rights in the area of mental health policy was a

basic step in the reforms in Russia, and that a similar development is ongoing in other post-socialist countries (Polozhij & Saposhnikova 2001; McDaid et al. 2006). The appearance of the new rhetoric on patients' rights might be explained by the broader democratic changes that triggered the recognition of individual freedoms. The study of Russian mental health policy documents demonstrates that the discussion of patients' rights, and subsequent programmes for the development of mental health services and the social inclusion of people with mental illness, was a significant advance in mental health policy, given its Soviet background. It is possible to suggest that the new principles of mental health policy development appeared as a result of the changes in politicians' attitudes to people with mental illness.

However, interviewed professionals and caregivers actively pointed to the discrepancy between policy declarations and their implementation. Monitoring by the Russian Independent Psychiatric Organization (2003) revealed "severe non-compliance" with the aims proclaimed in mental health policy documents. The programme for the reorganization of psychiatric care in 1995–1997 was financed with only 0.2 per cent of its planned budget (Independent Psychiatric Association 2004). The monitoring found that one third of the psychiatric hospitals in the country were in very bad and even unsafe condition. In 2014, the representatives of the Russian Independent Psychiatric Association pointed out that conditions in psychiatric hospitals had still not improved, remaining frequently inadequate and at times gruesome, and listed obvious drawbacks: 15 or more patients in one room, no bedside tables, bars on the windows, not enough toilets, and often no partitions (Savenko Y.& Perekhov A. 2014). The unremittingly bad situation in psychiatric hospitals does not correspond to the principle of patients' rights as proclaimed in policy documents. The reported deficiencies in policy implementation raise the question whether there were really any significant changes in the way people with mental illness were treated by policymakers. Petrea (2013) notes that with the dissolution of the USSR, many shortcomings of the Soviet mental health system were exposed, and decision makers came under international scrutiny. Russian policymakers were under pressure to recognize the human rights of people with mental health problems. It could be that the main underlying motive behind early post-Soviet political discussions of psychiatric reform was not to change attitudes to people with mental illness, but simply to improve the RF's international reputation.

The discrepancy between policy declarations and their implementation is not unique to Russia. In other post-socialist countries in Central and East Europe, which have also announced their commitment to reform, mental hospitals and internats are still the key services for mental healthcare (McDaid & Thornicroft 2005; Petrea 2013).

Despite the progress in some East European countries, the reform of mental healthcare systems in the region is slow, with insufficient funding and resource allocations, and a lack of service users' involvement in planning the services (Krupchanka & Winkler 2016). Dlouhy (2014) compared mental health policies in seven East European countries (Bulgaria, Czech Republic, Hungary, Moldova, Poland, Romania and Slovakia), and pointed out a lack of collaboration between social and healthcare services, as well insufficient links between health providers working with people with mental illness. Dlouhy (2014) states that in Romania, as reported by Amnesty International and many NGOs, the mental health system fails to protect the human rights and dignity of people with mental illness Poor living conditions in psychiatric hospitals were mentioned by the European Union progress report on Romania's accession. Despite the government's attempts to upgrade some of the inpatient and long-term care facilities and to develop community based care, the right to mental healthcare remained an aspiration rather than a reality in Romania (Vladescu, Scîntee, Olsavszky, Allin & Mladovsky 2008).

The study of Russian mental health policy documents revealed that some of the WHO principles, such as anti-stigmatization and the empowerment of services users, were not perceived as serious issues to be placed high on the political agenda. In post-Soviet Russia, mental health service users and their caregivers have more rights than in the Soviet period, and this can be considered a sign of empowerment and a step away from Soviet paternalism, at least at the level of policy declarations. However, this empowerment is limited, because people with mental illness and their caregivers still have no influence over policy planning or the work of mental health services. Despite this, users' involvement and participation can be seen as important principles when human rights in mental healthcare are addressed in policy documents, because the protection of individual rights is closely related to enabling individuals to take control of their lives. A lack of policy discussion of the participation of service users can be seen as reminiscent of the Soviet healthcare system, with a typically passive role assigned to ordinary citizens. The vertical approach to policymaking reported by mental health professionals, which was evident in a lack of dialogue between service staff and authorities, reflected this authoritarian approach to reform. The authorities' paternalistic attitude to citizens is a deep-rooted pattern in the Russian social structure (Rusinova & Brown 2003). According to Malksoo (2014), these historically developed patterns are very resistant to thinking about and implementing the principle of human rights in Russia. The paternalistic type of relationship between the state and citizens was typical not only in the Soviet period, but also in pre-Soviet Russia (Burmygina 2000).

Mahoney (2000) describes the power-based reproduction of institutions as one possible reason for path-dependent institutional development. Reproduction on the grounds of power is applicable if actors can resort to power in order to assert their interest in preserving previously established practices (Beyer 2010). This research suggests that policymakers in Russia are both interested and powerful enough to maintain the paternalistic approach to policy development. This tendency is evident not only in the field of psychiatry, but also in power relationships between authorities and citizens in other spheres, such as increasing state control over NGOs. The WHO (2005a, b) considers NGOs important actors for developing mental health services. NGOs have been the organizational form on which researchers have focused their attention in the study of the civil societies of transitional states (Sundstrom 2002). In 2006, the RF passed a law addressing the situation of NGOs in Russia (Federal Law 2006). Kahmi (2006) claims that the law significantly increased government control over NGOs and restricted the right to privacy of NGO members. Recently, the political discussion of the control of NGOs in Russia has increased. A new law, which further tightened control over NGOs funded from abroad, was approved in 2012 (Dufalla 2014).

Policymakers form a powerful interpretive community whose views on mental health policy development serve as a basis for the formulation of legislation and programmes, and directly affect policy implementation. However, the media, professionals and caregivers may support or oppose reforms proposed by the government. In the next section I will discuss the views of these interpretive communities on the reforms.

9.2.2   Contradictory role of the media

Although the media criticized Soviet psychiatry, and thereby supported the policy discourse on patients' rights, it simultaneously questioned the liberalization of psychiatry. The media considered the consensual nature of hospitalization and treatment, as well as the social integration of people with mental health problems, to be a risk to public safety. It was notable that throughout the analysed materials the media tended to represent people with mental illness as dangerous and unpredictable. The negative representation of mental illness is not exclusive to post-Soviet Russian media. Studies from other countries have also reported a tendency in journalism to focus on threats related to mental illness, which creates negative images of people with mental illness (Angermeyer & Schulze 2001; Garnello & Pauliey 2000; Siff 2003).

Cross (2004) points to a complex relationship between madness and culture that has deep historical roots. In The History of Madness, Foucault (2006) describes how people with mental illness were historically excluded on the basis of a dividing line between sanity and insanity, reason and unreason. This division led to the appearance of the great asylums in the 17th century, where madness was put under constraints (Peters & Besley 2014). Over the years, as madness gave way to modern notions of "mental illness", people with mental health problems were associated with possession and violence (Cross 2004). A number of studies have pointed to the stigmatization and social exclusion of people with disabilities in the USSR, explaining this in terms of the authorities' intention to hide those who had become troublesome to the Soviet state (Tomov et al. 2006; Phillips 2009). However, it could be argued that not only the Soviet past, but also more deeply rooted cultural associations between mental illness and danger are the reason why post-Soviet political discussions of liberalization in psychiatry were opposed by the mass media.

In order to change the negative public attitudes towards people with mental illness, governments are recommended to introduce special measures against stigmatization (WHO 2005a). As mentioned above, there was a lack of attention to the issue of stigmatization in the Russian policy documents. Furthermore, some policy documents even contributed to the reproduction of negative images of people with mental illness, for instance linking mental illness with drug abuse and crime.

Another possible reason why the media connects liberalization in psychiatry with an increase in crime might be found in the broader context of post-Soviet transformation. After the collapse of the USSR, crime and violence increased dramatically in the country, and the whole society was thought to be chaotic and unstable. People with mental illness were an easy group to blame for this. It could be argued that the "security first" discourse, particularly in the media, reflects wider concerns related to violence and crime in Russia, rather than just reactions to mental illness.

Regarding the principle of the empowerment of people with mental illness and their caregivers, the media mainly followed the policymakers' approach, representing service users in a paternalistic way and not taking account of their thoughts. Although professionals who participated in my study complained that the media were not interested in collaborating with them, there were several newspaper articles based on interviews with mental health professionals in my data. These articles echoed my participants' views on the reforms in terms of critiques of government policy and regrets about the destruction of Soviet work therapy and the unfavourable current social conditions for people with mental disabilities. Although a number of researchers

claim that government control of the media has increased in Putin's Russia (Becker 2004; Lipman & McFaul 2005), there were articles in my data criticizing the government's mental health policy. Probably the topic of mental healthcare is less popular, and is therefore less controlled compared with international conflicts or political elections. I must also point out that my data cover newspapers only up until 2012. It has been argued that Putin took strong control over the media only at the beginning of his third presidential term in 2012 (Ognyanova 2014). Media coverage of mental health policy reforms after 2012 needs further investigation.

9.2.3   Mental healthcare professionals' distrust of the reforms

The study revealed that professionals largely resisted mental healthcare reforms in Russia. Similarly, in the WHO survey (2014), experts from different countries reported this obstacle to deinstitutionalization reforms, arguing that mental health service staff wanted to maintain the status quo. Previous studies have pointed out that hospital staff especially oppose deinstitutionalization (Cooper 1990; Saraceno et al. 2007; Klein 2014). McDaid et al. (2006) reported that the key barrier to the reduction of the role of mental health hospitals in Russia was the funding mechanism, which motivated institutions to retain large numbers of beds. However, my study revealed that staff in outpatient clinics similarly opposed deinstitutionalization, and this therefore demonstrates that professionals' resistance to such reforms cannot be explained solely by the funding mechanism's encouragement of large bed numbers in psychiatric hospitals. It is also possible that suspicious attitudes towards "reform" might be a more general phenomenon in Russia, not only in respect of mental healthcare. Ries (1997) has noted the tendency of people in Russia to think reforms will go wrong. As former prime minister Viktor Chernomyrdin once put it: "We wanted the best, but it turned out as always" (Honneland 2010: 105).

However, the professionals' negative expectations of the reforms might be explained by the partial implementation of the policy declaration in Russia (Gurovich 2012). Many of the concerns reported in my study reflected objective shortcomings of the reforms. Although the government repeatedly declared its intention to improve conditions in mental health services, newspaper articles, professionals and caregivers pointed to poor material conditions in hospitals and outpatient clinics, demanding an increase in funding. Similarly, the policy intention to improve the system of vocational rehabilitation (Government of RF 1994) did not result in real changes in the situation; for example, professionals and caregivers interviewed in 2013–2015 complained about

a lack of work for people with mental disabilities. These deficiencies in government policy obviously decreased trust in the reforms. There were also multiple references to corruption in Russian society. Corruption can be defined as an abuse of public resources and powers for private benefit (Suhara 2004). The professionals were suspicious that ideas of deinstitutionalization were possibly being used as a cover for hidden purposes associated with authorities' financial gain. According to Shlapentokh (2003), corruption is particularly rampant in post-Communist Russia. A number of researchers have reported corruption in the healthcare system in Russia (Aarva, Ilchenko, Gorobets & Rogacheva 2009; Gordeeva, Pavlova & Groot 2014) and other post-socialist countries (Bonilla-Chacin et al. 2005; Falkingham et al. 2010; Habilov 2016).

Although supportive of WHO ideas as abstract principles, professionals doubted the success of such reforms in Russia. While they recognized the importance of patients' rights, they suggested that deinstitutionalization reforms were not always appropriate in contemporary Russia. The interviewees claimed that people with mental health problems needed protection from poverty, unfavourable life conditions and negative public attitudes, and that the existing psychiatric services played this protective role. There is a lack of collaboration between the health and social care services in Russia (Gofman 2008). Community-based services that could be used as alternatives to hospitals, such as supported housing, are still undeveloped (Gurovich 2012).

A question arises here about the degree to which the intention to protect people with mental illness could be interpreted as paternalistic on the professionals' part. The paternalistic approach to patients, formed by a totalitarian society, has been seen as an important barrier to mental healthcare reforms in post-socialist countries (Polubinskaya 2000). Bartenev (2005) reported that psychiatrists in Russia opposed deinstitutionalization reforms, and explained their resistance in terms of a paternalistic Soviet mentality: "people with mental illness are viewed as patients only and patients cannot be left without hospital health care" (Bartenev 2005: 7). Some of my respondents argued that professionals had great responsibility for their patients, criticizing the consumer-centred model of medicine which emphasizes patient autonomy. Yankowskii's (2011) study of post-Soviet psychiatric reforms in Ukraine claims that those reforms are increasing tensions between the cultural values of socialism and neoliberal capitalism, in relation to issues such as how providers view their patients and where the responsibility for health lies. My study demonstrates the existence of similar tensions in Russia.

However, I suggest that professionals' paternalism should not be seen only as a perpetuation of Soviet practices or taken as a sign of professionals' inability to accept new approaches that highlight patient's autonomy. Another possible reason for their paternalism lies in their perception of the RF's current socio-economic and cultural situation as very unfavourable for people with mental disabilities, and in their scepticism about any improvement of the situation in the future. From this point of view, professionals' paternalism can be explained as a sense of responsibility rather than an authoritarian attitude towards patients. Similarly, Friedman (2009) noted that the practice of hospitalizing persons who did not need treatment but only social support emerged in post-socialist Romanian psychiatry as a result of the authorities' desire to deinstitutionalize mental healthcare and mental health professionals' desire to protect their patients. However, it might also be that the justification of paternalistic attitudes through the necessity to protect patients is just a morally acceptable argument used by professionals to retain the "old" approach in their work. According to Mahoney (2000), legitimacy reasons for path dependency apply if institutions are reproduced because actors feel a moral commitment to do so or regard the institutions as legitimate. This example demonstrates that whilst there may be situations when path dependency theory can be useful, it should be used with caution, and people's other motives should also be considered.

Professionals' low expectations of the reforms can explain their desire to preserve the traditional Soviet model of mental healthcare provision. The image of Soviet psychiatry in Western scientific literature is rather negative. Many researchers claim that mental health services in the former Eastern bloc were not organized in an effective way (Jenkins et al. 2001; Rutz 2001), lacked quality and were characterized by outdated clinical methods (Figueras, Menabde & Busse 2005). However, professionals interviewed for this study actively questioned such criticisms, pointing to successful practices of work with mentally ill people in the USSR. The professionals claimed that the current system of outpatient clinics and day hospitals was an achievement of Soviet psychiatry. The representatives of all interpretive communities pointed to the well-developed system of vocational rehabilitation for people with mental disabilities in the Soviet Union. The interviewed professionals suggested that the image of Soviet psychiatry needed to be reconsidered in order to shed light not only on its obviously negative features, but also on some positive elements in the organization of mental healthcare in the USSR. Nevertheless, there were notable inconsistencies in how Soviet healthcare was perceived by professionals. This may be explained as an attempt to manage the ambivalence of attitudes about the Soviet past. Russian sociologist Kustarev (2007) suggests that nostalgia for the Soviet period helps to manage

Russians' attitudes to the past. He notes that nostalgia is evident in the tendency to recast what was "bad" in the past by discovering its "good" sides.

The professionals' opposition to reform might also be explained by the critique of the perceived negative outcomes of deinstitutionalization in some Western countries. As the WHO (2005a) recognizes, there is a gap between the principle of deinstitutionalization proclaimed by policy documents and the practice in many countries (WHO 2005a). International studies have reported that in some countries not enough alternative community-based services were created to replace the closed hospitals, and this led to an increased risk of homelessness (Lamb & Bachrach 2001) as well as addictive behaviours and inappropriate incarceration (Wallace, Mullen & Burgess 2004). Pointing to the negative experiences of some Western countries, the Russian professionals advocated a cautious approach to deinstitutionalization reforms. On the other hand, the professionals' views on deinstitutionalization might have been affected by broader processes in Russian society, such as public discussions about the West and its relationship with Russia, which in turn are influenced by processes of international politics and its representation in mass media. Guriev, Trudolyubov and Tsyvinski (2008) reported an increase in negative public attitudes in Russia towards the so-called Western model of society. A survey conducted by a major Russian independent pollster, the Levada Centre, found that anti-Western sentiments particularly rose in 2014. Seventy-one per cent of those taking part in the study had negative attitudes towards the European Union, and 81 percent towards the United States (Levada Centre 2015).

9.2.4   Caregivers' views: unclear and risky deinstitutionalization

The study revealed that the interviewed caregivers, similarly to the professionals, were very restrained in their support for deinstitutionalization, and were concerned about the possibility of losing the support they received from existing services. The respondents complained of feeling overwhelmed by their caring responsibilities, and hospitals provided them with at least some respite. Some international studies have found that carers in Western countries oppose deinstitutionalization because they are satisfied with existing inpatient services (Tabatabainia 2013). The caregivers in Russia criticized the hospitals while simultaneously arguing for their preservation. They were trying to adapt to the existing mental healthcare system, and even found some positive sides to its deficiencies. For example, the frightening conditions in hospitals were perceived as a helpful disciplinary measure. This system was seen by caregivers as non-

ideal, but as something already known and stable, while deinstitutionalization reforms were associated with uncertainty and the risk of losing even the minimal support they currently received.

According to Mannerheim (2016), due to the process of deinstitutionalization in Western countries, significant responsibility for care has been transferred from formal psychiatric care to families. Public policy often views informal caregiving as a personal and moral obligation, and not as an extension of the workforce (Levine 2010). The care allowance is very low in Russia: ₽1,200 (€20) per month (Government of the Russian Federation 2014). Furthermore, only caregivers who have no other income (such as a salary or pension) qualify for it. This restriction makes it is impossible for many caregivers in Russia to apply for the care allowance. Caregivers in Russia therefore suffer significant financial difficulties. As an example, we can compare this situation with the support for caregivers in the United Kingdom. In that country, a caregiver can qualify for care allowance (£62.10 a week) while working part-time or receiving a pension (Government of the UK 2016). It is understandable that caregivers in Russia, who are already overwhelmed with caring responsibilities, do not support further deinstitutionalization reforms. Most interviewees were mothers. This illustrates the phenomenon of the feminization of care practices, in which women are assigned the role of caregivers and expected to be willing to provide care without payment (Zdravomyslova & Temkina 2015). Several caregivers reported that they had changed to part-time, less-qualified and lower-paid work in order to have time to care for their relatives. They were thus subject to the "care penalty", which refers to a sacrifice one makes when performing care work, such as loss of personal time or job opportunities (Zdravomyslova & Temkina 2015).

The caregivers felt socially isolated, pointing to negative public attitudes towards the families of people with mental disabilities. They said that at the dispanser they received support from dispanser staff and other caregivers. The dispanser also served as a place where people with mental disabilities could communicate among themselves. Caregivers did not question stand-alone psychiatric services, but rather took them for granted. Discussing their relative's mental disability as a medical pathology that should be treated within special psychiatric services, the majority of caregivers considered such social segregation to be normal practice. The study revealed that carers needed information about the social approach to mental disability and alternative ways of organizing the mental healthcare system. This knowledge would help them to understand the meaning and significance of the reforms for the social integration of people with mental disabilities.

Associations for mental health service users and their carers can offer family caregivers emotional and practical support (WHO 2003). In Russia, such associations are undeveloped (Limankin 2016). The majority of the interviewed caregivers had not heard of such organizations in Russia. The lack of users' and caregivers' self-organized activity is typical not only of Russia, but also of other post-socialist countries, in contrast to the well-developed groups of service users in West Europe. Individual initiative was frowned upon under the Communist system. Therefore the local capacity to develop users' groups has been limited (Rose & Lucas 2006). As Petrea (2013) notes, the concept of "community" – a cornerstone of modern mental health services in Western countries, suggesting the self-organization and mutual support of caregivers – is at best shaky if not entirely absent in post-Soviet countries, which went through decades of dictatorship and are plagued by distrust among the people. Trust in relationships between individuals, groups and organizations, and a sense of community, is missing in many post-socialist countries (Tomov et al. 2006).

Service users' organizations can become advocates, denouncing stigma and discrimination, influencing policies and fighting for improved services (WHO 2003). In East European countries, after the fall of the state socialist regimes, the role of NGOs increased, albeit mainly with regard to the provision of social services and other kinds of material support (Holland 2008). The involvement of service users and their caregivers in policymaking is noticeably worse in post-socialist countries than in other EU countries (Krupchanka & Winkler 2016). Rose and Lucas (2006) claim that authorities have failed to enter constructive dialogue with service users and mental healthcare staff. There is still little evidence of users having any influence on mental health policy in post-socialist countries. Holland's (2008) study on disability activism in Poland, the Czech Republic, Slovakia and Hungary reported that most NGOs in these countries focused on service provision, rather than on advocacy or participation in policy planning.

The lack of NGO involvement in policymaking has been addressed in some international initiatives, such as the "Pathways to Policy" programme implemented by the international charity the Hamlet Trust in five East European countries. The programme aimed to establish local policy forums and organize a number of stakeholder meetings (Bureau & Shears 2006). As mentioned above, the Russian government is not favourable to NGOs, especially those that are funded from abroad and aim to influence policy development (Dufalla 2013). This policy restricts international collaboration, and seems to have contributed to the creation of negative attitudes to NGOs among family caregivers.

10 CONCLUSION

This study provided us with a deeper understanding of how mental healthcare reforms in Russia were playing out on the ground through their interpretation by different interpretive communities. Interpretive policy analysis gave an opportunity to gain a nuanced picture of how the interpretations of different actors can structure the mental health policy field. It illuminated a wide variety of beliefs and hidden assumptions made by different interpretive communities about mental healthcare reforms in Russia. Yanow's (1999) main argument for taking an interpretive approach to policy analysis was that interpretations of policy, rather than the policies themselves, drove change on the ground, and all communities of meaning involved in a policy intervention had a part to play in shaping its implementation.

The adoption of international policy documents was a basic step in the reform of mental healthcare in Russia. The psychiatric reforms were initiated by the Russian government in the 1990s primarily as a response to the bad reputation of Soviet psychiatry and to heighten Russia's prestige. As Petrea (2013) notes, the adoption of international documents in former Soviet countries did not emerge from acknowledged needs at the national level, or from a genuine willingness to change, but rather was instigated by international organizations. In reporting on mental health policies, the media was mainly concerned with the risks to society arising from the liberalization of psychiatry, associating mental illness with dangerous or strange behaviour. These negative media representations, along with a lack of policy attention to the issue of stigmatization, created a negative environment for the reforms. Interpretive policy analysis uncovered multiple problem areas between policy planning and practice in Russia. The way the policy was introduced by the government provoked distrust of the reforms among citizens affected by this policy.

In this thesis, I have discussed various mechanisms underlying changes and continuities in Russian mental health policy. Nostalgia about the Soviet period and a desire to preserve the "old" approaches is one example of how the Soviet past became evident in respondents' talk. The Soviet period was associated with stability and protection, and the reforms with uncertainty and risk. The study revealed the difficulties of transition from the Soviet to the neoliberal model of mental healthcare in Russia, and this is similar to findings reported by researchers in other post-socialist

countries (Yankowskii 2011; Friedman 2009). However, I think that the strongest sign of the Soviet heritage in Russian healthcare reforms is the state-driven approach based on authoritarian state power. This is evident in how the reforms are planned exclusively by the authorities, and in how mental health service staff and users lack of means to participate in policymaking. The consensus of scholarly analyses in the West concluded that although Russia entered a transition to democracy, this transition was not completed (Evans 2011). The mental healthcare reforms were planned to be implemented by the state and governmental organizations, and the role of other actors, such as the media and NGOs, was not considered important. This is also probably a reason why there is so little emphasis on themes such as empowerment and anti-stigmatization in the policy documents. In many respects, mental healthcare staff and relatives share the same suspicious attitudes towards the reforms and point to the negative role of the media; but their voices seem not to be heard by the policymakers, and are only partly reflected in the media.

As Dlouhy (2014) notes, two factors support reforms in post-socialist countries: firstly, the existence of motivated groups of professionals aiming to change the mental healthcare system; secondly, international support from the European Union, WHO and large international NGOs. Similarly, Krupchanka and Winkler (2016) claim that international collaboration and additional attention to the post-socialist countries are among the possible triggers of reform. Taking into account that the Russian government is not supportive of NGOs and becoming increasingly caution about their influence on policy development, along with the growing negative public attitudes to Western models of society (Levada Centre 2015), the future of mental health policy in Russia remains questionable.

Interpretive analysis presupposes a commitment to more democratic policy practice and analysis (Yanow 2007), because it suggests the involvement of professionals and service users in discussions of mental health policy issues. Although the caregivers interviewed for this study felt more like observers than potential participants in reform, and were quite surprised that I had asked their opinions, at the same time they were interested in participating in the study. I suggest that the engagement of caregivers in research might increase their awareness and thus change their passive orientation towards the reforms. Based on my experience of fieldwork in Russia, I suggest that the interest among mental health professionals in collaborating with Western partners seemed to slightly decrease in 2014 – 2015 compared with 2009. The professionals were becoming increasingly supportive of "traditional" approaches rather than of borrowing "Western" models.

The results of this study prove that transferring mental health policy ideas across national boundaries is a complex process. This underlines the importance of seeking balance between internationally driven initiatives and the readiness and willingness of multiple actors in the receiving country to accept the proposed changes. This study could help to develop an explanatory model for analysing mental healthcare reforms and social transformations in other countries too. The study not only sheds light on mental health policy, but also provides information about cultural changes in post-Soviet society in a broader sense: it demonstrates which kinds of values and norms have appeared, how the Soviet experience is being reconsidered nowadays, and which elements of the Soviet mentality persist. According to Rutz (2001), what mental health services are like, and how people with mental illness are treated and integrated into society, is one of the most sensitive indicators of the level of pluralism, democracy and tolerance in a country.

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Redesigning Mental Health Policy in Post-Soviet Russia
A Qualitative Analysis of Health Policy Documents (1992–2006)

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Acknowledgements

Abstract

This article analyzes developments in the mental health policy of post-Soviet Russia. It is based on a qualitative analysis of health policy documents of the Russian Federation published between 1992 and 2006. The developments are considered in the context of their social and historical background with due reference to the current World Health Organization (WHO) guiding principles on mental health policy. We analyze how the post-Soviet documents discuss aspects of mental health policy such as patients' rights,

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the integrative model of mental health and illness, the reorganization of mental health services toward deinstitutionalization and community-based care, the social inclusion and participation of mentally ill people, and measures to prevent their stigmatization. The results indicate that the post-Soviet documents increasingly articulate an intention to follow the international state-of-the-art in terms of civil and patients' rights, as well as an attempt to overcome conventional approaches related to the ineffectiveness of the existing mental health services system. Although the WHO mental health policy principles constitute the basis of post-Soviet legislation, this study reveals a lack of attention to the problem of stigmatization of mentally ill people. The results also show that mental service users are regarded mostly as objects of care and support rather than as active participants in the recovery process.

Introduction

The significant political and socioeconomic changes in Russia and other post-Socialist countries of the former Eastern bloc that occurred after the collapse of the Soviet Union have impacted mental health policy in these countries. This article addresses the evolution of mental health policy discourse in post-Soviet Russia through a qualitative analysis of national policy documents. It thus provides insight into a mental health-care system in transition: from questionable former Soviet standards to approaches consonant with international WHO principles. The article sheds light on the process by which changing values in society gradually infiltrate mental health policy. Although the focus of the study is on post-Soviet Russia, such an approach could help to develop an explanatory model for analyzing the developments of mental health policy in other post-Socialist countries.

The socio-political background is considered to be a crucial explanatory factor in understanding why mental health policy in former socialist countries lagged behind the developments achieved by other countries [1]. We therefore include a brief review of the historical development of mental health policy in Russia. It is based on a secondary analysis of scientific publications on this topic, whereas the analysis of the recent policy development is based on a qualitative analysis of important national mental health policy documents from 1992 to 2006.

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The key research questions are (a) how are the WHO guiding principles on mental health policy reflected in post-Soviet mental health policy discourse, and (b) how is the discourse manifest in contemporary documents pertaining to the basic tenets of Soviet mental health policy? By this analysis, we describe the process of how the mental health policy of post-Soviet Russia is represented in terms of distinction or links to the Soviet historical background.

The Need for Mental Health Policy Reforms in Post-Communist Countries

One of the underlying reasons for the need to develop mental health services was the public health crises in many post-communist countries after the early 1990s. Major changes in society created conditions of instability detrimental to the physical and mental health of their populations [2–4]. The public health crises were attributed to the upheaval in values, statuses, and social cohesions along with inability of most people to cope with prolonged psychosocial stress [1]. The high levels of mortality and morbidity in the region were explained by a cluster of stress and helplessness-related conditions, such as suicide, violence, and self-destructive lifestyles [1]. Varnik [5] noted that 9 of the 10 countries with the highest suicide rates in the world belonged to the former social-ist countries [1].

The difficult economic and social situation had a decidedly negative effect on the mental health of the Russian population [6–7]. The suicide rate in Russia doubled after 1991, reaching 44.8 per 100,000 population in 1999 [8], which is significantly higher than in most European countries [9]. The suicide rates among Russian men in 2002 were the second highest in the WHO European region, with rates of 69.3 per 100,000 men and 97.2 per 100,000 in the 45- to 54-year-old age group [9–10]. At the end of 1990, an increase in negative reactive states, neuroses, and personality disorders was noted, especially among children and young adults [6]. During the ten-year period from 1985 to 1995, registered disability due to psychiatric disorders increased by 31 percent [11]. The reduction of social protection for the mentally ill at the beginning of the 1990s took place in the context of a general and progressive deterioration in standards of

living. The official documents noted an increase in the number of mentally ill people lacking means of subsistence, housing, and social networks [11].

New mental health policy and legislation were also considered necessary because mental health services in the former socialist countries were not effectively organized. Overinstitutionalization of people with mental disorders and intellectual disabilities was typical in many of these countries [2, 12] while many health services lacked quality and were characterized by outdated clinical methods [3]. After the collapse of the Soviet Union, mental health policy reforms were also initiated because of infringements of human rights in psychiatric care during the Soviet era contrary to the principles of democracy [8, 13, 14].

Mental Health Policy in the Soviet Union

The mental health policy of the Soviet Union has a complex history with both positive and negative interpretations. During the communist era, the development of mental health policy in the Soviet Union was decisively influenced by the political ideology [15]. The main vision proclaimed by this ideology was universal access to social and health services [16]. The Soviet Union was the first state promising, in principle, universal, free access to health-care services including mental health services [17]. The Soviet welfare state regime was based on the idea of guaranteeing full employment in society [18]. Some researchers have noted that the system of vocational rehabilitation for mentally ill people was well organized in the Soviet Union [8, 19]. It began in the USSR in the 1920s and continued its development throughout the Soviet period and especially since the 1960s [19]. There were special workplaces for people with mental illness in industry and agriculture. Workshops as well as rehabilitation units for mentally ill people existed in outpatients and inpatients psychiatric clinics; the critical view claims that "work therapy" served to mask the exploitation of the labor of mentally ill patients [15, p.61]. The first psychiatric outpatient clinic in Europe was opened in Moscow in 1923, which was one of the successes in the development of mental health care in the USSR [8].

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In the 1930s, after Stalin's rise to power, the Soviet medical sciences—and science in general—started to isolate themselves from the international scientific community [20, 21]. The very existence of mental health problems in society was officially virtually denied or described as a relic of the old class society. "The absence of basic social conditions for the development of mental disorders in a socialist society" was proclaimed as the basic assumption [15, p. 55]. Because mental health was not considered a problem, the development of the mental health policy was paid little attention [10]. Accordingly, no special mental health legislation existed, and the work of psychiatric services was regulated by administrative instructions issued by the Ministry of Health [22, 23]. The denial of the existence of negative social factors in the USSR also led to a lack of social approaches in working with mentally ill people. No psychologists or social workers existed in mental health services at that time [8]. The government closed university departments and research laboratories of psychology, and the only officially accepted "scientific" psychology was Pavlov's theory [24, 25].The Khrushev era, after the death of Stalin in the 1950s, led to several positive changes in the mental health policy in terms of, for example, the establishment of new departments of psychology [25]. However, the late 1950s and early 1960s witnessed the inception of a campaign to pronounce political opponents mentally ill and to incarcerate them in psychiatric hospitals. Political control by deportation to the *gulag* or exile was less common after de-Stalinization.

In a speech published in the state newspaper *Pravda* on May 24, 1959, Khrushchev proclaimed: "Of those who might start calling for opposition to Communism . . . we can say that clearly their mental state is not normal" [cited in 1, p. 402]. When Brezhnev took over in 1964, repression increased once again and criticism of the regime was considered to be a "destructive activity" that had to be contained. Such containment was accomplished by political psychiatry [1, 26]. This political abuse constituted an infringement of human rights when psychiatric diagnoses were used to suppress behavior deemed as political dissidence. Thus, for instance, a number of political dissidents were committed to compulsory psychiatric treatment [15]. High doses of antipsychotic drugs were administered by injection to punish violators of hospital rules and to treat "anti-Soviet thoughts." Patients feared retaliation if they complained about their treatment, about abusive conduct by the staff, or about hospital practices [27].

Thus patients' rights were severely restricted [17], and the dominant approach to mental health care assumed a paternalistic orientation [28]. Other authors also argued that Soviet-style socialism suppressed individuality and individual initiative, promoting the development of a passive orientation to personal health [29].

The practice of political abuses resulted in the expulsion of the USSR from the World Psychiatric Association in 1982: it returned to the Association in 1989 after openly admitting that psychiatry had been abused for political purposes [8]. This situation was accompanied by the antipsychiatric campaign at the end of the1980s, which was a difficult period for mental health professionals who had to face accusations from patients, their relatives, journalists and the public at large [8].The democratic reforms in the early 1990s had a significant impact on the country's mental health policy. The Russian Federation formulated new policies for mental health care, taking into account international developments and principles. In 1992, Russia was the first country among the former Soviet republics to adopt a federal law on psychiatry [28].

Despite a large body of literature on developments in mental health policy and services in former socialist countries, a systematic empirical analysis of post-Soviet policy documents on mental health is lacking, particularly in Russia. Such an analysis is essential for a detailed picture of how the policy principles were modified after the fall of communism and the adoption in Russian society of democratic values.

Approach of the analysis

The approach of the analysis rests on the central European document, the Helsinki Declaration on Mental Health for Europe [30] and the related Mental Health Action Plan [31], endorsed by ministers of health of the 52 member states in the European region of the WHO and integrating the contributions of NGOs, service-users' organizations, and professionals. It was developed based on the recognition of the importance of policy development to overcome differences in mental health policy and practice, especially between Western and Eastern countries in the European region [32]. The declaration is pivotal to the current mental health policy development, exhorting countries to 'establish mental health policies, programmes and legislation which are

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based on current knowledge and consider human rights as a central precondition' and puts the focus on the transformation of mental health policy and services in the European Region, striving to achieve social inclusion and equality, and taking a comprehensive and wide approach ranging from prevention to care and treatment. Additionally it claims 'that services should be provided in a wide range of community-based settings' and calls for a reorganization of mental health services. Describing and summarizing the framework for mental health policies, the declaration recognizes that policy for and practice in mental health extend to the promotion of mental well-being and the prevention of mental health problems; care for people with mental health problems, providing comprehensive and effective services and interventions, offering service users and carers involvement and choice; the inclusion into society of those who have experienced serious mental health problems, tackling of stigma, discrimination and social exclusion.[30].

We take the WHO recommendations as our starting point of the analysis, because these areas and principles for action are widely respected worldwide and reflect ideas and opinions generally accepted by the international community. We do not, however, mean to present them as perfect ideals to be adhered to without question. Rather, in this study, these areas and principles are taken as a point of comparison to the Soviet historical context to outline the main developments in post-Soviet mental health policies, where policy discourses are influenced both by new international recommendations and the Soviet past.

As this study primarily compares Russian policy papers to the trans-formation of mental health policies, these declarations [30, 31] provide a framework to evaluate how and where the Russian policy papers reflect the WHO approach. The national Russian policy papers represent the national approach to policies and legislation and provide a framework for activities and interventions in mental health. We therefore focus on the core idea of the declarations. Through our analysis, we evaluate how much the implementation of mental health interventions is supported by the policy papers and what signs there may be of further development of standards in mental health and the respect for human rights in Russia.

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Methodological Approach, Research Materials, and Methods

In this study mental health policy documents are considered as socially constructed texts created in certain historical, social, and cultural contexts. Terms such as *mental diseases* and *mental health* are constructed by means of social interpretation, attitudes, and values; they are culturally and socially relative categories whose precise boundaries and meanings vary over time and place, and they are much disputed [32]. The political discourse is closely tied to the culture of a particular society [33]. Inglehart and Baker [34] claimed that cultural values can and do change but also that they continue to reflect a society's cultural heritage and are in this sense path dependent. Hence, it is probable that the post-Soviet mental health policy also partially reflects Soviet values and attitudes with respect to mental health and illness.

The research material consists of health policy documents issued in the Russian Federation during the period between 1992 and 2006. The collection of the documents was made using two on-line databases, Integrum (www.garant.ru) and Garant (www.integrum.ru), which are among the leading Russian information companies providing their users with specialized databases on all branches of the federal legislation. The main principles of health-care reform in the Russian Federation are stated in high-level health policy documents, called *conceptions* and prepared by the Ministry of Health, outlining the framework for the development and implementation of various national programs to protect and promote the physical and mental health of the population. A *conception* is a document written as part of a legislative process preceding a draft law or a regulation. It presents the key concepts and views intended to serve as a basis for action and development plans. The closest analogy in the European context (e.g. in the United Kingdom) is a white paper prepared for parliamentary or agency use. Three health *conceptions* were prepared in Russia after 1992 [35–37]. In addition to these, we consider the federal law [38] that laid down the principles for health legislation after the collapse of the Soviet Union and is particularly important for the development of health policy in the post-Soviet period. These four key health policy documents are, therefore, included in the research material.

At the next stage, we collected from the databases all federal health policy documents with titles containing the words *psychic* (mental), *psychiatric*, and *psychotherapeutic* issued in the Russian Federation during the period between 1992 and 2006. To ensure that we covered the most significant policy documents, we consulted outside collaborators working in the field of mental health care in Russia who helped us to include additional documents to the research material. The important criteria for including documents in the analysis were that mental health/illness was among the main topics in the document. In total, 16 special laws and orders regulating the scope and quality of mental health services in Russia and two mental health programs were included in the research material. Altogether 22 documents, including four key health policy documents, were thus selected for the study. The list of research material appears in Appendix.

When considering the results of this study, two important issues related to the research material have to be taken into account. First, the documents selected for the analysis did not cover mental health promotion of the general population but were focused on mental health care and patients. Widening the scope of the research to other aspects of mental health policy, such as mental health promotion or intersectoral collaboration within it, would have significantly increased the amount of the research material, because documents discussing mental health promotion can be found in many sectors throughout the federal government system, in social, educational, and military sectors, labor policy, and so on. Another important characteristic of the material is its focus on legislative documents issued at the federal level. Due to the enormous number of such regulations, we did not analyze the regional documents, although we believe that the developments in regional and local mental health policies do indeed present an interesting topic for further research. According to Adams, Daniels, and Compagni [39], national policies and plans serve as a guide for the whole system of mental health care in times of reform, providing models that are available for discussion and criticism in ways that impact on both national and local priorities as well as change efforts. Our primary interest in the federal documents is to describe the upper level processes, which may be considered the basic steps for reforms in the mental health policy and its value basis in post-Soviet Russia.

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The analysis focuses on those aspects of the documents dealing with issues related to the key principles of mental health policy as articulated in the recent WHO documents [30, 31].We pay special attention to those areas neglected during the Soviet era. The categories for the analysis reflect the main lines of the WHO documents in reference to mental health, prevention and care: (a) the protection of human and patients' rights and (b) an integrative model of mental health and illness, shifting to the inclusion of social determinants as preconditions for the transition that leads to the central task of a new mental health policy, namely (c) the reorganization of mental health services to include deinstitutionalization, community-based activity, integration of mental health services into primary health care, and strengthening prevention by applying principles for action as (d) social inclusion, participation, and empowerment of mentally ill people and their carers (i.e., family members, friends, and informal caregivers) and activities preventing stigmatization. These principles provide the basis for the development of mental health policy and could be deemed central to the analysis of the new Russian mental health policy regarding its separation from and links to its Soviet historical background.

The policy documents were analyzed using qualitative content analysis [40]. The text units identified were analyzed using a coding table with reference to the selected categories. We used different ways of reading the material: First, we analyzed what was said (i.e., which of the chosen principles were discussed in the documents); second, we analyzed what was not said (i.e., which of the principles were not discussed); and, third, we analyzed what was said differently (i.e., which of the principles were discussed differently and the key differences between formulations). Following the qualitative approach to stay as close as possible to the text, the categories were revised on the basis of the research material. We then summarized the ways in which the principles were presented, interpreted, and formulated in each document. Finally, we analyzed how the discourse on each category was linked to and reflected the ideas and heritage of Soviet mental health policy. The hypotheses, categorization process, and results of the research were regularly discussed in the research group and also with outside experts on mental health policy, who were consulted regarding the adequacy of the findings, their representativeness, and relevance.

Results

Human and Patient Rights as a Basis for Post-Soviet Mental Health Policy

At the very beginning of the transition period, citizens' rights and liberties in the field of health protection and promotion were emphasized, and the responsibility of the state as a guarantor of citizens' health was accentuated [38]. The basis for mental health policy of post-Soviet Russia was initially formulated in 1992 by the law, Psychiatric Care and Guarantees of Citizens' Rights in Its Provision1 [41]. The basic law on mental health took a stand for human rights, emphasizing that "the absence of proper laws on psychiatric care leads to use of psychiatry with non-medical intentions, violates personal dignity and human rights, and by this damages the country's international prestige" [41, Introduction]. Thus, human rights, together with the international prestige of the country, were used as a justification for the new mental health policy. The new rhetoric also advocated applying international standards to mental health care: "Diagnosis should be made in accordance with international standards and must not be based only on nonaccordance with socially recognized moral, cultural, political, or religious values" [41, article 10]. This article implicitly refers to the Soviet period and could be considered a separation from the Soviet past in terms of human rights.

The same document [41] emphasizes patients' rights in the field of mental health care regarding, for example, examinations, rules for admission and discharge procedures, and the general rights of mentally ill people to social protection. Overall, the documents analyzed argue that diagnostic or therapeutic measures and hospitalization may be carried out only with the consent of the person concerned [41, article 11]. Psychiatric care should be compulsory in certain conditions: namely, only if the person is a threat to himself or herself or to other people or if not administering an urgent treatment would seriously impair the person's health (article 29). This stipulation clearly differs from the Soviet time, when urgent hospitalization was totally at the discretion of psychiatrists and was regulated only by unpublished administrative guidelines [27]. According to the post-Soviet documents, the patient, or his or her legal representative, must receive information on the mental disease in an understandable form [41, article 11]. In addition, psychiatrists and other medical personnel are bound to medical confidentiality

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(article 9). The discourse on civil and patients' rights was one of the central themes in the policy documents. Such human rights rhetoric was found in most of the documents analyzed in this study. Also, reference was made to "new democratic societal values," such as strengthening individual autonomy and dignity and providing people with opportunities to make autonomous decisions and to control their own lives.

An Integrative Approach to Mental Health and Illness

The discourse on civil and patients' rights was one of the central themes in the policy documents. Such human rights rhetoric was found in most of the documents analyzed in this study. Also, reference was made to "new democratic societal values," such as strengthening individual autonomy and dignity and providing people with opportunities to make autonomous decisions and to control their own lives.

An Integrative Approach to Mental Health and Illness

The post-Soviet documents express their support for a biopsychosocial concept of mental health and also pay attention to influential social factors. The first general health law of the Russian Federation states that the protection of citizens' health is a sum of political, economic, legal, social, cultural, scientific, medical, hygienic, and antiepidemic measures aimed at the promotion of the physical and mental health of each person, and at ensuring a long active life and medical help in case of loss of health [38, article 1]. The concept of *health* in the 1992 law includes both physical and mental aspects [42]. Thus mental health is considered an inseparable part of public health corresponding to the WHO principles [30, 31]. The document argues that the rights of citizens to the protection of health must be ensured by environmental protection and by means of creating favorable conditions for work, everyday life and leisure, and citizens' upbringing and education [41, article 17]. The Ministry of Health's report, *Mental Health as a Problem of national Security of the Country* [42, p. 1] also addresses the difficult socioeconomic situation, international strife, and internal and external migration. Among factors negatively affecting the population's health, mention is made of excessive stress due to social factors, such as unhealthy working conditions [37, chapter 1].The integrative approach is reflected in arguments advocating different types

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of specialists working in mental health services—not only psychiatrists, but also psychologists and social workers [43–45]—and a complex educational program for all specialists engaged in mental health work [46, 47].

Reorganization of Mental Health Services

The first national mental health program of the Russian Federation [48], published in 1995, notes that inadequate equipment in psychiatric hospitals impedes the provision of adequate psychiatric care and points out that a considerable number of hospital buildings lack water supply, a sewerage system, and regular energy supply (chapter 1). It stresses that "a further organization of mental health services in the buildings of old monasteries and prisons is unacceptable" (chapter 1, §7). The next program related to the provision of services, published seven years later by the Ministry of Health [49], calls for the development of mental health services in the form of systematic decentralization of psychiatric care and optimization of psychiatric services by arranging more effective and cheaper outpatient services than those provided by hospitals (chapter 3). The arguments for the reorganization of services include a demand to ensure human rights by paying attention to the quality of life of patients diagnosed with mental diseases. The most significant demand in the reorganization of service provision in the documents studied, however, is for a shift toward community-based care.

The Ministry of Health report [49] requests that mental health services be integrated into primary health care to improve access to mental health care and to decrease the social exclusion of patients with mental disorders (chapter 3). The order instructs municipalities and administrative regions to organize mental health services such as psychotherapeutic offices and rooms for social-psychological help in outpatient units, which are the basic health-care institutions accessible to the majority of Russians [45]. The importance of preventive activities is highlighted in several Ministry of Health documents [44, 45, 50]. To prevent suicides, special telephone helplines, social-psychological help rooms, and crisis departments are proposed [44]. Furthermore, crisis facilities are proposed in general hospitals in addition to psychiatric hospitals [44, Appendix 3). Thus, the documents proclaim the priority of prevention, recognizing that,

instead of psychiatric treatment, most individuals with mental health problems need appropriate social and psychological support.

Social Inclusion and Participation of Mentally Ill People: The Problem of Stigmatization

Several documents [41, 43, 51] propose measures to reduce the social barriers of people with mental health problems and urge their inclusion in society. In addition to the integration of mental health care into primary health care, the documents call for vocational rehabilitation and state-owned workplaces for the mentally ill. The first national mental health program stresses that the collapse of the Soviet system caused serious difficulties in vocational rehabilitation due to a decline in state support to special industrial units and special sectors in factories for mentally ill people [48, chapter 11]. The documents propose the reestablishment of special industrial units, with labor therapy, education, and work, as well as workshops with less strenuous working conditions [51, chapter 2]. To ensure the employment of mentally ill people, the documents require a particular number of positions to be reserved under a quota scheme and mention economic benefits to employers [41, article 16].

Social exclusion is introduced in the documents in terms of integration of mental health care into primary health care but also from the perspective of restructuring vocational and social rehabilitation. However, no special action on the community level against stigmatization of mentally ill people appears in the documents. Only one document included in our data mentions briefly that the collaboration of mental health services with the mass media is a necessary measure to form adequate attitudes to the mentally ill in society [43, Annex 3]. Interestingly, some of the documents include statements that may even work against destigmatization. The policy discourse may create this kind of risk when paying attention to the negative influence of mental diseases on the state and society, referring, for instance, to the unfitness for military service of those with mental health problems [48, chapter 1]. Similarly, the way in which mental health problems are linked to drug abuse and crime [42, p. 1] seems to strengthen rather than decrease the risk of stigmatization.

The need to involve relatives and families to ensure successful prevention and care occurs only briefly in some documents. The order on education for social workers, released by the Ministry of Health in 1997 [47], states that the training of these specialists should aim at increasing their skills in communicating with the families of mentally ill people (Annex 2, chapter 2). Some of the documents, such as the 2003 Ministry of Health report [43], call for social activity for mentally ill people in the form of self-help groups and hobby clubs (Annex 3, §2.3). This document describes the organization of such clubs as the task of social workers. However, mental health service users are represented in quite a passive role throughout the research material. The documents do not acknowledge the experience and knowledge of service users and their carers—as proposed by the WHO [30]—as an important basis for planning and developing mental health services.

Possible explanations for the absence of such discussion could be found in the key health policy documents, which lay down the values and principles of health care and health promotion in post-Soviet Russia. In the latest health policy *conception* [37], the citizens are seen in a rather critical light: "Individuals do not have a personal sense of responsibility for the care and promotion of their own health" (chapter 1, §4). Therefore, the documents see the implementation of personal responsibility as an important goal for future health promotion: *Individuals' sense of moral and social responsibility must be awakened, likewise a collective consciousness of the value of health as a national resource and personal obligation. Towards this end, use will be made of all means, information transfer, administration, economy, and legislation. (chapter 4, §4)*

Thus, implementation of individual responsibility appears as an aim: Because individuals are presented as irresponsible and lacking the necessary knowledge, they are described as targets of change and supportive measures. Simultaneously, however, their role as active participants is restricted while the state organizations and officials remain the primary actors in charge of mental health policies and services.

Discussion

This article analyzes the developments in mental health policy in post-Soviet Russia. The perspective on the former Soviet Union's mental health policy affords an understanding of current developments. As previously discussed, public discussion on mental health problems was generally forbidden in the Soviet Union, and problems pertaining to the mental health situation were very seldom addressed in political declarations. The results of this study show that public discussion on mental health is developing in post-Soviet health policy papers. After the collapse of the Soviet system, the discourse on human and patient rights became a central component of the mental health policy reform. Several researchers have emphasized that the human rights approach in the area of mental health policy was a basic step in the post-Soviet reforms and that a similar process is ongoing in other transition countries [8, 17, 52].

Some experts have claimed that the Russian legislation still does not fully correspond to the generally recognized principles of international law with respect to people with mental disorders [23, 53]. According to Argunova [53], this mainly concerns the procedure of proclaiming people with mental illness to be legally incompetent and the establishment of guardianship. However, we suggest that despite these deficiencies in the legislation, the emergence of a widespread discussion on patients' rights is a significant step in the development of mental health policy in post-Soviet Russia.

The biopsychosocial approach to mental health/illness reflected in the documents could also be considered an important change in mental health policy compared to the Soviet period, when the existence of social problems and their negative influence on population health were simply denied. The biopsychosocial conception of mental health increases the role of psychologists and social workers in mental health services. The documents studied discuss new principles for the organization of men-tal health services in an attempt to overcome "traditional" approaches, such as infringement of patients' rights and the ineffectiveness of the old system. The intention to decentralize large psychiatric institutions and to bring the mental health services closer to the people could be considered an important step toward deinstitutionalization and community-based care. The documents note that the principle of decentralization has been successfully

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applied in Europe in recent decades. However, the documents include no criticism of the Western decentralization and deinstitutionalization processes where, in some cases, the old structures were dismantled but not enough alternative human services were created to replace the old institutions, leading to increased risk of homelessness [54] and addictive behaviors [55] among the mentally ill.

Jenkins et al. [10] pointed out significant barriers that need to be addressed in the Russian Federation to shift away from hospital-centered mental health services. These barriers include funding based on the existing number of hospital beds and bed occupancy rate, regulations stipulating periods of hospitalization for patients with mental illness, difficulties in redeploying staff, as well as underdevelopment of community-based services for mentally ill patients. According to McDaid, Samyshkin, Jenkins, Potasheva, Nikiforov, and Atun [17], the funding mechanism is the key barrier to any potential downsizing of institutional care, because it provides very strong incentives to an institution to maintain a large number of beds. By 2004, Russian mental health care continued to be predominantly institution-based, provided through 279 psychiatric hospitals and 110 inpatient units within 171 psychiatric clinics [56]. The Russian Federation continues to have one of the highest numbers of psychiatric beds per capita in Europe at 113.2 per 100,000 population, or more than 161,000 beds in 2005 [10, 57]. This continued dependence on hospital-based care has led to demands for the deinstitutionalization of mental health care.

The documents call for the social inclusion of people with mental health problems. However, strengthening the social inclusion of mentally ill people is mainly proposed through improvements in the institutional services instead of facilitation of the community to accept mental health problems as part of human life. Rutz [2] considered stigma to be the biggest obstacle to early intervention and reintegration into society. The move to community care in the countries of the former Eastern bloc was opposed by the widely held belief that the primary task of the mental health care system is the safety of "regular" citizens [1]. Comprehensive actions to change attitudes to mental illness and to reduce stigmatization are not discussed in the documents. Furthermore, some of the policy documents associate dangerous criminal activities with mentally ill persons. Mental diseases are thus considered conducive to crime. Such discourse contributes to

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the risk of stigmatization of mentally ill people. Activities to form positive attitudes toward mental health services and specialists seem to be necessary in post-Soviet Russia due to the negative images of psychiatry formed in the Soviet era and especially during an antipsychiatric campaign at the end of the 1980s [8]. However, the existence of these negative stereotypes is not acknowledged in current mental health policy. These findings are in line with Tashlikov [58], who pointed out the need for awareness and information campaigns to create positive images of psychiatrists, psychotherapists, and psychologists in today's Russia.

Funk, Minoletti, Drew, Taylor, and Saraceno [59] noted that governments are unlikely to be able to design and implement adequate mental health policies without the involvement of those who will be most directly affected by these policies. The non-government organizations (NGOs), including service users' organizations, are considered important actors for developing mental health services as well as activities against stigmatisation [30]. NGOs have been the organizational form on which scholars have focused their attention in the civil societies of transitional states [60]. On January 10, 2006, the Russian Federation passed a new law addressing the situation of NGOs in Russia [61]. Kahmi [62] claimed that the law significantly increases government control over NGOs. The results of our research show that, during the study period, 1992–2006, the role of NGOs in policymaking was not considered and discussed in mental health policy documents. Thus, it seems that associations of people with mental disorders and their relatives or advocacy organizations representing the interests of mentally ill people are not regarded as active agents in reforms.

From our point of view, the lack of discussion on the active participation of service users is reminiscent of the Soviet health-care system, with a typically passive role assigned to the ordinary people. This passivity suggests that the issue of empowerment among people with mental health problems and their carers arouses only marginal interest among decision makers. Nonetheless, the concept of empowerment can be seen as a core idea when individual rights in mental health care and promotion are ad-dressed in the policy papers, because the protection of human rights is closely related to enabling individuals to take control of their lives. The representation of the individual in the latest health policy *conception* [37] as irresponsible and lacking sufficient

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knowledge and motivation to fulfill his or her obligations regarding his or her own health could also be considered as a sign of these paternalistic attitudes. In Russian culture, the paternalistic attitude of officialdom to citizens is a practice very deep-seated in the social structures [63, p. 53]. The paternalistic type of relationship between the state and the population was typical not only in the Soviet period but also in pre-Soviet Russia [64]. The paternalistic attitudes to patients and the specific mentality of the majority of psychiatrists shaped by a totalitarian society were perceived as serious barrier to psychiatric reforms in former Soviet republics [28]. The results of our research demonstrate that in post-Soviet Russia mental health service users and carers have more rights than in Soviet Russia, which can be considered a sign of the empowerment and a step away from paternalism. However, we suggest that this empowerment is restricted, because mental health service users and carers can still exert no influence over the work of mental health services and policymaking. From this point of view, the position of specialists (both experts and policymakers), with the exclusive right to decide how the mental health system should work, is still paternalistic in relation to service users and their carers.

Our results show that in post-Soviet mental health policy, an appeal is made to international experiences. Nevertheless, the terms borrowed from the West actually currently compete with the traditional Soviet mental health terminology in the development of mental health policies. For example, the latest health policy *conception* uses terms such as *moral education* and *social–moral dominance on health*, demonstrating a discourse reminiscent of the Soviet era with features of paternalistic moralism. Similarly, terms such as *psychological correction* and *deviant behavior* are used in the post-Soviet documents related to mental health. Contemplated critically, such terms refer to the definition of a norm of humankind and a desirable normative behavior, which differs from WHO terminology.

In conclusion, the results of our study shed light on documents constituting the basis for mental health policy in today's Russia. According to Rutz [2], the type of mental health services offered and how mentally ill people are treated and integrated into society is one of the most sensitive indicators of the level of democracy, pluralism, and tolerance in a society. The guiding WHO principles are presented in the current Russian mental

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health policy documents, yet discussion of certain themes remains superficial. Although stigmatization and social exclusion are presented in these papers as undesirable phenomena, anti-stigmatization measures (e.g., through public awareness raising actions) are not at the center of mental health policy, nor are service users actively invited to influence the policies. However, the discussion on patients' rights, social determinants of mental health and illness, reorganization of mental health services, and measures for social inclusion of mentally ill people may be considered a significant advance in the general mental health policy discussion given its Soviet background.

Notes

1. All translations are the authors'.

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Appendix: List of research documents

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MENTAL HEALTHCARE REFORMS IN POST-SOVIET RUSSIAN MEDIA

Negotiating New Ideas and Values

After the collapse of the Soviet Union, democratic principles began to enter into different branches of Russian social and health policy. As part of these changes, the country demonstrated an intention to develop a new mental health policy based on approaches consonant with the principles of the World Health Organization. This study analyses how these new policy ideas and values are reflected in the Russian mass media, and in particular whether media discourses build upon those ideas or oppose them. It is based on a qualitative analysis of newspapers from the late Soviet period (1980s) through the transition period (1990s) to the present (2000s). The analysis focuses on (1) the protection of patients' rights, (2) the reorganisation of mental healthcare services and (3) activities preventing stigmatisation. While there was an absence of discussion of mental health problems in Soviet newspapers, the democratic changes of the 1990s triggered the recognition of the existence of mental illness, critiques of Soviet psychiatry and calls for reform. The media response to the new policies was quite ambivalent. Support for patients' rights and the social integration of the mentally ill was accompanied by fear about the detrimental effects of the reforms on public safety. Articles that challenged stigmatisation also contained negative images of mentally ill people. The media were sceptical about the success of the reforms due to the particularities of Russia's socio-economic situation and history.

Keywords: media, mental health policy, patients' rights, Post-Soviet transformations, social integration, stigma

Reformen im Zusammenhang mit der psychischen Gesundheitsförderung in den postsowjetischen russischen Medien: Diskussion neuer Ideen und Werte: Nach dem Zusammenbruch der Sowjetunion erschienen langsam die demokratischen Grundsätze in den verschiedenen Bereichen der russischen Sozial- und Gesundheitspolitik. Als Teil dieses Prozesses zeigte das Land seine Absicht, seine Politik in Bezug auf die psychische Gesundheit aufgrund des entsprechenden

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Ansatzes der Grundsätze der Weltgesundheitsorganisation zu erneuern. In unserer Studie untersuchen wir, wie diese neuen sozialpolitischen Ideen und Werte in den russischen öffentlichen Medien erschienen, insbesondere hinsichtlich dessen, ob die Diskussionen in den Medien auf diese Ideen bauten oder gegen diese Ideen waren. Die Untersuchung basiert auf der qualitativen Analyse der Pressemitteilungen von drei Zeitabschnitten: der Sowjetzeit (die 80er-Jahre), der Übergangszeit (die 90er-Jahre) und der Zeit bis zur Gegenwart (nach dem Jahr 2000). Die Analyse fokussiert sich auf den (1) Schutz der Rechte der Patienten, (2) die Reorganisation der Einrichtungen der psychischen Gesundheitsförderung und (3) die Aktivität gegen Stigmatisierung. Während in den Zeitungen der Sowjetzeit die Probleme im Zusammenhang mit der psychischen Gesundheit noch fehlten, wurde durch die demokratischen Veränderungen der 90er-Jahre das Wesen der psychischen Erkrankungen anerkannt, begann die Kritik an der sowjetischen Psychiatrie und das Drängen auf Reformen. Die neuartige Regelung wurde von den Medien ziemlich ambivalent empfangen. Neben der Unterstützung der Rechte der Patienten und der sozialen Integration von Menschen mit psychischen Störungen erschien auch die Angst, die die negativen Auswirkungen der Reformen auf die öffentliche Sicherheit betonte. Die Artikel, welche die Stigmatisierung infrage stellten, vermittelten zugleich ein negatives Image über die psychisch kranken Menschen. Mit Bezug auf die russische sozial-wirtschaftliche Lage und die Besonderheiten der Geschichte und in den Medien wurde der Erfolg der Reformen bezweifelt.

Schlüsselbegriffe: postsowjetische Umwandlung, Politik zur psychischen Gesundheit, Medien, Patientenrechte, soziale Integration, Stigma

1. Introduction

The major transformations in Russian society after the collapse of the Soviet Union had an impact both on mental health policy and services in the country and on ideologies regarding mental health and illness in general. As part of this process, post-Soviet Russia has demonstrated an intention to follow international standards of patients' rights in its mental health service system, which has been sharply criticised for its obvious ineffectiveness and political abuse (JENKINS et al. 2007). Simultaneously, the democratic reforms have influenced the mass media. During the Soviet period the task of the media was to lead the promotion of propaganda, and in order to fulfil this role the media were controlled by the Communist Party (DE SMAELE 2007). BECKER (2004) notes that democratic media began to emerge in Russia at the end of the 1980s under Soviet leader Mikhail Gorbachev, and this development continued in the 1990s under Russia's first president, Boris Yeltsin. The mass media received substantial freedom compared to the pre-glasnost period, and this gave journalists an opportunity to openly discuss different kinds of social problems in Russia (BECKER 2004).

We started our study on the assumption that media discussions of mental health/illness were influenced by democratic changes in Russia thanks to the extensive discussion of human rights in general and the emergence of new mental health policies in particular. In our study we monitored media discussions from the Soviet period (1980s) through the transformation period (1990s) to the present (2000s), aiming to understand how the mass media reflect the ideas and values

of the World Health Organization's (WHO) mental health policies. We analysed whether mass media discourses built upon these ideas or opposed them, and what signs there might be of further mental health policy development. In this study we focus on three aspects of mental health policy: (1) the protection of patients' rights, (2) the reorganisation of mental healthcare services, and (3) activities preventing stigmatisation. We focus our analysis on areas that were neglected during the Soviet era and that have therefore been the target of changes based on internationally recognised principles to achieve positive transformations in mental health policy and the lives of the mentally ill. We also pay special attention to the issue of stigmatisation, which has lacked recognition in post-Soviet mental health policy (SHEK et al. 2011), with the aim of understanding whether the media have a greater influence than policy on awareness of the problem.

We take the WHO recommendations as the starting point of our analysis because these principles for action are widely respected and reflect ideas and opinions generally accepted by the international community. In addition, they have served as the basis of mental health policy reforms in post-Soviet Russia (JENKINS et al. 2007). We do not, however, mean to present them as perfect ideals to be adhered to without question. Rather, in this study these principles are taken as a point of comparison with the Soviet historical context, in order to outline the main developments in post-Soviet media discussions of mental health issues. Although our main research interest was the post-Soviet period, we considered it necessary to start with newspapers from the late Soviet period in order to find out how the discussion of mental health issues has developed. We are aware that the WHO mental health policy is not restricted to the above-mentioned principles, but widening the scope of research to include other aspects would have significantly increased the amount of research material. We believe that the analysis of media reflections on other mental health policy topics, such as preventive action (for example, suicide prevention) or mental health promotion, constitutes a fruitful area for further research.

We approached the media discussion from a constructionist perspective (BURR 2003), according to which terms such as *mental health* and *mental illness* are constructed by means of social interpretations, attitudes and values. They are thus culturally and socially relative categories subject to contestation, the precise boundaries and meanings of which vary by time and place (BUSFIELD 2001). The journalistic discourse used in the media not only reflects but also creates dominating ways of perceiving mental health and illness. FAIRCLOUGH (2003, 18) argues that the media, as a cultural industry, are increasingly important because they construct and circulate 'representations, values and identities' that form the substance of our culture and society. The mass media are frequently named as a source of information on mental illness for the general public (LALANI & LONDON 2006; CROSS 2004; HARPER 2005). Political discourse is closely tied to culture (CHILTON & SCHÄFFNER 2002). The media thus create cultural attitudes and values that have a further effect on mental health policies (CUTCLIFFE & HANNIGAN 2001). In this paper we not only study

reflections on policy ideas in the media but also draw some conclusions about the possible influence of media discussions on mental health policy development.

2. The Soviet past and mental health policy reform in post-Soviet Russia

During the Communist era, Soviet science was isolated from Western countries, and the scientific discussion of mental health/illness was strongly influenced by Communist ideology (BUDA et al. 2009). The existence of mental health problems was officially almost denied or described as a remnant of the previous class society (KOROLENKO & KENSIN 2002). Because mental health was not considered a problem, little attention was paid to the development of mental health policy (JENKINS et al. 2007). There was therefore no special mental health legislation, and the work of psychiatric services was regulated by administrative instructions issued by the Ministry of Health (APPELBAUM 1998). Patients' rights were severely restricted (MCDAID et al. 2006), and the dominant approach to mental healthcare assumed a paternalistic orientation (POLUBINSKAYA 2000). Critical analyses of Soviet psychiatry have pointed to the social exclusion of mentally ill people, and to negative images of psychiatry and mentally ill people (KOROLENKO & KENSIN 2002). Soviet psychiatry has also been strongly criticised for its political abuses, which constituted an infringement of human rights when involuntary hospitalisation and treatment were used to suppress behaviour that was designated political dissidence (SPENCER 2000; LAVRETSKY 1998). The practice of political abuse resulted in the expulsion of the USSR from the World Psychiatric Association in 1982. The country returned to the Association in 1989 after openly admitting that psychiatry had been abused for political purposes (POLOZHIJ & SAPOSHNIKOVA 2001).

The democratic reforms of the early 1990s had a significant impact on the country's mental health policy. After the collapse of the Soviet system, the discourse on human and patients' rights became a central component of mental healthcare reform. The basis for the mental health policy of post-Soviet Russia was initially formulated in 1992 by a law enitled 'Psychiatric Care and Guarantees of Citizens' Rights in Its Provision'. This document proposed new principles in line with international standards for citizens' and patients' rights, and sought to overcome the 'old' approaches that had led to the ineffectiveness of the existing mental health service. This basic law on mental health took a stand on patients' rights, stipulating that diagnostic or therapeutic measures and hospitalisation can be carried out only with the consent of the person concerned (Supreme Soviet of the Russian Federation 1992, article 4). Psychiatric care can be compulsory only on certain conditions: if the individuals pose a threat to themselves or others, if they are not capable to take care of themselves, and if it is predicted that they will be subject to considerable harm without psychiatric care (article 29). Involuntary hospitalisation and treatment require court approval (article 33).

Thereafter several special laws, orders and programs were approved to regulate the scope and quality of mental health services in accordance with this basic law (SHEK et al. 2011). The first national mental health program of the Russian Federation (Government of the Russian Federation 1995) aimed mainly to improve conditions of care within psychiatric hospitals. The next program (Ministry of Health of the Russian Federation 2002) called for the optimisation of psychiatric services by arranging more effective and cheaper outpatient services than those provided by hospitals. New positions were established in psychiatric institutions for psychologists, psychotherapists and social workers (GUROVICH 2007). The latest program (Government of the Russian Federation 2007) proposes further action to reduce hospital involvement in mental healthcare, such as reducing the period of hospitalisation in psychiatric facilities, decreasing the number of repeated hospitalisations and creating a system of community-based mental health services.

The policy documents call for the integration of mental health services into general services to help overcome patients' social exclusion (MCDAID et al. 2006). However, the strengthening of the social inclusion of mentally ill people is mainly proposed through improvements to institutional services rather than by helping the community to accept mental health problems as part of human life. Previous research on Russian mental health policy documents has shown that although the WHO mental health policy principles constitute the basis of post-Soviet legislation, Russian mental health policy still lacks attention to the stigmatisation of mentally ill people (SHEK et al. 2011).

3. Materials and methods of research

In order to study the discussion of mental health issues, we selected key national-level newspapers from each period for analysis. The research material comprises articles published in Известия (*Izvestia*, *I*), Труд (*Trud*, *T*), Аргументы и Факты (*Argumenty i Fakty*, *AiF*), Российская газета (*Rossiiskaya Gazeta*, *RG*) and Комсомольская Правда (*Komsomolskaya Pravda*, *KP*). Newspapers were selected on the basis of their circulation and popularity. Newspaper samples were collected from the years 1982, 1987, 1992, 1997, 2002, 2007 and 2012, for the periods 7–20 March, June, September and December of each year. Altogether 883 individual newspaper issues were covered by the search for articles on mental health issues. The materials from Soviet newspapers, and some of the materials from the 1990s, were collected from the library in St. Petersburg, while the materials from post-Soviet newspapers (the 1990s and 2000s) were gathered using the electronic database Integrum, which is one of the leading Russian information companies providing users with specialised databases of media materials.

The research started with a search for articles that covered mental illness topics. In this search, the keywords were: психич* (psychic*, i.e. mental), психиатр* (psychiatr*), психопат* (psychopat*), and психотерап* (psychotherap*). The

word психол* (psychol*) was not used in the search terms because articles with this word could be found in abundance in discussions of mental health promotion to the general population, while the focus of our research was mainly on mental healthcare and rehabilitation. However, references to psychology were analysed when they appeared in discussions of the WHO principles in question. The research material included news stories, short reports, articles and editorials. We excluded commercial advertisements, TV programs and short descriptions of films from the research material because these materials are not the journalistic products of the newspapers themselves. We also excluded publications that included the keywords but did not refer to mentally ill people or mental health services/specialists. For example, articles in which the keywords were used figuratively (e.g. '*mental* attack on the opponent'; *T* 10 Sep 1997, our trans.)[1] or appeared in astrological predictions ('these cosmic factors can lead to strong *mental tension*'; *RG* 18 Sep 2007, our trans.)[2] were not included to the analysis. After this selection procedure, a total of 364 articles were available for further analysis.

The mass media data were analysed using qualitative content analysis (MAYRING 2000; HSIU-FANG & SHANNON 2005). The media text units identified were analysed using a coding table with reference to the selected categories. The categories for analysis reflected aspects of WHO mental health policy:

1. Protection of patients' rights, including key empowerment rights (such as information, consent, freedom of choice, privacy and confidentiality); the right to be protected from cruel, inhuman and degrading treatment; and the provision of a safe and hygienic environment (World Health Organization 2005).

2. *Reorganisation of mental healthcare services*, entailing the accessibility, comprehensiveness, coordination, effectiveness and equity of mental health services; the integration of mental health services into general services; and deinstitutionalisation and community-based activity (World Health Organization 2003b).

3. *Activities preventing stigmatisation*, implying the promotion of positive images of mentally ill people, with a focus on recovery from mental disorders and social integration; the debunking of myths and prejudices about mental illness, and increasing public awareness of mental health issues; and community education on mental health problems (World Health Organization 2003a; 2005).

A total of only 43 articles from the original sample of 364 included discussions of one or more of the chosen categories. In the rest of the articles the search words appeared in contexts that did not relate to the principles in question. A significant number (152) of the articles in the original sample were crime stories or representations of mentally ill people as dangerous. Most texts describing crimes only mentioned that the suspect had been referred to a psychiatric board for an examination of their mental health status. The negative representation of the mentally ill is not

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[1]   Original text: '*психическая* атака на соперника'
[2]   Original text: 'Это космическое влияние может привести к сильному *психическому* перенапряжению.'

exclusive to post-Soviet Russian media. Studies from other countries have also noted that the trend in journalism is to focus on threats related to mental illness, creating negative images of mentally ill people (ANGERMEYER & SCHULZE 2001; GRANELLO & PAULEY 2000; LINK & CULLEN 1986; SIEFF 2003). Therefore in our study we decided not to analyse such representations in detail, but rather to focus on how the new mental health policy ideas were reflected in newspaper coverage. We paid attention not only to what was said but also to what was not said, and to the aspects of the principles that were not discussed. Following a qualitative approach and staying as close as possible to the texts, we revised our categories on the basis of the research material. We then summarised the ways in which the principles were presented, interpreted and formulated in the newspapers in each historical period. The categorisation process and research results were regularly discussed within the research group.

4. Results and discussion

4.1. The missing mental health discussion in the Soviet press

Although our sample of newspapers does not allow us to make generalisations based on statistical analysis, it indicates a significant increase in the number of published articles that touch upon mental illness during the period covered by our study. While in the samples from the 1980s we found only two articles discussing mental illness (*I* 8 Sep 1982; *I* 9 Jun 1987), from the 1990s onwards the number of articles gradually increases. The main topic of the one single article from 1982 was unemployment in the USA. The article drew on statistical data to demonstrate that unemployment in the USA had led to a high level of mental illness, and contrasted this with the full employment in the USSR frequently described in newspapers of this period. The article thus exemplifies how during the Cold War the Soviet state attempted to demonstrate the USSR's prosperity, using Soviet newspapers as an important resource for the creation of a positive image of the USSR. The absence of discussion of mentally ill people might be explained by the symbolic danger posed by this social group to the prestige of the Soviet state. The conception of a healthy society with full employment and no mental illness was manifest in the media.

Our findings demonstrate that the Soviet mass media completely excluded even brief references to mental health problems in the USSR. Another article from the 1980s (*I* 9 Jun 1987) briefly mentions mental health problems as one of the factors leading to alcoholism and drug abuse. The article appeared in the context of an anti-alcohol company initiated by Gorbachev in 1985 (Ministry of Health of the USSR 1985). However, it is also striking that there was no increase in the discussion of mental health and illness during the Gorbachev era. Although this era was characterised by 'openness' (glasnost) and many new democratic principles, these did not result in wider media discussion of psychiatry and mentally ill people. The topic was closed for public discussion until official recognition in 1989 of the use of psych-

iatry for political purposes in the USSR (POLOZHIJ & SAPOSHNIKOVA 2001). At the beginning of the 1990s the newspapers openly recognised that mental illness had been underreported in the USSR (*I* 7 Mar 1992), and revealed data on the country's mental health (*I* 17 Sep 1992; *AiF* 12 Sep 1992; *AiF* 17 Jun 1992). The recognition in newspapers of the existence of mental health problems might be considered a first step towards the open public discussion of mental illness.

4.2. Patients' rights: the issue of involuntary mental healthcare

The democratic reforms of the 1990s triggered a problematisation of the social position of mentally ill people, which appeared in the context of a broader public discussion of citizens' and patients' rights. As mentioned above, in 1992 the basic law on mental health, 'Psychiatric Care and Guarantees of Citizens' Rights in Its Provision', was approved (Supreme Soviet of the Russian Federation 1992), and it was widely considered an innovation in the field of psychiatry and mental health services. Newspaper articles from the 1990s (*RG* Jun 1992; *I* 8 Jun 1992; *I* 17 Sep 1992) and the beginning of the 2000s (*AiF* 11 Dec 2002; *RG* Jun 2002) frequently reminded readers that during the Soviet period psychiatry had been used for political purposes, and that patients' rights had been abused. In the context of this critical discussion of psychiatry, mentally ill people were represented as victims whose right to be treated with respect and dignity had been violated. This was evoked with expressions such as 'patients are behind bars'[3] (*I* 17 Sep 1992) and 'patients are tortured by injections'[4] (*KP* 7 Dec 2002). Not only mentally ill people but also their relatives were represented as powerless against the staff in psychiatric services (*RG* 19 Sep 1997). Other studies have also highlighted anti-psychiatric public attitudes during the early post-Soviet period, when psychiatrists faced accusations from patients, patients' relatives, journalists and the public at large (POLOZHIJ & SAPOSHNIKOVA 2001). While this critical discussion might be taken as creating negative images of psychiatry, it simultaneously also increased awareness of the importance of patients' rights, and hence supported reform in this area.

Some aspects of the new policy, such as the consensual nature of diagnosis, hospitalisation and treatment, required by the new law of 1992, were questioned by journalists. The author of one article (*I* 11 Sep 1997) noted that patients' willingness to seek help, which the new law designated a prerequisite of psychiatric treatment, might lead to negative consequences such as delayed visits to psychiatrists. While the article acknowledges the importance of protecting patients' rights as a sign of progress over Soviet times, the impact of the Soviet legacy simultaneously gives cause to doubt the consequences of the new law. The article notes that because Soviet psychiatry created negative images of the mental health services and because

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[3] Original text: 'пациенты за решетками'
[4] Original text: 'пациенты замученные уколами'. .

information about mental health/illness was not then available to the general population, people nowadays might not be capable of seeking help voluntarily. References to the avoidance of mental health services due to the low level of mental health culture among post-Soviet citizens also appeared in the sample of newspapers from 2012 (*KP* 16 Mar 2012).The media regretted the cancellation of the compulsory checks on children's mental health that had been characteristic of the Soviet period (*I* 11 Sep 1997), noting that while adults have the right to make a choice, the situation with children is complicated because parents often reject hospitalisation or consultation with mental health specialists (*I* 10 Sep 2002; *T* 14 Sep 2002; *KP* 16 Mar 2012). The author of one of the articles notes that a visit to a psychiatrist is 'something shameful' in Russia, while in the West it is normal to have a personal psychiatrist or psychotherapist (*I* 10 Sep 2012, our trans.).[5] Taking the assumed differences between Russia and 'the West' for granted, the author thus does not realise that being a mental health service user means belonging to a stigmatised group in Western countries as well. People with mental health problems often meet fear and prejudice from others that may prevent them from seeking help for fear of being labelled (European Commission 2005).

Another line of criticism of the new policy links the consensual nature of hospitalisation with dangerous activity by mentally ill people (*T* 13 Sep 1997; *KP* 18 Jun 2007; *RG* 7 Jun 2007). One article explains that due to the new law of 1992, 'there are more crazy people in our proximity lately . . . because hospitalisation and even treatment may be carried out only with the consent of the person concerned' (*T* 13 Sep 1997, our trans.).[6] The article clearly emphasises the distance between 'us – healthy people' and 'them – the mentally ill', who have come into proximity with 'us'. The article also tells the story of a mentally ill man who killed his brother, thus implicitly connecting the liberalisation of psychiatry with crime. In another article from the later 2000s (*RG* 07 Jun 2007), a high-ranking police officer directly links an increase in violent crime with the liberalisation of psychiatry. Discussing different types of crime, he says:

> Tragic cases should be divided into three groups. First, crimes committed by maniacs and other mentally ill people. Such people have always existed, but their number has significantly increased in recent years. The reason for this is the closure of special hospitals, and the liberalisation of this area of the healthcare system so that the consent of the person concerned is necessary for hospitalisation.   (*RG* 7 Jun 2007, our trans.)[7]

This article connects patients' rights under the new policy regarding hospital admission and treatment, and also the reorganisation of services towards commu-

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[5]   Original text: 'чем-то компрометирующим'.

[6]   Original text: 'сумасшедших рядом с нами стало больше . . . на госпитализацию в стационар и даже на лечение также нужно разрешение человека с нарушенной психикой.'

[7]   Original text: 'Трагические случаи надо разделить на три категории. Первая – преступления, совершенные маньяками и прочими психически больными. Такие люди были всегда, но в последние годы их стало намного больше. Причина – закрытие спецбольниц, либерализация в этой отрасли здравоохранения, когда на госпитализацию такого человека часто нужно согласие самого больного.'

nity-based care, with an increase in violent crime. It opposes the reforms, representing the liberalisation of psychiatry as a source of public danger. The mental health services are portrayed in this case as a means to secure social safety and stability.

The majority of media discussions of patient rights' found in our sample focus on voluntary/involuntary care and do not take other patients' rights issues into consideration. Although our sample included a few articles that referred to the confidentiality of information about illness and treatment (*T* 11 Dec 2002) and to psychiatric hospital patients' right to vote (*T* Mar 2007; *RG* 13 Mar 2007), these issues were touched upon only very briefly, with no problematisation of the topics. Included in our sample is an article criticising the involuntary sterilisation of mentally ill people in Sweden and France after the Second World War (*KP* Sep 1997). This article can be considered an important example of the advocacy of mentally ill people's right to a private life. However, the article discussed the problem only from a historical perspective, with no reference to the contemporary situation in Russia. In conclusion, the media discussion of patients' rights centres on voluntary/involuntary care, whereas other rights, such as the rights to vote, to have access to information or to communicate with other people, receive marginal attention in the post-Soviet media.

4.3. Reorganisation of mental health services: selective support for the reforms

In our samples from the 1990s and early 2000s, we found several articles describing the poor material and hygienic conditions of post-Soviet mental health facilities (*I* 17 Sep 1992; *KP* 14 Jun 1997; *KP* 7 Dec 2002). In one of the articles the journalist criticises the lack of funding, and notes that the problem is not the poverty of the state but the low priority of mental health issues (*T* 18 Jun 1997). Pointing to a significant increase in mental illness in the country, articles criticise the underdevelopment of mental health services (*AiF* 20 Mar 2002), especially in small towns and villages (*KP* 11 Mar 2002). An article from 2012 also mentions poor access to mental health services in rural areas (*AiF* 19 Dec 2012). A special group discussed in the materials is children and young adults with mental health problems. The media advocate a comprehensive mental health service system for this social group (*AiF* 13 Mar 2002; *I* 10 Sep 2002; *T* 14 Jun 2002; *I* 18 Jun 2012). While the violation of patients' rights in Soviet psychiatry is strongly criticised by the media, the discussion of the organisation of Soviet mental health services is not so univocal. Although the media recognise such positive post-Soviet innovations as the appearance of psychotherapy and art therapy (*I* 17 Sep 1992; *KP* 19 Mar 1997), they also lament the destruction of the Soviet system of vocational rehabilitation (*RG* 19 Sep 1997) and regular checks on children's mental health (*I* 11 Sep 1997).

The articles from the 1990s mainly referred to the treatment of mentally ill people within psychiatric institutions but did not say anything about the deinstitutionalisation of psychiatric services and community-based care. Discussions of this topic appeared only in articles from the 2000s. An article (*RG* 15 June 2007) describ-

ing a regional program to combat depression noted that the program suggested the integration of mental health services into general healthcare and a close collaboration between primary health services and psychiatrists. An article called 'Reform of Psychiatric Care: Happiness from the Mind' ('Реформа психиатрической помощи: Счастье от ума', *I* 17 Sep 2007) informed readers about reforms in psychiatry initiated by the program of 2007 (Government of the Russian Federation 2007). In this article the possibility of recovering from a mental disorder was used as an argument for the deinstitutionalisation of psychiatry. The journalist presented several stories of mentally ill people and demonstrated that after hospitalisation in a mental health facility they had been able return to 'normal life'. According to one of the stories, (*I* Sep 2007) a non-governmental organisation (NGO) called New Opportunities helped one man to overcome despair and to interact socially after his treatment in a psychiatric hospital. It helped him to return to university and not to lose his friends. We should mention that it was the first and only reference in our research material to an NGO active in the mental health field.

However, the discussion of deinstitutionalisation is accompanied by negative views of psychiatry and methods of treatment in psychiatric hospitals (*I* 17 Sep 2007; *T* 14 Jun 2002; *T* 14 Dec 2012). The patients in these cases are represented as victims who 'seek to escape psychiatric hospital and start a new life' (*I* 17 Sep 2007, our trans.).[8] One man describing his treatment in a psychiatric hospital says that 'huge doses of medicine put me to a vegetative state, . . . but I was able not to lose my job' (*I* 17 Sep 2007, our trans.).[9] A psychiatrist arguing for the social integration of mentally ill children illustrates his argument with a story about a boy with learning disability who attended a mainstream school. He concludes that the boy has much better prospects of social integration because he has never been treated with psychotropic drugs (*T* 14 Jun 2002).

The articles voice some doubts about the success of deinstitutionalisation due to the lack of an infrastructure that might make community-based care possible. One article (*I* 17 Sep 2007) cites the success of deinstitutionalisation policies in the UK and Finland, acknowledging that for the moment there are very few such community-based services for mentally ill people in Russia. Evgenii Lubov, a leading researcher at the Moscow Research Institute of Psychiatry, whose opinion is presented in the article, notes that many chronically mentally ill people apply for admission to a psychiatric hospital because they cannot earn a livelihood in the community. This reflects the concern that patients discharged from psychiatric hospitals can became poor or homeless without proper community-based services and support. The journalist also suspects that certain people have commercial interests in psychiatric hospitals' land and buildings and that the reforms will take those away so that 'mentally ill people will be outcast again' (our trans.).[10]

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[8]   Original text: 'стремление вырваться из 'психушки', попытаться начать новую жизнь.'
[9]   Original text: 'большие дозы лекарств забили меня до растительного состояния, . . . но мне удалось не потерять работу.'
[10] Original text: 'люди с психическими отклонениями вновь будут брошены.'

A special group described in the material is old people who reportedly often apply for admission to a psychiatric hospital because of their poor material living conditions. They are therefore referred to as the 'healthy' elderly patients of psychiatric hospitals, where they can get basic care and support such as food and medicine. The article says that an increasing tendency towards 'hospitalisation for social reasons' (*AiF* 20 Mar 2002, our trans.)[11] was observed at the beginning of the 1990s and still exists in the 2000s. One article states that a mother killed her 58-year-old learning-disabled son because she was afraid that he would not receive any social support after her own death (*KP* 8 Jun 2007). Similarly, another article (*RG* 16 Mar 2007) relating the story of a 38-year-old mentally ill man noted that it was awful to think what would happen to him after his mother's death. Although these articles do not speak explicitly about the underdevelopment of community-based social services for mentally ill and learning-disabled people in Russia, we suggest that they point to this problem in an implicit way.

Media calls for the improvement of material conditions in mental health services and for an increase in their funding thus demonstrate restrained support for reforms towards the deinstitutionalisation of psychiatry. While criticising psychiatric treatment methods and recognising the possibility of recovery from mental disorders, the media nevertheless point to the absence of the social support and community-based services that would make such deinstitutionalisation possible.

4.4. Reproducing the stigma of mental illness while also arguing against it

Arguments against the stigmatisation of mentally ill people appeared as early as the beginning of the 1990s. One of the articles from 1992 concluded that mentally ill people did not commit crimes more often than healthy people. The article says that stereotyped images of the mentally ill as criminals are wrong and provides readers with statistical data to prove this (*AiF* Sep 1992: 34). In our research materials there were also articles stating that people can recover from mental illness (*KP* 18 Sep 1997; *I* 17 Sep 2007) and that psychiatric patients can live normal lives and be socially active (*T* 11 Dec 2002; *KP* 13 Mar 2012). However, in many cases articles that ostensibly seek to change negative attitudes to the mentally ill also include statements and images that might increase their stigmatisation (*I* 17 Sep 1992; *T* 13 Sep1997; *I* 11 Sep 1997; *KP* 19 Mar 1997). For example, an article titled '…Like a Madman with a Razor in His Hands' (*T* 13 Sep 1997, our trans.)[12] mentions that very few crimes are committed by mentally ill people, and that most such people are not dangerous in everyday life. Yet the title of the article may make a stronger impression on readers than its content. Another article (*KP* 19 Mar 1997) on the positive results of art therapy in psychiatric hospitals is illustrated with a humorous picture

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[11]   Original text: 'Госпитализация по социальным показаниям'.
[12]   Original title: '…Как сумасшедший с бритвою в руках'.

from a theatrical production, showing a patient with an aggressive facial expression wearing a straitjacket, with two male nurses behind him, thus reproducing stigma in a visual way.

Interviews with mental health specialists also included contradictory statements reproducing the stigma of mental illness. For example, in an article titled 'All of Us Want to Be Napoleon' (*T* 11 Dec 2002, our trans.),[13] a psychiatrist answers the journalist's question about the risk of psychiatrists being attacked by mentally ill patients: 'The probability of being targeted by bullies in the street is higher than of being attacked by patients. Furthermore, psychiatrists' sense of danger is slightly reduced, which of course is wrong, taking into account the specifics of our work' (our trans.).[14] At the beginning of the answer the psychiatrist tells readers that working with mentally ill people is no more dangerous than walking down the street, but at the end of his statement he criticises the reduced sense of danger typical of psychiatrists, because their job is in fact dangerous.

An article (*I* 10 Jun 2002) on a German photographic exhibition about disabled people, including the learning disabled, claims that the exhibition aimed to challenge the image of disabled people as recipients of support and objects of compassion but argues that such a goal would be premature for contemporary Russia. It states that disabled people still need a lot of compassion and support in Russian society due to the economic and social difficulties they face. Such opinions may be taken to reflect a paternalistic approach to learning-disabled and mentally ill people. Similar signs of paternalistic attitudes to the mentally ill were found also in other articles. One article (*RG* 19 Sep 2007) describing a community home notes that mentally ill people are taught to live there 'like small children' (маленькие дети) controlled by a social worker, 'a babysitter' (нянька). Paternalism can be understood as an attempt to access and address the needs of individuals or groups in the same way as a caring parent who nurtures and protects a child without waiting for permission (BREEZE 1998). The same tone was found in descriptions of psychoneurological boarding facilities, with adult patients being referred to as 'our wards' (подопечные, *AiF* 7 Mar 2012) or 'our children' (наши дети, *KP* 13 Mar 2012). Although such expressions do not connect mental illness with violence or danger, they contribute to the stigmatised, passive image of mentally ill people as incapable of active participation in social life.

Articles promoting the public understanding of mental health and illness can significantly contribute to anti-stigma activity (World Health Organization 2005). As early as the beginning of the 1990s, there were articles recognising the need for educational activity on mental health issues. One article (*T* 12 Dec 1992) argued for a special television program on mental health issues. Another (*AiF* 20 Mar 2002), calling for the organisation of information campaigns about mental health/illness for the general public and special groups such as young adults, the elderly and pregnant

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[13]   Original title: 'Все мы метим в Наполены.'
[14]   Original text: 'Вероятность пострадать на улице от хулиганов выше, чем подвергнуться нападению больного. Более того, чувство опасности у психиатров даже несколько снижено, что, конечно, неправильно, учитывая специфику нашей работы.'

women, referred to Western countries, where information brochures are distributed to the population. There were also several articles in our research material explaining the causes and symptoms of mental health disorders: depression (*KP* 12 Sep 2007), schizophrenia (*T* 11 Dec 2002) and post-traumatic stress disorder (*I* 10 Sep 2002). A special focus was placed on the mental health problems of children and young adults (*I* 11 Sep 1997; *AiF* 13 Mar 2002; *T* 14 Sep 2002; *I* 18 Jun 2012). Most of the educational articles as well as articles with positive images of mentally ill people were based on interviews with mental health specialists, which demonstrates their significance in the support of anti-stigmatisation activity. However, their voices were drowned out by negative representations of the mentally ill, which were abundant in the research material. As we mentioned in our description of the data, almost half of the articles represented mentally ill people as dangerous, and even articles that sought to work against stigma often contributed to its reproduction.

5. Summary and conclusion

In this study we have analysed how the media reflect the ideas and values of the WHO mental health policies, which served as the basis of post-Soviet Russian reforms in this area. In this last section, we summarise our main findings about support for and opposition to these reforms, and make some suggestions about the possible effect of media representations on mental health policy development.

As reported above, the public discussion of mental health and illness was strongly restricted in the Soviet Union, and problems pertaining to the USSR's mental health situation were very seldom addressed in the mass media (KOROLENKO & KENSIN 2002; RICHARDSON & TARASKIN 2006). Their discussion was ultimately triggered by democratic changes in post-Soviet Russia in the 1990s, enabling the public recognition of the existence of mentally ill people in Russian society, of violations of patients' rights and of the deficiencies and failures of mental health services. Our study demonstrates that particularly at the beginning of the 1990s, mentally ill people were represented as victims of the old Soviet mental healthcare system with its ineffective treatment and its denial of patients' rights. This may be interpreted as a reaction to the social changes underlying the new democratic principles, and as a simultaneous distancing from the Soviet past. The criticisms of Soviet psychiatry and calls for change in this area can be considered important factors supporting mental health policy reforms.

However, attitudes to the Soviet past were not so straightforward. There were also positive comments on some elements of the Soviet mental healthcare system, such as regular checks on children's mental health and the vocational rehabilitation of the mentally ill. Other researchers have also noted that the system of vocational rehabilitation for mentally ill people was well organised in the Soviet Union (POLOZHIJ & SAPOSHNIKOVA 2001; TIGANOV 1999). There were special workplaces in industry and agriculture for people with mental illness. Workshops and rehabilitation units for

mentally ill people existed in outpatient and inpatient psychiatric clinics. The critical view claims that this 'work therapy' served to mask the exploitation of the labour of mentally ill patients (KOROLENKO & KENSIN 2002, 61). Such inconsistencies in how Soviet healthcare is described may be explained by the need to manage the ambivalence of attitudes about the Soviet period. The Russian sociologist KUSTAREV (2007) suggests that nostalgia for the Soviet period serves to manage Russians' relationship to the past. He notes that the rapid decrease in the welfare of the Russian population in 1990s resulted in a tendency to emphasise the best aspects of the Soviet period, and to recast what had been 'bad' by discovering the 'good' sides of the past.

The media's perspectives on the Soviet past also serve to legitimate doubts about the success of the new policy. While the requirement of consent in mental healthcare is recognised as an important development compared to the Soviet period, the articles also point to the 'low level of mental health culture' among post-Soviet citizens, which makes patients incompetent to make 'well-timed decisions' about their own diagnosis and treatment. Psychiatric clinics and treatment methods were subject to criticism not only in the early post-Soviet period but also in discussions of the deinstitutionalisation of psychiatry. Although such critiques promote awareness of the problems and thus open a window of opportunity for change in this area, they simultaneously contribute to negative images of psychiatry. Activity to shape positive attitudes towards mental health services and specialists seems to be necessary in post-Soviet Russia, due to the negative images of psychiatry formed in the Soviet era (POLOZHIJ & SAPOSHNIKOVA 2001).

The new ideas in mental health policy were also opposed because of fears over public order and safety. Our results demonstrate that, although policy papers call for the integration of the mentally ill into society, the media encourage more exclusionary and controlling policies, representing the mentally ill mostly as criminals or as people with strange behaviour whose integration into society poses a risk to public safety. We found that the principle of voluntary hospitalisation and measures for the deinstitutionalisation of psychiatric care were connected by the media with a depiction of mentally ill people as dangerous. Thus the media discussion reflected the conflict between the individual's right to autonomy and society's obligation to prevent danger to all citizens. Other researchers also note that a move towards community care in countries of the former Eastern Bloc was opposed by the widely held belief that the primary purpose of the mental healthcare system is the safety of citizens (TOMOV et al. 2006).

In Western European countries and the USA, an awareness of the influence of the mass media on mental healthcare policy came only after increased negative media representations of the mentally ill had contributed to a shift to a more controlling policy in the 1990s (CUTCLIFFE & HANNINGAN 2002; HALLAM 2002; HOLLOWAY 1996). KAMERĀDE (2005) claims that Central and Eastern European countries still have an opportunity to use the mass media to strengthen public awareness of the rights of mentally ill people and to prepare the general public for community-based mental healthcare policies in advance of policy activities. However, our research

demonstrates that in Russia a negative media response to the reforms preceded policy programs for deinstitutionalisation.

NGOs, including service users' organisations, are considered important actors for developing activities against stigmatisation and for community-based care (World Health Organization 2005). However, there were no news stories whose author was a representative of such an organisation. NGOs have been the organisational form on which scholars have focused their attention in the civil societies of transitional states (SUNDSTROM 2002). A number of studies claim that civil society has remained weak and underdeveloped in Russia (COOK & VINOGRADOVA 2006; HOWARD 2002; MALTSEVA 2011). The results of our research demonstrate that NGOs are not actively engaged in media discussions of mental health reforms. Our previous study of mental health policy documents (SHEK et al. 2011) similarly showed that the role of NGOs was not considered in mental health policy documents. It thus seems that associations of people with mental disorders, their relatives, and advocacy organisations representing the interests of mentally ill people are not regarded as active agents in either policy reforms or mass media discussions of this topic.

The voices of people with mental health problems were missing from the articles. All of the stories were told by mental health specialists or journalists on behalf of people with mental health problems. This absence of service users' participation is reminiscent of the Soviet healthcare system, with a typically passive role assigned to ordinary people. Paternalistic expressions in media representations of mentally ill people are also a sign of such attitudes. INGLEHART and BAKER (2000) claim that cultural values can and do change, but also that they continue to reflect a country's cultural heritage and are in this sense path-dependent. Hence it seems that post-Soviet media partially reflect Soviet attitudes to mental health and illness.

The discussion of mental healthcare reforms often involved comparison of 'our society' with 'Western society'. Several articles throughout the study period referred to successful examples of mental health policies from the West. Although some studies claim that negative attitudes to the Western model of society have recently increased in Russia (GURIEV et al. 2009), the results of our study demonstrate that the media represent Western mental health policies in a rather positive way, albeit noting that some practices might be premature and difficult to implement in Russia due to the particularities of Russia's current socio-economic situation and historical context. BLUMLER and KAVANAGH (1999) suggest that debates conducted in public spheres, including newspapers, constructed by the media reflect a process in which policy is increasingly made in the media. Policy and the media can both be considered important actors in the creation of ideologies and values regarding mental health and illness. Our research reveals only some hints of the interconnections between these two areas and suggests that this relationship warrants further investigation.

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The Limits for Deinstitutionalization of Psychiatry in Russia: Perspectives of Professionals Working in Outpatient Mental Health Services.

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Abstract: The purpose of this study was to explore the views of mental health professionals on deinstitutionalization reforms in Russia. Qualitative interviews were conducted with 33 specialists from outpatient mental health clinics. The data were analyzed using thematic analysis. The results revealed that the professionals appeared very restrained in supporting the reforms. They argued for the preservation of the existing mental health care system rather than its transformation. Their lines of argumentation were organized around four key themes as follows: 1) critiques of state policies and a suspicion of reforms, 2) tradition instead of innovation: reclaiming the image of Soviet psychiatry, 3) hospitals as a means of social control, and 4) reform as a threat to the protection of people with mental health problems. The findings suggest that practitioner resistance to deinstitutionalization is a complex phenomenon, demonstrating how various political, economic, social, and cultural factors are intertwined in the construction of professional discourse on the reforms.

INTRODUCTION

As part of the major political and social transformations that followed the collapse of the Soviet Union, the Russian Federation has initiated reforms of the mental health care system. Soviet psychiatry was sharply criticized for political abuses [1], restriction of patients' rights [2], and over-institutionalization of people with mental illness [3, 4]. New post-Soviet mental health policies were formulated with reference to World Health Organization (WHO) principles [5, 6]. According to the Mental Health Declaration for Europe [7], which was signed by the Russian authorities, governments must take concrete steps to move from institutionalized mental health care towards community-based services. Correspondingly, the latest Russian mental health programs from 2002 and 2007 [8, 9] called for decentralization of psychiatric care, reduced hospitalization periods, decreasing the number of repeated hospitalizations, as well as developing community-based mental health care services. These policy documents reflect the international tendency for the deinstitutionalization of psychiatric care [10].

Notwithstanding policy pronouncements, in practice the Russian mental health care system is still largely based on institutional care [5]. The number of beds in psychiatric hospitals has decreased from 113.2 per 100,000 population in 2005 to 109.53 per 100,000 population in 2011 [11]. Despite these reductions the number of psychiatric beds is substantially higher than the European median of 39.4 per 100,000 population [12]. A high number of patients stay in hospital for more than a year (22.2% of patients) and a significant number for up to 5 years. In some regions, of the Russian Federation the share of long-term patients is as high as 50% [13]. We should also note that the average stay in hospitals for all causes in Russia is higher than in most of European countries [14]. In Russia, there is a high rate of hospitalization to psychiatric hospitals of patients with nonpsychotic disorders who could be receiving outpatient services [15]. The extent of deinstitutionalization, however, cannot be assessed only on the basis of the numbers of beds in psychiatric hospitals. Alongside psychiatric hospitals, another type of care institution in Russia is the "internat" psycho-neurological inpatient facilities that are large institutions (often containing more than 500 beds) where people with mental disability generally stay for life [16]. The internats are managed by the Ministry of Social Protection, while psychiatric hospitals are managed by the Ministry of Health. As Tiganov [17] notes, there were 442 internats with 124,600 beds in 1999. According to the Ministry of Social Protection, there were 505 internats with 145,191 beds in

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Russia in 2013 [18]. This data indicates that a decrease in the number of psychiatric beds in hospitals has been accompanied by an increasing number of beds in internats. Gurovich [13] points out that in Russia the number of people with mental illness living in internats is 85.5 per 100,000 population, which is more than in any other European country for equivalent facilities.

A gap between the basic principles of deinstitutionalization programs and practice is evident in many countries [19]. The challenges for deinstitutionalization are particularly great in Central and Eastern Europe, where psychiatric hospitals and long-stay social care homes (internats) continue to be the mainstay of mental health care [20]. As Petrea [12] notes, the development of mental health policy in former Soviet countries was instigated by inter-national organizations, such as WHO, with mandates covering deinstitutionalization reforms. While the Russian government seems to follow these ideas in their official programs, little is known about the situation on the ground. In this article, we shine light on these matters from the perspective of mental health services staff via a study of their opinions on the reforms outlined above.

The transformation of mental health care systems is predicated not only on changing programs and policies, but also on changing the beliefs of the people involved [21]. Some studies have noted that resistance of hospital staff is one of the biggest obstacles to deinstitutionalization reforms [22–24]. In the WHO survey [25], experts from different countries pointed to this obstacle, claiming that mental health professionals prefer to maintain the status quo. Makhashvili and Voren [26] note that resistance from service providers is an important chal-lenge to deinstitutionalization reforms in many post-Soviet countries. It has been also argued that funding mechanisms form the key barrier to any potential downsizing of institutional care in Russia because they provide very strong incentives to an institutions' staff to maintain large numbers of beds [5, 27]. According to Litvinova [10], the latest Russian mental health program of 2007, which underlined the importance of deinstitutionalization, met strong criticism not only from mental health professionals, but also from human rights activists, who pointed to the unpreparedness of psychiatric service for the reforms.

The above review of previous research thus shows that many studies have referred to mental health care specialists' attitudes as a substantial barrier for deinstitutionalization reforms, and particularly to the central role of hospital staff in resisting such reforms. It is also evident that whilst emphasizing the role of hospital staff, previous studies have not empirically analyzed the views of

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professionals working in outpatient services on the reforms. This may be a shortcoming, as attitudes of the staff of outpatient services may be expected to play an equally important role in enacting deinstitutionalization reforms in Russia. Our study, therefore, addresses this gap in the literature by exploring the deinstitutionalization-related opinions of professionals from the most typical Russian outpatient mental health services, so called psycho- neurological dispensaries ("dispanser" in Russian, a word adopted from French dispensaire).

The first dispensary was opened in Moscow in 1923 [28]. To date, the mental health service system in Russia is characterized by a widely developed network of dispensaries. These services are typically a person's first point of contact with the mental health care system. An access to appointments in a psycho-neurological dispensary is not limited by referrals from general physicians or mediated by other specialists, but it is usually open, immediate, and direct [29]. The staff at dispensaries often decides if a person needs inpatient or outpatient care and thus serve the function of gatekeepers. Therefore, their opinions on the shifting of balance between inpatient and outpatient care in the country are especially important. The purpose of this study was to analyze the Russian mental health policy reforms from the outpatient mental health practitioners' viewpoint with the following research questions: How do professionals from outpatient services see mental health care reforms toward deinstitutionalization and community based care in Russia? Do they support the new ideas or oppose them? How do they justify their views?

METHODOLOGICAL APPROACH, RESEARCH MATERIALS, AND METHODS

The study is based on a constructionist theoretical framework [30], which emphasizes the social nature of individual beliefs and recognizes their cultural and historical groundings. Terms such as mental health and mental illness are thus socially relative categories subject to dispute, the precise boundaries and meanings of which vary by time and place [31]. From this perspective, the professional discourse on mental illness and its treatment and correspondingly their individual views on the development of mental health services are socially constructed. They are tied to the cultural, social, and political contexts of a particular society. This article aims to enrich our understanding of the various processes and factors involved in the construction of the professional discourse on deinstitutionalization of mental health care in Russia.

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The study was conducted in a large city in the Russian Federation, which tends to play an important role in leading innovation programs nationally. Therefore, we were interested in the degree to which the reforms of the mental health care system would be supported in a theoretically "vanguard" milieu. The data for the study consisted of 33 qualitative semistructured interviews undertaken with mental health care professionals from working within psycho- neurological dispensaries for adults. The series of semistructured interviews was conducted in 2010 (12 interviews) and 2013/2014 (21 interviews). The respondents from five dispensaries in a large city in the Russian Federation participated in the study. The main professional groups were represented as follows: psychiatrists (14), psychotherapists (1), clinical psychologists (7), social workers (3), speech therapists (2), and psychiatric nurses (6). In selecting the respondents, we aimed to involve professionals with both medical (psychiatrists, psychotherapists, nurses: 21 interviews) and nonmedical backgrounds (psychologists, social workers, speech therapists: 12 interviews). Specialists with medical education traditionally prevail in Russian mental health services, and therefore, our sample reflects this tendency. Interview duration (30–90 minutes) was dependent upon availability of the respondent's time and willingness to share information. The professionals were informed on their right to freely decide whether to participate in the study, and the right to withdraw at any time. The study plan was assessed and accepted in terms of research ethics by the Scientific Postgraduate Committee of the School of Health Sciences, University of Tampere.

The interviews were conducted by a native Russian-speaking researcher (first author). At inter-view commencement, the interviewer introduced herself as a researcher from University of Tampere. It seemed that this encouraged interviewees to speak about the influence of international ideas in relation to the reforms in post- Soviet psychiatry. On the other hand, however, we suspect that this also provoked—in some cases—superficial answers or even outright refusal to participate in the study. The attitudes of mental health specialists to researchers from the West are understandably cautious due to the history of psychiatry in the Soviet Union, as well as the antipsychiatric campaigns that followed [28]. This caution was especially evident in the interviews with professionals who were active in the Soviet era. Increasingly negative attitudes towards the researcher since 2014 seemed to be associated with recent political tension between Russia and Western countries.

During the initial stages of the research in 2010, respondents were asked about post-Soviet reforms of mental health care in rather broad terms. The interviews were focused on topics which could be deemed central to the analysis of the new Russian mental health policy regarding its separation from, and links to, its historical Soviet origins. The question guide covered such aspects of mental health policy as improvement of patients' rights, reorganization of mental health care services, activities preventing stigmatization as well as the empowerment of service users. The respondents also had opportunities to discuss other aspects of the reforms that they considered important for understanding post-Soviet changes in mental health care.

The process of qualitative data analysis can begin during the early stages of data collection [32]. This early involvement in the analysis phase helps move back and forth between concept development and data collection in order to direct the subsequent research [33, 34]. After preliminary analysis of the first part of the interviews, we found out that reform towards the deinstitutionalization of psychiatry was one of the most contested topics in the respondents' accounts. Therefore, to cover this topic in detail, we refocused our further data collection on deinstitutionalization. We asked the professionals' opinions on such aspects of the reforms as downsizing institution-based care, decentralizing psychiatric services, reducing periods of hospitalization, decreasing the number of repeated hospitalizations, integrating mental health care in general health care services as well as the development of community-based care. At the second stage in 2013–2014, the interviewing strategy was more structured than at the initial one, although there was still quite a lot of flexibility in its composition. Therefore, some unexpected topics, such as the Soviet system of vocational rehabilitation, became accentuated in the respondents' narratives. Open-ended questions encouraged the respondents to give long, elaborate answers and also gave us an opportunity to identify new ways of understanding the topic. Three respondents, who were interviewed during the earlier stages of the research (2010), were contacted again in 2014, in order to clarify their opinions and ask additional questions.

The data were analyzed using thematic analysis [32]. Both authors of the article are fluent in Russian. Therefore, the interviews were analyzed in Russian. At the first stage of the analysis, we read all interviews and selected the parts that were relevant to the focus of our interests: reforms toward deinstitutionalization of psychiatry. The next phase involved the production of initial codes. Coding identifies features of the data that appear interesting to the analyst, and refer to the most

basic segment of the data that can be assessed in a meaningful way regarding the phenomenon [35]. Codes were developed by considering each phrase or paragraph of the data set in order to summarize arguments for or against deinstitutionalization. As a result, we had a list of the different codes which we identified in our materials. The next phase involved sorting the different codes into potential themes, and allocating all coded data extracts within the relevant themes. Each theme reflects some important and patterned way of argumentation by which the respondents approach the issue of deinstitutionalization reforms. Boyatzis [35] distinguishes two "levels" at which themes can be identified: the semantic or explicit levels, and latent or interpretative level. The latter tradition tends to come from a constructionist paradigm, where broader assumptions, structures, and meanings are theorized as underpinning what is articulated in the data [32]. In our research, the development of the themes involved interpretative work in an attempt to understand the sociocultural context and structural conditions that enabled the professionals' arguments. At this stage of the research, we reread all the interviews to ascertain whether the themes "worked" in relation to the whole data corpus. We also enriched the revised themes with additional data which did not seem relevant to deinstitutionalization in earlier coding stages, but appeared to be important for the understanding of the topic during further analysis. The final phase of the analysis consisted of the synthesis and conceptualization of the key themes in order to arrive at the main conclusions.

RESULTS: PROFESSIONALS' RESISTANCE TO THE DEINSTITUTIONALIZATION OF PSYCHIATRY IN RUSSIA

The ideas of deinstitutionalization and development of community-based care were familiar to most professionals. When discussing these concepts in abstract terms or with reference to experiences from Western countries, the professionals pointed to both positive and negative sides of the reforms. Protecting patients' rights was the main argument for deinstitutionalization in psychiatry. The professionals recognized that hospitalization restricts freedom and privacy of a person. They also referred to the possible economic advantages of community-based care as well as to its better accessibility by, and acceptability for, patients. However, the tone of their comments on deinstitutionalization turned out to be more negative when they were speaking about possible reforms in this direction in Russia. In other words, when they considered reforms in their concrete social environment—instead of abstract principles—their views were substantially more negative. Only one interviewee had a positive stance towards speeding up deinstitutionalization in Russia,

while others expressed doubts in relation to the feasibility of the reforms. In the results to follow, we will present the professionals' discourse on deinstitutionalization in psychiatry, paying special attention to their explanations of why such reforms are not seen as suitable in the contemporary Russian context. The professionals' lines of argumentation have been organized in four key themes as follows: 1) critics of state policies and suspicions of reforms, 2) sticking to traditions, 3) hospitals as a means for social control, and 4) reforms as a threat for the protection of mentally-ill people.

CRITICS OF THE STATE POLICY AND LOW EXPECTATIONS FOR REFORMS

Professionals strongly criticized the situation in the existing psychiatric hospitals in Russia, pointing to the lack of staff and poor material conditions. The professionals described huge chambers of 20–30 people, without doors, reporting that "patients always feel observed there" (clinical psychologist, 4). They claimed that the situation in the existing mental health services, both inpatient and outpatient, needs substantial improvements and that these should form the first step of the reforms. For example, one of the respondents, pointing to his own poor working conditions in the dispensary, said as follows:

I think that before decentralizing, it is necessary to get things in order. Look at our dispensary, at our walls. I think that if your Finnish colleagues compared their work conditions to ours, theirs are probably not the same. One could say a lot about this. [referring to the policy declarations]. Of course, it would be very good if my office was in my patients' neighborhood, somewhere in its center, so it could be close to all my patients … We have very good day treatment facilities, but, can you imagine, they are in K. district! When I tell my patients that they need to go to street N., their hair stands on end and they tell me: "Doctor, we will never arrive there." To arrive there at 10 a.m., they need to leave their homes at 6 a.m. (...) In our country when they [the authorities] start to improve something, this usually ends up making things worse, without a doubt. (Psychiatrist, 8)

Although this psychiatrist acknowledges that decentralization, e.g., organization of smaller community-based clinics, is a good idea, he does not believe that such reorganization of the services will be successful in practice. He complains about a lack of resources, and underlines this by referring to better material conditions in Finnish mental health care services. He points out that recently organized daycare facilities are too far from patients' homes. Several respondents expressed the same conclusion: remoteness of outpatient services leads to the hospitalization of

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patients who could otherwise be treated in the community. The interviewees strongly criticized state mental health policy, referring to such problems as the perceived low priority of mental health issues, a gap between policy declarations and practice, and a lack of funding. They complained that policy makers lack competence and do not take professionals' opinions about the development of mental health policy into account. Several specialists who argued against reforms mentioned the perceived high level of corruption in Russia. A psychiatric nurse (2), when describing how the dispensary's staff and relatives of the patients protested against possible closure of one of the psychiatric hospitals, suspected that the hospital building was already sold to a commercial firm, and this was the main reason for "such a reform." However, she was also proud to say that "we have managed to win the battle and the hospital still exists."

The interviewees compared mental health care services in Russia with Western countries. In the excerpt below, a psychologist discusses psychiatric reforms in the United States, and continues the theme with more general conclusions about the differences in the organization of Russian society, as follows:

The idea of deinstitutionalization suggests that we should close psycho-neurological dispensaries, psychiatric hospitals, and open psychiatric departments in hospitals in their place. This is how it was done in the US, and their mentally-ill people are homeless. They are free, but they do not understand that they need treatment. I am categorically against deinstitutionalization and by all means always will be against it, especially in Russia. We have no democracy, we have another kind of society. (Clinical psychologist, 6)

Pointing to the perceived negative effects of deinstitutionalization in the United States, she stressed that "especially in Russia" the consequences could be even worse. She further explained that "specificity of the Russian context" is characterized by a high level of corruption, poverty of people with mental health problems, and lack of proper social support. Therefore, she was not convinced that deinstitutionalization reforms in the name of freedom of the mentally ill were appropriate for contemporary Russia. Finally, she concluded that "it is necessary to be very careful in Russia, when you support seemingly democratic innovation." This account reflects the suspicions that many of our interviewees had about reforms: ideas of deinstitutionalization aimed at improving the lives of the people with mental health problems may work as a cover for other, hidden purposes, most often associated with financial benefits.

TRADITION INSTEAD OF INNOVATION: RECLAIMING THE IMAGE OF SOVIET PSYCHIATRY

Many professionals emphasized that Russia should follow their own way in developing mental health care rather than adopting Western practices of deinstitutionalization. A psychiatric nurse (4) claimed that traditionally, systems of mental health care in Russia differ from Western countries, and that, therefore, "you should not break something that it is proved to be good by the years." In discussing post-Soviet mental health policy, professionals frequently recalled Soviet times. The respondents argued that ideas of deinstitutionalization were not new in Russia and that the importance of outpatient care as well as the negative effects of long-term hospitalization were already recognized by Soviet psychiatrists. Many respondents suggested the further development of already existing "traditional" forms of outpatient care, such as day hospitals. Several professionals suggested that big centralized outpatient centers can provide a higher quality of mental health care compared to small outpatient clinics in the community, because they ensure more effective communication between different specialists.

While acknowledging some negative sides to Soviet psychiatry, such as political abuses or restrictions of patients' rights, those specialists who were active in the Soviet era often claimed that post-Soviet changes in the organization of mental health care were for the worse. When dis-cussing the reforms, respondents often used such expressions as "we have managed to save" or "it was destroyed" that reflect an apparent nostalgia about the "good old (Soviet) times"—-i.e., traditions, in the face of the perceived chaos of the post-Soviet reforms. It also points to implicit tensions between "they" (the authorities) and "we" (mental health specialists). The most often mentioned example of these negative trends was the eradication of the Soviet system of vocational rehabilitation of people with mental health problems. The interviewees suspected that under the slogan of "deinstitutionalization" the system of psychiatric services would be destroyed, similarly with vocational rehabilitation, and nothing new would replace the old "good" practice. One of the psychiatrists, who was active in the Soviet time, said as follows:

Yes, vocational workshops were destroyed. The same applies to hospitals. Look, during the Soviet period several psychiatric hospital buildings were destroyed, they are trying to do the same now. Not one psychiatric hospital is being built ... We should recognize that several dispensary buildings were restored in recent years. Not a single new psychiatric hospital was built. They just close

hospitals, it is an absolutely mindless and dangerous policy, and this all has been done under the slogan of supposedly strengthening outpatient care. (psychiatrist, 11)

Although most of the respondents who were active in Soviet times gave positive comments on psychiatry during that period, there was also certain ambivalence in their accounts. For instance, the psychiatrist in the previous excerpt criticized both Soviet and post-Soviet destruction of hospitals, arguing that it resulted from a perceived false ideology.

Interviewees claimed that vocational workshops made it possible to manage patients daily and thus helped to notice worsening conditions and correct pharmacological therapy in a timely manner. In the workshops, patients were provided with "rather good" food and they received "not bad" money. For example, one of the psychiatrists said that some of his patients received up to 50–60 rubles per month while his salary as doctor was 110 rubles (psychiatrist, 4). Respondents reported that nowadays most of their patients cannot find a job and live on a very low disability pension. Thus, they regretted the destruction of such an important means for the social protection of people with mental health problems and argued against further reductions in inpatient care.

From the interviewees' point of view, vocational workshops in dispensaries and hospitals served not only the provision of labor activity, but also social rehabilitation. These were also a good means to support the relatives of patients. A psychiatric nurse (5) who has been working in a dispensary since the 1970s described the workshops in the following way:

I should say that vocational workshops—as I need to say and not only me—all our staff, from the height of age and time we remember and really regret that we do not have such vocational workshops anymore ... . It was helpful because, first of all, their relatives felt calm. They brought the patient here in the morning and took him away at 4 p.m. The patients received medicine and food during the day. We fed them breakfast and they went to their workplaces. They hung out with each other and the staff. We also tried to educate them morally. If they had appointments, a nurse escorted them there in the evening. So, if they needed a doctor, it was not necessary for the relatives to run here and worry. We escorted them to the ground floor and they had their appointments. We had our own psychiatrist ... These vocational workshops were like nursery school for kids.

The above account demonstrates that the interviewee misses not only vocational rehabilitation itself, but also a comprehensive organization of work when staff can take care of various patients' needs as a result of which they can provide comfort for relatives. It is also interesting to note that in

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her following talk the nurse described service users in a very passive and diminishing way; in her description, patients were primarily objects of care. Similar views of the relationship between the patients and staff were notable in several interviews.

One psychiatrist (13) thought that mental health professionals should have a sense of responsibility, like parents do for their children. He claimed that such a sense of responsibility was typical of the Soviet times and it has been lost nowadays:

We can honestly say that health care has suffered, has suffered a lot from restructuring. First of all because doctors have lost their sense of responsibility. So who is the doctor scared of now? He is scared of lawyers, in short, of the possibility of making a mistake, but this involves a different sense of responsibility … . In fact, the doctor should have a sense of responsibility, in which this is your child, and you are his father.

In this interview extract, the psychiatrist argues against an arising neoliberal model of medical care in the post-Soviet era, which suggests a shift of responsibility from doctors to patients who are increasingly seen as equal partners in care. While his view of doctors as parents could be taken to reflect a commitment to a paternalistic model of health care, an authoritative stance towards patients also highlights a "sense of responsibility," as a guiding principle of care, which was frequently underlined in respondents' accounts. This kind of "sense of responsibility" may largely explain the professionals' apparent logic of argumentation against deinstitutionalization reforms that will be presented in the next two subsections.

PSYCHIATRIC INSTITUTIONS AS A MEANS OF CONTROL OF PEOPLE WITH MENTAL HEALTH PROBLEMS

Psychiatric institutions were seen as a means of controlling people with mental health problems and of protecting both their relatives and wider society. One of the social workers interviewed said that "All psychiatry is built on a fear that a mentally-ill person can mess up things [do something dangerous]" (Social worker, 3). Those interviewed noted that an important factor which must be recognized in mental illness is the patients' lack of awareness of their own condition, self-control, and motivations for treatment. Therefore, some respondents criticized the decreasing periods of hospitalization, arguing that many patients do not want to take medicines and regularly visit the

dispensaries whereas a psychiatric hospital would offer the possibility for constant control. They claimed that neither the number of mental health hospitals nor their capacity should be reduced.

Hospitalization was also considered as a means to help relatives with caring for people with mental health problems. A psychologist (5) noted that "relatives, when they are very tired, can hospitalize them [the mentally ill]." She explained that relatives in Russia often need to work very hard (at several jobs) to get sufficient economic resources for the family with a mentally-ill member. In discussing the relatives being overburdened by care, a psychiatrist (4) concluded as follows:

In our country several generations often live together. In many countries it is not like this. And when people cannot care for themselves they quickly go to care facilities and live there, but we have no such tradition.

It is interesting that this psychiatrist referred not only to the absence of proper housing and community mental health support, but also explained this absence through the "traditions" in Russian society.

Hospitalization was also represented as a means to protect public order and safety, which can be disturbed by "asocial" people with mental health problems. The specialists provided examples of the people with mental health problems who "terrorized" the neighbors or relatives. A psychiatrist (1), discussing the dilemma between the controlling functions of psychiatry and patient freedom said as follows:

How to draw the line, how to provide adequate care to a patient without restricting his liberties and at the same time, how to ensure that the mentally ill person does not harm anyone?

Let's say, a person had been in the hospital for several months, half a year, and was then discharged. That day he got drunk and killed somebody. On the other hand, sometimes people stay in the hospital too long and it is not clear why they are there for so long. However, there could be a social reason for this, they have no place to live. But this is the state's problem, that it is necessary to build public housing, etc. And how to draw this line? It is clear why it is so difficult. Because psychiatry is underfunded, as a result, there's a lack of social programs of the type found in Scandinavian countries. Social support is well-developed in those countries, so deinstitutionalization has occurred there.

Referring to the insufficient financing of psychiatry and comparing it with Nordic countries, the respondent claims that long-term hospitalization could be justified in Russia due to the lack of

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social support for people with mental health problems in the community. Many interviewees claimed that not so much the society, but rather people with mental health problems themselves need protection and the existing psychiatric institutions play this protective role.

DEINSTITUTIONALIZATION AS A THREAT FOR THE PROTECTION OF THE PATIENTS

Although professionals criticized the current situation in psychiatric hospitals, such as large wards or poor nutrition, they thought that many patients would have even worse conditions in their homes or "on the street." The professionals reported that some chronically mentally- ill people apply themselves for an admission to a mental hospital because of lack of livelihood in the community. One of the nurses noted as follows: "Sometimes a person is hospitalized just to get some food, for moral support. We are all people. The Russian soil is gracious, great" (psychiatric nurse, 3). In this quotation, the nurse refers to a special characteristic of Russian mentality ("gracious and great soil"), claiming that because of it, people with mental health issues have the possibility of hospitalization for protection from starvation and moral suffering, for so called "social reasons." We should note that perceiving people with mental health problems as victims was quite typical among the professionals. The respondents claimed that people with mental health problems need a lot of compassion, not only due to their suffering from mental illness, but also because of the economic and social difficulties they meet in their lives. The staff of outpatient clinics pointed to a high level of unemployment and low disability pensions 4,000–6,000 rubles (100–150 Euros) in 2013. The conflict in relationships of people with mental health problems and their relatives was also mentioned as an argument for admission to psychiatric hospitals. Those interviewed noted that in some cases mentally-ill people need and ask for hospitalization to escape constant malicious contacts with their relatives.

In discussing the protective role of psychiatry, the staff of outpatient clinics also pointed to negative public attitudes towards people with mental health problems. They suggested that public attitudes would have to change before the reforms could be implemented. The interviewees claimed that people with mental health problems do not want their psychiatric diagnosis to be disclosed in a general hospital or a polyclinic for fear of being stigmatized. Although they recognize that some mental health specialists also have negative attitudes to the mentally-ill, they think that attitudes are better in psychiatric institutions than in mainstream health care and society in general. They argued

that their own attitudes to the mentally unwell had become more positive as a result of working in psychiatric services and that they had become more tolerant (psychiatrist, 4), had lost fear of mentally ill people (social worker, 2), and nowadays believe in the possibility of recovery (speech therapists, 1). It is interesting to note that one of the nurses told that her relationship to her patients had not changed, because she was working with children before. She said: "those are small children and these are big children" (nurse, 6).

One of the psychiatrists (13) pointed to negative public attitudes about mental illness and attached them to the characteristics of the Russian society:

It is useless to introduce the idea that "a person suffering from mental illness is like you" to our society, because our society is very wild, it is not on a low intellectual level but very selfish. People cannot see this problem from a global perspective.

Pointing to the existence of negative public attitudes, this respondent was quite pessimistic about the possibility of their changing. In the following excerpt, he proposed to develop special health and social services for people with mental health problems rather than to integrate them into mainstream institutions. Another psychiatrist (7) claimed that people will not accept discharged patients of mental hospitals as neighbors:

The first association people have with mental illness, what they think of first is schizophrenia, and schizophrenics are atypical and unpredictable, that's the way it was, is, and always will be. So these attitudes will always exist and they will never change ... If the mass media represents mentally ill people in a positive way, public attitudes could change, but this is only a fantasy.

Several professionals discussed the leading role of the mass media in the creation of negative images of mental illness. Interviewees claimed that the mass media do not only represent men-tally-ill people in a negative way, but are also not interested in collaborating with mental health specialists who want to improve public perceptions of mental illness. However, not all professionals were so pessimistic about the possibility of changes in public attitudes to mental illness. For example, one of the psychologists (3) reported that attitudes are becoming better now, because of organization of cultural events such as art exhibitions of pictures drawn by people with mental health problems. A social worker (1) described the special art workshops for the "mentally ill" "and "healthy" people, aimed at changing negative social attitudes. However, such examples were the exception from a general tendency to consider modern Russian society as being very hostile to people with mental health problems.

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DISCUSSION AND CONCLUSIONS

In this study, we analyzed the perspectives of professionals' from outpatient mental health clinics on the deinstitutionalization of psychiatry in post-Soviet Russia. We found that most of our interviewees argued against the possibilities for such reforms. While the resistance of hospital staff to deinstitutionalization has been broadly reported in previous international and Russian studies, the opinions of specialists from outpatient clinics have, so far, been understudied. Our main finding, namely, that the staff of outpatient clinics has a similarly negative stance towards deinstitutionalization, was unexpected. This highlights that professionals' resistance to deinstitutionalization reforms in Russia cannot be explained only by funding mechanisms which make the maintenance of a high number of beds profitable. Instead, resistance is a much more complicated phenomenon, which should be considered in relation to the historical, social, political, economic, and cultural contexts of the country at hand.

Our analysis of the professionals' arguments suggests that many of them are not directed against the concept of deinstitutionalization in itself, but rather reflect their doubts about the success of implementing such reforms in contemporary Russia. The lack of resources and underfunding of psychiatry were considered as significant obstacles to deinstitutionalization reforms. The low level of trust in the authorities and negative expectations for reform were also obvi-ous in the professional accounts. As their expectations were quite pessimistic, the professionals interviewed argued for preserving the existing model of mental health care provision. As Makhashvili and Voren [26] noted, a resistance to mental health care reforms is widespread throughout the former republics of the USSR, where anxiety about the future is a general feature, and reforms are often seen as a risk to one's livelihood. We suggest that being suspicious about "reform" might be a more general phenomenon in Russia, not only regarding mental health care. Several studies have noted the tendency for Russians to expect things to go wrong in their country [36]. As formulated by former Prime Minister Viktor Chernomyrdin: "We wanted the best, but it turned out as always" [37]. Similar scepticism was found in our respondents' accounts on the potential for changes in negative attitudes to people with mental health problems.

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However, we need to point out that partial implementation of deinstitutionalization [9] could be considered as another reason for the professionals' apparent skepticism about the reforms. As Gurovich [13] notes, the reduction in the number of hospital beds was not followed by the parallel development of new forms of care to replace existing in-patient ones. Rather, in opposite manner, the number of services and staff decreased in existing outpatient services in the period during the reforms. Recognizing the importance of a multidisciplinary approach to the care in the community, he notes that the number of psychologists and social workers has also decreased. He reports that there are still no social workers in 13 regions of the Russian Federation.

The sociopolitical background is considered to be a crucial explanatory factor in understanding why mental health policy in the former socialist countries were behind the developments achieved by other countries [38]. While international studies often criticize Soviet psychiatry [12, 39], many of our respondents were quite positive about the mental health care system in the USSR, trying to counter its negative image. The older generation of psychiatrists inter-viewed remembered the Soviet past in nostalgic tones. A Russian sociologist, Kustarev [40] suggests that nostalgia for the Soviet period serves to manage Russians' relationship with the past. He noted that the rapid decrease in the welfare of the Russian population in the 1990s resulted in a tendency to emphasize the best aspects of the Soviet period, and to recast the "bad" of the past by discovering its "good" sides. However, some positive comments on Soviet psychiatry appeared also in the younger generation of the respondents. We should also note that attitudes to the Soviet past were not straightforward. While claiming that mental health services were well organized in the USSR, the professionals also recognized the cases of political abuses and restriction of patient rights under Soviet psychiatry.

In discussing mental health policy reforms in Russia, the respondents referred both to "our traditional way" (Russian and Soviet) and supposedly "new" ideas perceived to originate from the West. Some of the interviewees described Western mental health policies in a rather positive way, albeit whilst simultaneously viewing these practices as possibly premature and difficult to implement in Russia. Other interviewees were more skeptical and pointed to the differences between Western societies and Russia. In this line of thinking, new ideas should not be copied from the West, but Russian policy-making should be based on "our traditional way" of the organization of mental health care.

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As Guriev, Trudolyubov, and Tsyvinski [41] claimed, negative attitudes to a so-called Western model of society have increased in Russia. A study conducted by a major Russian independent pollster the Levada Center found that anti-Western sentiments rose, especially in 2014. Seventy-one percent of those taking part in the survey expressed negative attitudes towards the European Union and eighty-one percent towards the United States [42]. Similar tendencies were evident in our interviews of 2014 compared to those conducted in earlier stages of the study. It is interesting to note that some respondents who were quite positive about Western experiences of deinstitutionalization in 2010 changed their opinions to more negative ones in 2014. Simultaneously, we noticed that professionals' attitudes toward the researcher (from a Western country) seemingly became more suspicious. Thorough analysis of this phenomenon goes beyond the scope of the study. However, this demonstrates that professionals' ideas on deinstitutionalization can be influenced by broader processes in Russian society, such as public discussion about the West and its relationship with Russia that, in turn, are influenced by processes of international politics. On the other hand, the apparent deterioration in outpatient mental health care [13] is another possible reason for the professionals' increasing skepticism about the reforms.

Professionals' stance against deinstitutionalization can also be explained by the critique of some perceived negative outcomes of the reforms in Western countries. International studies have recognized that in many cases the old structures were dismantled but not enough alternative community-based services were created to replace the old institutions, leading to an increased risk of homelessness [43] as well as inappropriate incarceration and addictive behaviors [44]. Taking into account this experience in some Western countries, the professionals interviewed in Russia argued for a cautious approach to potential reforms.

The perception of psychiatry as an institution for ensuring public safety and control can rep-resent another barrier for deinstitutionalization [45]. The negative representations of people with mental health problems alongside the protective role assigned to psychiatry have also been widely expressed by Russian media [46]. Although our respondents also pointed to these functions of psychiatry, they also argued for the protection of mentally-ill people from mainstream society. They proposed to protect the mentally ill, among others, from abusive family members, from stigmatization and incompetence in general health care services, and from discrimination in the workplace. The studies of psychiatric reforms in post-Soviet Ukraine similarly found that mental

health specialists were concerned about the abuse of mentally-ill patients by family members, neighbors, police, and the state [47]. When describing the living conditions and employment status of people with mental health problems, the professionals interviewed argued for the necessity of hospitalization due to so- called "social reasons." Similarly, Friedman [48] noted that the "social case" label (e.g., hospitalization of persons who do not need treatment but only social support) emerged in post-Soviet Romanian psychiatry at the intersection of plans of deinstitutionalization by the state and the desire of psychiatrists to protect their patients. For example, the climate in many Russian regions presents a problem, with winter temperatures falling below zero, posing a huge risk for homeless people. Therefore, it is understandable why professionals are so concerned that discharged patients of the hospitals might end up homeless. Multidisciplinary coordination (health, social welfare, housing, employment, education) at all levels is needed to develop and maintain local community-based, comprehensive care [19]. Gofman [49] identified a lack of collaboration between the health and social care sectors in Russia. The professionals inter-viewed made the implicit point that the provision of shelter, food, medication, and rehabilitation are very straightforward to apply in a single institution; however, they consider it difficult to make such provision in the community in the specific Russian context.

In our study, professionals' claims for a need for protection were also reinforced by an apparent regret for the destruction of the Soviet welfare system that had provided at least minimal support to people with mental health problems, as to other social groups. For example, the dis-appearance of such elements as vocational workshops, where patients received daily free food and medicines, as well as some money, was thought to increase the necessity of institutional care. Although Russian professionals recognized that hospitalization restricts patients' liberties, they were not convinced that in these unfavorable social conditions freedom to live in the community is the best choice for someone with mental health problems.

A question that might be asked here, however, is to what degree the desire to protect patients reflects a paternalistic attitude to people living with mental illness. The paternalistic attitudes to patients shaped by a totalitarian society have been perceived as a serious barrier to implementation of psychiatric reforms in former Soviet countries [50]. Bartenev [51] reported that Russian psychiatrists argued against deinstitutionalization reforms and explained their stance by paternalistic Soviet mentality: "people with mental illness are viewed as patients only and patients cannot be left

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without hospital health care" [51]. Some of our interviewees argued for the responsibility of doctors towards their patients and criticized a consumer-centered model of medicine, which emphasizes patient autonomy. However, rethinking their paternalism we can suggest that it is not necessarily just a replication of the Soviet practice. One of the explanations for their paternalistic position could be rooted in their perception of the current situation in the country as unaffordable for people with mental health problems and skepticism about the possibility of change. In such an interpretation, "paternalism" is primarily based on the professionals' "sense of responsibility" rather than an authoritarian attitude towards patients. A dilemma between paternalism and patients' autonomy within mental health care services is a well-known phenomena, typical not only for post-Soviet countries, and there is thus a huge ethical dilemma about whether paternalism can be justified or not [52].

We recognize that our study has certain limitations typical of qualitative studies, such as small sample size, all interviewees being from one city in the Russian Federation, and the great variety of interviewees' educational backgrounds. It could be that the opinions of professionals from other regions of the Russian Federation might be different. Further research is, therefore, needed, e.g., exploring if there are differences in opinions on deinstitutionalization of mental health service between regions and occupational groups. Despite these limitations, it is important to pay attention to the consistency in how our interviewees expressed their ideas about deinstitutionalization reforms, independently of their occupation, gender, or age.

Finally, we would like to note that the adoption of international policy principles, such as deinstitutionalization of in-patient psychiatry, would be an important step towards mental health care reform in post-Soviet Russia. However, developing the new policy might have difficulties of implementation due to professional resistance. Our study demonstrates that the staff of Russian outpatient clinics is very restrained and careful in supporting deinstitutionalization. The professionals rather argued for preserving the existing mental services system rather than for its reorganization. We would like to underline that many of their concerns are at least potentially valid and can be considered as legitimate barriers to deinstitutionalization in Russia. It is also worth noting that they have good reasons to doubt the reforms when the reforms are not accompanied by proper funding, multidisciplinary collaboration, or the development of community-based care. Although WHO recommendations for action are widely respected world-wide and reflect ideas and

opinions generally accepted by the international community, this study demonstrates that they cannot be adhered to without sociocultural adaptation. Transferring mental health policy ideas across national boundaries is, thus, far from being a top-down practice [53], which underlines the importance of seeking a balance between internationally driven initiatives and the readiness of local professionals to accept change. Our study revealed only some hints on the understanding of this process, and suggests that this topic needs further investigation.

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THE VIEWS OF FAMILY CAREGIVERS ON THE DEINSTITUTIONALISATION OF PSYHIATRIC CARE IN RUSSIA

As with many other countries, the Russian Government has declared its intention to deinstitutionalise mental health care and provide people with mental disabilities with services that go beyond inpatient care, thus offering better prospects for integration into society. These policies have major effects not only on the lives of the people with mental disabilities but also on informal caregivers such as parents and spouses, who care for diagnosed children and partners. This study explores the views of family caregivers on the deinstitutionalisation of psychiatric care in Russia. The study is based on interpretive policy analysis. Qualitative interviews were conducted with twenty caregivers in a large Russian city. The results revealed that there was very limited support among caregivers for the reforms. They did not question the practice of institutionalised care or treatment in stand-alone psychiatric clinics, but rather took this for granted. Highlighting negative social attitudes towards the people with mental disabilities, carers claimed that stand-alone psychiatric services provide a protective environment away from the hostile outside world. Caregivers lacked knowledge about any particular social approach to mental disability or alternative ways of organising the mental healthcare system. Besides this, the caregivers were strongly disturbed by the prospect they may lose the support they receive from existing services. Although the carers criticised the current situation in psychiatric hospitals, they claimed that hospitalisation provided them with significant respite from care. All interviewees reported being overburdened, complaining of insufficient financial and social support. We suggest that caregivers in Russia have good reason to be suspicious of the reforms, which in many cases are not accompanied

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by proper funding, or by the development of alternative services or activities to prevent stigmatisation.

Deinstitutionalisation is a topical issue in international mental health policy. It can be defined as the replacement of large and centralised psychiatric institutions by smaller, less isolated community-based alternatives for the care of people with mental disabilities (WHO 2003a). This policy also suggests integration of mental health services into general health facilities to reduce the stigma associated with seeking help from stand-alone psychiatric services (Ibid). The major arguments for deinstitutionalisation are that it protects human rights, increases the quality of life of individuals with mental illness, and prevents their isolation and stigmatisation. These aims emerged first in the UK and USA in the mid-1950s, and subsequently in continental Europe and Scandinavia. The reforms gradually led to the closing or downsizing of psychiatric hospitals and the development of community-based services in many countries (Novella 2008). These ideas were later introduced into Central and Eastern Europe (Becker, Vázquez-Barquero 2001).

As part of the major political and social transformations that followed the collapse of the Soviet Union, reforms of the mental health care system have been initiated in the Russian Federation (RF), whose healthcare system was earlier sharply criticised for its political abuse, restrictions of patient rights and over-institutionalisation (Jenkins et al. 2007). The basis for a Post-Soviet mental health policy was formulated in 1992 in the law 'On Psychiatric Care and Guarantees of Citizens' Rights in its Provision' (Supreme Soviet 1992). This document proposed new principles in line with international standards in protecting patient rights. Thereafter, several specific bills, orders, and programmes were approved to regulate the scope and quality of mental health services in accordance with this basic provision (Shek et al. 2011). The policy documents called for the integration of mental health services into general health services to help overcome the social exclusion of patients (McDaid et al. 2006). The most recent federal mental health programme (MoH 2007) called for the decentralisation of psychiatric care, a reduction in hospitalisation periods, a decrease in the number of repeated hospitalisations, and the development of outpatient services. This policy programme reflects the international trend towards the deinstitutionalisation of psychiatric care (Litvinova 2010).

The process of deinstitutionalisation has led to the changes in the social organization of care for people with mental disability. It underlines the importance of collaboration between the healthcare system, social welfare services and families, all of whom jointly take responsibility for care. In many countries deinstitutionalisation reforms have not been accompanied by the sufficient provision of

community-based services that would offer social support to people with mental disabilities (WHO 2003a; Petrea 2012). A similar tendency can be observed in Russia where there is a lack of social services provision and economic support for caregivers (Gurovich 2012). The current care allowance is only 1,200 roubles (20 EUR) per month (Presidential Decree 2014). Furthermore, only caregivers who have no other income (such as a salary or pension) qualify for it. This means that caregiving is not considered a paid job, and many carers suffer financial difficulties. The process of deinstitutionalisation without the development of sufficient alternative services increases the burden on family caregivers (Blomgren Mannerheim et al. 2016). Caregivers thus face a higher risk of serious role distress and consequently a low quality of life (Quah 2014). Therefore, family caregivers are considered to be an important group affected by the burden caring imposes. This article aims to shed light on how family caregivers perceive reforms aimed at the deinstitutionalisation of psychiatric care in Russia. Caregiving is viewed as a set of activities involved in meeting the physical and emotional requirements of dependent people in the normative, economic and social contexts within which the care is assigned and carried out (Daly, Lewis 2000). It requires material, physical, intellectual and emotional resources.

A number of studies have shown that families of people with mental disabilities have expressed their opposition to the closing of hospitals (Heller et al. 1988; Larson, Lakin 1991; Tabatabainia 2003). This is due to uncertainty over how people with mental disabilities and their carers will be affected by deinstitutionalisation (Tossebro 1996). They pointed to the inadequacy of available community-based settings and the provision of good services by existing institutions (Tabatabainia 2003). Caregivers were also concerned about the negative effects of premature discharge from hospital (Brand 2001) and the challenging behaviour of their relatives with mental disabilities (Sherman 1988). A European survey that was conducted with family caregivers from nine West European countries (Brand 2001) revealed that families often feel abandoned as a result of deinstitutionalisation reforms, as they are left without sufficient information or support services. However, in those cases when sufficient non-institutional services were provided, strong initial opposition to closure of hospitals was converted to support for the new services (Conroy 1985; Heller et al. 1988).

Russian researchers (Levina, Ljubov 2009; Limankin 2016) have also revealed resistance to reforms on the part of carers. They found that caregivers do not support the development of new types of service, demanding instead better funding for existing services. Oleg Limankin (2013) points to a lack of attention to the views of family caregivers in Russia, explaining this as a result of the dominance of a paternalistic approach in Russian psychiatric care. According to this line of thinking, officials and professionals responsible for organising health care are not interested in the viewpoints of patients and their relatives and, therefore, fail to take them into account. According to the WHO (2003b), however, the personal experiences of family caregivers offer valuable insights, which

should be considered when designing and developing services. Therefore, in this study we are interested in learning how informal caregivers, who in most cases are spouses and parents of persons with mental disabilities, evaluate existing inpatient and outpatient mental health services in Russia. We are also interested in what they think needs to be done to restructure and improve these services and whether they support reform on the basis of deinstitutionalisation.

The context of caregiving in Russia

Although 46,500 psychiatric beds have been cut across Russia since the 1990s (almost a quarter of the total national bed capacity), the Russian mental healthcare system is still largely based on institutional care (Kotsjubinsky et al. 2013). The number of psychiatric beds is 109.53 per 100,000 (WHO 2011), which is higher than the European median of 39.4 per 100,000 of the population (Petrea 2012). A substantial proportion of patients (22 per cent) stay in hospital for more than a year, and a significant number for up to five years (Gurovich 2012). As Isaak Gurovich (2012) notes, the reduction in the number of hospital beds was not followed by the development of new alternative forms of care that could have compensated for the reduction of institutional, inpatient care. Alongside psychiatric hospitals, another type of care institution in Russia is the *internats*, psychoneurological inpatient facilities that are large institutions (often containing more than 500 beds), in which people with mental disabilities generally remain for life (Krivoshei 2001). Lonela Petrea (2012) claims that the old Soviet practice of hiding people deemed disabled translates nowadays into the practice of relocating them from mental health hospitals to *internats*.

The mental health service system in Russia is also characterised by a widely developed network of outpatient clinics, known as *dispansers*. These services are typically a person's first point of contact with the mental healthcare system. Although these are outpatient services, they do not meet the criteria of well-organised community based care (Bartenev 2005). According to the WHO (2003a) the key features in assessing community based care are the accessibility of services and success in reducing the level of stigma associated with mental disorders. In most Russian regions, *dispansers* cover large areas and large numbers of people, a fact that does not seem to support the goal of greater accessibility. In large Russian cities, a *dispanser* may be responsible for populations over 1 million people. Additionally, visiting a dispanser carries a lot of stigma with it due to the Soviet stigmatised practice of *uchet* (registration), whereby patients are listed on a psychiatric case register (Kotsjubinsky et al. 2013). In actuality, these *dispansers* appear far closer to the WHO definition of institutions that deliver stand-alone mental health services functioning in isolation from communities and lacking strong links with the rest of the healthcare system (Ibid).

According to the WHO (2003a), community mental health services can also be provided by local community members without professional training.

The associations of service users and their carers, as well as other non-governmental organisations, can advocate for patient rights, and offer family caregivers emotional and practical support. In Russia, such associations are undeveloped (Limankin 2016). The concept of community, a cornerstone of modern mental health services at the Western countries involving self-organization and mutual support of caregivers, is at best shaky, if not lost in Post-Soviet countries (Petrea 2012). Furthermore, current governmental policy in Russia is not favourable to NGOs. In 2006 the Government passed a law significantly expanding control over NGOs and restricting their right to privacy (Kamhi 2006). Then, a 2012 Law was passed tightening control on NGOs funded from abroad (Dufalla 2014).

Methodological Approach and Research Materials

The methodology of this study is based on an interpretive policy analysis (Yanow 2000), which focuses on the meanings that policies have for a broad range of the policy-relevant public. In this analytical framework, the notion of policy, instead of being primarily viewed in legislative document or state rhetoric, is understood by referring to the multiple interpretations of policy-relevant groups. Sharing thought, speech, practice and their meanings, policy-relevant groups are defined as interpretive communities (Ibid). Policy analysts working with interpretive methodology study how representatives of interpretive communities construct their realities, as well as define policy problems and their solutions (Sheikh, Porter 2010). This approach focuses on understanding values, feelings, or beliefs that interpretive communities express in discussing policy problems (Yanow 2000). Dvora Yanow (2000) argues that at least three such communities operate in any policy situation: policymakers, implementing agencies, and affected citizens. In our study, family caregivers are viewed as an interpretative community with its own opinions on how to conduct mental healthcare reform. Interpretive policy analysis is derived from a constructionist approach in social research (Sheikh, Porter 2010). From this perspective, the term mental disability is a socially relative category subject to dispute, the precise boundaries and meanings of which vary according to time and place (Busfield 2001). Therefore, the caregiver discourse on mental disability and the development of mental health services is viewed as socially constructed and tied to the political, social and cultural contexts of a particular society.

The participants of this study were recruited at a mental health outpatient clinic (*dispanser*) in a large Russian city. In order to ensure the anonymity of our interviewees, the city's name is not revealed in this article. Access to the field was based on previous research collaboration with the *dispanser's* staff. The first author (Olga Shek) had the opportunity to interview family caregivers at the *dispanser* when accompanying their relatives with disabilities. Several participants were additionally recruited using the snowball method, which entailed interviewed family caregivers assisting the researcher in identifying other potential respondents.

Research participants were chosen in accordance with the definition of family caregivers used in previous studies (Quah 2014; Perlick et al. 2008) according to the following criteria: (1) they were immediate family members of the care recipient, (2) they supported the care recipient financially, (3) they were the most frequent collaborators in treatment, and (4) they served as the main contact in case of emergency. In total, twenty semi-structured interviews were conducted in 2014–2015 with family caregivers of adults with mental disabilities. Most interviewees were mothers aged between 40 and 73 (17 interviews). The interviewees also included one sister (aged 30), one father (aged 53) and one grandfather (aged 65). All participants consented to be interviewed and for their anonymous data to be used for analysis.

We asked the caregivers how they viewed existing mental health services, both inpatient and outpatient, and how the services should be improved. The question guide also covered aspects of mental health policy such as the downsizing of hospitals, the reduction in the number and length of hospitalisations, the integration of psychiatric services into general healthcare, and the development of community-based services. At the start of the interview, the interviewer introduced herself as a researcher from a Finnish university. It seemed that this encouraged some interviewees to speak about deinstitutionalisation with reference to Western countries.

We recognise that our study has certain limitations typical of qualitative studies, such as the small sample size and the fact that all the interviewees came from one big city in Russia with relatively good access to mental health services. It might be that the opinions of caregivers from other Russian regions or rural areas would be different. The chosen city tends to play an important role in leading innovation programs nationally, which was the reason why we were interested if the new mental health policy ideas were supported there.

The data was analysed using thematic analysis. Three key themes emerged in the arguments of carers: (1) the current policy of deinstitutionalization is unclear; (2) their attitudes to hospitals are ambivalent; (3) stand-alone psychiatric services are seen to provide a protective environment for people with mental disabilities and their carers away from the hostile outside world.

An Unclear Policy of Deinstitutionalisation

The interviewed caregivers lacked knowledge about the ideas behind deinstitutionalisation and how these reforms were being implemented in Russia. Some of them had heard about deinstitutionalisation in Western countries, however their knowledge about it was quite vague. For example, one of them said: '*I read that there [in Western countries] a person could always decide if he wanted to take medicine or not, could decide whether to live or not. I do not agree with this*' (woman, age 61). Another, expressing her negative attitudes towards deinstitutionalisation, said:

> I have extremely negative attitudes to those who give out leaflets with things written on them like 'If your relative had a bad experience in psychiatric services, you should complain'. There is a global trend to leave people alone, not to treat patients, to close hospitals. I do not know what their final aim is. But of course there are many problems in our hospitals (woman, age over 40).

Although this woman complained about hospitals, she was not eager to support the initiatives, addressed to criticise psychiatric care, which she viewed as a set of organised attacks. She suggested that '*somebody must be paying these people*' to argue against psychiatric care. She was suspicious about such activity, associating it with an anti-psychiatric movement, deinstitutionalisation. The woman thought that this '*global trend*' leads to an absence of treatment. One plausible reason for her negative interpretation of these activities is the effect of broader processes in Russian society, such state policy promoting suspicious attitudes to NGOs, especially to those funded from abroad. She was concerned that the reforms would further damage a previously stable and powerful psychiatric system, bringing uncertainly and risks.

Although the caregivers had negative views about NGOs criticising psychiatric care, they supported actions against the state authorities, such as signing a petition, when proposed by mental health professionals. One of the interviewed mothers remembered how she was frightened by the possible closure of the hospital: '*When I was told that the hospital would be closed, I thought that's it, it will be the end for all the patients*' (woman, age 73). She was also proud to say that she had signed a petition put forward by mental health professionals against the closure of the hospital, and that the hospital still operated. In this case, participation in 'activism' had resulted in a victory against the system. The caregivers and professionals built a coalition against state authorities whose perceived aim was to dismantle the system (see, also Shek, Pietilä 2016).

In some cases caregivers felt it was inappropriate to complain about psychiatric care. A father of a man with mental disability explained his acceptance of his son's illness, the hospital's problems as well as his passive attitudes to the reforms by reference to the religious sentiment of humble acceptance:

> There is question here, 'do I deserve this kind of treatment or not?' I have done a lot of bad things in my life. <…> I do not think that my opinion is important. I don't think about this [reform], I take it as it is. <…> Do you remember the film 'The Heart of a Dog'? In this film, somebody said that as soon as the cleaners find their way into government then everything would fall apart (man, aged 53).

This father aligned the relatives of people mental with disability with cleaners, who, as he thought, should not be involved in the decision-making process about psychiatric reforms, suggesting only professionals could decide how the system should be organised.

'The Hospital is Bad, but We Need It'

Although the carers criticised the current situation in psychiatric hospitals, they nevertheless argued against downsizing them. They voiced a shared concern about poor material conditions and rude nursing staff. One of the mothers described the hospital in the following way:

> There are 20, 30, 40 patients in a ward here. Somebody wheezes, somebody snores, somebody sings. All this has an effect on them. But the staff has very bad attitudes towards patients. I saw myself that they treated them badly: they called them bad names, abused them and shouted. All this is a big minus. <…> However, I was satisfied with hospitalisation, the treatment was good. I am very satisfied that she [daughter] was in the hospital for two months. She left the hospital as a person, an absolutely normal, healthy person (Woman, age over 50).

The excerpt demonstrates that our interviewees had ambivalent attitudes towards hospitals. The decision to hospitalise a relative was often described by interviewees as a difficult one due to the bad conditions there and simultaneous need for help. They also recognised that hospitalisation provided them with some respite from care. The respondents pointed to their own tiredness and the lack of any financial or social support from the state. Most interviewees were mothers. This fact illustrates the phenomena of feminisation of care practice, when women are assigned a role of caregivers and show a readiness to do this job without payment (Zdravomyslova, Temkina 2015). Several caregivers reported that they had changed their jobs to part-time, less-qualified and lower-paid work in order to have enough time to care for their relative. They, therefore, were a subject to what has been termed a 'care penalty'; this represents the idea that carers make sacrifices when performing care work, such as loss of personal time or job opportunities (Ibid). Many of our respondents were close to retirement age or retired. Because of their own age they found it increasingly difficult to care for their relatives. However, a lack of support to family caregivers is typical not only of Russia; international studies also point out that public policy often views the work of informal caregivers as a personal, moral obligation, and not as an extension of the workforce (Levine et al. 2010).

The carers acknowledged that the 'unacceptable' or aggressive behaviour of relatives could be difficult for themselves and those around them. One of the mothers, recalling the hospitalisation of her son, said:

> The hospital has disciplined him. He had a feeling of licence: if I want to, I can break a window. This feeling of licence is a rather dangerous tendency. So he ended up in the hospital. He realised that there were bars on the windows, there was no outdoor activity. Because of this he understood that there is a thing such as restraint. This feeling of licence started to disappear (woman, age 51).

From this mother's perspective, frightening conditions in the hospital had an unintended positive effect, serving as a punishment for 'bad' behaviour and

disciplining her son. She said that after hospitalisation she disciplined her son by reminding him about the hospital. Another mother (age 47) also confirmed that after a five-month hospitalisation her daughter became more responsible. She explained this not in terms of any positive results of the treatment, but rather in terms of the daughter's fear of being hospitalised in such a 'terrible' hospital again.

A mother whose daughter had remained continuously in a psychiatric hospital for the past six years said that her daughter was very bored there. She complained that the psychiatrist did not permit her even to take her daughter to the church nearby the hospital. She tried to improve her life in the hospital by making informal payments to hospital staff:

> Unfortunately, I have no money to encourage the hospital staff. I give them a little bit so that they will look after my daughter. At one point she was sleeping on the bed frame because she suffered from bed-wetting and did not want to wear a nappy. Then we started to buy our own mattress and blankets for the hospital. I give a little bit to the staff, cigarettes, 100 roubles, cheese or something too. Then they change her gowns, because they get absolutely ragged (woman, age over 40).

Despite her criticisms of the hospital, she concluded: '*I need the hospital very much, because I'm not able to cope with my daughter at home*.' When she was asked why her daughter had stayed in the hospital for so long, she answered that the daughter was '*really ill*' and there were no alternative services for such people. From the carers' point of view, the only existing alternative to hospital was the *internat*. Their opinions about *internats* were extremely negative. One of the mothers said: '*Internat is the end of everything, they do not receive any treatment there. They [internat staff] say honestly that in six months they [patients] will die*' (woman, age 71).

The carers were pessimistic about their relatives' lives after they were no longer able to care for them. However, one of the mothers (woman, age 64) knew of a positive example. She spoke about a sports club for young people with disability that simultaneously provided an opportunity for carers to meet each other. She described how the club members had helped a young man with mental disability to live in his own room after his mother's death. However, such examples of independent living and mutual help between caregivers are an exception rather than a common practice.

Protective Environment in Stand-alone Psychiatric Services

When discussing existing outpatient services, the caregivers complained about poor material conditions, long queues, or occasionally negative attitudes from the staff. However interviewees tended to have more positive views of *dispanser* (stand-alone psychiatric outpatient clinics) compared to district policlinic (outpatient clinics that provide general and specialist care for both people

with mental illness and 'mentally healthy' people). Several respondents claimed that policlinic staff were less attentive than those working in dispansers: '*There is an old regime in the dispanser, they phone and ask about a patient's health, while the policlinic care less*' (woman, age 73). By 'old regime' she was referring to the Soviet period. Although this practice was reminiscent of the Soviet *uchet*, she thought that such attitudes were better than the indifference she encountered in general healthcare. Taking into account the social isolation of caregivers, it seems that carers understand the notion of 'being supported' as connected to those cases when somebody other than themselves is interested in the well-being of their relatives. One of the mothers complained about the absence of proper care for her son in the policlinic:

> Doctors in policlinic are afraid of such patients. They send them to psychiatric care. I asked for a health certificate for summer camp for my son. It was not about mental health, but just about physical health. The doctor gave me such a look. She didn't give me the certificate (woman, age 53).

The interviewees also thought that general practitioners in policlinic did not have negative attitudes, but simply had less time for each patient because they were overwhelmed with paperwork. The carers also experienced negative attitudes from visitors of a policlinic. And, on the contrary, as one of the respondents pointed, there is a 'special atmosphere' in the *dispanser*. Describing the shabby old *dispanser* building, she said that she felt she had gone back to the 'Brezhnev era'. While such an association might be deemed a criticism, she also suggested that the *dispanser* environment, along with the staff's caring attitudes towards caregivers, created a 'calming atmosphere':

> I like it that they see the problem here, they look into the soul of a person. I want to say that they spend time. It was very difficult for me. <…> I feel better here. Then we started to meet mothers. The *dispanser* is like a second home for me (woman, age 46).

As was mentioned above, the carers often complained of social isolation. They said that in a dispanser they had an opportunity to meet other carers and discuss shared problems with them. Several caregivers reported that most of what they had learned about mental disability and the types of service available had been gathered from communication with other carers.

The caregivers noted that the day hospital (a part of the *dispanser*) provides an opportunity for people with mental disability to communicate with each other. One of the mothers said: '*There are children who attend it for many years. Attending the day hospital serves as a means of communication for our children <...>, they make friends there*' (woman, age over 50). To justify the necessity of special services for the people with mental disability she explained that her daughter was discharged from local rehabilitation centre because of her 'inappropriate' behaviour. This demonstrates that people with

mental disability are sometimes excluded even by the organisations aimed to help people with any kind of disability. The respondents thought that their relatives had significant difficulties in communicating with 'mentally healthy' people and needed a 'protective' environment provided by stand-alone psychiatric services. They also claimed that sometimes 'mentally healthy' people had difficulties in communicating with those with mental disability because of the latter's aggressive or improper behaviour. Although most relatives pointed to the usefulness of special segregated services, a couple of the mothers said that they had tried to find other organisations that worked with 'mentally healthy' and 'ill' people together. One of the mothers (woman, age 63) claimed that for her son it was much better to communicate with healthy people because he learned new social skills. However, she recognised that such people should be specially prepared to accept her son's occasionally unusual behaviour.

Conclusion

This study has revealed that the interviewed caregivers were very reserved in their support for the deinstitutionalisation and concerned about the possibility of losing the support from existing services. The respondents were overwhelmed by their caring responsibilities, and the hospital provided them with at least some respite. While international studies have demonstrated how the carers in the Western countries have opposed deinstitutionalisation due to satisfaction with existing inpatient services (Tabatabainia 2003), our respondents simultaneously argued for preserving the hospitals while also criticising them. They were trying to adapt to the exiting mental healthcare system and even found some positive sides in its deficiencies, such as the frightening conditions in hospitals that were perceived as a helpful disciplinary measure. This system was seen by caregivers as non-ideal, but something already known and stable while deinstitutionalisation reforms were associated with uncertainty and the risk of losing even the minimum support they get now. However, these concerns may well reflect an objective shortcoming of the reforms. As was mentioned above, the decrease in the number of beds in psychiatric hospitals has not been accompanied by the development of alternative services.

Stress among carers is increased by the social isolation and stigmatisation of families of people with mental disability. The caregivers claimed that stand-alone psychiatric services provided a protective environment away from a hostile outside world. The *dispanser* was a place where people with mental disability could communicate between each other and caregivers get support from staff and their peers. Discussing their relative's mental disability as a medical pathology that should be treated by special psychiatric services, the majority of caregivers considered such segregation to be normal. They lacked knowledge about alternative ways of organising the mental healthcare system. Information about the social approach to mental disability would help them in

understanding the meaning and significance of the reforms for the social integration of people with mental disabilities. The interviewed caregivers felt more like observers than potential participants of reforms. We suggest that the engagement of caregivers in research might increase their awareness. And finally, we need to underline that the provision of sufficient economic and social support to caregivers is an essential factor in changing their suspicious attitudes towards the reforms and important precondition for their readiness and ability to participate in measures to improve the delivery of services.

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