Collaboration in psychiatry between Archangelsk and Northern Norway

Psychiatry in Russia is dominated by large psychiatric hospitals and specialized open services, while the primary health and social services are underdeveloped and offer little in terms of treatment to people with psychological problems. This contrasts with the structure in Norway and many other countries, where mental disorders are more widely treated in the primary health services, and where the role of psychiatric hospitals has been reduced in favour of decentralized provision. Here, we will share some experiences from the Norwegian-Russian collaboration in the field of psychiatry.

Tore Sørlie
tore.sorlie@unn.no
Psychiatry Research Group
Institute of Clinical Medicine
Faculty of Health Sciences
University of Tromsø
and
Clinic for General Psychiatry
University Hospital of Northern Norway

Grigory Rezvy
Nordland Hospital
and
Psychiatry Research Group
Institute of Clinical Medicine
Faculty of Health Sciences
University of Tromsø

Tordis Sørensen Høifødt
Clinic for General Psychiatry
University Hospital of Northern Norway
and
Psychiatry Research Group
Institute of Clinical Medicine
Faculty of Health Sciences
University of Tromsø

Vera Yashkovich
District Psychiatric Centre of Archangelsk Oblast

Elena Proselkova
Health Care Department of Archangelsk Oblast

The historical roots of international cooperation in the Barents Region reach back to Viking times. From the 1740s, the Pomor trade between Northern Norway and North-Western Russia constituted a necessary as well as a natural exchange between neighbouring peoples in the North. A separate language, Russo-Norwegian, was developed to promote communication and cooperation. The Russian Revolution put a temporary stop to this interchange. Towards the end of World War II, however, The Red Army came as the liberators of Finnmark. Later, perestroika and the fall of the Iron Curtain spelled the end of Soviet isolationism. Since then, Norwegian-Russian collaboration has gained new momentum.

The Kirkenes Declaration, which formalized Norwegian-Russian international cooperation in the Euro-Arctic Region, was signed in 1993 (1). Since 1999, project funding has been available through the Barents Health Programme. Collaboration on health between Tromsø and North-Western Russia dates back to the early 1990s. Since then, the Northern Norway Regional Health Authority has signed general agreements on cooperation with Murmansk and Archangelsk oblasts, in which the parties commit themselves to collaboration in the fields of public health, health services and networking.

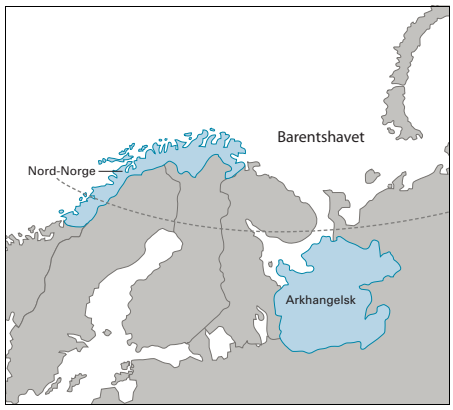
The collapse of the Soviet Union brought with it increasing social insecurity, inequality and unemployment. Mental health problems have become widespread, including a high incidence of depressive disorders, suicides and high mortality from alcohol-related diseases (2). Psychiatry was regarded as a medical field in which the need for renewal was most prominent.

Russian and Norwegian psychiatry

Soviet psychiatry was largely isolated internationally, and psychiatry was also exploited for non-medical purposes, such as internment of dissidents (3). Russian psychiatry today is characterized by high professional standards and modern health legislation, as well as increasing contact and cooperation with other countries (3).

Specialized open services

While Western psychiatric hospitals have been all but dismantled during the last forty years in favour of the development of regionally decentralized service provision, Russian psychiatry continues to rely mainly on large hospitals. In Norway, this structural change has been spurred by favourable economic conditions and an increased emphasis on active treatment methods and differentiation of the service provision, as well as on the principle that patients should as often as possible be provided with services in their home area (4). The anti-authoritarian movements originating in the late 1960s and the escalation plan for Norwegian psychiatry have also served as important factors (5).



In Russia, the primary health and social services are not well developed. However, a specialized, open service is provided at centrally located district polyclinics, where psychiatrists work in cooperation with other medical specialists. Large psychiatric polyclinics («dispensaries») are found in the largest cities in each oblast, which may also include outpatient services. In Norway, most patients with mental disorders tend to receive treatment from the primary health services, and a separate model has been developed for cooperation between the regional psychiatric centres and the municipalities in the geographical areas covered (6).

The maintenance of this heavy emphasis on institutionalized psychiatry in Russia is caused by a lack of resources (7, 8). Furthermore, health legislation has barred general practitioners who have no specific specialization in psychiatry from diagnosing or treating mental disorders (9). However, recent legal amendments seek to enable general practitioners to treat depressive and psychosomatic disorders, diagnose serious mental disorders and follow up psychiatric patients after their treatment by the specialist health services. These amendments still have the status of recommendations, and are subject to approval by the health authorities in each oblast before they can come into force. (V. Popov, Institute of Family Medi-

cine, Medical University of Archangelsk, personal communication, 20 March 2011).

Labour

Western European countries put a lot of effort into keeping people with long-term mental disorders within the labour market (10). The rehabilitation programmes undertaken in the Soviet Union in the 1970s and 1980s were completely dismantled during the period of perestroika, however (3), and today, the employment rate of people with serious mental disorders is extremely low (11).

Resources

Archangelsk psychiatric hospital has approximately 900 beds, nine emergency wards with 50–70 beds each, and very limited staff resources. Corresponding wards in Norway have 10–12 beds and far more staff.

In relation to the total population, of 1.2 million inhabitants of Archangelsk oblast and approximately 470,000 in Northern Norway, the number of emergency beds in the two areas is comparable. However, some of the beds in Archangelsk are used also for planned admissions as well as so-called «admissions on social indications». Discharge from the emergency wards often tends to be delayed because of social problems or lack of local follow-up, especially outside Archangelsk city. Emergency admissions in the case of alcohol or drug-related conditions are usually made to specialized «narcological» units in the major cities.

Russian mental health legislation mainly stipulates the same conditions for involuntary admissions. However, the implementation of the legal act is monitored by the regular local courts, and not by a separate monitoring commission, as in Norway.

While the use of psychoactive drugs is a key approach to emergency psychiatry in both countries, the use of milieu therapy and psychosocial interventions are more common in Norway, as are interdisciplinary cooperation and involvement of the patients in their own treatment plan (12–14).

Fifteen years of collaboration in psychiatry

The first Psychiatric Forum for the Barents Region was arranged at the then still-existing Åsgård Hospital in September 1996, and included participants from Archangelsk and Murmansk oblasts, Karelia and Komi republics, and Lappland, Norrbotten, Nordland, Finnmark and Troms counties. The conference helped establish contacts and elucidate the historical, cultural and social preconditions for the formation of ideas and practices in the various regions. Three further Barents conferences in psychiatry have subsequently been held, and in 2011 the next conference will be arranged in Tromsø.

Since 2001, there has been continuous project-based collaboration between clinical and academic psychiatry in Northern Norway and the Chief Medical Officer, the regional psychiatric hospital and the Medical University of Archangelsk. Early involvement of the Chief Medical Officer in Archangelsk in the plans and contracts ensured formal backing and compliance with regional and central guidelines for the development of psychiatry. A number of meetings were held, face to face as well as by videoconference. Because of the language barrier the meetings relied on the use of interpreters.

The psychiatric hospital in Archangelsk. Photo: Private

Professional content

For the Russians, the first priority was to obtain help in improving the treatment provided at the regional hospital. An interdisciplinary, two-year training programme in the use of patient groups and team cooperation for staff on the emergency wards was initiated in 2001, with Russian-speaking, Lithuanian group analysts as instructors. Here, the participants were given group supervision of their own work with patients and of their cooperation as teams. Following an instruction from the hospital director, all participating departments rapidly became engaged in group-based activities for patients. It is our impression that the staff soon became more assured and confident in their contact and cooperation with patients as well as colleagues. Growing initiative among the staff also encouraged criticism of the existing systems, with proposals for improvements. To draw maximum benefit from the increased sense of initiative, a separate support group was established to assist the director and his management group (12). Maintaining the group activities over time has represented a challenge in some units.

The effects of the training have been evaluated with the aid of comparative measurements of the ward atmosphere in emergency wards with and without training. As a result of this work, the psychometric properties of the Ward Atmosphere Scale (WAS) have been tested for the first time in a Russian psychiatric hospital (13). The findings indicate that the participating wards have developed a higher degree of «order and organization» and «practical orientation», which is regarded as beneficial in wards for patients suffering from psychotic disorders (13).

In addition, training in diagnostics has also been provided, and Russian colleagues have observed clinical work at the psychiatric wards at the University Hospital of Northern Norway. A sub-project has focused on early identification and treatment of patients with first-time psychosis. In addition to the training in diagnostics and psycho-educative multi-family work, emphasis has been placed on interdisciplinary and inter-agency cooperation with regard to individual patients. The training in family-related work has been implemented in cooperation with Stavanger University Hospital and a group of experts in Stavropol, Russia.

Currently, the most prioritized area for the Norwegian-Russian cooperation is to

promote cooperation between the Russian primary health care services and the specialized psychiatric care .

Approach

Appropriate project planning and implementation have depended on cooperative relationships characterized by respect and trust, with opportunities for discussion of misunderstandings and disagreements. Throughout the project period, one psychiatrist (GR) from Archangelsk has acted as a catalyst for the development of the collaboration. With his good personal relationship with central Russian and Norwegian partners, his knowledge of the Russian and Norwegian languages and the culture, health services and psychiatry of the two countries, he has acted as translator and communicator in formal as well as informal situations. The cooperation on documentation of the project has also revealed the differences of opinion and varying interpretations of joint experiences. This exchange has been dependent on the translation of various written documents from Russian into Norwegian and vice versa. A PhD project (14) published in 2007 has systematically compared the psychiatric health services in Archangelsk and Northern Norway in terms of resources, organization and professional content. This work has promoted mutual understanding and dialogue between professionals and administrators in the two countries.

Development of competence in Russia

The objective has been to enable the Russian partners to continue the desired professional activities on an independent basis. Resource persons who have been trained through the inter-disciplinary, two-year educational programme will henceforth serve as instructors in local programmes. For a transitional period they will receive supervision in their role as teachers from the Lithuanian group analysts. Local training programmes can be supported by the Medical University of Archangelsk.

Making use of Russian capabilities in this manner serves to strengthen as well as legitimize this competence, and counteracts an unhealthy dependence on outsiders. As a result of this approach, the Russian contributions have gradually grown in volume.

Discussion

Stability among the key Norwegian and Russian partners has facilitated a gradual renewal of the project leadership group when this has been required. It may appear that relationship capital is given greater emphasis in Russia than in Norway. The amicable relationship has made it fairly simple to establish the other conditions required for the working group, such as realistic project goals that have been agreed with the top management and that comply with regional and central guidelines, and agreement on working methods, resources, distribution of responsibility and roles.

In future collaboration we ought to make even greater efforts to reveal the resources that are being used in addition to the external project funding, especially from the Russian side. This includes, for example, planning and implementation of project activities, implementation of new forms of treatment and cooperation, documentation of the effects of the interventions and the fulfilment of responsibilities as host institutions. The Russians have a more caring culture than the Norwegians.

Mutuality also requires that the Norwegian partner should benefit. We have seen that a more autocratic form of management is able to implement decisions more rapidly in practice than we can at home. In situations characterized by a scarcity of personnel and other material resources, it has been instructive to observe the mutual help that patients give to each other. It has been a pleasure for us to provide help, but for us, the most important result is the friendship that has been established.

Tore Sørlie (b. 1947)
is a Psychiatrist and Professor of Psychiatry at the Institute of Clinical Medicine, Faculty of Health Sciences, University of Tromsø. His interests are the psychological aspects of somatic illness and treatment, and the relationship between culture and mental health.
Stated conflicts of interest: None.

Grigory Rezvy (b. 1963)
is from Archangelsk. He works as Senior Consultant at the psychiatric polyclinic for adults in Fauske/Bodø, and has a part-time position as Associate Professor of Clinical Medicine at the University of Tromsø. He is a Specialist in Psychiatry, and has previously worked as a psychiatrist in Russia (1988–2000). He has a PhD in Psychiatry from Russia (1997) as well as from Norway (2007). He has participated in the professional cooperation in psychiatry between Northern Norway and Russia since 1996.
Stated conflicts of interest: None.

Tordis Sørensen Høifødt (b. 1953)
is a Psychiatrist Dr.Med, and works at the Clinic for General Psychiatry, University Hospital of Northern Norway.
Stated conflicts of interest: None.

Vera Anatoljevna Yashkovich (b. 1958)
is a Specialist in Adult Psychiatry and Narcology (addiction). She has worked as Senior Consultant and Head of Clinic at the Archangelsk Oblast Psychiatric Hospital (1996–2004), and later as Chief Surgeon/Director at Archangelsk Oblast Psychiatric Dispensary (DPS).
Stated conflicts of interest: None.

Elena Vladislavovna Proselkova (b. 1958)
is a Doctor and Specialist in Adult and Child Psychiatry. She has worked for a number of years as a child psychiatrist, psychotherapist and counsellor, and since 1999 as Regional Chief Psychiatrist in Archangelsk Oblast.
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