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Mental Health Indicators in Russia

A Study of the Availability of European Indicators for the
MINDFUL Project



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Foreword

The current study is the first attempt to compare mental health indicator data from the Russian Federation with data from the EU Member States. The study indicates that data availability in the Russian federation is on a comparable level with availability in the EU Member States, and that international comparisons are feasible.

Mental health is becoming an extremely important resource in society. Developing information societies and the form of production specific to them requires actors with various mental capabilities, such as creativity, innovativeness and inventiveness, as well an ability to learn and produce new information. Flexibility and an ability to have an impact are also required. Given that mental disorders currently impact significantly on the resources of communities through both state budgets and the financial potential of individual families, the approach to the future should engage in a policy of mental health promotion and disorder prevention. Therefore it is important to provide information on the state of mental health in different countries.

The study originated from the enthusiasm and incessancy of Olga Sakharova, who has been in charge of collaborating with the health statistical bodies in the Russian Federation, managing the statistical data and summarizing the analytical materials under the supervision of Professor Isaac Gurovich, PhD (Moscow Research Institute of Psychiatry), Professor Kristian Wahlbeck (STAKES), and Professor Valery Krasnov, PhD (Director of the Moscow Research Institute of Psychiatry). The Finnish partners have shown great enthusiasm and generously invested their resources in this work.

The report indicates that a considerable number of mental health indicators are available in Russia, enabling international benchmarking of Russian mental health services. However, the availability of data on population mental health, i.e. psychiatric morbidity and positive mental health was low. The data that are available illustrate clear positive trends over time, such as a decrease in hospital beds and an increase in out-patient services. The pilot study also demonstrates the need for development in the field of mental health information and also on the level of measures to support and improve population mental health.

The authors have been closely collaborating with prominent Russian psychiatrists, clinical psychologists, sociologists, medical demographers and statisticians from a wide range of RF institutions: Federal State Statistics Service Rosstat; Ministry of Health and Social Development of the Russian Federation; Central Scientific and Research Institute for Organization and Informatisation of Public Health; State Research Centre for Social and Forensic Psychiatry named after V. Serbsky; Mental Health Research Center, Russian Academy of Medical Sciences; National Scientific and Research Institute of Public Health, Russian Academy of Medical Sciences; All-Russian Public Opinion Research Center; Institute of Sociology, Russian Academy of Sciences; Multinational Center of Quality of Life Research; Russia Children Helpline Association; Evidence Clinical and Pharmaceutical Research, etc.

Professor Ronald C. Kessler, PhD (Department of Health Care Policy, Harvard Medical School, USA); Professor Evelyn J. Bromet, PhD (State University of New York at Stony Brook, USA), Tim Slade, PhD (School of Psychiatry, University of New South Wales at St Vincent's Hospital, Darlinghurst, Australia) and Victoria Zachozha (Head of Methodology Department at the Kiev International Institute of Sociology) have kindly consulted the authors on the availability of the WMH-CIDI Russian version. The authors are also thankful to Professor Ruut Veenhoven, PhD (Department of Social Sciences, Erasmus University Rotterdam, Netherlands), for rendering information on the RUSSET study.

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Abstract

Olga Sakharova, Isaac Gurovich, Kristian Wahlbeck. *Mental Health Indicators in Russia. A Study of the Availability of European Indicators for the MINDFUL Project*. STAKES, Reports 13/2007. pp. 118, price 20 €. Helsinki 2007. ISBN 978-951-33-2025-6

This summary report is based on a joint Finnish-Russian exploratory study by the Mental Health Group of the Finnish National Research and Development Centre for Welfare and Health (STAKES) and the Moscow Research Institute of Psychiatry (MRIP), Clinico-Social Department (Outpatient Psychiatry and Mental Health Organization Unit), conducted in September 2005–February 2007.

The MINDFUL (Mental Health Information and Determinants for the European Level) Project (2004–2006), co-funded by the Public Health Programme of the European Commission, was aimed at improving mental health information within the European Union. The MINDFUL mental health indicator set comprises 35 mental health indicators for monitoring mental health in the EU Member States. Of these, 18 indicators were register-based and derived from annual statistics, 15 indicators related to population survey data, and two required special system-level surveys.

The aim of this study was to search for and collect the available Russian national annual data on the MINDFUL mental health indicators and to draw conclusions on their reliability and comparability with those of the EU countries. This has never been done before. A comprehensive analysis of the data taken from the key Russian mental health statistical bodies did not form part of the study, although evident correlations and discrepancies between them have been revealed and commented on.

Stage I of the study focused on the thorough analysis of the Russian Federation (RF) national and regional health statistics procedures as well as the availability of MINDFUL mental health indicators for Russia. In the RF, five major statistical bodies, including the Federal State Statistics Service, Rosstat, as well as the Ministry of Health and Social Development (MHSD) and its three institutions – the Central Scientific and Research Institute for Organisation and Informatisation of Public Health, the Moscow Research Institute of Psychiatry, and the Scientific and Research Center for Social and Forensic Psychiatry named after V. Serbsky – implement state and ministerial (both defined as official) statistics for 11 out of 18 register-based MINDFUL indicators, thus making them available for Russia. Of the 11 available register-based MINDFUL indicators for Russia, two are based on mortality statistics, three on health resources-related statistics, four cover psychiatric care utilisation and two deal with social welfare services. Of the 15 survey-based MINDFUL indicators, one (on self-reported happiness) is available due to longitudinal international survey studies in which Russia has been involved. Two more survey-based indicators (on sense of mastery and self-esteem) are basically available for 2002, 2003, 2004 and 2005, but will need to be retrieved from the 1992–2005 Russia Longitudinal Monitoring Survey files. Russian participation in the World Health Organization Regional Office for Europe (WHO EURO) monitoring of national suicide prevention activities provided an additional indicator available for Russia. Thus, a total of 13 MINDFUL indicators proved to be available for Russia.

Stage II aimed to collect and arrange the available RF national MINDFUL mental health indicators obtained from the key Russian mental health statistics bodies. For comparison, the relevant statistics on RF MINDFUL indicators were also obtained from the WHO Health for All database.

The Russian national state and ministerial statistics on mental health obtained from the major RF statistical bodies proved to be reliable and comparable with each other as well as with the

relevant data for RF from WHO EURO. In general, the RF data also seemed adequate compared to European data available from the MINDFUL Database. The large amounts of RF statistics on European mental health indicators obtained during the course of the study have enriched the MINDFUL project database and will serve in the benchmarking of population mental health in Russia against EU member states.

Keywords: mental health, health indicators, Russian Federation, population surveys, survey instrument, death rate

Краткий обзор

О.О.Сахарова, И.Я.Гурович, К.Валбек. Индикаторы психического здоровья в России. Результаты исследования, посвященного изучению доступности российских статистических данных по Европейским индикаторам психического здоровья проекта MINDFUL. STAKES, Reports 13/2007, 118 с. Цена 20 евро. Хельсинки, 2007. ISBN 978-951-33-2025-6.

Настоящее издание посвящено результатам пилотного финляндско-российского (Отдел психического здоровья Финляндского Национального Центра по изучению и развитию социального обеспечения и здравоохранения STAKES; Отделение внебольничной психиатрии и организации психиатрической помощи в составе Отделения клинично-социальной психиатрии Московского НИИ Психиатрии Росздрава) научного исследования, проведенного в период с сентября 2005 г. по февраль 2007 г.

Целью исследования явилось изучение вопроса о доступности российских статистических данных по показателям (индикаторам) психического здоровья MINDFUL, а также сбор самих данных за исследуемый период (с 1990 по 2005 г.г.) с последующим анализом их надежности и сопоставимости с европейскими, что было сделано впервые.

Реализованный в 2004–2006 г.г. проект Еврокомиссии MINDFUL (Mental Health Information and Determinants for the European Level), был направлен на совершенствование качества информации по вопросам психического здоровья в странах-членах Евросоюза.

Разработанный в рамках проекта для нужд мониторинга психического здоровья в странах-членах ЕС Перечень Индикаторов Психического Здоровья MINDFUL включает в себя 35 различных статистических индикаторов состояния психического здоровья населения. 18 из них являются общепринятыми индикаторами ежегодной государственной статистики в области психического здоровья (первая группа), 15 основаны на данных популяционных опросов с использованием различных опросных инструментов (вторая группа); два базируются на данных соответствующих международных мониторинговых исследований.

13 из 35 индикаторов MINDFUL оказались доступными для России. Большую часть из них (11) составляют индикаторы первой группы. Имеющиеся (не требующие специального подсчета) российские статистические данные по индикаторам этой группы были получены из следующих российских источников: Федеральная служба государственной статистики Росстат, Министерство здравоохранения и социального обеспечения РФ и подведомственные ему учреждения (ФГУ ЦНИИ Организации и Информатизации Здравоохранения, МНИИ Психиатрии, ГНЦ Социальной и Судебной Психиатрии имени В.В.Сербского). Из 15 индикаторов опросной группы национально-репрезентативные российские данные за отдельные годы в рамках исследуемого периода нами получены лишь для

одного («Счастье»). Следует отметить, что расчет данных по опросным индикаторам «Субъективный контроль» и «Уровень самооценки» является принципиально возможным на основе обширной статистической базы данных лонгитудинального Российского Мониторинга экономического положения и здоровья населения (RLMS), частью которого они являлись в 2002–2005 г.г. Участие РФ в мониторинговых исследованиях Европейского Регионального Бюро ВОЗ, посвященных изучению национальных стратегий в области профилактики суицидов, обеспечило доступность еще одного, тринадцатого, индикатора MINDFUL для России.

Полученные из различных российских источников данные сопоставлялись между собой, а также с расчетными данными ЕвроВОЗ для России (База Данных Здоровье-для-Всех), и данными европейских стран-членов ЕС (База Данных Проекта MINDFUL).

Нами сделан вывод о надежности российских статистических данных, полученных из различных российских источников, и их сопоставимости между собой, а также с расчетными данными ЕвроВОЗ для России и с европейскими данными (в частности, стран Балтии, которые, наряду с Россией в начале исследуемого периода входили в состав СССР). Полученные российские статистические данные значительно обогатили Базу Данных Проекта MINDFUL и могут служить для нужд сопоставления с европейскими, полученными в ходе реализации проекта

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Foreword

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1 INTRODUCTION

MINDFUL was a two-year (2004–2006) project co-funded by the Public Health Programme of the European Commission. It aimed at improving the status of mental health information within the European Union by widening the scope of its mental health monitoring systems to cover not only mental ill-health but also positive mental health, mental health promotion and the prevention of mental disorders, which had been previously neglected. Furthermore, it entailed the development of current survey and reporting methods with regard to mental health.

The MINDFUL project developed a mental health indicator set, comprising 35 indicators (Appendix 1), for monitoring mental health in the EU Member States. A total of 18 indicators are register-based and must be derived from annual statistics, 15 indicators relate to population survey data, and two require special system-level surveys. The population survey instruments recommended by MINDFUL are given in Appendix 2.

The MINDFUL indicator database (available at www.stakes.fi/mindful) includes national and regional (NUTS 2¹ regions) mental health indicator data. The database covers the period from 1990 to the latest year for which national data is available.

The MINDFUL project has revealed that data availability varies significantly between indicators and countries. Investigation of the mental health care monitoring systems in the five Member States that joined in 2000 is of special interest. Three of them (Estonia, Latvia and Lithuania) as well as Russia itself originated in the former USSR and are deemed to have much in common in terms of their health monitoring systems. However, during the fifteen years since the three Baltic republics seceded from the USSR in 1991, the year the USSR collapsed, the Post-Soviet countries have established national health monitoring systems which to some extent correspond with international and European basic standards.

Our aim was to search for and collect any annual MINDFUL indicator data available from Russia, in order to form conclusions on the data's reliability and comparability with that of the EU countries (particularly the Baltic countries). This has never been done before.

¹ The Nomenclature of Territorial Units for Statistics (NUTS) is a geocode standard developed by the European Union in 1995 for referencing the administrative division of the EU countries for statistical purposes (NUTS divisions do not necessarily correspond to administrative divisions within the country). The acronym is derived from the French name for the scheme (“nomenclature des unités territoriales statistiques”). The predominant factors for the division of NUTS 1, NUTS 2 and NUTS 3 regions are: total population, population density and gross domestic product per capita. Within the NUTS 2 regions, the population varies from 800,000 to 3,000,000 people, population density is less than eight citizens per square kilometre and GDP per capita does not exceed 75% of the EU average taken over the previous three years.

2 HIGHLIGHTS OF STAGE I

Stage I of the study investigated the availability of the entire set of MINDFUL indicators in Russian, countrywide annual 1990–2005 health statistics.

2.1 Overview of the Russian mental health related statistics system

Basically, there are two main sources of official health statistics in Russia: the official state statistics collected, arranged, released and disseminated by the Federal State Statistics Service, Rosstat (previously named Gosstat) and the official ministerial statistics collected, arranged and disseminated by the Ministry of Health and Social Development of the Russian Federation (MHSD) and its institutions. Official mortality statistics are an exception – they are processed solely by Rosstat.

Rosstat accumulates health and mortality data from all federal medical and non-medical institutions with medical staff, retrieving data irrespective of the authority to which the institution is subordinate, including ministerial statistics. Alongside other ministries, the MHSD must submit the relevant ministerial health statistics to Rosstat. However, non-state (private) medical institutions do not contribute to the health statistics – they are obliged to provide only facts and figures reflecting the financial aspects of their functioning. Rosstat regularly publishes and widely disseminates large amounts of statistical data. Of special interest are the mental health-related statistics produced by Rosstat, which are available in the Rosstat statistical yearbook, “Public Health in Russia.”

Alongside the Rosstat statistics, the MHSD and its institutions produce their own annual national and regional statistics based on health indicators, covering the public health bodies subordinate to MHSD (the overwhelming majority of public health institutions in Russia). Obviously, ministerial statistical data comprises the entire range of health-related indicators and is generally more comprehensive than that of Rosstat, but the Rosstat data is more representative (and the numbers are larger) so far as it covers the entire range of medical bodies.

The MHSD is responsible for submitting national and regional health data (including Rosstat-originated mortality statistics) at international level, in particular to the Health for All database (HFA-DB) of the World Health Organization Regional Office for Europe (WHO EURO). The HFA-DB is one of the WHO statistical databases covering a wide range of health indicators (about 600)². Rosstat reports data on mortality and other public health demographic indicators to the MHSD, whereas the MHSD delivers these indicators, alongside data on a number of major public health indicators (basically on morbidity and health resources), to the HFA-DB – all in absolute numbers. Thus, Rosstat provides absolute numbers on MINDFUL indicators # 1 “Suicide” and 2 “Deaths of undetermined intent”, whereas the MHSD provides absolute numbers on indicators # 21 “Number of psychiatric beds”, 24 “Number of in-patient episodes due to mental health conditions” and 25 “Number of long-stay patients”. The WHO EURO calculates total and gender-specific standardised death rates (SDR) for Russia based on MINDFUL indicator # 1 “Suicide” (HFA-DB indicators # 1780–1782) and rates per 100,000 population based on MINDFUL indicators # 21 “Number of psychiatric beds” (HFA-DB indicator # 5070), #24 “Number of in-patient episodes due to mental conditions” (HFA-DB indicator #2383) and #25 “Number of long-stay patients”

² The HFA-DB online version is available at www.euro.who.int/hfadb.

(HFA-DB indicator # 2380). The estimations of WHO/EURO on MINDFUL indicators available from the HFA-DB online version differ somewhat from those of both Rosstat and the MHSD. For comparison, the data from HFA-DB is given in the relevant tables alongside the existing official Russian statistics on MINDFUL indicators (see Chapter 5).

The MHSD has its own statistical services, the Central Scientific and Research Institute for Organisation and Informatisation of Public Health (CSRIOIPH). Mental health-related ministerial statistics are produced by the MHSD and the CSRIOIPH in close collaboration with the two major ministerial psychiatric institutes: the Moscow Research Institute of Psychiatry (MRIP) and the State Research Centre of Social and Forensic Psychiatry (SRCSFP) named after V. Serbsky. The mental health statistics processed by the MRIP and the SRCSFP cover a wider range of mental health-related indicators than the Ministry (CSRIOIPH) itself. For a list of major mental health-related statistical bodies in Russia, see Appendix 3.

The MRIP Clinico-Social Department (Outpatient Psychiatry and Mental Health Organization Unit, in particular) is responsible for processing mental health-related annual regional and national statistics on a wide range of issues. This data is published in five-year period statistical handbooks in 1,000 copies (1965–1970, 1971–1975, 1976–1981, 1982–1985, 1986–1993, 1994–1999 as well as for 2000–2005, which is ready for publication).

At the Serbsky SRCSFP, the Department on Epidemiological and Organizational Problems of Psychiatry is responsible for mental health-related regional and national statistics, in particular forensic psychiatric statistics. The SRCSFP applies the obtained data to research needs and disseminates it to the public (though in fewer editions and based on fewer mental-health indicators than the MRIP).

2.2 Availability of register-based MINDFUL indicators for Russia

The availability of the 18 register-based MINDFUL indicators for Russia within the investigating period (1990–2005) has been thoroughly studied. As a result, each indicator was classified as either available or unobtainable.

2.2.1 Available register-based MINDFUL indicators

Country-level data for 11 out of 18 register-based MINDFUL indicators (i.e. # 1 “Suicide”, # 2 “Deaths of undetermined intent”, # 21 “Number of psychiatric beds”, # 22 “Number of psychiatrists”, # 23 “Number of child psychiatrists”, # 24 “Number of in-patient episodes”, # 25 “Number of long-stay patients”, # 26 “Number of involuntary placements”, # 27 “Use of out-patient services”, # 33 “Disability pensions due to mental disorders”, and # 34 “Sickness allowance spells due to mental disorders”) proved to be readily available. Countrywide (and regional) data on these indicators are contained in annual Russian official public health statistics. These are available from either the Federal State Statistics Service (Rosstat) or the Ministry of Health and Social Development (MHSD) and its institutions (MRIP and SRCSFP).

Age and gender-specific data on indicator # 1, “Suicide,” proved to be available from Rosstat (absolute numbers, standardised death rate (SDR), crude death rate (CDR)) as well as from the CSRIOIPH (SDR, CDR).

Age and gender-specific data based on indicator # 2, “Deaths of undetermined intent,” proved to be available from Rosstat (absolute, CDR) and the CSRIOIPH (SDR, CDR).

The RF data based on indicator # 21, “Number of psychiatric beds,” is available from Rosstat (absolute, per 100,000 inhabitants) and the CSRIOIPH (absolute, per 100,000 inhabitants) as well as the MRIP (rate per 100,000 inhabitants) and the SRCSFP (rate per 100,000 inhabitants).

Countrywide data on the absolute number and rate per 100,000 inhabitants based on indicator # 22, “Number of psychiatrists,” proved to be available from Rosstat as well as from the CSRIOIPH and its institutions: the MRIP (rate per 100,000 inhabitants) and the SRCSFP (rate per 100,000 inhabitants).

Countrywide data based on MINDFUL indicator # 23, “Number of child (and adolescent) psychiatrists,” is not collated either by Rosstat or the MHSD (CSRIOIPH) and is available solely from the MRIP (absolute, per 100,000 inhabitants).

Countrywide data based on indicator # 24, “Number of in-patient episodes due to mental conditions,” is available in absolute numbers only from the CSRIOIPH. The MRIP and the SRCSFP implement national and regional statistics based on admissions to mental institutions, not on discharges.

The RF’s data based on indicator # 25, “Long-stay patients,” was available from the CSRIOIPH (absolute number) and the MRIP (rate per 100,000 inhabitants).

Countrywide statistics based on indicator # 26, “Involuntary placements,” is not collected by either Rosstat or the MHSD (CSRIOIPH), but is available in absolute numbers and rates per 100,000 from the MRIP.

Absolute numbers based on indicator # 27, “Use of out-patient services,” is available from the CSRIOIPH.

Countrywide data based on MINDFUL indicator # 33, “Disability pensions due to mental disorders,” is not included in the official statistics. The overall number of disabled (irrespective of the reason for disability) adults as well as the number of disabled (due to mental disorder) adults is processed by the RF Pension Fund and the MHSD, respectively.

Countrywide day and case-related data based on indicator # 34, “Sickness allowance spells due to mental and behavioural disorders,” (absolute, as a % of all sickness allowance spells) is available from the MHSD.

2.2.2 Unobtainable register-based MINDFUL indicators

a. Drug and alcohol-related deaths (Indicators # 3 and # 4)

The MINDFUL definition of “drug related deaths,” refers to “those deaths that are caused directly by the consumption of drugs of abuse (and which generally occur shortly after the consumption of the substance (s))” (MINDFUL, 2006). As far as the kind of substance used is concerned the MINDFUL project recommends use of the European Monitoring Centre for Drug and Alcohol Abuse³ (EMCDDA) definition of drug-related death. This definition includes deaths, which, using the WHO International Classification of Diseases and Related Health Problems, 10th revision (ICD-10), are coded as being caused by “Harmful use, dependence, and other mental and behavioural disorders due to opioids (F11), cannabinoids (F12), cocaine (F14), other stimulants (F15), hallucinogens (F16), multiple drug use (F19) or by accidental poisoning (X41, X42), intentional poisoning (X61, X62), or poisoning by undetermined intent (Y11, Y12) by opium (T40.0), heroin (T40.1), other opioids (T40.2), methadone (T40.3), other synthetic narcotics (T40.4), cocaine (T40.5), other and unspecified narcotics (T40.6), cannabis (T40.7), lysergide (T40.8), other and unspecified psychodysleptics (T40.9), and psychostimulants (T43.6)”.

³ <http://www.emcdda.europa.eu/>

The definition of “alcohol related deaths” refers to “those deaths that are caused by long-term use, as well as sudden poisonings directly related to the use of alcohol” (MINDFUL, 2006). The MINDFUL recommendation, derived from the Nordic Medical Statistics Committee (NOMESCO)⁴, is that causes of death coded according to ICD-10 be included, as follows: Mental and behavioural disorders due to use of alcohol (F10), Degeneration of nervous system due to alcohol (G31.2), Alcoholic polyneuropathy (G62.1), Alcoholic myopathy (G72.1), Alcoholic cardiomyopathy (I42.6), Alcoholic gastritis (K29.2), Alcoholic liver disease (K70), Alcohol-induced chronic pancreatitis (K86.0), Maternal care for (suspected) damage to foetus from alcohol (O35.4), Fetus and newborn affected by maternal use of alcohol (excludes foetal alcohol syndrome) (P04.3) and Accidental poisoning by and exposure to alcohol (X45).

National level statistics based on MINDFUL indicators # 3, “Drug related deaths,” and indicator # 4, “Alcohol related deaths,” for Russia are unobtainable. This is mainly due to the way in which mortality statistics are gathered in Russia.

The quality of mortality statistics is subject to national certification and coding procedures. Regional coverage of death registration varies from close to 100% in the WHO European region to less than 10% in the WHO African region. According to an evaluation (Mathers et al., 2005), 23 WHO member states provide high quality mortality data, 55 provide medium quality mortality data and 28 deliver low quality mortality data to the WHO. Russia is reported to belong to the group which delivers “medium quality” mortality data. For mortality statistics, Russia uses the ICD-10 coding. In the group of countries providing “medium quality” cause of death information, the rate of completeness of coding causes of death is 70-90% or ill-defined codes appear on 10-20% of registrations.

Cause of Death (COD) statistics in Russia are obtained from the inscriptions on medical death certificates completed by physicians (the medical certification of a death is an obligation across Russia). The physician is required to code the death according to the ICD (prior to 1999 – 9th revision; since 1999 – ICD-10). However, the tabulation of mortality data is performed by Rosstat in accordance with the Abbreviated List of Main Causes of Death (ALMCD), since 1997 based on ICD-10. Previously (from 1981 to 1996) the Abbreviated List of Main Causes of Death, based on ICD-9, was used. The two federal subjects of Russia (Chechen Republic and Republic of Ingushetia) are exceptions: in these areas cause of death information on death certificates is coded according to the ALMCD (Appendix 4), not ICD-10.

The current version of the ALMCD was adopted in 1997. It was developed by the National Institute of Public Health (NIPH)⁵ within the Russian Academy of Medical Sciences in collaboration with the Commonwealth of the Independent States (CIS) Committee on Statistics. It comprises a set of 254 codes which do not fully correspond to the relevant ICD-10 codes. For correlations between the ALMCD and ICD-10 with respect to the blocks relevant to MINDFUL indicators # 3, “Drug related deaths,” and #4, “Alcohol related deaths,” see Table 1.

The Russian ALMCD codes are not comparable to the ICD-10 codes used to define the MINDFUL indicators # 3, “Drug related deaths,” and # 4, “Alcohol related deaths,” and this makes statistics on these MINDFUL indicators unobtainable for Russia.

Rosstat implements annual national and regional statistics on the following alcohol-related ALMCD codes: 97 (Chronic alcoholism), 98 (Alcoholic psychosis, encephalopathy, dementia), 173 (Alcoholic liver disease), and 247 (Accidental poisoning by, and exposure to, alcohol) as well as on the drug-related ALMCD codes: 100 (Mental and behavioural disorders due to drug use and use of other psychoactive substances), and 101 (Mental and behavioural disorders due to use of other psychoactive substances). Alongside these statistics, national and regional data on ALMCD code 247 are gathered monthly. Selected countrywide alcohol-related mortality statistics from Rosstat on the four abovementioned ALMCD codes (taken together) are given in Table 2.

⁴ <http://www.nom-nos.dk/>

⁵ Formerly The Science Research Institute of Social Hygiene, Economics, and Healthcare Management named after N.Semashko.

TABLE 1. MINDFUL cause specific mortality indicators

Comparison between Abbreviated List of Main Causes of Death (ALMCD) 1997 codes and the relevant ICD-10 codes.

ALMCD code	ALMCD title	Relevant ICD blocks
100	Mental and behavioural disorders due to drug use and use of other psychoactive substances	F11, F12, F14, F13 (part), F15 (part), F16 (part), F19 (part)
101	Mental and behavioural disorders due to use of other psychoactive substances	F17, F13 (part), F15 (part), F16 (part), F19 (part)
248	Accidental poisoning by, and exposure to, noxious substances	X40–X44, X46–X49
249	Suicide and self-inflicted injury	X60–X84
251	Intentional self-harm	Y10–Y34
237	Poisoning by drugs, medicaments and biological substances	T36–T65
97	Chronic alcoholism	F10.0–3, F10.6 (part) F10.8, 9
98	Alcoholic psychosis, encephalopathy, dementia	F10.4–5, F10.6 (part) F10.7
111	Other diseases of the nervous system	G10–G12, G23–G25, G31, G36, G37, G43–G45, G47, G50–G72, G81–G98
132	Other forms of heart disease	I30–I51
168	Gastritis and duodenitis	K29
173	Alcoholic liver disease	K70
178	Acute pancreatitis and other diseases of the pancreas	K85–K86
203	Other direct obstetric causes	O12, O22–O28, O30–O43, O44.0, O47, O48, O60–O66, O68–O71, O73, O75, O80–O84, O86.1–4,8 O87, O90, O91.2, O92
247	Accidental poisoning by, and exposure to, alcohol	X45

Source: The CSRIOIPH Unit on Analysis of Population Health statistics' files.

TABLE 2. Alcohol related deaths, absolute (thousands), RF, whole country

		1990	1995	2000	2001	2002	2003	2004
Total	All ages	18.2	57.7	47.5	53.9	60.5	63.1	62.1
	Working age*	14.7	45.8	37.0	41.1	46.1	49.3	49.2
Male	All ages	14.5	44.8	36.3	40.8	45.2	47.0	45.8
	Working age*	12.6	38.1	29.9	32.9	36.5	38.8	38.6
Female	All ages	3.7	12.9	11.2	13.1	15.3	16.1	16.3
	Working age*	2.1	7.7	7.1	8.2	9.6	10.5	10.6

* 16–59 years (men), 16–54 years (women).

Source: The CSRIOIPH Database, 2006.

Consumption of alcohol (often illicit or surrogate) as well as drug abuse have now reached epidemic proportions in Russia. Official statistics indicate that alcohol consumption in Russia (i.e. the former Russian Soviet Federative Socialist Republic) rose in the 1960s and 1970s. It began to decrease in the late 1980s, in large part due to the 1985 anti-alcohol legislation that limited alcohol sales and raised the legal purchasing age to 21. Three years later, this law was repealed, resulting in a substantial increase in alcohol consumption between 1992 and 1994 (consistent with a sharp

alcohol price reduction). Alcohol consumption rose by 25 to 30 percent as the price dropped by 58 percent during this period. A significant proportion of the increase in the number of deaths of middle-aged men between 1992 and 1994 is attributed to cases of sudden cardiac pathology related to alcohol poisoning. Although a rise in the price of alcohol and a reduction in alcohol consumption were observed between 1994 and 1996, in 1995 12.5% of all deaths from injuries and poisoning in Russia were caused by alcohol poisoning, even outstripping the countrywide percentage (11.1 %) of deaths due to traffic accidents (World Bank, 2005). Lately, some data indicates that a turning point in these figures may be imminent. In 2006, the death rate from acute alcohol poisoning, as estimated by Rosstat (Scherbakova, 2007) decreased by as much as 7.5% from the 2005 level (with a peak registered in January, as commonly occurs).

Adult per capita alcohol consumption in Russia in 1999 was 10.7 litres (which can be compared to 8.6 litres in the US and 9.7 litres in the UK (WHO, 2003). Recent data from the Russian Longitudinal Monitoring Survey (a series of nationally representative surveys designed to monitor the effects of socioeconomic reforms on health and economic welfare in the RF 1992–2005) indicate that in 2002 per capita alcohol consumption was 14.5, 2.4 and 1.1 litres among men, women and teenagers, respectively (RLMS, 2005). However, it is believed that self-reported alcohol consumption underreports the amount of alcohol intake (Laatikainen et al., 2002).

High rates of alcohol consumption as well as alcohol poisoning are a rapidly growing problem in rural areas, where the relevant death rate is 128 per 100,000 among adult men, twice that of the country as a whole (Nemtsov, 2002). This phenomenon is viewed as a result of using poorer quality or illicit alcoholic beverages and stronger traditions with respect to habitual drinking.

The 1985–1988 Union of Soviet Socialist Republics' (USSR) anti-alcohol campaign has provided a unique opportunity to estimate correlations between the consumption of alcohol and mortality. The decrease in alcohol consumption by 2.1 litres (from 14.0 in 1980–1984 to 11.9 in 1985–1992) resulted in the decrease in mortality first registered as early as June 1985 (the anti-alcohol campaign was launched on June 1st). The consequent 1985–1992 decline in total mortality from all causes gave an estimated 1.4 million saved lives (919,900 men and 463,600 women). This makes $181,000 \pm 16,500$ saved lives per year within a period of eight years (Nemtsov, 2006).

Alcohol use is the number one health risk factor in the male, and the fifth greatest in the female, Russian population (WHO EURO 2006). Table 3 lists the top 10 risk factors (in descending order) for males and females in Russia, measured in DALYs⁶.

TABLE 3. The WHO-estimated ten leading health risk factors in the Russian Federation, 2002

Rank	Males		Females	
	Risk factors	Total DALYs (%)	Risk factors	Total DALYs (%)
1	Alcohol	22.8	High blood pressure	19.6
2	Tobacco	20.5	High cholesterol	12.7
3	High blood pressure	14.1	High Body Mass Index	10.7
4	High cholesterol	12.0	Low fruit/vegetable intake	7.0
5	High Body Mass Index	7.1	Alcohol	6.8
6	Low fruit/vegetable intake	7.0	Physical inactivity	5.2
7	Physical inactivity	4.3	Tobacco	2.5
8	Illicit drugs	2.7	Unsafe sex	1.8
9	Occupational risk factors for injuries	1.3	Illicit drugs	1.3
10	Lead	1.2	Lead	0.9

Source: WHO EURO, 2006.

6 DALY (disability-adjusted life year) is a summary measure that combines the impact of illness, disability and mortality on the population's health. One DALY can be thought of as one year of healthy life (WHO EURO 2006).

Alcohol-related mortality has also been addressed at a high political level. In his State-of-the-Nation Address to the Federal Assembly of the Russian Federation on April 25th, 2005, President Vladimir Putin said: “I would like to dwell on another subject which is difficult for our society – the consequences of alcoholism and drug addiction. Every year in Russia about 40,000 people die of alcohol poisoning alone, primarily caused by alcohol substitutes. These are mainly young men, breadwinners. However, this problem cannot be resolved through prohibition. Our work must result in the young generation recognising the need for a healthy lifestyle and physical exercise. Each young man must realise that a healthy lifestyle means success, his or her personal success” (Putin, 2005).

The Russian Ministry of Health and Social Development (MHSD) is currently launching the Federal Target Programme, “On Preventing and Combating Socially Important diseases for the period 2007–2011,” aimed at preventing and curbing early deaths, ill health and disability caused by non-communicable diseases (NCDs) and injuries, and alcohol and drug-related deaths in particular.

The 2005 World Bank Report “Dying Too Young: Addressing Premature Mortality and Ill Health Due to Non-Communicable Diseases and Injuries in the Russian Federation” states that, despite strong economic growth, Russia is facing an alarming population decline, due in large part to untimely deaths from heart disease, traffic accidents and alcoholism. It appreciates the MHSD initiative on establishing a federal programme (intended to be effective at local, regional and federal levels) for the prevention of NCDs and states, “Reducing NCDs and injury-related mortality rates among Russian working-age adults will have a major macroeconomic and social impact, with benefits far outweighing initial outlays to cover the cost of health promotion and disease prevention activities” (World Bank, 2005).

Policies and programmes to combat diseases and injuries should properly be based on current, timely information on the nature and extent of health problems, and the most widely available and commonly used data of this kind comprises cause-of-death statistics (Mathers et al., 2005). Automated coding systems (ACS) are recognised to be the best way of ensuring the reliability, homogeneity and comparability of the COD coding process (Pavillon and Johansson, 2001). Russia participates in the International Collaborative Effort on Automating Mortality Statistics, established by the U.S. National Center for Health Statistics⁷ (NCHS) in 1996 to promote international collaboration in applying technology to the collection, processing and dissemination of mortality statistics.

In 2001, in collaboration with their colleagues from the NCHS, the experts of the CSRIOPH and the Tula Oblast Bureau for Medical Statistics developed a computerised system for population birth-rate and mortality monitoring (Starodubov et al., 2002), sponsored by the Open Society Institute⁸. This software is based on the US Automated Coding System (US ACS) for causes of death which comprises four components: SUPERMICAR (translates the full text of the conditions reported on the death certificate into standardised expressions), MICAR (translates standardised expressions into the ICD codes and performs editing), ACME (selects the underlying cause of death⁹) and TRANSAX (produces the codes for multiple cause analyses). All four components can be used separately, providing that the input data is correctly formatted. This newly developed Russian language suite of computer programs enables the identification of the underlying cause of death and its coding under ICD-10 as well as the processing of proper mortality statistics on federal subject level.

7 <http://www.cdc.gov/nchs/about/major/dvs/about.htm>

8 <http://www.soros.org/about>

9 “Underlying cause of death is defined as “the disease or injury which initiated the train of morbid events leading directly to death, or the circumstances of the accident or violence which produced the fatal injury” in accordance with the rules of the International Classification of Diseases” (WHO/Health Statistics and Health Information Systems/About the WHO Mortality Data. <http://www.who.int/healthinfo/statistics/mortdata/en/index.html>).

Some 17 out of 89 federal subjects¹⁰ of the Russian Federation currently use this automated mortality statistics software product. Some of these have significantly improved the reliability of COD data (Vaisman et al., 2001). However, the quality of automated mortality statistics differs across the 17 RF subjects due to a range of factors revealed in a recent CSRIOPH study (Pogorelova, 2004). The inspection of 70,000 death certificates in the Tula Oblast and the Stavropol Krai as part of the study revealed that the percentage of incorrectly completed and processed death certificates averaged as much as 50% (varying from 35% to 60% across local bodies of medical statistics). The predominant factors underlying the poor quality of ACS-based COD statistics were a) *human* (49%) referring to incorrectness of death certificates (26%) (due to the poor qualifications of clinicians selecting the underlying cause of death and the appropriate ICD-10 coding, bad handwriting, unclear abbreviations), as well as inadequate quality of expertise (23%) (due to lack of qualifications and experience as well as routine overloading of medical experts and statisticians); b) *managerial* (18%) (managerial incompetence, inadequate supervision by administration and health professionals, lack of relevant documentation, underestimation of the importance of correct mortality statistics); c) *organisational* (17%) (poor control over documentation, lack of training seminars and manuals, incomprehensive transition to ICD-10 across federal subjects); and d) *technological* (16%), i.e. a deficit of up-to-date ACS versions and technologies.

To improve the quality of ACS-based mortality statistics, complex measures to be realised on regional (federal subject) level have been designed and promoted by the CSRIOPH experts (Pogorelova, 2006). They include regular training sessions for physicians, statisticians, experts and trainers; application of the “RUTENDON” (Russian version of TENDON) computer-based ICD-10 training package aimed at self-education (with an online or face-to-face instructor) for physicians and medical students; a thorough expert check of death certificates before loading the data into the database; as well as proper analysis (applying an automated analytical block) of the obtained data.

Mortality statistics have improved across the 17 federal subjects to varying degrees due to the introduction of some, or the whole complex system of, measures (Pogorelova, 2006). Thus, in the Tula Oblast (an RF pioneer and leader in the ACS statistics) the installation of ACS has reduced the number of incorrectly completed certificates from 80% to 20% and improved the reliability of COD data from 50% up to 96%. In the Kirov Oblast, the quality of COD data has been improved to 95% and in the Krasnoyarsk Krai to 87%. In several other federal subjects, COD reliability has been improved to 75% within the last few years (Pogorelova, 2006).

The introduction of the ACS Russian version will make annual regional (17 out of 89 RF federal subjects) data available on MINDFUL indicators # 3 and # 4, beginning from 2001, from either CSRIOPH or the appropriate regional bodies of medical statistics.

The improvement of regional COD data reliability can contribute to the prevention of high death rates, alcohol-related death rates in particular (especially high among men of 25–54 years) in Russia, which is now an urgent issue. Thus, the findings of a recent study (Leon et al., 2005) conducted in Izhevsk (the Udmurt Republic) revealed that 4 out of 10 capable men who died in 2003–2005 in Izhevsk were heavy alcohol addicts and 8 out of 10 who died within the same period were both heavy alcohol addicts and smokers. The relevant countrywide rates total as many as 170,000 and 360,000 deaths a year, respectively. The study also revealed that 18% of all deaths among male residents aged 25–54 years were certified as alcohol related: mental disorders due to alcohol, alcoholic cardiomyopathy, alcoholic cirrhosis of the liver and acute alcohol poisoning. However, this excludes the substantial proportion of deaths that are attributable to alcohol but which arise from causes that do not explicitly imply the involvement of alcohol: injuries, violence and a wide range of illnesses e.g. respiratory and cardiovascular diseases (Leon et al., 2005). In 2004 the percentage of direct and indirect alcohol-related deaths in Russia amounted to 30% of all deaths among men and 15% of all deaths among women (Nemtsov, 2006).

¹⁰ Administrative and territorial units of the Russian Federation (see Appendix 5).

The term *drug (substance) abuse* “constitutes the use of any substance under international control for purposes other than medical or scientific, including use without prescription, in excessive dose level, or over an unjustified period of time” (UN ODCCP¹¹, 2000). Drug abuse commonly refers to continuous pathological use of narcotic drug(s), whereas substance abuse refers to continuous pathological use of psychoactive substance(s).

Narcotic drugs are controlled by the 1961 Single Convention on Narcotic Drugs and the 1972 Protocol Amending the Single Convention (United Nations, 1977). According to the Lexicon of Alcohol and Drug Terms,¹² a narcotic drug is a chemical agent, either natural or synthetic, that can modify normal behavior and “induce stupor, coma, or insensibility to pain” (WHO, 1994). In common parlance and legal usage, the term is often used imprecisely to mean illicit drugs, irrespective of their pharmacology. Narcotic drugs, more correctly known as narcotic analgesics, are differentiated from psychoactive substances.

Psychoactive (psychotropic) substances are controlled by the 1971 Convention on Psychotropic substances (United Nations, 1978). According to the Lexicon of Alcohol and Drug Terms psychoactive substance is any chemical substance, either licit or illicit, that “affects mental processes, e.g. cognition or affect” (WHO, 1994). Commonly these are stimulants or hallucinogens, as well as sedatives, tranquilizers, hypnotics, volatile solvents, etc. All patterns of drug and substance abuse refer to the ICD-10 block “Mental and behavioral disorders due to psychoactive substance use” F10-F19 (ICD-10, 2007).

In Russia narcotic drugs and psychoactive substances are controlled by the RF Federal Law # 3-FZ from 1998 “On Narcotic Drugs and Psychotropic Substances”¹³ as well as by the “List of Narcotic Drugs, Psychotropic Substances and their Precursors Subject to Control in the Russian Federation”¹⁴ (hereafter the List) adopted by the Governmental Act # 681 from 1998. The List is based on the two above mentioned UN Conventions as well as the Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances (United Nations, 1988).

According to the Russian psychiatry’ approach all kinds of drug/substance abuse are classified as either “narcomania” or “toxicomania” depending whether the substance belongs to the List or not, which is a matter of not only medical but also juridical importance (Tiganov, 1999). A pattern of continued pathological use of illegal (belonging to the “List of Narcotic Drugs, Psychotropic Substances and their Precursors Subject to Control in the Russian Federation”) drug is defined as “narcomania”. For the needs of domestic statistics it is coded by the relevant ICD-10 code followed by letter “H” (the first letter in the Russian word for “narcomania”). Mental and behavioral disorders due to use of opioids (F11), cannabinoids (F12), and cocaine (F14) are an exception (the ICD-10 codes are not accompanied by “H” as obviously belonging to this category). A pattern of continued pathological use of a substance which is not included into the “List of Narcotic Drugs, Psychotropic Substances and their Precursors Subject to Control in the Russian Federation” is defined as “toxicomania”. For the needs of domestic statistics it is coded by the relevant ICD-10 code followed by letter “T” (the first letter in the Russian word for “toxicomania”).

11 United Nations Office on Drug Control and Crime Prevention, renamed in October, 2002 as United Nations Office on Drugs and Crime (UNODC). <http://www.unodc.org/unodc/index.html>

12 http://www.who.int/substance_abuse/terminology/who_lexicon/en/

13 <http://www.kodeks.ru/noframe/legrfsearch?d&nd=9056021>

14 According to the Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances a precursor is a chemical substance that in the manufacturing process becomes incorporated in full or in part into the molecule of a narcotic or psychoactive substance (UN ODCCP, 2000).

15 http://www.innovbusiness.ru/pravo/DocumShow_DocumID_74735.html

The terms “narcomania”, “toxicomania”, as well as “polynarcomania”¹⁶, “polytoxicomania”¹⁷ and “complicated narcomania”¹⁸ though not specified in the ICD-10 are widely used by psychiatrists and narcologists in Russia, for statistical needs in particular.

Rates of narcotic drug and psychoactive substance abuse are high in Russia. However, estimated numbers vary from one source to another. According to A.G. Mikhailov, Chief of the Federal Service for Control over Drug Trafficking¹⁹ (interview with the “Mayak” radio station on 31.03.2004, cited by Kharchenko et al., 2004) the number of illegal drug users has increased in Russia as much as nine-fold within the last 10 years, whereas in the USA it has decreased from 25 million to 12 million people within the same period. According to monitoring measures within the Federal Target Program “Complex Measures on Prevention of Drug Use and Illicit Drug Utilization: 2002–2004,” the overall number of drug and substance addicts (those diagnosed with either “narcomania” or “toxicomania”) on January 1, 2005 totalled as many as six million people, including 1.9 million teenagers and youngsters under 24 years of age. The official MHSD statistics on the numbers of drug addicts are far less aggravated (Tables 4, 5). However, the actual number of drug users in the country is known to exceed the official estimate, probably by five to eight times (Cherkesov, 2005). Some of these are intravenous drug addicts who are estimated to have a 20 times higher risk of death than the general population (UNISEF, 2004).

Table 4 indicates that according to the official ministerial statistics absolute majority (96% in 2005) of registered drug takers in Russia used illegal drugs (were diagnosed with “narcomania”). The numbers and the rates of all registered drug users have been increasing at least within the last six years. The ratio of new diagnosed illegal drug addicts has grossly (by 69%) decreased within the same period, and the ratio of new diagnosed legal drug addicts has had a moderate upward trend. New diagnosed drug addicts amounted in 2000 to 26% of all registered drug addicts; by 2005 the relevant percentage has decreased to only 8%.

TABLE 4. Registered drug and substance addicts, all ages; absolute number (thousands), rate per 100,000 inhabitants in the Russian Federation (estimates by MHSD)

		2000	2001	2002	2003	2004	2005
First diagnosed users							
Narcomania	Total	73.3	62.8	27.3	22.9	21.0	24.4
	Rate	50.4	43.4	18.9	16.0	14.7	17.2
Toxicomania	Total	1.4	1.7	2.2	2.3	2.2	2.0
	Rate	1.0	1.2	1.5	1.6	1.5	1.4
All registered users							
Narcomania	Total	269.1	317.1	322.9	326.6	325.7	328.0
	Rate	185.2	219.4	224.5	228.3	228.8	231.6
Toxicomania	Total	12.2	12.0	12.7	13.5	14.1	14.5
	Rate	8.4	8.3	8.8	9.4	9.9	10.2

Source: TheCSRIOIPH Unit on Analysis of Population Health Statistics’ files

16 A person addicted to two or more substances (being used simultaneously or at different time) which are included into the “List of Narcotic Drugs, Psychotropic Substances and their Precursors Subject to Control in the Russian Federation” is diagnosed with “polynarcomania” (Tiganov, 1999).

17 A person addicted to two or more substances (being used simultaneously or not) which are not included into the “List of Narcotic Drugs, Psychotropic Substances and their Precursors Subject to Control in the Russian Federation” is diagnosed with “polytoxicomania” (Tiganov, 1999).

18 Addiction to legal and illegal substances (being used simultaneously or at different time) is specified as “complicated narcomania”. (Tiganov, 1999)

19 <http://www.gnk.gov.ru/>

TABLE 5. Registered child and adolescent drug and substance addicts; total numbers and rates per 100,000 inhabitants in the Russian Federation (estimates by MHSD)

		2000	2001	2002	2003	2004	2005
Children (0–14 years)							
Narcomania	Total (persons)	317	212	157	111	99	51
	Rate	1.2	0.9	0.7	0.5	0.5	0.2
Toxicomania	Total (persons)	1,488	1,294	1,516	1,720	1,833	1,642
	Rate	5.8	5.3	6.5	7.7	8.5	7.9
Adolescents (15–17)							
Narcomania	Total (thousands)	9.1	7.4	3.9	2.3	1.8	1.4
	Rate	120.7	87.9	52.2	31.3	24.9	21.8
Toxicomania	Total (thousands)	3.5	3.2	3.3	3.7	4.1	4.2
	Rate	46.4	41.9	44.3	49.6	58.1	63.4

Source: The CSRIOIPH Unit on Analysis of Population Health Statistics' files.

Table 5 indicates that large majority (77% in 2005) of registered minor drug addicts are adolescents in Russia. They dominate in either legal or illegal drug use relevant statistics. However before 2003 major part of them had used illegal drugs, whereas in 2005 two thirds of them used legal drugs. Most of registered drug takers among children (97% in 2005) traditionally use legal drugs. More particularly these are organic solvents present in many domestic and industrial products (such as glue, aerosol, paints, industrial solvents, lacquer thinners, gasoline or petrol, and cleaning fluids) and the aliphatic nitrites such as amyl nitrite being inhaled for psychoactive effects (Tiganov, 1999). The absolute numbers of registered child and adolescent addicts have been constantly decreasing (more grossly in adolescents) within this period of time. The total number of minor drug addicts in 2005 was almost two times less than in 2000 (7.3 thousand vs. 14.4 thousand respectively).

In Russia, approximately 70,000 people die per year from drug overdoses (Kharchenko et al., 2004). Obviously, the high rates of alcohol and drug-associated mortality rates in Russia are only serving to worsen the country's depopulation crisis²⁰.

The Federal Target Program, "Complex Measures on Prevention of Drug Use and Illicit Drug Utilization: 2005–2009,"²¹ aims at the following achievements by 2010: a) a decrease in the overall number of drug and substance addicts by 16–20% (i.e. by 950,000–1 200,000 people); b) 25% coverage of minors (11–24 years) with preventive anti-drug measures; c) an increase in the number of treated addicts with at least a 3-year remission by 30–40%; d) a further 20% restriction on access to narcotic drugs and psychoactive substances; e) improved effectiveness in the prevention of criminality and delinquency related to illicit drug use and utilisation; f) improved statistics on drug and substance use in Russia. The MHSD Act # 623 from 2003, "On Promotion of Narcological Assistance to Minors,"²² is also being implemented.

20 Since 1992, the population of Russia has decreased by 4.1 million or 2.8%. According to demographic projections (United Nations, 2005), the resident population is expected to decline further by 5% or 6% before the situation stabilises around 2016.

21 <http://fcp.vpk.ru/ext/180/content.htm>

22 <http://www.bestpravo.ru/fed2003/data01/tex10071.htm>

b. Consumption of psychiatric drugs (Indicators # 29–32)

MINDFUL indicators # 29-32 cover the countrywide consumption of antidepressants (Anatomical Therapeutic Chemical²³ (ATC) Classification System Class NO6A), antipsychotics (ATC Class NO5A), anxiolytics (ATC Class NO5B), and hypnotics (ATC Class NO5C), respectively, in defined daily doses (DDD²⁴) per 1,000 inhabitants during a given year. The related calculation is based on the volume of sales to pharmacies and hospitals by wholesalers (MINDFUL, 2006).

The RF Federal Law # 86-FZ from 1999, “On Medicinal Products,”²⁵ and the RF Federal Law # 3-FZ from 1998, “On Narcotic Drugs and Psychoactive Substances,” provide legal grounds for psychopharmaceutical drug circulation in Russia. The official state statistics on the circulation of pharmaceutical products in Russia comprise statistics on domestic production volumes, export volumes from the country/imports into the country, as well as on retail and wholesale trade volumes. These are implemented by Rosstat, the Federal Customs Service of Russia and the State Planning and Research Institute of Medical Industry, “ОАО ГипроНИИмедпром,” (SPRIMI) and disseminated by Rosstat.

As far as production is concerned, SPRIMI implements quarterly and annually comprehensive statistics on the volumes of domestic production of each and every medicine related to the 98 classes of common national classification (Mashkovsky, 2006), the psychopharmaceutical class in particular in so-called “natural” (tablets, capsules, ampoules, bottles etc) and monetary units. On an annual and monthly basis, Rosstat estimates the volumes of domestic drug production in relation to 15 classes defined by MHSD, one of these being psychopharmaceuticals (as a total figure, without any breakdown) in natural units (Table 6).

The annual total value of RF domestic drug production is also available from Rosstat, but no breakdown in drug classes is provided. Statistics on the volumes of imported drugs are gathered separately by the Federal Customs Service of Russia for each medicine in monetary (US\$) and weight (kg) units. These statistics are available at Rosstat. On an annual basis, Rosstat estimates the overall value of drug (either domestic or imported) retail sales and hospital purchases in monetary units (roubles).

The volumes of consumption of psychopharmaceuticals in relation to the relevant WHO ATC classes in DDD units are not subject to the RF official statistics. Routine national statistics procedures thus do not provide the data required for MINDFUL indicators on the consumption of psychoactive drugs (# 29–32).

TABLE 6. Production of psychopharmaceuticals in Russia

	1990	1995	2000	2001	2002	2003	2004
Mln ampoules	NA	5.3	74.2	66.4	101.0	93.2	86.2
Mln packages	32.0	30.7	43.7	99.5	61.1	92.4	91.0

Source: Rosstat, 2006 (Table 10.1).

23 The ATC Classification System based on the European Market Research Association (EPhMRA) Classification (EphMRA/PBIRG, 2006) was developed by Norwegian researchers in the early 1970-s. In 1981 the WHO Regional Office for Europe recommended the ATC/DDD system for international drug utilization studies (WHO Collaborating Centre for Drug Statistics Methodology <http://www.whocc.no/atcddd/>)

24 The DDD is the assumed average maintenance dose per day for a drug used for its main indication in adults (the Nordic Council on Medicines, 1976. The WHO Collaborating Center for Drug Statistics Methodology, 1982).

25 http://cra-club.ru/images/documents/drug_law.pdf

The Research Marketing & Business Consulting Group²⁶ (RMBC) established in 1999 and a member of the European Pharmaceutical Market Research Association²⁷ (EphMRA), is a major Russian commercial company on audit, marketing, consulting and information services in the pharmaceutical market. It gathers and disseminates large amounts of statistical data on drug circulation in Russia, Ukraine, Belorussia and Kazakhstan which are available in monthly Russian and English versions of the AIPM (Association of International Pharmaceutical Manufacturers) RMBC Market Bulletin²⁸.

According to the AIPM-RMBC Market Bulletin (AIPM-RMBC, 2006) psychoactive drugs belong to the top 10 ATC classes in Russia. Thus, in 2005 psychoanalptics²⁹ were ranked 5th by either pharmacy sales or hospital purchases, whereas psycholeptics³⁰ were ranked 10th and 4th out of the top 10 ATC classes by pharmacy sales and hospital purchases, respectively (Tables 7 and 8).

TABLE 7. Top 10 ATC Groups by Pharmacy Sales Value, RF, 2005

Rank	ATC code	ATC class	Share in total pharmaceutical sales (%)
1	J01	Antibacterials for Systematic Use	6.1
2	N02	Analgesics	5.8
3	A11	Vitamins	4.6
4	L03	Immunomodulating Agents	3.8
5	N06	Psychoanalptics	3.6
6	C09	Agents acting on the Renin-Angiotensin System	3.5
7	R05	Cough and Cold Preparations	3.4
8	G03	Sex Hormones and Modulators of the Genital System	3.3
9	M01	Antiinflammatory and Antirheumatic Products	3.2
10	N05	Psycholeptics	2.6
Total top 10			39.9

Source: AIPM-RMBC, 2006 (Table 4 p.3).

TABLE 8. Top 10 ATC Groups by Hospital Purchases, RF, 2005

Rank	ATC code	ATC class	Share in total pharmaceutical sales (%)
1	J01	Antibacterials for Systematic Use	21.5
2	B05	Plasma Substitutes and Perfusion Solutions	9.0
3	L01	Antineoplastic Agents	5.4
4	N05	Psycholeptics	4.2
5	N06	Psychoanalptics	3.6
6	C01	Cardiac Therapy	3.0
7	B01	Antothrombotic Agents	2.7
8	N01	Anaesthetics	2.6
9	L03	Immunomodulating Agents	2.2
10	V08	Contrast Media	2.1
Total top 10			56.3

Source: AIPM-RMBC, 2006 (Table 4 p.4).

26 <http://www.rmbc.ru/index.php>

27 <http://www.ephmra.org/main.asp?page=0>

28 <http://www.rmbc.ru/analytics/bulletin/aipm/>

29 According to the ATC/DDD classification system Psychoanalptics (ATC code NO6) combine: Antidepressants (NO6A); Psychostimulants, agents used for ADHD (Attention Deficit Hyperactivity Disorder) and Nootropics (NO6B); Psycholeptics and psychoanalptics in combination (NO6C); Anti-dementia drugs (NO6D).

30 According to the ATC/DDD classification system Psycholeptics (ATC code NO5) combine: Antipsychotics (ATC code N05A); Anxiolytics (N05B); Hypnotics and Sedatives (N05C).

The RMBC implements a wide range of statistics on drug utilisation in Russia, based on the WHO DDD/ATC System in particular. However, there is no readily available DDD/1000 Russian data related to the MINDFUL indicators # 29–32.

c. Expenditure on mental health services (Indicator # 35)

This indicator relates to “the total national expenditure on mental health services (either inpatient or outpatient) as a percentage of the total health budget” (MINDFUL, 2006).

Total health expenditure is defined by the WHO as “the sum of general government health expenditure and private health expenditure in a given year, calculated in national currency units in current prices. It comprises the outlays earmarked for health maintenance, restoration or enhancement of the health status of the population, paid for in cash or in kind” (WHOSIS, 2007).

General government health expenditure (commonly called public health expenditure) is defined as “current and capital spending from government (central and local) budgets, external borrowings and grants (including donations from international agencies and non-governmental organizations) and social (or compulsory) health insurance funds” (UNDP, 2003).

Private health expenditure is the sum of “direct household (out of pocket) spending, private insurance, spending by non-profit institutions serving households and direct service payments by private corporations” (UNDP, 2003).

The RF Ministry of Health and Social Development (MHSD), the Federal Treasury³¹ (FT) under the RF Ministry of Finances³² as well as Rosstat generate statistics on a wide range of RF macroeconomic health indicators, health expenditure in particular. However the data on the countrywide total, public and private health expenditure differs from one source to another because of differences in routine statistical procedures.

Expenditure data processed by MHSD is submitted to the WHO. The FT submits data (including that on the RF health expenditure) to the International Monetary Fund and Rosstat. Rosstat applies the FT-originated statistics on basic indicators referring national health expenditure to the development of its own data (on health expenditure, in particular), and disseminates it through the Rosstat two-year periodical statistical handbooks “Public Health in Russia” and other editions.

However, before 2005 the FT-processed data (and consequently that of Rosstat) on the RF health expenditure has not included the resources from governmental off-budget funds (the second largest out of three main financial sources of public health expenditure in Russia). Starting from 2007³³ Rosstat is expected to provide the FT-estimated data on health expenditure in Russia with the governmental off-budget funds’ resources included. Consequently, the previously (and currently) available FT (and Rosstat) statistics on the RF health expenditure have been underestimated. The underestimated data on the RF health expenditure is also found on the international health-related websites and databases.

The WHO HFA-DB on-line indicator #6711, “Total health expenditure as % of gross domestic product (GDP)” for Russia (accessed on September 3rd, 2007) is an example. Supposed to reflect domestic (e.g. MHSD-submitted) data, it provides definitely underestimated figures available for 1989–1993, 1995, and 1999–2000 (and amounting to 2.18%, 2.26%, 3%, 2.3%, 3%, 2.2%, 2.8% and 2.9% respectively), whereas the HFA-DB on-line data for Russia on indicators #6710, 6712, and 6713, providing the WHO-estimated total, public and private health expenditures as a % of

31 <http://www.roskazna.ru/p/fk/polozhenie.html>

32 <http://www1.minfin.ru/>

33 The Rosstat next statistical two-year handbook “Public Health in Russia in 2007” is due to be released in December 2007 (“Public Health in Russia in 2005” was the previous).

TABLE 9. The WHO-estimated health expenditure as a % of GDP for Russia, 1998–2004

	1998	1999	2000	2001	2002	2003	2004
Public health expenditure	3.7	3.2	3.3	3.4	3.5	3.3	3.7
Private health expenditure	2.7	2.4	2.5	2.3	2.4	2.3	2.3
Total health expenditure	6.4	5.6	5.8	5.7	5.9	5.6	6.0

Source: the WHO HFA Database on-line <http://www.euro.who.int/hfad>.

Indicators: #6710 "Total health expenditure as % of gross domestic product (GDP), WHO estimates", #6712 "Public sector expenditure on health as % of gross domestic product (GDP), WHO estimates", and #6713 "Private sector expenditure on health as % of gross domestic product (GDP), WHO estimates," for the Russian Federation (last accessed on September 3rd, 2007).

TABLE 10. The WHO-estimated total health expenditure as a per cent of the GDP for Russia related to the relevant WHO-estimated percentages for the country reference groups, HFA-DB, 2004

EU members before May 2004	Eur A ¹	EU	European Region	EU members since 2004 or 2007	Eur B+C ²	Russia	CIS	CARK ³
9.29	9.25	8.7	7.69	6.51	6.22	6.0	5.75	4.7

1 The 27 countries with very low child mortality and very low adult mortality are designated Eur-A by WHO. Eur-A comprises Andorra, Austria, Belgium, Croatia, Cyprus, the Czech Republic, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Israel, Italy, Luxembourg, Malta, Monaco, the Netherlands, Norway, Portugal, San Marino, Slovenia, Spain, Sweden, Switzerland and the United Kingdom.

2 The 25 countries with low child mortality and low or high adult mortality are designated Eur-B+C by WHO. Eur-B+C comprises Albania, Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, Bulgaria, Estonia, Georgia, Hungary, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Poland, Republic of Moldova, Romania, Russian Federation, Serbia and Montenegro, Slovakia, Tajikistan, The former Yugoslav Republic of Macedonia, Turkey, Turkmenistan, Ukraine and Uzbekistan.

3 Four Central Asian republics (Kyrgyzstan, Tajikistan, Turkmenistan, and Uzbekistan) and Kazakhstan collectively are referred to as CARK countries (<http://www.carkforum.tj/index1.html>).

Source: The WHO HFA-DB on-line <http://www.euro.who.int/hfad>. Indicator #6710, "Total health expenditure as % of gross domestic product (GDP), WHO estimates," Table A (last accessed on September 3rd, 2007).

GDP,³⁴ respectively (see Table 9), are reasonable and comparable to the corresponding MHS D figures (given in Table 11).

When compared with the 2004 relevant WHO-estimated figures for the common country reference groups (available from the HFA-DB on-line version), the latest available 2004 WHO-estimated total health expenditure as a per cent of the GDP for Russia ranks as follows (Table 10).

The official MHS D data on the RF health expenditure is comprehensive and reliable. However it is very rarely cited yet, either globally or nationally.

According to MHS D (Starodubov, Flek and Dmitrieva, 2007) the major part (62% in 2005) of the total health expenditure in Russia is public health expenditure. There are three main financial sources of public health expenditure in the Russian Federation: the federal budget, consolidated budgets of federal subjects and governmental off-budget funds. The consolidated budgets of the federal subjects³⁵ are the major source of the RF public health expenditure, although they are constantly diminishing (in 2005, the ratio amounted to 43.9% against 50.8% in 2003).

34 "GDP is specialized abbreviation for the gross domestic product: the total value of goods and services produced by a country in a year" (Cambridge Advanced Learner' Dictionary on-line available at <http://www.cambridge.org/elt/dictionaries/cald.htm>).

35 Consolidated budgets of the federal subjects comprise regional and municipal budgets (Rosstat, 2005).

The governmental off-budget funds are the second largest source of the RF public health expenditure (in 2000–2005, these ratio has increased by 2.7 times, amounting in 2005 to 34.4%). These are three funds established in the early 1990s to protect interests of the RF citizens in the transition period: the Compulsory Medical Insurance Federal Fund³⁶ (CMIFF), The Social Insurance Fund of the Russian Federation³⁷ (SIF) and the Pension Fund of the Russian Federation (PF).³⁸ The CMIFF is in turn the largest of the three governmental off-budget funds to contribute to the public health expenditure.

The federal budget is the smallest source of public health expenditure in Russia, although it is constantly increasing (from 9.5% in 2003 to 21.7% in 2005) – see Figure 1.

The RF public health expenditure is constantly increasing. Thus, within the last six years (from 2000 to 2005) it has increased 3.3 times, e.g. by 229% (Table 11).

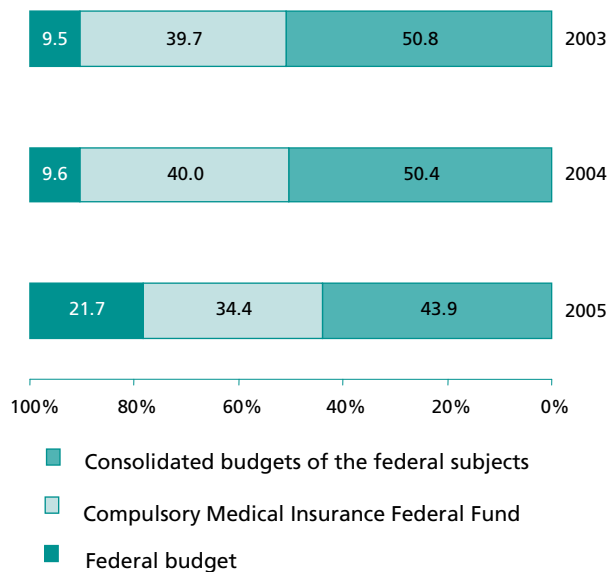


FIGURE 1. Ratio of financial sources of the RF public health expenditure, MHS estimates

Source: The 2006 MHS “Report on the Implementation of the Programme of State Guarantees on Providing RF Citizens with Free Medical Care in 2005”; unpublished.

TABLE 11. The MHS-estimated public health expenditure (billion roubles, %), RF, 2000 – 2005

	2000	2001	2002	2003	2004	2005
Consolidated budgets of the federal subjects	110.8	139.9	171.7	198.9	242.0	288.0
Compulsory Medical Insurance Federal Fund	72.2	92.9	133.4	155.6	191.8	225.7
Federal budget	16.1	22.2	30.6	37.0	45.9	142.3
Public health expenditure*	199.1	255.0	335.7	391.5	479.7	656.0
As a per cent of gross domestic product (GDP)	2.7	2.9	3.1	2.9	2.9	3.0

* The SSF and PF funding is not included.

Sources: The 2006 MHS “Report on the Implementation of the Program of State Guarantees on Providing RF Citizens with Free Medical Help in 2005,” unpublished.

36 <http://www.ffoms.ru/webffoms/phonebook.nsf/ffomsphonebook?OpenView&Start=1&Count=30&Collapse=3#3>

By 1st January 2005 as much as 96.8% of the RF population was insured under compulsory medical insurance agreements (Rosstat, 2006).

37 <http://www.fss.ru/>

38 <http://pfrf.ru/>

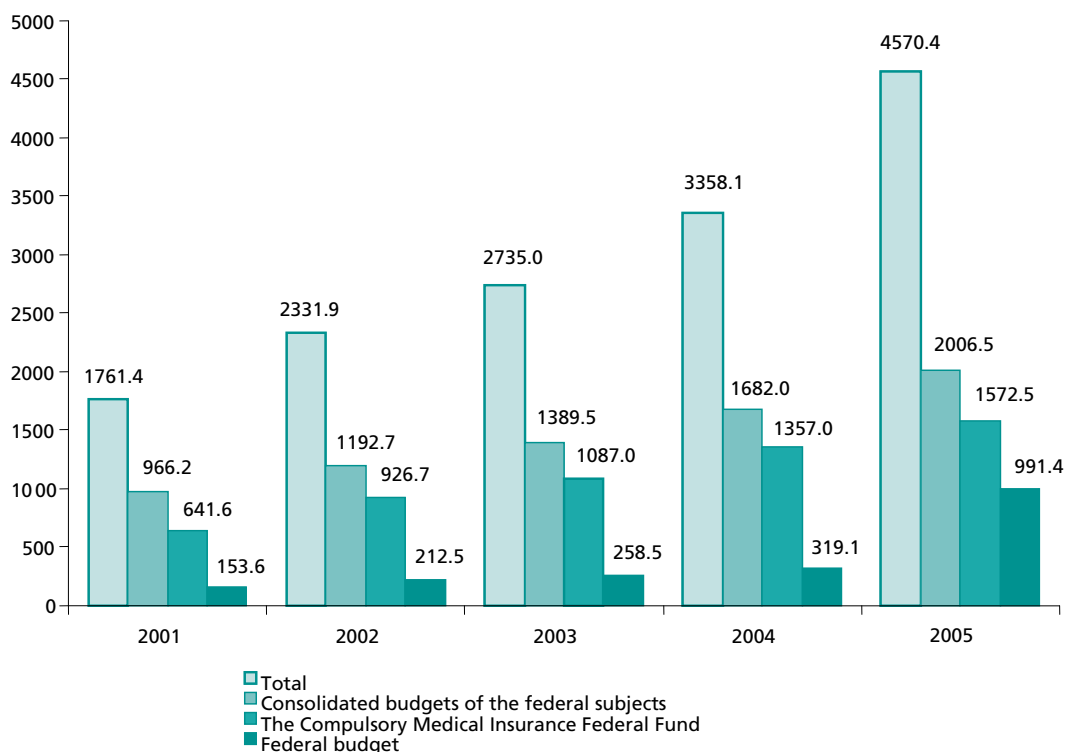


FIGURE 2. The MHS-estimated public health expenditure (roubles) per capita, RF, 2001–2005

Source: The 2006 MHS “Report on the Implementation of the Program of State Guarantees on Providing RF Citizens with Free Medical Care in 2005,” unpublished.

The per capita public health expenditure in Russia is also constantly increasing (Figure 2).

The RF private health expenditure covers about 40% (38% in 2005) of the total health expenditure. Direct household (out-of-pocket) spending is in turn the largest (amounting to 90%) of all financial sources of the private health expenditure in Russia. Direct household spending in 2002–2005 has increased by 3 times coming in 2005 to 388.1 billion rubles (e.g. 90.6%) of private health expenditure in the country (Starodubov et al, 2007). External grants and donations³⁹ (from abroad) commonly amount to 1% (1.1% in 2005) of the RF total health expenditure (Starodubov et al. 2007).

The MHS-estimated total health expenditure in relation to the three (MHS-specified) financial sources are indicated in Table 12.

However, a breakdown of total health expenditure to enable estimation of expenditure on mental health services is not provided by official (state or ministerial) statistics, making MINDFUL indicator # 35 “Expenditure on mental health services” unobtainable from national health-related statistics bodies. Nevertheless, the World Bank estimated RF government and non-government expenses on the treatment of mental and behavioural diseases in 2003 (World Bank, 2005).

³⁹ According to the RF MHS these are formally the third (alongside public and private) integral part of the RF total health expenditure (Starodubov et al, 2007), despite the common definition of total health expenditure.

TABLE 12. The MHS-D-estimated health expenditure for Russia in relation to the financial sources⁴⁰ (FS), (billion roubles (current prices), percentage of the gross domestic product (GDP)), 2000–2005

	2000	2001	2002	2003	2004	2005
Government health expenditure	237.2	297.7	382.0	435.7	526.3	698.1
Nongovernment health expenditure	158.9	209.8	266.0	305.1	357.0	428.2
External funds	0.8	1.0	1.2	1.1	1.1	1.1
Total	396.9	508.5	649.2	741.9	884.4	1,127.4
As percentage of the GDP	5.4	5.6	6.0	5.6	5.3	5.2

Source: Starodubov et al, 2007 (Table 1, p. 16).

National expenditure on mental and behavioural disorders for Russia (relevant to the MINDFUL indicator #35) amounted to 28,624 million roubles (USD 933 million) in 2003, accounting for 0.22% of Russia's GDP as well as for 7 % of the total health expenditure in Russia (World Bank, 2005). When ranking costs by diagnostic group, expenditure for mental and behavioural disorders ranked fifth, after expenditure for diseases of the circulatory system (21 % of total health expenditure), diseases of the respiratory system (11 %), injuries and other external causes (9 %) and diseases of the digestive system (9 %) (World Bank, 2005). When compared with the relevant figures of the European countries, the WB-estimated national mental health expenditure for Russia (7.2% in 2003) as percentage of the total health expenditure is rather high. The latest available (2004) European figures fluctuate between 3.0% (Czech Republic) and 13.4% (Luxembourg) (the MINDFUL Database).

2.3 Availability of survey-based MINDFUL indicators for Russia

No national data on the 15 survey-based MINDFUL indicators was available except for that under the indicator #12, "Happiness." Two more survey indicators (i.e. #14, "Sense of mastery," and #15, "Self-esteem") proved to be basically available, but will need to be retrieved from the Russia Longitudinal Monitoring Survey for 2002, 2003, 2004 and 2005

2.3.1 Available survey-based indicators

Indicator # 12 ("Happiness")

Happiness is defined as "the degree to which an individual judges the overall quality of his life-as-a-whole "favourably". Within this concept two components of happiness are distinguished: hedonic level of affect (the degree to which pleasant affect dominates) and contentment (perceived realization of wants). These components represent respectively "affective" and "cognitive" appraisals of life and are seen to figure as subtotals in the overall evaluation of life, called overall happiness" (MINDFUL, 2006).

⁴⁰ To be differentiated from holders of finances (HF).

Perception of happiness is commonly derived from population self-reported survey data based on 3-, 4- and 5 step verbal specific questions on happiness. The recommendation of the MINDFUL project is to apply the Andrews four-step verbal question on happiness: “Taking all things together, would you think you are: very happy, quite happy, not very happy, not at all happy?” (Andrews and Witney, 1976).

The nationally representative total Russian data on MINDFUL indicator # 12, “Happiness,” based on the Andrews’ four-step question on happiness was obtainable from World Values Survey (waves 1, 2 and 3), the Russian panel study RUSSET (waves 1, 5, 6 and 7), the VCIOM 1998 survey as well as the “Living Conditions, Lifestyle and Health” Project 2001 survey.

The World Values Survey⁴¹ (WVS) is a comprehensive cross-cultural longitudinal survey of human (sociocultural, moral, religious and political) values of different cultures around the world. The WVS arose from collaboration between researchers worldwide. It began as the European Values Survey in 1981 involving 10 countries, but has since expanded to cover more than 80 countries and currently conducts population surveys every four years. In 2004, the WVS Association was founded. Each WVS study is designed to be nationally representative of the population aged over 18. The WVS questionnaire consists of around 250 questions resulting in some 400 to 800 measurable variables, on the perception of happiness in particular. The 1990, 1995 and 1999 WVS-based Russian nationally representative face-to-face interview survey studies were conducted by the Russia Public Opinion and Market Research⁴² (ROMIR).

The Russian Socio-Economic Transition Panel⁴³ (RUSSET) is a representative longitudinal study of Russian households. Its interviews were held on a yearly basis from 1993 till 1999, the period which followed the collapse of the Soviet Union. The study was funded by The Netherlands Organization for Scientific Research and involved the Institute for Comparative Social Research⁴⁴ (CESSI). In 1993-1999, a period when many social, political, economical and cultural changes occurred in Russia, RUSSET provided information on household composition, satisfaction, employment, earnings, health and political participation, among other things. The RUSSET data on the Andrews four-step question on happiness covered by waves 1, 5, 6, and 7 is available for 1993, 1997, 1998, and 1999 accordingly.

The VCIOM All-Russian Public Opinion Research Center⁴⁵ is the oldest and the most widely known Russian company in the field of public opinion studies. It was founded in December 1987 as part of the USSR Ministry of Labor and the Council of the Trade Unions. In 2003, VCIOM was reorganised as an open joint-stock company under full state ownership. The priority sphere of VCIOM is conducting socio-economic, socio-political and electoral studies ordered by federal and regional governmental structures. In 1989 (prior to the period on which this study focuses) and in 1998 VCIOM conducted nationally representative surveys on perceived happiness. In 1989, however, the modified Andrews question on happiness was applied⁴⁶. In fact, the 1989 VCIOM survey on happiness was representative of the former RSFSR whereas the 1998 VCIOM survey is RF-representative.

The EU fifth research framework project, the “Living Conditions, Lifestyle and Health” Project⁴⁷ (LLH) 2000–2003, coordinated by the Institute for Advanced Studies (Institute für Höhere Studien IHS, Austria) studied the relationship between living standards, lifestyle and health of the populations of eight former Soviet countries (Armenia, Byelarus, Georgia, Kazakhstan, Kyrgyzstan, Moldova, Russia, and Ukraine). The Russian nationally representative LLH Survey

41 <http://www.worldvaluessurvey.com>

42 <http://www.rmh.ru/en>

43 <http://www.vanderveld.nl/russet.html>

44 <http://www.cessi.ru/index.php?id=1&L=1>

45 <http://wciom.com/>

46 “In general, would you say you are: very happy, quite happy, not very happy, not at all happy; don’t know; happiness is not the most important thing.”

47 http://www.llh.at/llh_partners_start.html

(2001) data on happiness was obtained from face-to-face interviews of 4,000 respondents conducted throughout Russia by the experts of the Center for Sociological Studies at the Moscow Lomonosov State University⁴⁸.

Indicators #14 (“Sense of mastery”) and #15 (“Self-esteem”)

The Russia Longitudinal Monitoring Survey (RLMS) is a collaborative effort by the University of North Carolina at Chapel Hill⁴⁹, USA, and the Institute of Nutrition⁵⁰, Russian Academy of Medical Sciences, and Institute of Sociology⁵¹, Russian Academy of Sciences. This data has been collected 14 times from 1992 to 2005 through a series of nationally representative surveys (applying the valid Russian RLMS version) designed to monitor the effects of transitional reforms on the health and economic welfare of households and individuals in the Russian Federation. The processed annual data is age and sex adjusted.

The MINDFUL instruments on indicators #14, “Sense of mastery,” (the seven-item version of the Sense of Mastery questionnaire, SOM, (Pearlin et al, 1981) and #15, “Self-esteem,” (the ten-item Rosenberg Self-Esteem Scale, RSES, (Rosenberg, 1965)) were included in the RLMS in 2002, 2003, 2004, and 2005 (Rounds XI, XII, XIII, and XIV, respectively) and validated. The RLMS versions of the instruments slightly differ, in stylistic terms, from the questionnaires recommended by MINDFUL (Tables 13 and 14). However, the IOS experts are confident that this does not affect the reliability of the appropriate RF-representative RLMS-based data, which can be found relevant to the MINDFUL indicators #14 and #15.

The Russia-representative data on MINDFUL indicators # 14 “Sense of mastery” and #15 “Self-Esteem” is therefore basically available for 2002, 2003, 2004, and 2005, if retrieved from the 1992 – 2005 RLMS files (Rounds X, XI, XII, and XIV, respectively).

TABLE 13. Stylistic differences between MINDFUL (left) and RLMS (right) Sense of Mastery

Questionnaires	
In the following, I will present you with seven statements on your experience of your ability to control and master things in your life. I will present you with four options for each statement: strongly agree, agree, disagree, strongly disagree.	Please read the expressions below and decide if you agree with them. Circle the number corresponding to your opinion: absolutely disagree (1), disagree (2), agree (3), absolutely agree (4).
There is really no way I can solve some of the problems I have.	I cannot handle my problems.
Sometimes I feel that I am being pushed around in life.	Sometimes I feel that somebody is harassing me in my life.
I have little control over the things that happen to me.	I have little influence over the things that happen to me.
I can do just about anything I really set my mind to.	I can always execute my plans.
I often feel helpless in dealing with problems in life.	I always feel helpless when problems arise in my life.
What happens to me in the future mostly depends on me.	What happens to me in the future largely depends on me.
There is little I can do to change many of the important things in my life.	What I can do changes my life very little.

Source: The RAS Institute of Sociology RLMS files.

48 http://www.llh.at/llh_partners_russia.html

49 <http://www.unc.edu>

50 <http://www.ion.ru>

51 <http://www.isras.ru>

TABLE 14. Stylistic differences between Rosenberg (left) and RLMS (right) Self-Esteem Scales

Below is a list of statements dealing with your general feelings about yourself. If you strongly agree, circle S. If you agree with the statement, circle A. If you disagree, circle D. If you strongly disagree, circle SD.	Please read the expressions below and decide if you agree with them. Circle the number corresponding to your opinion: absolutely disagree (1), disagree (2), agree (3), absolutely agree (4).
I feel that I'm a person of worth, at least on an equal plane with others.	I think that I'm no worse than anybody else.
I feel that I have a number of good qualities.	I think I have a lot of good characteristics.
All in all, I am inclined to feel that I am a failure.	In general, I think that I'm a loser.
I am able to do things as well as most other people.	I can do everything as well as anybody else.
I feel I do not have much to be proud of.	I think I don't have many things to be proud of.
I take a positive attitude toward myself.	I have a good attitude toward myself.
On the whole, I am satisfied with myself.	In general, I'm satisfied with myself.
I wish I could have more respect for myself.	I would like to have a more respectful attitude toward myself.
I certainly feel useless at times.	Sometimes I feel that I'm useless.
At times I think I am no good at all.	Sometimes it seems to me that I'm a bad person.

Source: The RAS Institute of Sociology RLMS files.

2.3.2 Unobtainable survey-based MINDFUL indicators

However, Russian data on the other MINDFUL survey-based indicators is not available, mainly because of unfamiliarity in Russia with some of the survey instruments recommended by MINDFUL and the absence of valid Russian language versions of some or most of them (except for SF-36 and CIDI (CIDI-SF), SOM, and RSES).

RAND-36

RAND-36 (Hays et al., 1993), or to be more precise, its replica SF-36⁵² (Medical Outcomes Study 36-Item Short Form Health Survey) (Ware et al., 1993), has been translated into Russian⁵³ (along with more than 50 languages) and validated under the auspices of the International Quality of Life Assessment⁵⁴ (IQOLA) project, established in 1991 to translate, validate and norm the SF-36 Health Survey for international use, by the experts of Evidence Clinical and Pharmaceutical Research⁵⁵ (Evidence CPR) in collaboration with the Multinational Center of Quality of Life Research⁵⁶ (MCQLR).

Evidence CPR is a contract research organisation, conducting multinational clinical trials in Russia and Eastern Europe since 1989. Evidence CPR was the first clinical research group in Russia to conduct Quality of Life (QoL) studies. Since 1993, it has translated hundreds QoL instruments into Russian and other Eastern European languages and validated them in various patient populations.

52 <http://www.sf-36.org/>

53 The Russian SF-36 is available at http://www.evidence-cpr.com/question/sf-36_guidelines.pdf

54 <http://www.iqola.org/>

55 <http://www.evidence-cpr.com/about-us/overview.shtml>

56 <http://www.quality-life.ru/index.php>

SF-36 is a multi-purpose, short-form health survey instrument comprising a set of 36 items belonging to eight health-related scales (each of 2-10 items) as well as two summary measures. All but one (self-reported health transition) of the 36 items are used to score the eight SF-36 scales (Physical Functioning (PF), Role- Physical (RP), Bodily Pain (BP), General Health (GH), Vitality (VT), Social Functioning (SF), Role- Emotional (RE), and Mental Health (MH)). Each item is used in scoring only one scale. Three scales (PF, RP and BP) correlate most with the physical component and contribute most to the scoring of the Physical Component Summary (PCS) measure. Three scales (MH, RE and SF) correlate most with the mental component and contribute most to the scoring of the Mental Component Summary (MCS) measure. Three scales (VT, GH, and SF) have noteworthy correlations with both components (Ware et al, 1994). In interpreting the results of SF-36, the original 0-100 scoring system is used.

RAND-36 (Hays et al, 1993).), the name of which was derived from a contraction of the term research and development, has different scoring algorithms for two – Bodily Pain and General Health – of the eight scales which constitute the survey instrument. The MINDFUL project recommend using RAND-36 for the indicators # 9 “Psychological distress”, #11 “Energy, vitality”, and #13 “Psychological impairment”. These indicators are not affected by the difference in scoring between SF-36 and RAND-36.

RAND-36/SF-36 is suitable for self-administration, computerised administration, or administration by a trained interviewer in person or by telephone. Training seminars for field interviewers on the Russian version of SF-36 are conducted at the MCQLR twice a year.

Within the period of 1990-2005, several Russian institutions have conducted population surveys based on SF-36, a tool which makes it possible to obtain statistical data on the three MINDFUL indicators: # 9, “Psychological distress,” # 11, “Energy, vitality,” and # 13, “Psychological impairment.” The Multinational Center of Quality of Life Research (MCQLR); the Scientific and Research Institute of Internal Medicine (SRIIM), Siberian Branch of the Russian Academy of Medical Sciences; as well as MRIP and SRCSFP are among these institutions. However, none of the surveys were nationally representative.

In collaboration with the IQOLA project in 1998-2000, the Multinational Center for Quality of Life Research (MCQLR) was the first in the RF to conduct an SF-36 based survey study and to obtain self-reported health-related quality of life statistics (Novik et al., 2003). The population sample covered 2,114 citizens aged 15–85 of both sexes (895 men and 1,219 women) in the Saint Petersburg metropolitan area. The sample was age and gender representative of the overall adult population of Saint Petersburg.

The study revealed that the average score for all scales deviated from 54.1 points (GH) to 79.6 points (PF) in the Saint Petersburg population sample (at least for age and sex). Statistically valid gender deviations were revealed across all scales but, in general, the scoring on every scale was higher in men than in women, although in different respects between different age groups. The gender deviations were most significant for the group aged 45–65 years. The Mental Component Summary score was much lower for women of 50–60 years than in men of the same age and the Physical Component Summary (excepting GH) score was lower for women aged 45-65 than in men of the same age. The GH score was lower for women aged 20-24 than for men of the relevant age group. However, gender differences were insignificant in aged persons (of 65 years and older) (Table 15).

The MCQLR experts believe the results are representative of any large city in the North-Western federal district (see Appendix 6), but some experts view the RF federal cities of Saint Petersburg and Moscow as having unique features.

The results of the study were further compared with two populations studied as part of the IQOLA project: the USA population and the Swedish population. When compared with the USA general population sample of 2,474 people, the average scores on all scales (excepting VT and

Table 15. Total and gender average SF-36 based scoring (\pm SD) in the Saint Petersburg population sample, 1998, MCQLR

	Total (2114)	Men (895)	Women (1219)
Physical Functioning	79.6 \pm 22.0	83.7 \pm 21.2	76.5 \pm 22.0
Role- Physical	64.9 \pm 37.0	70.5 \pm 35.0	60.7 \pm 37.8
Bodily Pain	66.4 \pm 25.0	69.4 \pm 25.7	64.2 \pm 24.1
General Health	54.1 \pm 19.4	57.5 \pm 19.5	51.6 \pm 18.9
Vitality	56.2 \pm 18.2	60.1 \pm 17.7	53.3 \pm 17.9
Social Functioning	68.0 \pm 22.1	71.6 \pm 22.3	66.7 \pm 21.6
Role- Emotional	66.5 \pm 36.7	70.9 \pm 34.9	63.3 \pm 37.6
Mental Health	58.0 \pm 16.4	61.8 \pm 15.9	55.2 \pm 16.1

Source: Novik et al., 2001 (Table 6, p.7).

GH) were similar (Novik, 2001). The PF scoring was the highest in both populations whereas GH scoring was the lowest in the Saint Petersburg population sample and VT scoring the lowest in the USA one. However, the overall QoL parameters of the Saint Petersburg population were lower than those of the USA, mainly due to psychological rather than physical functioning. Thus the MH, RE and SF average scores were lower by 17%, 23% and 17%, respectively. The average GH score was less in the Saint Petersburg population sample by as much as 25%, whereas the average VT score was less by only 8%. However, these were different among different age groups, being most significant in aged persons.

It was shown (Novik et al, 2003) that the QoL parameters of the Saint Petersburg population were generally lower than those of the Swedish one (Sullivan and Karlsson, 1998). A gender comparison of the obtained empirical data revealed that QoL parameters were higher for men than for women in both populations. However, the most significant difference between Swedish men and women was revealed in the 75 and over age group, whereas for the Saint Petersburg population it was revealed in the 45-64 age group. Moreover, the decline in QoL parameters in the Saint Petersburg population sample related to psychological, not physical, functioning. Being rather high in the Saint Petersburg population in the 15-34 age group, both the MH and SF scorings rapidly (for over 65 year olds) decreased by 30% whereas in the Swedish population the MH scoring does not correlate with age and the SF decreased by only 10% as the age group became higher.

In 2002-2005, as part of the HAPIEE (Health, Alcohol and Psychosocial factors In Eastern Europe) Study⁵⁷, the Scientific and Research Institute of Internal Medicine (SRIIM), the Siberian Branch of the Russian Academy of Medical Sciences, conducted a health-related QoL survey based on a random sample of 2,156 male and 2,769 female Novosibirsk citizens aged 45-69. The HAPIEE Study is a multi-centre study assessing the effects of nutrition, alcohol consumption and psychosocial factors on health. It was conducted in Russia (City of Novosibirsk), Poland (2 districts of Krakow), Lithuania (City of Kaunas) and the Czech Republic (2 cities) on random samples of men and women aged 45-64. Thus, it covered four Central and Eastern European countries undergoing rapid social and economic transition. The project was coordinated by University College London.

Novosibirsk, the third largest Russian city (population 1.3 million), is the capital and major industrial city of western Siberia. Despite its Siberian location, in terms of its social development, health and behaviour it is considered fairly typical for Russian urban populations. Two city districts with different social profiles (Oktyabrsky and Kirovsky) were selected for the study. The study showed that quality of life parameters were significantly higher for men than for women on all scales, and that they tended to decrease with increasing age (Simonova et al., 2006). The gender

⁵⁷ <http://www.ucl.ac.uk/easteurope/hapiee.html>

TABLE 16. Total and gender QoL average (\pm m) parameters in the Novosibirsk sample, 2002

	Total (4925)	Men (2156)	Women (2769)
Physical Functioning	73.4 \pm 0.4	81.0 \pm 0.5	68.5 \pm 0.5
Role- Physical	54.1 \pm 0.6	65.4 \pm 0.9	46.5 \pm 0.8
Bodily Pain	64.3 \pm 0.4	71.7 \pm 0.6	59.3 \pm 0.5
General Health	48.8 \pm 0.3	52.5 \pm 0.4	46.6 \pm 0.3
Vitality	55.1 \pm 0.3	61.4 \pm 0.4	50.7 \pm 0.4
Social Functioning	74.2 \pm 0.32	79.6 \pm 0.4	70.4 \pm 0.4
Role- Emotional	58.8 \pm 0.6	69.3 \pm 0.9	51.5 \pm 0.8
Mental Health	60.1 \pm 0.3	65.6 \pm 0.3	56.3 \pm 0.3

Source: Simonova, 2006 (Table 1, p.53).

differences amounted to 30% for RP, 25% for RE, 17% for both VT and BP, 15% for PF, 14% for MH, 11% for SF, and 10% for GH (Table 16).

The QoL parameters declined in both men and women in this age group on all scales except SF. The most significant decline was observed in the age group of 65–69 years. Overall, the highest QoL parameters were shown for PF and SF while the lowest was recorded for GH. The QoL indices in Novosibirsk proved to be lower (especially on GH) than in Canada (Hopman et al., 2000), England (Brown et al., 1999) and New Zealand (Scott et al., 1999) for the same age groups, but were similar to the Saint Petersburg population (Simonova et al., 2006). The calculated Kronbach's alpha reliability coefficients⁵⁸ were high (0.7–0.9) except for GH and SF (0.6–0.65) and very similar in both Russian populations, which demonstrated the high reliability⁵⁹ of the SF-36 validated Russian version used (Simonova et al., 2006).

AUDIT-5

The MINDFUL project recommends the use of the AUDIT-5 (five-item version of Alcohol Use Disorders Identification Test (Saunders et al., 1993; Babor et al., 2001)) for indicator # 7, "Hazardous and harmful drinking." AUDIT-5 has proven to provide a more valid and reliable (Lavikainen et al., 2006) estimate of alcohol dependence than CAGE.⁶⁰ (Mayfield et al., 1974). AUDIT-5 is not yet widely used in Russia. The CAGE-12 months questionnaire for alcoholism is known to have two valid Russian versions ("YPBO" and "BPBIT") and is widely used.

58 Kronbach's alpha is a coefficient used to measure reliability (<http://www.ats.ucla.edu/STAT/SPSS/faq/alpha.html>). A value of 0.7 is considered fairly high, and implies that the indicators can be added up to form a joint scale (<http://www.kulsoz.eu.v-ffo.de/EU%20Projekt/papers/Pp16.pdf>).

59 Reliability is the extent to which repeated use of the instrument gives the same result. It is the consistency of the measurement, or the degree to which an instrument measures in the same way each time it is used under the same conditions with the same subjects (WHO WVS General Information <http://www.who.int/healthinfo/survey/whspaper37.pdf>).

60 CAGE (Cut, Annoy, Guilty, Eye-opener) questionnaire for alcoholism (12-month version).

C = cut down (Have you ever felt you should cut down on your drinking?); A = annoyed (Have people annoyed you by criticizing your drinking?); G = guilty (Have you felt bad or guilty about your drinking?); E = eye-opener (Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover?).

Previously related to the MINDFUL indicator #7, "Hazardous and harmful drinking;" in 2005 was replaced by AUDIT-5 (MINDFUL, 2006).

CIDI-SF

The valid Russian language version of the CIDI (Composite International Diagnostic Interview⁶¹) Version 2.1 (1997)-12 months (along with CIDI-Short Form⁶² (Kessler et al., 1998)) was developed in line with the WHO translation protocol under the auspices of the WHO World Mental Health Survey Consortium⁶³ at the Survey Research Center⁶⁴ of the Institute for Social Research, University of Michigan in cooperation with the experts of the Kiev International Institute of Sociology⁶⁵. However, the validated Russian CIDI-Short Form (CIDI-SF) did not cover the section, “Specific phobia,” which, alongside, “Generalized Anxiety Disorder,” “Social phobia,” “Agoraphobia” and “Panic attack” is one of the five diagnostic scales used to obtain data on MINDFUL indicator # 5, “Any anxiety disorder.” According to our e-mail correspondence with the developers (R. C. Kessler (USA), E. J. Bromet (USA), and Victoria Zachozha (Ukraine)), the WMH-CIDI Russian version has not been provided to any Russian institution. The WMH-CIDI PAPI (paper and pencil) Russian and Ukrainian language versions were administered in Ukraine to a nationally representative sample (4,725 individuals aged 18 and older of both sexes) in 2002, to survey the epidemiology of psychiatric and alcohol disorders (Bromet et al, 2005. Bromet et al., 2007).

The lack of personnel specially trained in administering CIDI is another problem. The Russian and any linguistic WMH-CIDI versions are designed to be used by interviewers trained at one of the WHO CIDI designated Reference and Training centres⁶⁶.

Representative population for Russia

Russia (**population** 142.8 million persons (as of 1st January 2006)) is a federation which consists of 89 subjects⁶⁷ (administrative and territorial units) – see Appendix 5. These 89 federal subjects are divided into seven federal districts (Map 1) and 12 economic regions (Map 2). The division into federal districts is purely administrative, while the division into economic regions is performed for economic and statistical purposes.

Federal districts (four in Europe, three in Asia), designed for the convenience of the federal government, were established by the Decree of the RF President # 849 in 2000. Each federal district includes several federal subjects (Appendix 6).

61 <http://www.hcp.med.harvard.edu/wmhcid/index.php>

62 http://www.hcp.med.harvard.edu/wmhcid/ftpd_dir_public/cidif_readme.pdf

63 <http://www.hcp.med.harvard.edu/wmh/>

64 <http://www.isr.umich.edu/src/>

65 <http://www.kiis.com.ua/index.php?id=1&sp=1&lng=eng>

66 <http://www.crufad.com/site2007/cidi/ciditrainingcentres.html>

67 Each subject of the Russian federation belongs to one of the following categories: republics (21), autonomous okrugs (10), oblasts (49), krais (6), federal cities (2) and autonomous oblasts (1).

Republics, nominally autonomous, represent areas of non-Russian ethnicity and have the right to establish their own official language. Each of the republics has its own constitution, president and parliament and is represented by the federal government in international affairs.

Autonomous okrugs (autonomous districts) are less autonomous than republics but more so than oblasts; they usually represent substantial or predominant ethnic minorities. Most of the autonomous okrugs, while federal subjects in their own right, are at the same time part of other federal subjects (Chukotka is an exception). On January 1, 2007, the Evenk and Taymyr Autonomous Okrugs merged into Krasnoyarsk Krai. On January 1, 2008, the Ust-Orda Buryat Autonomous Okrug will be merged into the Irkutsk Oblast. On July 1, 2007, the Kamchatka Oblast and the Koryak Autonomous Okrug will merge to form the Kamchatka Krai.

Oblasts (provinces) are the most common, regular administrative units, with a federally appointed governor and locally elected legislature.

Krais (territories) are essentially the same as oblasts. The title “krai” or “kray” (“edge”, “border”) is historic, originally given because they were once considered frontier regions.

Federal cities (cities under the direct jurisdiction of the Federation) are major cities that function as separate regions. There are two, Moscow and Saint Petersburg.

The Jewish Autonomous Oblast is the sole representative of the “autonomous oblast” (“autonomous province”) category.



MAP 1. "Federal districts of the Russian Federation"

1. Central Federal District; 2. Southern Federal District; 3. Northwestern Federal District; 4. Far Eastern Federal District; 5. Siberian Federal District; 6. Urals Federal District; 7. Volga Federal District.

Source: http://en.wikipedia.org/wiki/Federal_districts_of_Russia.

Economic regions of the Russian Federation share the following characteristics: common economic and social goals and participation in development programmes; relatively similar economic conditions and potential; similar climatic, ecological and geological conditions; similar methods of conducting customs oversight; and overall similar living conditions for their populations. Each of the economic regions comprises several federal subjects (Appendix 7), although the Kaliningrad economic region is an exception.⁶⁸

The Rosstat and MHSD and SRCSFP regional health and mental health statistics are based on the administrative and territorial breakdown related to the seven federal districts, whereas the MRIP regional statistics are based on the administrative and territorial breakdown in relation to the twelve economic regions (Gurovich et al, 2000).

⁶⁸ The Kaliningrad economic region (the westernmost part of the RF), with no land connection to the rest of the country, is an exclave of Russia surrounded by Lithuania, Poland and the Baltic Sea.



MAP 2. "Economic regions of the Russian Federation"

1. Central economic region; 2. Central-Chernozom economic region; 3. East-Siberian economic region; 4. Far Eastern economic region; 5. Northern economic region; 6. North Caucasian economic region; 7. North-western economic region; 8. Volga economic region; 9. Urals economic region; 10. Volga-Vyatka economic region; 11. West-Siberian economic region; 12. Kaliningrad economic region.

Source: http://en.wikipedia.org/wiki/Economic_regions_of_Russia

VCIOM has a specialised sampling program which encompasses the whole of Russia. Using VCIOM, a population sample of at least 1,600 (corresponding to a statistical error rate of < 3.4%) or 2,400 (statistical error rate of < 2.7%) adult (18+ years old) people of both sexes as well as any larger number (to decrease the statistical error rate even further), surveyed in a set of 153 different communities belonging to 46 RF federal subjects, has been established as nationally representative.

The above-mentioned MCQLR and SRIIM health-related quality of life survey studies, though not fully correspondent to the VCIOM assessment criteria, are of special interest since the population samples surveyed were large enough and the results were comparable with each other (Simonova et al., 2006). In both studies, the psychometrically tested valid SF-36 Russian version was applied.

2.4 Availability of MINDFUL indicators on promotion and prevention for Russia

MINDFUL indicators #19 "Suicide prevention" and #20 "Mental health promotion" are based on the assessment of national suicide prevention activities and on current activities promoting the mental health of children and adolescents, respectively.

Suicide prevention is defined by MINDFUL as "current national activities on suicide prevention. "Activities" is defined as specified action in order to prevent suicides through the use of various methods "National" is defined as a comprehensive approach within a country in different settings" (MINDFUL, 2006).

In 2001/2002 and 2003/2004, Russia participated in WHO monitoring studies on national suicide prevention activities in Europe and thus furnished data on the national suicide prevention activities available to Russia (Wasserman et al., 2002; Wasserman et al., 2004).

MINDFUL indicator #20 “Mental health promotion” is based on national activities for mental health promotion among minors which mainly target bullying in school, parenting and social skills training programmes (MINDFUL, 2006). In 30 European countries, these data had been collected using the specially designed IMHPA (Implementing Mental Health Promotion Action) inventory which resulted in country profiles on mental health promotion activities (Jané-Llopis and Anderson, 2006). Since Russia was not among the countries involved, MINDFUL indicator #20 is currently unobtainable for the country.

However, since 1993 Russia has had a comprehensive national strategic plan related to health promotion, social protection and the welfare of minors. Within the period from 1993 to 2002, a number of 2 to 3-year-old “Children of Russia” Presidential Federal Programs, coordinated by the MHSD, have been implemented (each with a set of sub programmes).

The Federal Target Programme, “Children of Russia: 2003-2006,”⁶⁹ (budget 22 billion roubles) adopted by RF Governmental Act # 732 on October 3, 2002 has recently been successfully implemented under the MHSD coordination. Implementation of the programme resulted in a decrease in neonatal mortality (from 12.4 to 11 deaths per 1,000 live births), in estimated maternal mortality (from 31.9 to 30.5 deaths per 100,000 live births), in the number of homeless children (from 7.5 thousand to 4.3 thousand), in the number of neglected children (950,000 to 676,000) as well as in the 26% increase in the number of families with disabled children to whom social support was rendered in 2005 in contrast to 2003 (Concept of the Federal Target Programme, “Children of Russia: 2007-2010”⁷⁰). There were five sub programmes within the “Children of Russia: 2003-2006” programme: “Healthy Child,” “Talented Children,” “Prevention of neglect of, and delinquency in, minors,” “Orphaned Children,” and “Children with Disabilities.”

The sub programme, “Healthy Child,” was aimed at the prevention of genetic and inborn diseases and prenatal infections; investigations into correlations between the psychosomatic status of parents and health determinants of children as well as adaptation mechanisms in minors. The sub programme, “Children with disabilities,” provided rehabilitation measures for children with autistic disorder, Down’s Syndrome, Cerebral Palsy, cerebral traumas, infectious diseases of the central nervous system as well as deafness.

The Federal Target Programme, “Children of Russia: 2007-2010,” adopted by the RF Governmental Act # 172 in 2007, is currently being launched. Based on a total budget of around 48 billion roubles (including 36 billion roubles from the consolidated budgets of the RF federal subjects, 10 billion roubles from the RF federal budget and 1.4 billion roubles from off-budget sources) it has three sub programmes, “Healthy Generation,” “Children and Family” and “Gifted Children.” The programme is targeted at improving the quality of life and health indicators of minors, as well as providing state protection and medico-social-pedagogical rehabilitation for orphans, and disabled and neglected children. As indicated in the Concept of the Program today, there are 731,000 orphaned, 587,000 disabled and 676,000 neglected children out of a total of 29 million RF children. The sub programme, “Healthy Generation,” aims at safety maternity; the application of modern approaches to diagnostics and the prevention of hereditary diseases and inborn defects; the protection of the health (incl. reproductive health) of minors; preventative work with respect to morbidity, disability and mortality among children and youngsters; psychological and pedagogical support for children in distress; the improvement of health indicators for children in Far Northern (and equivalent) areas, and publicity promoting healthy lifestyles. In every RF federal subject, similar regional programmes are underway.

69 <http://fcp.vpk.ru/cgi-bin/cis/fcp.cgi/Fcp/ViewFcp/View/2006/152/>

70 <http://fcp.vpk.ru/cgi-bin/cis/fcp.cgi/Fcp/ViewFcp/View/2007/210/>

The Federal Target Programme, “On Improvement of Physical Culture and Sport in the Russian Federation for 2006–2015,”⁷¹ adopted by RF Governmental Act # 7 in 2006, has a budget of 107 billion roubles. It is intended for the promotion of health and prevention of diseases and disability due to chronic diseases in the RF population of all ages, minors in particular. Its objectives are as follows: to increase the overall number of people participating in physical culture and sport (from 12% to 30%), to decrease total countrywide annual levels of sickness allowance spells for whatever reason by 15% by 2015, as well as promoting the free access of children and students to sports facilities and perfecting the sports infrastructure related to educational institutions and local communities.

The Federal Target Programme, “On Preventing and Combating Socially Important diseases for the period 2007–2011,”⁷² was adopted by RF Governmental Act # 280 in 2007 (designated budget about 76 billion roubles). It includes nine sub programmes: “Insular Diabetes,” “Tuberculosis,” “Vaccination,” “Anti-HIV/AIDS,” “Oncology,” “Sexually Transmitted Diseases,” “Viral Hepatitis,” “Hypertension” and “Mental Disorders.” The sub programme, “Mental Disorders,” aims to achieve the following by 2011: a) increase the number of psychiatric patients to whom team-based treatment is rendered from 5% (in 2005) to 41%; b) decrease the overall ratio of mental in-patients to all registered mental patients from 16% (in 2005) to 14.5%; c) decrease the average duration of mental in-patient treatment from 75.6 days (in 2005) to 73.9 days; d) decrease the ratio of recurring admissions to mental hospitals from 20% (in 2005) to 11.5%.

Initiated by President V.Putin and designed by the Russian Family Planning Association (RFPA) the Federal Family Planning Programme⁷³ (launched in 1994), focusing on different aspects of reproductive health promotion among minors, is currently being implemented.

There are also a number of ongoing regional strategies, international programmes, and projects (“Regional Programme on Healthy Lifestyle Propaganda,” coordinated by the “Cultural Initiative” of the Soros Foundation for Russia; “How to Live in the AIDS Era”; “Reproductive Health Promotion School” etc).

A number of non-governmental and non-commercial organisations target the prevention of “social orphanage,” legal protection, social skills training and health promotion for minors. The National Foundation for the Prevention of Cruelty to Children⁷⁴ (NFPCC), founded in 2004 to promote the interests and welfare of children and to prevent child abuse and neglect, is one of these. NFPCC is one of the implementing partners (alongside **The International Research & Exchanges Board**⁷⁵ (IREX)) participating in the Assistance to Russian Orphans Program⁷⁶ (ARO), which is the first large-scale non-governmental programme in Russia to work on child abandonment and abuse prevention.

71 <http://fcp.vpk.ru/cgi-bin/cis/fcp.cgi/Fcp/ViewFcp/View/2006/191/>

72 <http://fcp.vpk.ru/cgi-bin/cis/fcp.cgi/Fcp/ViewFcp/View/2007/214/>

73 <http://www.owl.ru/eng/womplus/1998/raps-e.htm>

74 <http://www.siroststvo.ru/fond/>

75 <http://www.irex.org/>

76 <http://www.aro.ru/index.php?lg=2&aro=3>

3 HIGHLIGHTS OF STAGE II

Stage II of the study was aimed at collecting the existing countrywide annual 1990-2005 Russia statistics on the 13 available MINDFUL indicators. 10 of these (# 1 “Suicide,” # 2 “Deaths of undetermined intention,” # 19 “Suicide prevention,” # 21–27 on health resources and health care utilisation) are register-based, indicator # 12, “Happiness,” is survey-based, and indicator # 34 is a monitoring study based indicator. Regional data or sex- or age-specific data were not collected.

3.1 Data sources of MINDFUL indicators available for Russia

Suicide (Indicator # 1)

The official state suicide countrywide annual statistics for 1990–2005 (absolute numbers, SDRs and CDRs – all genders and total) have been obtained from the Rosstat Informational and Publishing Center, “Statistics of Russia”. The official ministerial annual countrywide suicide standardised and crude death rates (gender-specific and total) for 1990–2005 have been obtained from the CSRIOIPH. WHO gender-specific and total standardised death rates for 1990–2005 have been gained from the online HFA-DB version (files 1780, 1781 and 1782). The data is compliant with the MINDFUL definition of suicide, i.e. the cause of death is classified in the ICD-10 categories, X60–X84.

Deaths of undetermined intent (Indicator # 2)

The official state gender-specific and total absolute numbers and total CDRs for deaths of undetermined intent for 1990–2005 have been provided by the Rosstat Informational and Publishing Center, “Statistics of Russia.” The official ministerial gender-specific and total data on SDRs for deaths of undetermined intent have been provided by the CSRIOIPH. This data is compliant with the MINDFUL definition of death of undetermined intent, i.e. the cause of death is classified in the ICD-10 categories, Y10–Y314.

Happiness (Indicator # 12)

The nationally representative Russian data based on WVS, RUSSET and LLH Survey studies for 1990, 1993, 1996, 1997–1999 and 2001 was obtained from Internet sources (Veenhoven, R., *World Database of Happiness*, Erasmus University Rotterdam; Documentation of the EVS/WVS <http://www.worldvaluessurvey.com>; 3rd Annual LLH Project Conference, Vienna 2002. http://www.llh.at/publications/01_ihs_01.pdf). The VCIOM data on perceived happiness (1989, 1998) was granted by VCIOM.

Suicide prevention (Indicator # 19)

The data for Russia from the 2001/2002 and 2003/2004 WHO monitoring studies on national suicide prevention activities in the WHO European member states was retrieved from Internet sources (<http://www.euro.who.int/document/E77922.pdf>; http://www.ki.se/suicide//rapporter/Suicide_Prevention_in_Europe.pdf).

Number of psychiatric beds (Indicator # 21)

The official state absolute numbers and rates of psychiatric beds per 100,000 inhabitants for 1990-2005 were either taken from the Rosstat handbooks on public health in Russia (Goskomstat, 2001. Rosstat, 2006), or provided by the Rosstat Informational and Publishing Center, "Statistics of Russia." The official ministerial (CSRIOIPH-submitted) absolute numbers of psychiatric beds for 1990-2005 were obtained from the online HFA-DB (file 5071). MHSD-estimated and MRIP-estimated rates of psychiatric beds per 100,000 population for 1990-2005 were either obtained from the MRIP statistical handbooks (Gurovich et al, 1995; 2000; 2007), or granted by were granted by the MRIP Outpatient Psychiatry Mental Health Organization Unit (Gurovich et al., 2007). The MRIP Database). The 1990-2005 SRCSEFP countrywide rates of psychiatric beds per 100,000 population were either obtained from the SRCSEFP 2004 Analytical Review (Churkin and Tvorogova, 2005), or granted by the SRCSEFP Department on Epidemiological and Organizational Problems of Psychiatry. WHO 1990-2005 rates of psychiatric beds per 100,000 population for Russia were obtained from the online HFA-DB version (file 5070).

Number of psychiatrists (Indicator # 22)

The official state countrywide absolute numbers of psychiatrists for 1998-2005 were provided by the Rosstat Informational and Publishing Center, "Statistics of Russia." The official ministerial absolute numbers as well as MHSD- and MRIP-estimated rates of psychiatrists per 100,000 population for 1990-2005 were either granted by the MRIP Outpatient Psychiatry and Mental Health Organization Unit (Gurovich et al., 2007. The MRIP Database) or obtained from the MRIP statistical handbooks (Gurovich et al, 1995; 2000; 2007). The SRCSEFP-processed national rates of psychiatrists per 100,000 inhabitants in 1990-2005 were either obtained from the SRCSEFP's "Mental Health Service in Russia in 2004: Analytical Review" (Churkin and Tvorogova, 2005), or granted by the SRCSEFP Department on Epidemiological and Organizational Problems of Psychiatry.

Number of child (and adolescent) psychiatrists (Indicator # 23)

National absolute numbers and rates per 100,000 inhabitants of child (and adolescent) psychiatrists for 1990-1993 and 2000-2005 were processed and granted by the MRIP Outpatient Psychiatry and Mental Health Organization Unit.

Number of in-patient episodes due to mental health conditions (Indicator # 24)

The official ministerial (CSRIOIPH-submitted) absolute numbers of in-patient episodes due to mental conditions as well as the relevant WHO EURO estimated rates per 100,000 population for 1990-2005 were obtained from the online HFA-DB (files 2382 and 2383 accordingly).

Number of long-stay patients (Indicator # 25)

The MHSD (CSRIOIPH-submitted) absolute numbers of long-stay mental patients in 1993-2005 were obtained from the online HFA-DB (file 2381). MRIP rates of long-stay mental patients per 100,000 population for 1993-2005 were culled from the MRIP statistical handbooks (Gurovich et al, 1995; 2000; 2007), relevant statistical data from the latest MRIP handbook (Gurovich et al., 2007) as well as from the MRIP Database was granted by the MRIP Outpatient Psychiatry and Mental Health Organization Unit. WHO-estimated rates of long-stay mental patients per 100,000 population for 1993-2005 were taken from the online HFA-DB (file 2380).

Involuntary placements (Indicator # 26)

National statistics on involuntary psychiatric commitment rates are only available at the MRIP. The MRIP statistics comprise data for 1994–2005 on hospital admissions on the grounds of Art.29 (absolute numbers, rate per 100,000 inhabitants) as well as on the grounds of Art.35 (absolute numbers, rate per 100,000 inhabitants) of the Federal Law “On Psychiatric Care and Guarantees of Citizens’ Rights in Its Provision,” and the relevant ratio. The data on involuntary placements was partially taken from the MRIP statistical handbooks (Gurovich et al, 1995; 2000; 2007), and partially (relevant statistical and analytical data from the 2007 MRIP handbook (Gurovich et al, 2007) as well as from the MRIP Database) granted by the MRIP Outpatient Psychiatry and Mental Health Organization Unit .

Use of outpatient services (Indicator # 27)

The official ministerial countrywide absolute numbers of visits to psychiatric outpatient units for the years 1990–2005 were obtained from the MRIP statistical handbooks (Gurovich et al, 1995; 2000; 2007).

Disability pensions due to mental disorders (Indicator # 33)

The official state (Pension Fund-originated) 1990–2005 total absolute numbers of disabled adults referring to indicator #33 were ordered from Rosstat. MRIP experts granted the MHSD-originated 1990–2005 absolute numbers of disabled adults due to mental disorders as well as estimated the percentage.

Sickness allowance spells due to mental disorders (Indicator # 34)

The 1994–2005 total numbers of sickness allowance spells due to all mental and behavioural disorders as a % of all sickness allowance spells beginning each year processed by the MHSD (day- and case-related) were ordered from the Rosstat Informational and Publishing Center, “Statistics of Russia.” Rosstat does not routinely implement national statistics related to this indicator.

4 MENTAL HEALTH DATA FROM RUSSIA BASED ON THE MINDFUL INDICATORS

Mental MINDFUL indicator data from Russia are presented according to the health indicator groups and domains of the European Community Health Indicator (ECHI) system⁷⁷, which also is the basis for the indicator classification of MINDFUL (Appendix 1).

4.1 Health status: Cause specific mortality

#1a. Suicide (SDR)

Suicides (ICD-10 codes X60–X 84) are defined as “deaths caused directly by intentional self-harm, including purposely self-inflicted poisoning or injury” (MINDFUL, 2006). This indicator relates to suicides, measured as standardised death rates (SDRs). SDR is a weighted average of age-specific mortality rates. The weighting factor is the age distribution of a “standard reference population”, as defined by the WHO. This facilitates international comparability by removing differences in rates caused by different population age structures between countries. As a method of standardisation, the direct method is applied. Standardised death rates are calculated for age groups in five-year steps, and for the total of all ages.

The 1990–2005 gender-specific and total absolute suicide numbers (all ages) are shown in Table 5.1. However, the 1993–2003 Russian absolute numbers do not cover statistics from the Chechen Republic and the 2003–2004 Russian absolute numbers do not include statistics from the Republic of Ingushetia (in both cases, due to socio-political reasons).

All SDRs taken from different sources were calculated using a direct method based on the WHO European standard population (Waterhouse et al., 1976). The arbitrary standard population (Table 17) facilitates international comparability by removing differences in rates due to different population age structures between countries.

Absolute mortality figures originate from Rosstat (and are submitted to the MHSD which, in turn, submits them to the HFA-DB) whereas the SDRs taken from these three sources differ and are subject to comparison. At a glance, the Rosstat all male and total SDRs are greater than their MHSD equivalents, whereas female Rosstat and MHSD SDRs are not only very similar but identical for 10 out of 16 years of the investigating period (1990–1992, 1997, 2000–2005). WHO EURO-estimated male SDRs are the highest of all relevant ones, whereas female HFA-DB SDRs are very similar to the Rosstat and the MHSD figures.

The Russian mortality rate due to suicides and self-inflicted injuries is known to have risen sharply between 1992 and 1994 (Figure 3). According to Rosstat, it had increased by 60% percent over this period and reached a level of 42.4 per 100,000 population in 1994.

⁷⁷ http://ec.europa.eu/health/ph_information/dissemination/echi/echi_en.htm

TABLE 17. The WHO European standard population, persons of both sexes

Age group	Abs. number
0	1,600
1-4	6,400
5-9	7,000
10-14	7,000
15-19	7,000
20-24	7,000
25-29	7,000
30-34	7,000
35-39	7,000
40-44	7,000
45-49	7,000
50-54	7,000
55-59	6,000
60-64	5,000
65-69	4,000
70-74	3,000
75-79	2,000
80-84	1,000
85+	1,000
All	100,000

Source: Waterhouse et al., 1976.

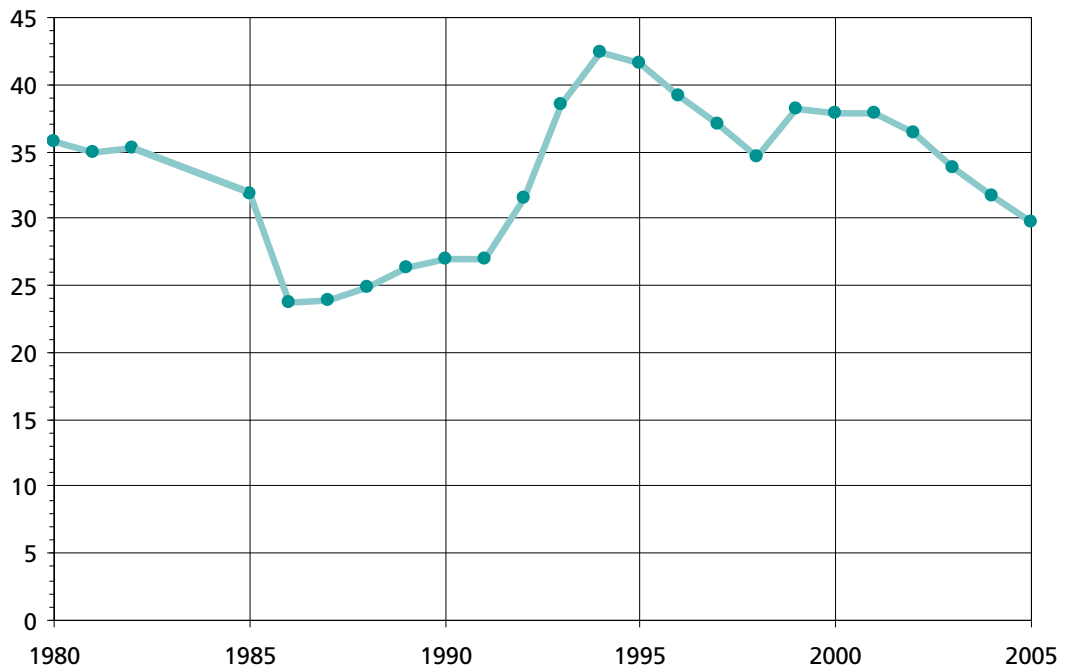


FIGURE 3. SDR, suicide and self-inflicted injury, all ages per 100,000

Source: The WHO HFA DB on-line version, accessed in January 2007.

TABLE 18. Absolute numbers of suicides by age groups and gender (Russian Federation, whole country, 2004)

Age (years)	5–14	15–24	25–34	35–44	45–54	55–64	65–74	75+	All
Male	288	5,891	7,955	8,354	9,111	4,078	3,637	1,580	41,155
Female	73	992	1,042	1,255	1,413	820	1,209	1,398	8,223
Total	361	6,883	8,997	9,609	10,524	4,898	4,846	2,978	49,378

Source: WHO SUPRE,⁷⁸ 2007.

Since 1995, suicide mortality has fallen substantially but remains one of the highest in the European region. According to the WHO Mortality Database⁷⁹, the 2004 suicide rate for Russia in the 15–34 age group was the second highest (after Lithuania) of all WHO European member states. Absolute numbers of deaths from suicide indicate that suicides are still a major cause of death in the Russian male population (Table 18).

In fact, the overall rate of deaths from external causes of injury in Russia can be described as an epidemic of injury and violence (WHO EURO, 2006). External causes of injury (ICD codes V01–Y98) include unintended injuries (transport-related injuries, poisoning, injuries due to falls, fires, drowning and other) as well as intended injuries (self-inflicted, due to violence, war and other). The 1985–1988 anti-alcohol campaign during the perestroika period produced a decline in mortality due to external (from homicide and road traffic accidents in particular) causes (Cockerham, 2005). Then, it almost doubled (influenced by the negative impact of the political, social and economic reforms of the early 1990s) and peaked in 1994. Starting from 1995, it has been reducing slightly. Table 19 depicts the 1990–2004 trend in the mortality rate due to external injuries in relation to the mortality rate due to suicide and self-inflicted actions. The table clearly indicates that the absolute number of deaths from external causes decreased by only 6% within 1995–2004 whereas the absolute number of deaths from suicides decreased by as much as 19%.

From 1993 up to 2005 external causes (peaking in 1994) have been the second most frequent cause of death in the RF (after diseases of the circulatory system) whereas beyond 1992 they took third place (after diseases of the circulatory system and neoplasm) (Table 20).

TABLE 19. “Deaths from external causes of injury in relation to deaths from suicides/ absolute, per 100,000 population /total, both sexes / Russian Federation, whole country”

		1990	1995	2000	2001	2002	2003	2004
External causes (V01–Y98)	Absolute (thousands)	198.3	348.5	318.7	331.6	339.3	335.2	327.1
	Per 100,000 population	134.0	236.8	219.0	228.8	235.3	233.6	227.5
Suicides (X60–X84)	Absolute (thousands)	39.2	61.0	56.9	57.3	55.3	51.7	49.4
	Per 100,000 population	26.5	41.4	39.1	39.5	38.4	36.1	34.3

Source: Rosstat, 2006 (Table 1.6).

78 http://www.who.int/mental_health/prevention/suicide/suicideprevent/en/index.html

79 <http://www.who.int/healthinfo/morttables/en/index.html>

TABLE 20. Deaths from external causes of injury in relation to deaths from neoplasm and diseases of the circulatory system (absolute numbers, RF, whole country)

	1988	1992	1993	1994	1995
Diseases of the circulatory system (ICD codes I00–I99)	898,488	960,531	1,131,911	1,230,376	1,163,511
Neoplasm (ICD codes C00–D48)	274,705	299,986	304,534	303,583	298,710
External causes of death (V01–Y98)	162,706	257,199	335,560	368,365	348,507

Source: The Rosstat Database.

In the recent Russian mortality statistics by Rosstat for January–December 2006, based on monthly statistics⁸⁰, total mortality due to external causes ranked third (after cardiovascular diseases and neoplasm) for the first time since 1992 (Scherbakova, 2007). It has decreased by 13.6% from the 2005 level, which is accounted for by the favourable decrease in mortality from external causes among women (in 2006, female deaths from external causes amounted to 6.6% and ranked 3rd out of all female deaths, whereas male deaths from external causes amounted to 19.8% and ranked 2nd out of all male deaths). In 2006, the ratio of deaths from external causes amounted to 12.5% (vs. 13.2% in 2005) of all deaths, whereas the 2006 ratio of deaths from cardio-vascular diseases amounted to 56.5% (vs. 56.1% in 2005), and the 2006 ratio of deaths from neoplasm amounted to 13.1% (vs. 12.4% in 2005). The decrease in the total mortality ratio due to external causes in 2006 was accounted for by the decrease in either acute alcohol poisoning (by 7.5%), homicide (by 7.1%), and suicide (by 3.6%), as well as in traffic injuries (by 2.3%). The 2006 peak in suicide rates was registered in May, the month during which the peak commonly occurs (Scherbakova, 2007).

Despite a subsequent fall in mortality from external causes of death, Russia continues to show the highest rate in the WHO European Region. External causes are responsible for 226 deaths per 100,000 population in Russia while the corresponding figure in Eur-B+C is 140 and the Eur-A average is 40 (WHO EURO, 2006).

The recent Rosstat estimate for 2006 (Scherbakova, 2007) indicates a decline (by 7.8% from the 2005 level) in the total absolute number of suicides, which accounts for a 3.6% decline in its ratio of all deaths to external causes of death via the 2005 level. This is in line with the continual decrease in the total suicide rates which followed the latest 1999–2001 peak.

1b. Suicide (CDR)

Crude death rates (CDR) is the ratio between the number of deaths in a population during a given year and the total mid-year population for the same year. MINDFUL recommends calculating suicide (ICD-10 codes X60–X84) CDR per 100,000 inhabitants. Crude death rates are calculated for age groups in five year steps and for all age groups.

The gender-specific and total CDR data (all ages) for suicides in 1990–2005 is shown in Table 5.2. The figures for Rosstat and MHSD are very close and were for several years identical (males: 1990, 1991; females: 1990, 1991, 1992, 1999, 2003; total: 1990, 1992, 1997, 1998, 1999). Gender and total Rosstat and MHSD figures for 2004 and 2005 absolutely coincide. It is also illustrative to compare the CDRs for suicides to the CDRs for external causes of death (Table 21).

⁸⁰ The finalised 2006 RF mortality data are due to be released by Rosstat in June, 2007.

TABLE 21. Death rates from external causes of injury in relation to death rates from suicide/CDR per 100,000 inhabitants, both sexes, all ages, Russian Federation, whole country

	1990	1995	2000	2001	2002	2003	2004
External causes	172.1	312.6	274.1	279.7	283.3	281.6	274.9
Suicides	26.5	41.4	39.1	39.5	38.4	36.1	34.3

Source: Rosstat, 2006 (Table1.7).

2a. Deaths of undetermined intent (SDR)

Deaths of undetermined intent (ICD-10 codes Y10–Y34) are defined as events where the available information is insufficient to enable medical or legal authorities to make a distinction between accident, self-harm and assault. These causes of death include self-inflicted injuries, but not poisoning, and it is not specified whether they are accidental or with intent to harm (MINDFUL, 2006).

The 1990–2005 gender and total MHSD SDRs (all ages) for deaths of undetermined intent are given in Table 5.3. However, absolute numbers for Russia in 1993–2003 do not include statistics from the Chechen Republic and the 2003–2004 Russian data does not include statistics from the Republic of Ingushetia (for socio-political reasons).

2b. Deaths of undetermined intent (CDR)

The existing Russia statistics on this indicator are shown in Table 5.4. These comprise Rosstat total as well as MHSD total and gender CDRs (based on the relevant Rosstat absolute numbers). The total Rosstat and MHSD CDRs differ slightly, but for 1990, 1992, 1997, 1998, 2004 and 2005 they coincide.

The absolute numbers, SDR and CDR for deaths of undetermined intent all show a sharp upward swing in 1994, being influenced by the political, social and economic reforms of the early 1990s. Deaths of undetermined intent have been falling since 1995, the absolute number having decreased in 2005 by 7.4% from the 1994 level but remaining high. The high rates of mortality from events of undetermined intent in Russia are believed to be connected with improper death registration in cases of violent death. Depending on the federal subject, deaths of undetermined intent proved to be overstated mostly due to understated either suicides or homicides (Ivanova et al., 2004).

4.2 Health status: Morbidity, generic

12. Happiness

“Happiness is a degree to which a person evaluate the overall quality of his present life-as-whole positively. In other words, how much the person likes the life he/she leads” (Veenhoven, 1997).

Happiness is a reference point; a relative state of mind to which people compare other emotions. A person’s evaluation of his or her life may be in the form of cognitions (e.g., when a person gives conscious evaluative judgments about his or her satisfaction with life as a whole) as well as in the form of affect (when a person is experiencing unpleasant or pleasant moods and emotions in reaction to his or her life). The cognitive and affective components of happiness are highly interrelated (Diener et al., 1997). Being happy is one of the human’s ultimate goals and an essential quality of life determinant.

Quality of life is an aggregate measure of an individual's well-being. The WHO defines quality of life as "an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns. It is a broad-ranging concept affected in a complex way by the person's physical health, psychological state, personal beliefs, social relationships and their relationship to salient features of their environment" (WHO, 1993).

The first survey studies that involved measure of happiness were performed in the USA in early 1960-s (Gurin et al, 1960). Currently happiness is a frequent topic in empirical research. The most common practice is single direct question in the context of survey interview.

The Russian, nationally representative total average scores on happiness for MINDFUL indicator # 12 are based on the Andrews specific question on happiness. These were obtained for the analysed period from the European Values Survey/World Values Survey (EVS/WVS) studies conducted in 1990 (wave 1), 1995–1996 (wave 2) and 1999 (wave 3) (Table 22); the Russian panel studies RUSSET 1, 5, 6 and 7 (1993, 1997, 1998 and 1999 respectively), the 1998 VCIOM survey on happiness, and from the Living Conditions, Lifestyle and Health (LLH) project survey (2001). Taken together, they cover the period of 1991–2001 (see Table 5.5). Comparing the year and source, they are clearly homogenous, but the latest available (2001) LLH average score is the highest. When compared with that of the Baltic EU countries (available for 1990, 1996 and 1999) the relevant RF total average scores are lower than the equivalent scores in the Baltic countries (for 1996 and 1999).

The available Values Surveys Russian data (WVS, 2000) indicates that the percentage of respondents who considered themselves "not at all happy" increased within the transitional period of the 1990s by 6%, whereas the percentage of respondents with indeterminate feelings on the issue decreased by 7%. The percentage of "very happy" respondents has slightly (by less than 1%) increased (Figure 4).

Age and sex breakdowns of the WVS-related Russian data on happiness are also available (Tables 23, 24).

TABLE 22. Feeling of happiness, positive answers (absolute number, percentage), Russia, WVS

	WVS 1 (1990)		WVS 2 (1995)		WVS 3 (1999)		Average	
	Abs. n.	%	Abs. n.	%	Abs. n.	%	Abs. n.	%
Very happy	104	5.3	125	6.1	149	6.0	378	5.8
Quite happy	822	41.9	899	44.1	1,054	42.2	2,775	42.7
Not very happy	776	39.6	822	40.3	993	39.7	2,591	39.9
Not at all happy	68	3.5	156	7.6	235	9.4	459	7.1
Don't know	191	9.7	38	1.9	65	2.6	294	4.5
No answer	0	0.0	0	0.0	3	0.1	3	0.0
Total	1,961	(100%)	2,040	(100%)	2,500	(100%)	6,501	(100%)
Mean score	2.5		2.5		2.7		2.6	

Source: WVS, 2000. <http://www.worldvaluessurvey.com> /accessed in May 2007.

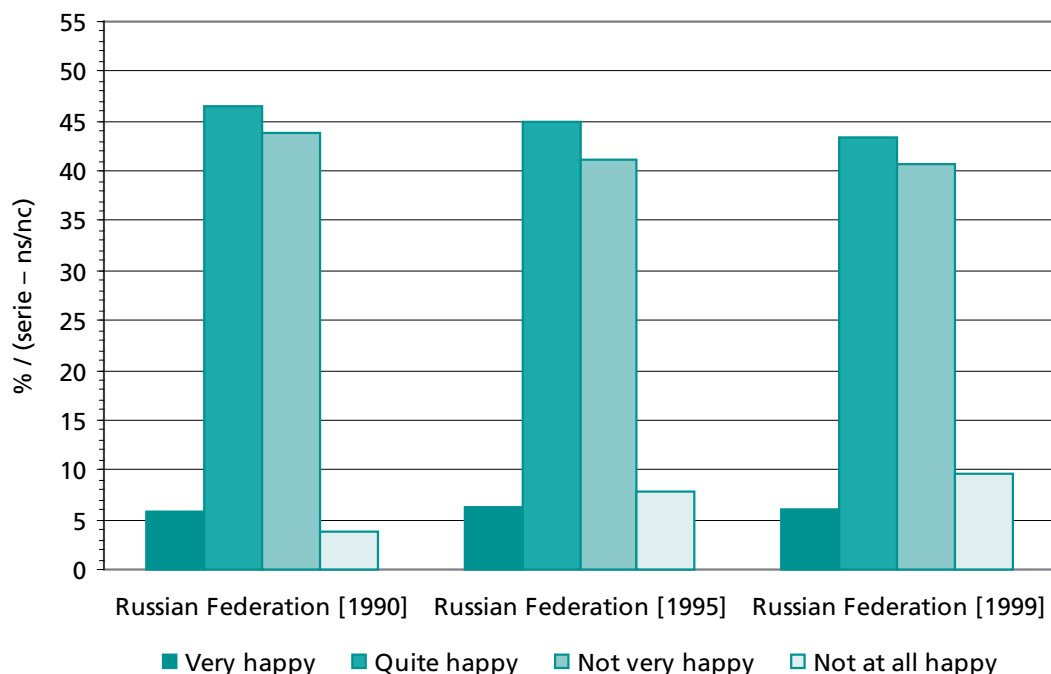


FIGURE 4. "Feeling of happiness, WVS 1 (1990), 2 (1995) and 3 (1999), Russia"
Source: WVS, 2000. <http://www.worldvaluessurvey.com/> accessed in May 2007

TABLE 22. "Feeling of happiness, positive answers (absolute number), sex breakdown, WVS 1-3, Russia."

	Total	Male	Female
Very happy	378	183	196
Quite happy	2,775	1,282	1,493
Not very happy	2,591	1,063	1,528
Not at all happy	459	133	326
Don't know	294	153	141
No answer	3	0	3
Total	6,501	2,815	3,686

Source: WVS, 2000. <http://www.worldvaluessurvey.com/> accessed in May 2007.

TABLE 23. "Feeling of happiness, positive answers (absolute number), age breakdown, WVS 1-3, Russia"

	Total	15–29 years	30–49 years	50 and more	Unknown
Very happy	378	105	168	105	0
Quite happy	2,775	749	1,162	864	0
Not very happy	2,591	418	1,099	1,073	1
Not at all happy	459	27	129	302	1
Don't know	294	78	141	75	0
No answer	3	0	2	1	0
Total	6,501	1,377	2,702	2,420	2

Source: WVS, 2000. <http://www.worldvaluessurvey.com/> accessed in May 2007.

Actually findings from WVS for 1999–2001 prove that people in Latin America, Western Europe and North America are happier than their counterparts in Eastern European countries and Russia. Of the surveyed countries, Nigeria has the highest percentage of happy people followed by Mexico, Venezuela, El Salvador and Puerto-Rico, while Russia, Armenia and Romania have the lowest (Inglehart et al., 2004).

TABLE 25. "Self-reported happiness in Russia, RUSSET."

	RUSSET1 (1993)	RUSSET5 (1997)		RUSSET6 (1998)			RUSSET7 (1999)
Very happy (%)	3.9	3.9	4.9	3.3	3.4	3.1	2.6
Quite happy (%)	44.0	45.2	47.2	42.5	43.2	42.0	44.4
Not very happy (%)	41.6	40.1	37.0	42.7	41.1	47.4	46.6
Not at all happy (%)	5.5	4.3	4.3	5.4	5.5	7.4	6.4
Don't know (%)	5.0	6.6	6.7	6.1	6.7	4.1	2.3
Mean score	2.5	2.5	2.6	2.5	2.5	2.4	2.4

Source: Veenhoven, 2007 http://worlddatabaseofhappiness.eur.nl/hap_nat/nat_fp.htm accessed in June 2007.

The RUSSET data on happiness (Table 25) covers the period of 1993-1999 (waves 1, 5, 6, and 7).

The RUSSET 1, 5, 6, and 7 mean happiness scores deviate from 2.4 to 2.6 and are generally lower than those of WVS. The average RUSSET mean score is 2.48, which is somewhat less than the relevant WVS one (2.6).

The LLH 2000–2003 nationally representative survey studies in eight successor countries of the Soviet Union enabled the gathering of information on a wide range of variables: living conditions, lifestyles, use of health services, alcohol and tobacco use, as well as psycho-social attitudes, including locus of control, optimism/pessimism, life satisfaction, feeling of happiness (Table 26), etc. For each conceptual topic, multiple indicators were collected.

The table shows that, notwithstanding the collective shocks of political and socio-economic transformation, two-thirds of the Russian people feel happy. The median respondent describes his/her condition as "fairly happy", and the proportion claiming to be "very happy" outnumbered those who describe themselves as "very unhappy" by a margin of well over two to one. Moreover, in all eight successor states, a majority of people (in Russia – 65%) say they are happy. The mean score for Russia is 2.8 (Haerpfer, 2002).

TABLE 25. Level of self-reported happiness in eight CIS countries, LLH, 2001

	AM	BY	GE	KZ	KG	MD	RU	UA	Total
Very happy (%)	26.7	14.1	32.5	20.8	37.6	8.3	15.4	13.5	20.3
Fairly happy (%)	40.2	45.7	31.0	51.0	43.3	42.4	49.2	39.4	43.4
Not too happy (%)	14.0	16.1	9.5	14.5	10.0	28.1	17.9	23.0	16.9
Very unhappy (%)	10.8	8.2	5.5	3.7	3.8	9.4	7.4	12.7	7.8
Do not know (%)	8.3	16.0	21.5	10.1	5.4	11.8	10.1	11.4	11.6
Valid (N)	2,000	1,997	2,013	2,000	1,995	1,998	4,000	2,381	18,384

AM–Armenia, BY–Byelorussia, GE–Georgia, KZ–Kazakhstan KG–Kirgizia, MD–Moldova, RU–Russia, UA–Ukraine.

Source: 3rd Annual LLH Project Conference, Vienna 2002. http://www.llh.at/publications/01_ihs_01.pdf.

Within the LLH survey study, a series of Ordinary Least Square⁸¹ (OLS) regression analysis based on the empirical data were undertaken to test influences on happiness in Post-Soviet societies. The domain-related happiness variables were these:

1. Material conditions (current household economic situation, consumer goods, household economy compared to past, adequacy of income);
2. Health: “mens sana in corpore sano” (general health, control over life, self-confidence);
3. Social capital (number of friends outside the family, confidants, most people can be trusted, pride in country, trust in government, not worried about street crime, belongs to organisation, nationality same as state nationality);
4. Human capital (age, gender, education);
5. Context (satisfaction with environment, current level of political freedom, town size, national economy compared to past, log of cumulative inflation since 1989).

The regression analysis results proved that, in the eight surveyed Post-Soviet countries, happiness is most influenced by health. Material conditions also register a substantial influence. Social and human capital indicators are both of secondary importance (although social capital indicators influence happiness slightly more than human capital ones). Context indicators are of far less influence. It is particularly striking that inflation, which is supposed to affect everyone in a money economy, fails to register any statistical significance as an influence on happiness in the surveyed countries. In other words, how an individual responds to post-Soviet transformation is far more important to his/her feeling of happiness than the objective nature of a contextual stimulus (Rose, 2003).

To reveal interrelations between happiness and health in individuals of the surveyed countries, a two-stage OLS regression was run. It confirmed that there is an exchange of influence. Health has the largest influence on happiness. Likewise, happiness has the most influence on health (Rose, 2003). Notwithstanding this reciprocal influence, the causal model of happiness proved to be substantially different from that for health. For health, age is the most important influence, whereas it fails to achieve significance in terms of happiness. Moreover, the two other human capital indicators (gender and education) are also much more influential with respect to health than happiness. Material wellbeing is of slight importance to health in comparison with age; and both social capital and context are insignificant influences. The differences in the causes of health and happiness show that they are not interchangeable indicators of human wellbeing and welfare but that each is distinctive, albeit overlapping, in its importance to individuals (Rose, 2003).

The RF data obtained from the nationally representative survey on happiness conducted by the All-Russian Public Opinion Research Center VCIOM in February 1998 (Table 27) is very similar to that of the LLH (2001) data. However, they differ from both the WVS3 (1999) and the average RUSSET6 (1998) ones: the VCIOM percentage of “very happy” respondents is more than twice as much as those under WVS3 and five times as much as for RUSSET6 respondents, whereas the VCIOM percentage of “not very happy” respondents is two times less than the relevant WVS4 and RUSSET6 ones. The VCIOM mean score of 2.8 is slightly higher than WVS3 and RUSSET6 (2.7 and 2.5 respectively).

81 OLS stands for Ordinary Least Squares. This definition derives its name from the criterion used to draw the best-fit regression line: a line such that the sum of squared deviations of the distances of all points on the line is minimised. OLS is the usual method of estimation for the regression model in regression analysis (which examines the relation of a dependent variable to specified independent variables, e.g. predictors).

TABLE 27. Self-reported feeling of happiness, VCIOM, RF, 1998

Taking all things together, would you say you are:

		Frequency	Percent
Valid	very happy	251	15.7
	quite happy	704	44.0
	not very happy	304	19.0
	not at all happy	102	6.4
	difficult to answer	237	14.8
	Total	1,598	99.9
Missing	No answer	2	0.1
Total		1,600	100.0

Source: The VCIOM database

The average mean score of happiness for Russia derived from the series of WVS, RUSSET, as well as from LLH and VCIOM, surveys covering the overall period of 1990–2001 is 2.4, one of the lowest in the world (Inglehart et al, 2004). It is however believed that “current unhappiness is not due to the Russian national character, but has more to do with the troublesome transitions taking place in Russian society” (Veenhoven, 2001).

4.3 Health systems: Prevention, health protection and promotion

19. Suicide prevention

Suicide constitutes a major public and mental health problem in Russia. The prevention of suicide and suicidal behaviour, especially among youngsters, is clearly one of Russia’s main and urgent public health concerns. In 2001/2002 and in 2003/2004, 48 out of 52 WHO European member states (including Russia) were monitored using the specially designed WHO inventory on national suicide prevention activities. Some 38 (2001/2002) and 37 (2003/2004) countries (including Russia) out of all WHO EURO countries involved have responded to the inventory.

According to the results of the two monitoring studies, the WHO European member states were divided into two groups with respect to the existence of national suicide prevention activities (Wassermann, 2004). The first group comprises 17 countries with countrywide integrated activities carried out by government bodies. The second one comprises 22 countries (including Russia) without national suicide prevention activities but carrying out regional-level activities.

According to MINDFUL recommendations, countries should be classified as either having or not having national suicide prevention activities. Russia is thus classified as not having a national suicide prevention programme. However, Russia is a country with strong regional-level suicide prevention strategies and traditions. The first suicide prevention primary services were established in the RSFSR major cities (Moscow, Kazan, Nizhniy Novgorod, Rostov-on-Don, S.-Petersburg, Ufa etc.) as far back as in the 1970s and early 1980s. In 1998, the MHSD adopted Act # 148 “On specialized care for individuals suffering from distress and suicidal behavior⁸²” (hereinafter the Act). This makes Russia one of only three countries in the WHO study which, despite not having nationwide suicide activities, still have an official document regulating their regional-level suicide prevention activities.

82 <http://www.humanities.edu.ru/db/msg/60558>

The Act established regional suicidological services and determined their main principles and organisational model. These services comprise a network of confidential helplines (Annex 1 to the MHSD Act #148, 1998) and socio-psychological emergency rooms (Annex 2 to the Act) within local general out-patient facilities as well as specialised ones (psycho-neurological dispensaries); crisis centres envisaged for suicide attempters within general hospitals; and specially trained staff (for the needs of treatment and rehabilitation of suicide attempters) at emergency hospitals (Annex 3). This wide network of suicide prevention and crisis centres based on the facilities of primary medical institutions plays a very important role in regional strategies (making a patient-oriented approach as well as aftercare for suicide attempters available and effective). This has resulted in a country-level decrease in the number of repeated suicide attempts in individuals with strong suicidal tendencies.

The activity of the regional suicidological services in each RF federal subject is supervised by both the chief psychiatrist and the chief psychotherapist of the relevant federal subject. General coordination is administered by the Suicide Prevention Unit (within the Moscow Research Institute of Psychiatry).

Rosstat collects annual regional and national suicide mortality statistics while the MHSD and its institutions gather data on suicide attempters, conduct epidemiological and analytical studies aimed at decreasing suicide rates and administer monitoring population surveys, mainly on regional (federal subject) level to reveal mood, anxiety, alcohol and drug/substance related disorders which may predict suicidal risks in the population.

Regional suicide prevention activities in Russia are targeted not only at improving health/mental health care services and promoting better access to them, but also at minimising access to means of suicide and at public educational and media initiatives. In Russia, suicide-preventive educational projects are carried out in at least 3–5 social arenas. They are focused not only on children and adolescents (as in most of the countries) but also on special risk groups: drug users, alcoholics, suicide attempters, unskilled workers and participants in combat operations, which is exceptional (Wasserman et al., 2002). The Army also contributes to suicide prevention strategies.

The Russian Orthodox Church is known to play an important role in suicide prevention. The Patriarchs' Center for the Spiritual Development of Children and Youth provides many activities, e.g. the "Patriarch – to Children" Internet project⁸³ (launched in 1995). The Center has a website⁸⁴ and forum⁸⁵ as well as a freefone line. There is a broad array of Orthodox Treatment and Rehabilitation Centres (staffed with health professionals as well as clergymen) for drug/substance and alcohol addicts as well as for those suffering from compulsive gambling and computer or Internet addiction, e.g. individuals at high risk of committing suicide.

Non-governmental organisations (NGOs) and non-commercial organisations (NCOs) also implement suicide prevention activities. The Russian Association of Telephonic Emergency Services⁸⁶ (RATES) established in 1982 is one of the country's non-commercial organisations involved in suicide prevention activities. There are currently 215 TES centers all over Russia where more than 2,500 trained professionals are available for those in distress and despair, 24 hours a day. RATES centres are known to receive as many as 1,500,000 calls every year. In 1993, a National programme for training TES workers, "Telephonic Emergency Service in Russia: through education towards a healthy society," was developed (every TES worker is obliged to improve their skills constantly). RATES guarantees anonymity, confidentiality as well as respect for and the protection of callers. All forms of ideological as well as political and racial pressure

83 <http://www.patriarch-detyam.ru/index.php?fw=5>

84 <http://www.cdrm.ru/>

85 <http://www.cdrm.ru/ibforum/index.php>

86 <http://evolkov.iatp.ru/rostell/en/index.html>



MAP 3. The coverage of the RF territory with children helplines (rose-coloured), 2007

Source: NFPCC, 2007. <http://www.siroststvo.ru/telefon/helplines/russ.shtml> accessed 01.08.2007.

are inadmissible. RATES is a member of the International Association of Suicides Prevention⁸⁷ (IASP).

The Russia Children Helpline Association⁸⁸ is now functioning within the National Foundation for the Prevention of Cruelty to Children⁸⁹ (NFPCC), a member of the Children Helpline International⁹⁰ (CHI). The first Trustline for teenagers was established in Moscow in 1989. Four years later, in 1993, the first Children helpline was founded to help children of school and preschool age. In 1995 alone, it received more than 18,000 calls⁹¹. The Children Helplines across Russia facilitate 24-hour free of charge, urgent access to specially trained staff. There are currently 85 regional Children Helplines in 41 RF subjects covering altogether major part of the country territory (Map 27). In some regions, they provide psychological assistance in both Russian and the relevant ethnic majority language (e.g. in the Republic of Tatarstan, in the Chukotka Autonomous Okrug) while, in some RF regions, online psychological help especially envisaged for children and youths is available.

It is internationally accepted that individuals with suicidal intentions make 1% to 5% of all calls on emergency lines whereas, in Russia, they amount to as much as 5-10% (NFPCC, 2006). It is reported that child helplines in Russia prevent intended suicides in 8 out of 10 cases (NFPCC, 2006).

The range of mental health and psycho-social problems forcing children (and adults) to make a call to a helpline (based on the comprehensive statistical data on the three Russian regional helplines: Tomsk (established in 1996), Magadan (est. in 2002) and Moscow “Gavrosh” (est. in 2004)) is detailed in Table 28.

87 <http://www.med.uio.no/iasp/>

88 <http://www.siroststvo.ru/telefon/events/index.shtml>

89 <http://www.siroststvo.ru/fond/>

90 <http://www.childhelplineinternational.org/>

91 Alongside immature callers are known to make as many as 53% of all calls on local phone helplines – those not specially envisaged for children and youngsters – in Russia (NFPCC, 2006).

TABLE 28. "Reasons for calls ("Mental health, psycho-social" group) via the three Russian regional children helplines for the periods during which statistics were implemented (total, up to 31/12/05)"

Reason for call	Child	Adult
Self-harm	29	18
Suicide	72	119
Body/physical appearance	225	97
Boredom	166	58
Loneliness	403	682
Lack of confidence	768	352
Eating disorders	15	64
Fear and anxiety	1,429	2,295
Depression	169	546
Identification	178	8
Total	3,454	4,239

Source: The 2006 NFPCC Report to the CHI, unpublished.

The majority (67%) of callers on the child helplines in Russia are known to belong to the prepubertal age group (10-12 years olds), 27% of the callers are teenagers (NFPCC, 2007). The gender proportion varies from 35% males via 65% females to equal gender rates (The NFPCC 2006 Report for CHI, unpublished).

Russia, although currently lacking a nationwide suicide prevention plan, will soon be able to initiate one, based on the experience (as a former Soviet republic) of the anti-alcohol campaign during the perestroika period. This campaign is believed to be the most effective suicide prevention programme for males in the 20th century. Prior to the anti-alcohol campaign, in 1984, 60% of suicide attempters in Russia (compared to 30%-40% in western European countries) were known to take alcohol prior to their suicide attempt; while in 1986 this percentage had decreased by half (Nemtsov, 2002). Annual alcohol consumption within the same period (1984-1986) fell from 15.4 to 10.4 litres per person, e.g. by 33% (Nemtsov, 2002). The fall in alcohol consumption brought about by Gorbachev's anti-alcohol 1985-1988 policy was followed by a 40% decline in suicide rates among men in the labour force in all 15 Soviet republics (Cockerham, 2005). In Europe, during the same period, the fall in the male suicide rate was as small as 3% (Wasserman, 2004). The direct correlation between the rate of alcohol consumption and gender suicide SDRs for Russia within 1965-1999 is depicted in Figure 5.

Table 29 depicts the rate of the shift in the suicide mortality rate (per cent) per change in alcohol consumption (by 1 litre per capita) in Russia and several European countries.

The table indicates that Russia (alongside Norway and Sweden) belongs to the group of countries with a high association between alcohol consumption and suicide rates.

Alongside regional suicidological services, anti-alcohol measures and advocating a healthy way of life are the main objectives of suicide prevention policies in Russia. Post-soviet Russia's integration into major research, health, social, human rights, educational, etc international projects, programmes and bodies as well as the further promotion of health/mental health care systems combine to form solid ground for the future prevention of high suicidal rates amongst the RF population. In the RF "national institutes are available and could be involved in coordinating national activities" (Wasserman et al, 2002).

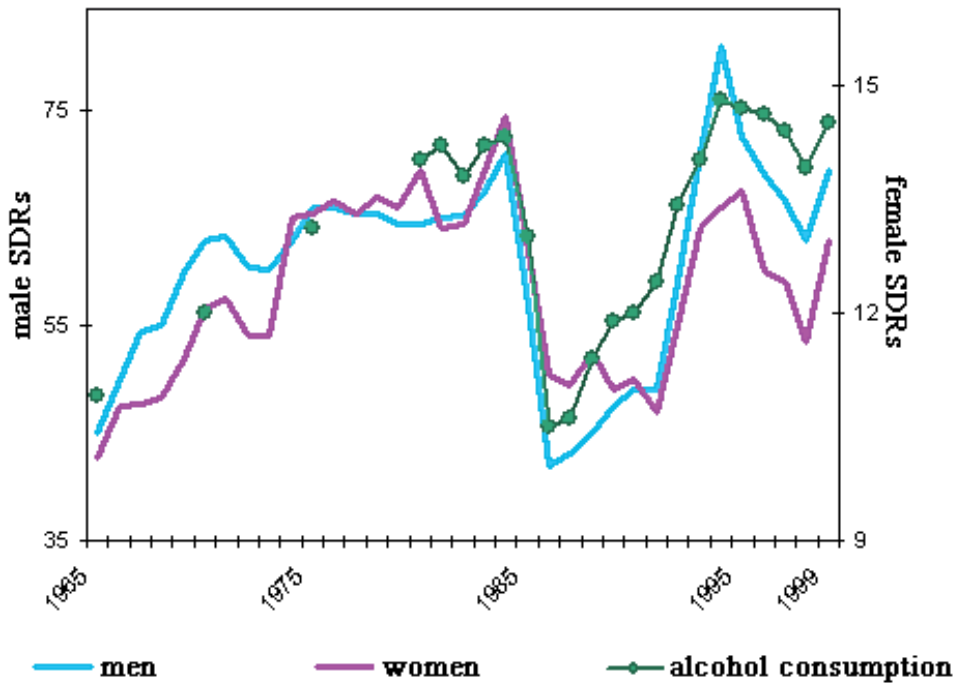


FIGURE 5. "Direct correlations between male (left) and female (right) SDRs and the rate of alcohol consumption, RF "

Source: Nemtsov, 2002.

TABLE 29. Shifts in suicide mortality rate (per cent) in relation to the change in alcohol consumption (by litre per capita)

Country	Shift (%)	Authors
Sweden	15	Norstrom, 1988
Norway	16	
France	2.6	
Hungary	5	Skog & Elekes, 1993
Sweden	10	Norstrom, 1995
France	3-4	
Denmark	2.5	Skog, 1993
Russia	11.9	Nemtsov, 2002

Source: Nemtsov, 2002.

4.4 Health systems: Health resources

Mental health services in Russia have a solid and comprehensive infrastructure based on the traditional mix of in-patient (hospital) and out-patient (dispensary) services established in the 1920s-1930s. This was strongly modified with a special emphasis on primary care in the 1970s and 1980s due to the establishment of an out-of-dispensary service. Shifting from in-patient to out-patient care was the main goal of the reform within this period, enabling the provision of specialised psychiatric help (suicidological, psychotherapeutical, neuropsychiatric, logopaedical, gerontopsychiatric, sexological etc) for patients within local facilities. The Federal Law # 3185-1,

from 1992 “On Psychiatric Care and Guarantees of Citizens’ Rights in Its Provision”⁹² not only formed the legal grounds for psychiatric care utilisation but also served as a transition from paternalism towards partnership in psychiatrist-patient relationships. The key mechanisms in the reform of the psychiatric care system in the 1990s were decentralisation and a community-based approach, which have strengthened primary psychiatric services even more. Part-time in-patient care, “hospital at home” and other hospital-replacement initiatives have begun to be developed. Since 1995, numbers of clinical psychologists, psychotherapists and social workers have entered psychiatric in-patient and out-patient institutions to implement the transition from a mainly medical to a “biopsychosocial”⁹³ (e.g. polyprofessional) model of psychiatric care, based on a team approach to its utilisation (Gurovich et al, 2004). In the early 1990s, disaster psychiatric facilities (for people traumatised by a disaster, accident, act of terrorism, ecological catastrophe, violence, war etc.) were also framed.

RF mental services are currently being further improved in line with the Branch Programme, “Reorganization of mental service infrastructure in the RF in 2003-2008”⁹⁴, adopted by the MHSD Act # 98 in 2002 (with a designated budget of 42.4 million roubles). It envisages the further decentralisation of in-patient mental services; the strengthening of out-patient mental services (by increasing the number of day in-patient departments, labour therapy accommodation, dormitories, night in-patient units, PNDs in urban areas as well as psychiatric admission rooms in rural areas); the modernisation of design, construction, reconstruction, and equipment technologies and the promotion of better conditions for patients and medical personnel within all branches of the mental care system. In more than 75 federal subjects, similar regional branch reforms are currently underway.

The RF mental health system currently consists of three major branches which are closely linked: a hospital, dispensary and out-of dispensary, as well as disaster psychiatric facilities.

The hospital branch covers all specialised psychiatric hospitals, specialised psychiatric departments in general hospitals, full and part time in-patient units within major psycho-neurological dispensaries, psychiatric ambulance facilities etc.

The dispensary branch is an integral part of the out-patient mental health services. It is based on a broad network of psycho-neurological dispensaries (PNDs) which form its structural and functional units. The PNDs are patient-oriented local mental health institutions which have a range of supplementary facilities at their disposal. Commonly, each PND has day-time hospital facilities, occupational therapy facilities, hostels for individuals who have lost their social connections, workshops especially envisaged for the mentally ill as well as specialised services (gerontological, suicidological, adolescent etc.). In rural areas, psychiatric consulting rooms are available within local general hospitals.

The out-of dispensary branch also belongs to the out-patient mental health services. It commonly includes a wide range of psychiatric (psychotherapeutic, somatopsychiatric, logopaedical, sexological etc) consulting rooms within the general in-patient and out-patient local facilities, as well as institutions, enterprises etc.

As an example, the Tver Oblast (total area of 84,000 squared kilometres, population – 1.5 mln. persons), is a federal subject within the Central federal district. *The hospital branch* of the Tver Oblast mental care service is represented by two major specialised psychiatric hospitals (equipped with 1,200 and 510 beds), eight specialised psychiatric departments within general hospitals, as well as a full-time in-patient unit (equipped with 150 beds) and three part-time in-patient units (intended for a total of 200 patients) within the oblast psycho-neurological dispensary. These form

92 <http://www.med74.ru/documentsitem11.html>

93 “Biopsychosocial model”, an alternative (to the previous “biomedical”) vision for health care, introduced by George Engel in 1977, is based on understanding of a patient as a human person placed within a nexus of biological, psychological, and social determinants influencing manifestation, development and outcomes of either somatic or psychiatric disorders (Engel, 1980).

94 http://www.vcom.ru/cgi-bin/db/zakdoc?_reg_number=%C20201828

a grand total of 2,231 specialised psychiatric beds. The *dispensary branch* is represented by the Tver Oblast PND and its facilities. The PND (alongside regular out-patient admission facilities) has a mental health centre, labour-therapy facilities for 100 persons, a 24-hour phone helpline and a social welfare unit. A high number of rehabilitation workshops (theatrical, puppet-show, poetic, musical, ceramic handicraft, culinary) are also available within the Tver Oblast PND. Some 34 psychiatric consulting rooms alongside the PND belonging to the dispensary branch of the oblast psychiatric service are available in rural general in-patient facilities. The *out-of-dispensary* branch is represented by a range of specialised psychiatric consulting rooms within municipal as well as corporative and institutional in- and out-patient medical facilities.

21. Number of psychiatric beds

The term *psychiatric beds* is defined by MINDFUL as “beds accommodating patients who are formally admitted or hospitalized to an institution for psychiatric treatment and/or care, and who stay for a minimum of one night in the hospital or institution providing in-patient care. Nursing and residential facilities are not included” (Lavikainen et al., 2006).

In Russia, “psychiatric beds” are defined as beds in psychiatric in-patient institutions as well as beds for psychiatric patients within general hospitals (traditionally defined in Russia as “psychosomatic” beds) equipped with the required appliances and ready to receive psychiatric patients, irrespective of whether the beds are occupied or remain vacant. “Sub-specialist” psychiatric beds (beds for children, adolescents, and the elderly; for patients with eating disorders; forensic patients, etc) excepting those for alcohol and drug takers are included. Day care service beds⁹⁵, as well as beds in specialized psycho-neurological institutions (welfare nursing homes and boarding schools) are excluded.

This indicator is traditionally recorded by the hospitals and included in the Russian state statistics (absolute, per 1,000 population) collected by both Rosstat and the MHSD. The official state and ministerial 1990-2005 countrywide absolute numbers as well as Rosstat, MHSD, MRIP, SRCSFP and HFA-DB rates of psychiatric beds per 100,000 inhabitants are shown in Table 5.6. From 1996, data on the Chechen Republic is missing for socio-political reasons. Due to their better coverage of institutions, Rosstat absolute numbers are higher than MHSD ones. The differences between the rates of psychiatric beds taken from different sources are minor, and for 1996 coincide.

Overall, the absolute number of psychiatric hospital beds in Russia has been gradually decreasing since 1990, which is a positive development (Figure 6). This also corresponds to a similar trend in the EU member states (MINDFUL Database) and the Baltic countries. Thus, the rate of hospital psychiatric beds in Russia per 100,000 population has decreased by 13% from the 1990 level according to Rosstat, whereas the beds in the Baltic countries have decreased more clearly: by 72%, 35% and 31% for Estonia, Lithuania and Latvia, respectively. The more remarkable decrease in the Baltic states is partly explained by their higher number of psychiatric beds at the outset: in 1990, the former Baltic republics were much better equipped with psychiatric beds than the RSFSR. Thus, the 1990 RSFSR rate of psychiatric beds was 135 per 100,000 inhabitants whereas the Estonian was 186, the Lithuanian 165, and the Latvian was 200 (according to data derived from the MINDFUL Database). However there are national differences in defining a psychiatric bed, which impairs the comparability of the country data (Lavikainen et al., 2006).

⁹⁵ Beds in “day hospitals,” intermediate between in-patient and out-patient services, where patients don’t stay overnight, but do stay for several hours.

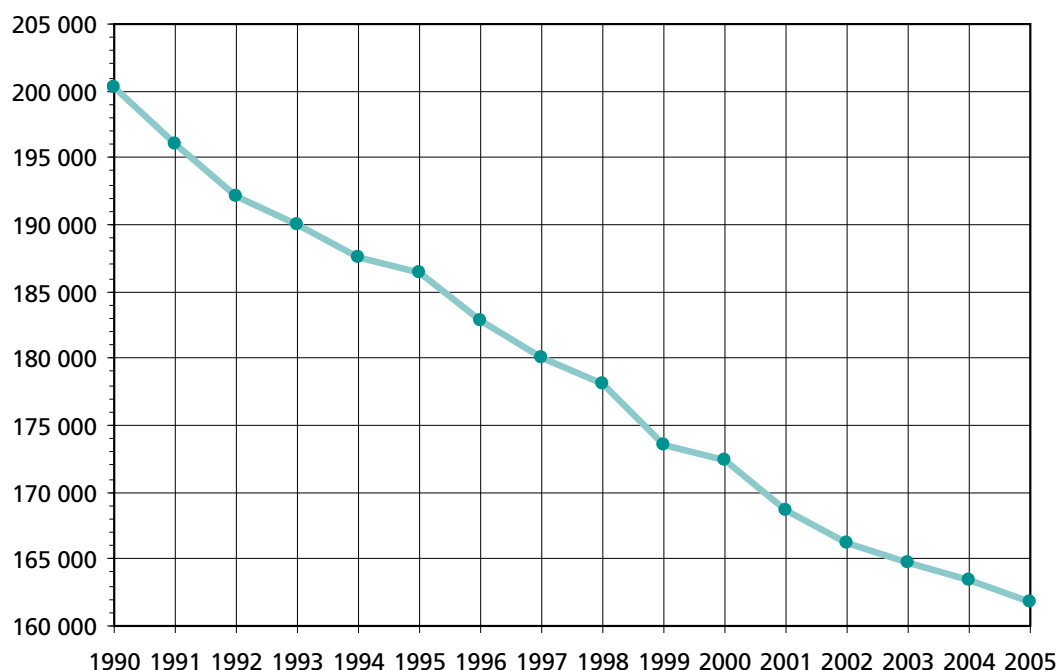


FIGURE 6. Number of hospital psychiatric beds (absolute), Russia

Source: The WHO HFA DB on-line version, <http://www.euro.who.int/hfadb> accessed in January 2007.

TABLE 30. Number of in-patient facilities in Russia, whole country

	1985	1990	1995	2000	2001	2002	2003	2004	2005
Hospitals	286	293	280	274	277	276	277	275	270
In-patient PND units	95	89	100	104	109	109	110	111	115
Total	381	382	380	378	381	385	387	386	385

Source: The MRIP database

The vast majority of the decrease in psychiatric beds is due to the downsizing of psychiatric hospitals rather than to a decrease in beds for in-patient units within the psycho-neurological dispensaries (Gurovich et al., 2007). In addition, the number of psychiatric hospitals has decreased (by 8%) during the last fifteen years, and the number of in-patient PND units has increased (by 29%) whereas the total number of in-patient facilities has remained almost constant (Table 30).

Taken together with the fact that approximately 15,000 available beds (13% of the total number of psychiatric beds) remain vacant throughout the year (Gurovich et al., 2000), these tendencies prove the effectiveness of one of the main objectives in current Russian mental health service policy – the decentralisation strategy aimed at the improvement of local mental services, and out-patient services in particular, in the context of a community-based mental care approach (MHSD, 2001).

However the 2001 Resolution of the MHSD Collegium (MHSD, 2001) states the urgency to decrease the number of psychiatric beds in Russia by 21.8% within a ten year period “to reach the average Europe of 9.3 per 10,000 inhabitants”.

22. Number of psychiatrists

The indicator refers to the number of “registered medical specialists in psychiatry/neuropsychiatry. Registered medical specialists are licensed, not necessarily economically active. Thus retired, unemployed, working abroad, etc. are included. Trainees are excluded.” (MINDFUL, 2006). The indicator covers the numbers (absolute, rate per 100,000 inhabitants) of registered psychiatrists (persons). The Russian data on the total number of psychiatrists includes all psychiatrists (physicians with a higher medical education specialising in psychiatry) engaged in treatment in sanitary organisations, social security institutions, research institutes, personnel training institutions, public health bodies and others. Common specialisations in this field are as follows: psychiatrists, psychotherapists⁹⁶, neuropsychiatrists, sexologists and forensic psychiatrists.

Countrywide and regional numbers of psychiatrists are traditionally a matter of annual MHSD statistics. Rosstat began processing countrywide and regional data on these in 1998. Table 5.7 shows both absolute numbers (Rosstat, MHSD) of psychiatrists and the rates of psychiatrists per 100,000 inhabitants (Rosstat, MHSD, MRIP, SRCSEFP) over the entire investigating period. These absolute numbers do not include statistics on the Chechen Republic for socio-political reasons. The SRCSEFP rates per 100,000 population do not include psychotherapists. SRCSEFP-estimated country-level rates of psychiatrists specialising in psychotherapy per 100,000 inhabitants are presented in Table 31.

From the mid-1960s, the absolute number of psychiatrists (persons) in the former RSFSR and Russia has constantly increased (1976 was an exception related to the separation of psychiatric and narcological services in 1975, which led to a statistical decline in the absolute number of psychiatrists). Thus, in 1995 the absolute number of psychiatrists was 2.6 times as great as in 1965, and the provision of psychiatrists (rate per 100,000 inhabitants) rose to 2.2 times as great as in 1965 (three decades earlier). According to MHSD statistics, this increase peaked in 1999, after which the number of psychiatrists began to decrease (2004 is an exception). The Rosstat 1998–2005 annual figures indicate that the number of psychiatrists continues to rise.

Both the MHSD (and its institutions’) as well as the Rosstat rates per 100,000 population have been gradually increasing within the investigating period. Thus the MHSD data (available since 1992) reveal that the rate has increased by 21.9% in 2005 from the 1992 level. This corresponds with the Lithuanian upward trend of 30%, whereas the Estonian and Latvian rates have remained almost constant (after numerous oscillations from 1990 to the last available figures in 2003).

The RSFSR 1990 rate of psychiatrists per 100,000 inhabitants was 8.1, whereas the Estonian rate was 13.1, the Lithuanian rate 13.4 and the Latvian rate 9.4 (the MINDFUL Database).

The number and the rates of countrywide psychiatric positions per 100,000 population have also increased within the investigating period, although more strongly (Table 32).

TABLE 31. Number of psychotherapists, per 100,000, RF, whole country

1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
0.5	0.6	0.7	0.8	0.8	1.0	1.1	1.2	1.3	1.3	1.3	1.4	1.4	1.4	1.3	1.3

Source: Churkin and Tvorogova, 2005 (Table 3, p.6).

TABLE 32. “Psychiatric positions (absolute, per 100,000 inhabitants), RF, whole country”

	1985	2000	2001	2002	2003	2004	2005
Absolute number	13,035	21,743	21,971	22,270	22,537	22,667	22,562
Per 100,000	9.1	15.0	15.2	15.5	15.8	15.9	15.9

Source: The MRIP database

⁹⁶ Psychiatrists specialising in psychotherapy

The increase in the number of registered psychiatrists can only be a positive development, taking account of the fact that mental health services in Russia are well organised and structured, being currently based on the “biopsychosocial” model of mental health and aimed at community-based determinants.

#23. Number of child (and adolescent) psychiatrists

The indicator refers to “registered medical specialists in child and adolescent psychiatry. Registered medical specialists are licensed, not necessarily economically active. Thus retired, unemployed, working abroad, etc. are included. Trainees are excluded.” (MINDFUL, 2006). The indicator covers the number of registered psychiatrists (persons) specialising in child and adolescent psychiatry (absolute, rate per 100,000 inhabitants).

A major proportion (around 80%) of registered psychiatrists in Russia provides mental care for adult patients. Together with psychotherapists (around 8%), adult psychiatrists amount to a total of approximately 88–90% of all psychiatrists. Child/adolescent psychiatrists belong to the remaining 10% of all registered psychiatrists.

In Russia, there is no separate registration for either child or adolescent psychiatrists, but there are registered psychiatrists who specialise in child/adolescent psychiatry and provide psychiatric help for minors. In urban areas, there is a network of out-patient psychiatric rooms for children and adolescents (separately) within local PNDs and general out-patient child (for those aged between 0 and 14) or adult (15 years of age and older) facilities. It is envisaged that there should be one child (adolescent) local psychiatric position for every 10,000 of the relevant population whereas each adult local psychiatric position should cover 25,000 of the adult population. In rural areas, psychiatric help for either adults or minors is rendered by general psychiatrists (one position envisaged for every 40,000 inhabitants) from rural psychiatric rooms. There are specialised psychiatric hospitals (centres) for minors in major cities, as well as specialised psychiatric departments for minors within general psychiatric hospitals.

The 1990–1993 and 2000–2005 MRIP absolute numbers and rates per 100,000 inhabitants of child/adolescent RF psychiatrists are demonstrated in Table 5.8. The table shows that the absolute number of child/adolescent psychiatrists and the rate per 100,000 inhabitants reached a maximum in 1993 (becoming 15% higher than in 1990) and then returned to around the 1990 level.

In Lithuania, a small increase can be seen from 1991 to 2003 (from 1.2 to 1.4 child psychiatrists per 100,000 inhabitants) whereas in Latvia child psychiatrists have diminished by as much as 67% (from 0.9 in 1992 to 0.3 in 2003) and Estonia has reported data for only 1990 and 1995, amounting to 1.6 and 1.5 child psychiatrists per 100,000 population respectively (the MINDFUL Database).

MRIP-estimated rates of child/adolescent psychiatrists per 100,000 relevant (aged 0–17) members of the population and per 100,000 inhabitants are subject to comparison; for 2000–2005, they are given in Table 33.

TABLE 33. Rates of child/adolescent psychiatrists per 100,000 relevant members of the population (0–17 years old) and per 100,000 inhabitants

	2000	2001	2002	2003	2004	2005
Child/adolescent psychiatrists per 100,000 of the relevant population	5.1	5.3	5.5	5.6	5.9	5.7
Child/adolescent psychiatrists per 100,000 inhabitants	1.1	1.1	1.2	1.2	1.1	1.1

Source: The MRIP database.

TABLE 34. "Number of child and adolescent psychiatric positions, Russia, whole country"

	2000	2001	2002	2003	2004	2005
	Absolute number					
Child psychiatrists	2,175	2,226	2,253	2,317	2,377	2,382
Adolescent psychiatrists	335	322	333	312	313	296
Child/adolescent psychiatrists	2,510	2,548	2,586	2,629	2,690	2,678
	As % of all psychiatric positions					
Child psychiatrists	13.2	13.6	13.7	14.1	14.6	14.7
Adolescent psychiatrists	2.0	2.0	2.0	1.9	1.9	1.8
Child/adolescent psychiatrists	15.2	15.6	15.8	16.0	16.5	16.5

Source: The MRIP database.

TABLE 35. "Child and adolescent psychiatric positions, rates per 100,000 children (0–14) and adolescent (15–17) population, RF, whole country"

	2000	2001	2002	2003	2004	2005
Child psychiatric positions	8.5	9.1	9.7	10.4	11.1	11.4
Adolescent psychiatric positions	4.5	4.3	4.4	4.2	4.4	4.5

Source: The MRIP database.

TABLE 36. Child/adolescent psychiatric positions, rates per 100,000 children and adolescents

	2000	2001	2002	2003	2004	2005
Child/adolescent psychiatric positions	7.4	7.7	8.1	8.6	9.0	9.4

Source: The MRIP database.

In addition, the numbers of child and adolescent psychiatric positions taken separately (absolute, as a per cent of all psychiatric positions) are processed by the MRIP on regional and national (Table 34) levels.

Rates of child and adolescent psychiatric positions per 100,000 relevant population served are also part of the MRIP statistics on child/adolescent psychiatrists (Table 35).

The national (and regional) rates of child/adolescent psychiatric positions per 100,000 children/adolescent (0–17) population are also available from the MRIP (Table 36).

Psychiatric care for minors in Russia is currently improving in two main directions: team (polyprofessional) approach, and better cooperation with stuffed clinical psychologists (Gurovich et al, 2007).

4.5 Health systems: Health care utilisation; psychiatric care and social services

#24. Number of in-patient episodes due to mental conditions

This indicator relates to “the number (absolute, rate per 100,000 inhabitants) of all discharges (full-time or part-time) for all mental and behavioural disorders during a given year”: absolute, rate per 100000 inhabitants (MINDFUL, 2006).

The official ministerial 1990–2005 countrywide absolute numbers of discharges from mental health institutions per year, as well as the estimations from WHO EURO on rates per 100,000 inhabitants, are shown in Table 5.9. Oscillations in absolute numbers during the 1990s gave way to stable figures in the early 2000s. According to the WHO-HFA database, in 1991 the lowest absolute number occurred in 1991, whereas the highest occurred in 1994 – soon after Federal Law # 3185-1 “On Psychiatric Care and Guarantees of Citizens’ Rights in Its Provision” came into force (Figure 7).

The RF rate of in-patient episodes due to mental conditions per 100,000 inhabitants, as estimated by WHO EURO, has increased by 7.5% within the period 1990–2005, despite its several oscillations (being at its lowest in 1991 and its highest in 2001). Whereas the available Estonian and Latvian 1998–2004 data saw few changes, the Lithuanian 1990–2004 data differs greatly from these, increasing by as much as 47%, with a maximum of 1,346 per 100,000 inhabitants in 1998, but then decreasing (the MINDFUL Database).

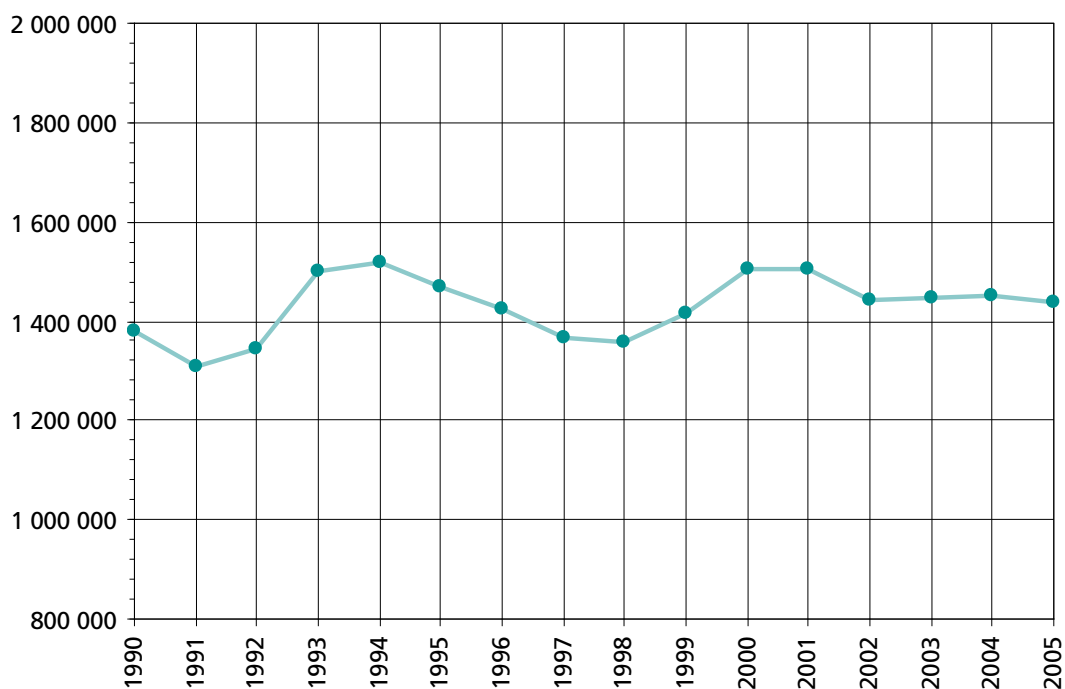


FIGURE 7. “Number of hospital discharges, mental and behavioural disorders, absolute, RF”

Source: The WHO EURO HFA DB on-line version, <http://www.euro.who.int/hfadb> accessed in January 2007.

25. Number of long-stay patients

This indicator covers the numbers (absolute, rate per 100,000 inhabitants) of mental patients with continuous residence in hospitals of more than 365 days by the end of each year (MINDFUL, 2006).

In the former RSFSR, the duration of hospitalisation at a psychiatric institution was two-three months and often extended to one/one and a half years. Today, the situation is radically different: the terms of hospitalisation have reduced significantly. Russian psychiatry has proclaimed the priority of out-patient treatment. The Federal Law “On Psychiatric Care and Guarantees of Citizens’ Rights in Its Provision”, (hereinafter “the Federal Law”) that has been in effect since 1993, provides that the duration of stay at a psychiatric institution should be proportionate to the patient’s mental condition and the type of therapy required.

Article 5-2 of the Federal Law states that “the patient... has the right to stay at the psychiatric institution strictly within the adequate period of time required to be examined and treated”. Besides, if voluntarily admitted, the patient (as well as his/her representative) may complain and request to be discharged at any time, and physicians have no right to hold them if they do not pose a danger to themselves or others (Art. 40-2 of the Federal Law). Should the patient prove unable to resolve this issue with the doctor whose care they are under, they have the right to address the head physician or head of department (Art. 37-2 of the Federal Law).

Where patients are unable to live independently due to their mental condition and their relatives refuse to take care of them (or they have no close relatives), the clinic petitions the court and requests that the patient be accorded the status of legally incompetent and transferred to a specialised (psycho-neurological) welfare nursing home – in line with Art.41-1 of the Federal Law.

A competent psychiatric patient ready to be discharged may also lawfully apply for a transfer to a specialised nursing home for certain reasons (no permanent domicile, conflicts with relatives or neighbours etc.). His/her application must be supported by the conclusion of the physician’s commission (with a psychiatrist included). The conclusion must clearly testify that the patient has no grounds for being designated incompetent, but should be transferred to a specialised (not regular) welfare nursing home (Art.41-1 of the Federal Law).

Minor patients (under 18) should be transferred to a specialised (psycho-neurological) boarding school upon the request of a relative or guardian, or any other legal representative, followed by consideration of the case by an expert commission. Art. 42 of the Federal Law states that the expert commission (a psychiatrist, a psychologist and an educational specialist) must present a thoroughgoing argument, in its conclusion, for the necessity of placing the minor in a specialised boarding school.

Article 16-2 of the Federal Law provides, in particular, that the state should create hostels for individuals with mental conditions who have lost their social connections (supported by the Statement adopted on 25.05.94 by RF Government Act # 522). In 1995, the MHSD included the creation of such hostels in the Federal Target Programme “Immediate measures on the improvement of psychiatric care in 1995-1997” adopted by RF Government Act # 383, 20.04.95. The Federal Branch Programme, “Reorganization of infrastructure of psychiatric care in Russian Federation (2003–2008),” adopted by the MHSD Act # 98 on 27.03.02 is also targeted at the provision of specialised psychiatric household institutions.

Since the Federal Law as well as the abovementioned governmental and ministerial initiatives entered into force, the nationwide number of long-stay patients has been constantly decreasing. Thus, the number of long-stay psychiatric patients in Russia has decreased from 39,743 in 1993 to 32,933 in 2005 (as estimated by the MHSD). The HFA-DB line chart (Figure 8), based on RF MHSD-submitted data, illustrates the 1993-2005 dynamics of this indicator in Russia.

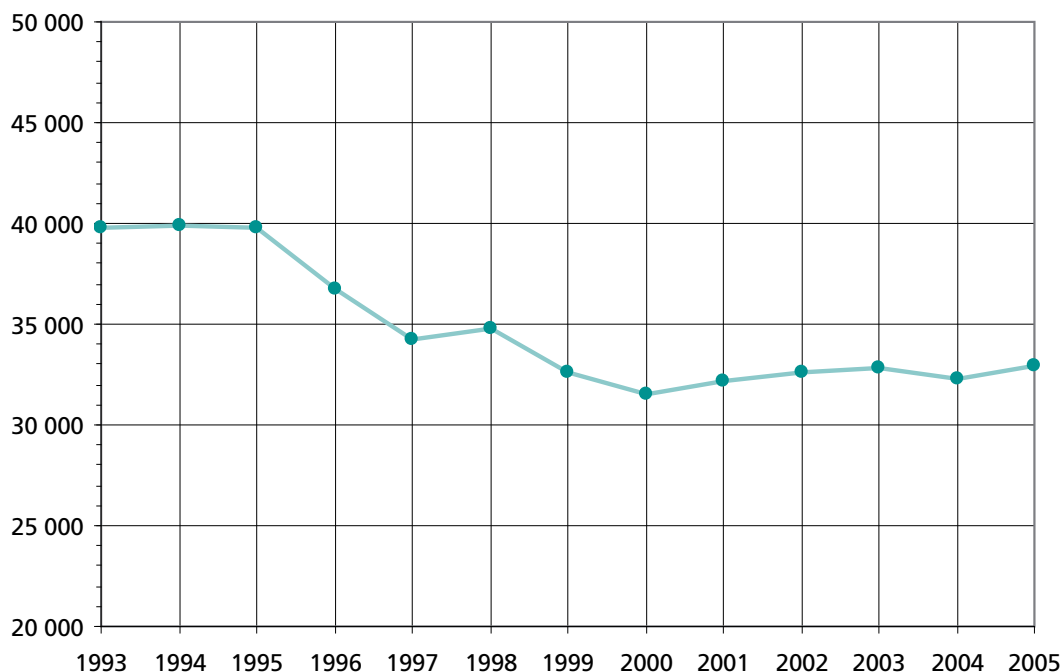


FIGURE 8. "Number of mental patients staying in hospitals 365+ days, absolute, RF"

Source: WHO/Europe HFA DB , <http://www.euro.who.int/hfadb> accessed in January 2007.

Available (the MRIP and the WHO HFA-DB) rates for long-stay patients in Russia per 100,000 population (Table 5.10) decreased by approximately 15% in the period 1993–2005, which is similar to the development in Latvia: a decrease by 18% was seen in 1997–2004 but numbers remained rather high. The 1991–2004 Lithuanian rates decreased much more strongly (by 73 %). Estonia has not yet submitted any data on its rates of long-stay psychiatric patients (the MINDFUL Database).

In Russia, data on long-stay mental patients is collected by the traditional "single day census" of resident psychiatric patients (undertaken annually on December, 31 from 1993), which enables the gathering of information on the number of long-stay resident psychiatric patients. This also permits the estimation of the duration of treatment, albeit subject to a possible seasonal bias – in so far as correlations between the season and the number of patients seeking mental health care and the severity of the patients' mental conditions are known.

The absolute numbers are collected by the MHSD and then submitted to its subordinate institutions for research needs, as well as to the WHO/Euro HFA-DB. The MRIP and the HFA-DB experts make calculations on the rates of long-stay patients per 100,000 inhabitants. The MRIP experts also perform a wide range of calculations on long-stay psychiatric patients: the percentage of long-stay mental patients of all resident patients by the end of the year; the absolute number, rate per 100,000 inhabitants, and proportion of long-stay mental patients related their nosological distribution, etc. - nationally and regionally. The MRIP-estimated long-stay mental patients currently make up one fifth of all RF mental patients countrywide and the situation in general remains far from perfect (Table 37).

TABLE 37. "Proportion of long-stay mental in- patients, Russia, whole country"

	2000	2001	2002	2003	2004	2005
Number of long-stay patients as % of all mental resident patients	20.3	20.7	21.2	21.4	21.7	21.4

Source: The MRIP database.

The major reason accounting for the high number of long-stay patients is the deficit of suitable social establishments for mentally disabled persons. There are serious problems with PNI provision in the Republic of Adygeya, Republic of Kalmykiya, Republic of Komi, Republic of Mari El, and Udmurt Republic, in the Krasnodar territory, Perm, Pskov, Sverdlovsk, Rostov, and Chita regions. Sometimes, patients wait to be transferred to nursing homes for several years, occupying beds in psychiatric hospitals (MHG, 2004).

The programme on hostels for mentally challenged persons who have lost their social connections (as part of the Federal Target Programme "Immediate measures on the improvement of psychiatric care in 1995–1997") has not been properly funded and the full establishment of such hostels depends on local officials. Thus, in St. Petersburg, thanks to the efforts of the city chief psychiatrist, L. Rubina, the City Duma has funded a regional programme on the development of its psychiatric services. Today, there are eight such hostels in St. Petersburg (the first having been created in 2000) and six in the Leningrad Oblast, and the problem of homeless mentally-challenged persons has to some extent been solved. A hostel with 100 beds has been established in Bashkortostan within the Republican psychiatric clinic, there is a hostel in Pervouralsk (Sverdlovsk Oblast) and in a few other territorial units (Omsk, Tambov, Ryazan, Kaluga Oblasts etc.). Sometimes, psychiatric clinics (not counting on state or local authority assistance) manage to organise alternative nursing homes or hostels within their own facilities (MHG, 2004).

A large number of mental patients are taken to psychiatric institutions on the basis of social indications (i.e. homeless, neglected etc.) and often have no identification documents. It is up to the social divisions of psychiatric institutions to find out their names, restore their documents, search for their relatives and place them in social institutions. All of this takes a great deal of time to complete and, during this period, the homeless person remains within the psychiatric institution. In some cases, this is the clinic at which the patient is registered, so that the patient can receive his/her pension benefits that are only paid at the place of registration.

The 2003 monitoring of 93 psychiatric institutions in 61 federal subjects of Russia conducted by the Moscow Helsinki Group⁹⁷ (MHG), in alliance with the Independent Psychiatric Association of Russia⁹⁸ (IPA) revealed that, in 16 psychiatric clinics (17% of those surveyed), the share of individuals who have been admitted on the basis of social indications exceeded 5% of all patients. The percentage was as high as 40% (e.g. at the Republican psycho-neurological dispensary of Kalmykiya), where it may have contributed to the long duration of hospitalisation (approximately one year). To some extent, the high number of long-stay patients can be accounted for by in-patients admitted on the basis of "social indications" and not in terms of any genuine need for psychiatric treatment.

A certain number of long-stay in-patients comprise delinquent persons hospitalised in psychiatric institutions for compulsory treatment through a court decision. According to statistical form #36-PL, newly-established by Rosstat (Act # 80, 11.11.2005), in 2006 the number of long-stay delinquent psychiatric in-patients amounted to as many as 10,188 thousand out of all long-stay

97 The oldest (1976) human rights organization in Russia (<http://www.mhg.ru/english>)

98 Non-governmental psychiatric and human rights organization (<http://www.npar.ru/about/>), based in 1989, member of the World Psychiatric Association (<http://www.wpanet.org/>)

psychiatric patients (32,789 thousand), which makes 31% (Gurovich et al., 2007). The average in-patient treatment duration for such patients was 479 days in 1998 (MHG, 2004).

Quite a large number of psychiatric patients with comorbid tuberculosis (who stay at specialised psychiatric clinics or specialised departments of general psychiatric clinics for as long as several months) also contribute to the number of long-stay patients.

Expert bed turnover, as well as turnover for geriatric beds, is usually longer than that of regular beds.

Sometimes physicians are obliged to delay the discharge of patients in order to complete the course of therapy when a certain kind of treatment cannot be continued on an out-patient basis, due e.g. to the fact that some institutions are better provided with pharmaceuticals than outpatient services.

However the findings of the abovementioned MHG Monitoring of human rights in psychiatric institutions in Russia related to the duration of hospitalisation terms revealed that, in 13 psychiatric institutions (14% of those surveyed), therapy terms did not exceed 45 days whereas, in a total of 8–9% of the surveyed clinics, patients had stayed for more than 100 days. However, in the majority of the surveyed clinics, patients remained for as long as two-three months – an adequate term for being examined and undergoing a therapy course (MHG, 2004).

26. Involuntary placements

This indicator covers annual numbers (absolute, rate per 100,000 inhabitants) of “patients committed to involuntary psychiatric hospital treatment... in various types of institutions (psychiatric hospitals, psychiatric wards in general hospitals, forensic wards and psychiatric nursing homes)” (MINDFUL, 2006).

Involuntary admissions to psychiatric institutions have a solid juridical background. The fundamental laws in the area of mental healthcare in Russia are the Foundations of Legislation of the Russian Federation on Healthcare of the Citizens⁹⁹ adopted in 1993 (hereinafter the Foundations) and Federal Law # 3185-1, enacted in 1992 “On Psychiatric Care and Guarantees of Citizens’ Rights in Its Provision”, hereinafter the Federal Law, as well as by certain articles of other statutes.

Article 17 (Section IV) of the Foundations states that “the state guarantees its citizens protection against any forms of discrimination related to their health disorders”.

Article 5 of the Federal Law prohibits any limitation of the rights and freedoms of mentally ill individuals based on a psychiatric diagnosis, the fact that they have been treated in psychiatric clinics, psychiatric centres or that they have been taken to a psycho-neurological facility for social care or special training. The observance of Federal Law is monitored by the regional prosecution bodies and the Prosecutor General’s Office of the Russian Federation.

Article 46 of the Federal Law enables public associations, both professional, and non-professional, “to exercise control over the observance of the rights and legal interests of citizens in providing psychiatric care to them.” Article 38 of the Federal Law accounts for the establishment of the independent (not subordinate to the MHSD) Service for the Protection of the Rights of Resident Patients, though still to be implemented (under the supervision and subordination of the Apparatus of the Russian Human Rights Ombudsman¹⁰⁰).

Psychiatric clinics are controlled by local, self government and health care (both federal, and regional) bodies, and those covering social protection and education. Representatives of a public association can visit a psychiatric institution upon the request (or application) of a resident patient.

99 http://www.hro.org/docs/rlex/health/index_1.php ; http://www.hro.org/docs/rlex/health/index_2.php

100 http://ombudsman.gov.ru/doc/a-sp_doclad.shtml

Besides external control, the Federal Law provides for internal control: Articles 47 and 48 grant a patient the right to complain about the unlawful actions of medical staff to a court, supervising authority or public prosecutor. If the patient complains to a court, the case is considered in accordance with the Code of Civil Procedure of the Russian Federation¹⁰¹ (adopted 1994, in use from 1995).

The Federal Law secures the universally accepted principle of voluntarism with respect to those seeking psychiatric care. All exceptions to this principle are strictly defined in Article 11 (“Consent to Treatment”), Article 23 (“Psychiatric Examination”) and Article 29 (“Grounds for Involuntary Placement in a Psychiatric Hospital”), and are primarily dictated by the interests of the patient. The list of exceptions is exclusive. First and foremost, it includes being a direct danger to oneself and others (associated with a high risk of suicidal and aggressive behaviour); helplessness, i.e. inability to take care of oneself; pathological conditions requiring urgent psychiatric care without which one’s health can be significantly impaired as well as a court decision.

A mental disorder or the necessity to conduct a psychiatric examination may serve as the grounds for a person’s admission to a psychiatric institution. According to article 11, the physician in charge of admission must first of all ascertain whether the patient’s mental condition enables the patient to realise and consciously express his/her opinion with respect to hospitalisation, then discuss this issue with the patient, explaining the right to refrain from hospitalisation. Following this, the physician must document the patient’s consent or refusal. The Law does not allow the exertion of pressure against the patient or coercing him or her into hospitalisation.

An individual’s consent to hospitalisation and therapy (a matter of strict necessity for institutions that offer insulin-comatose and/or electroconvulsive therapy) is documented in writing within hours following admission. If the person does not wish to give his/her signature and submit to hospitalisation and treatment, the case must be reviewed by the clinic’s psychiatric commission within the next 48 hours (in accordance with Article 32 of the Federal Law). The same Article also states that, if solid grounds for the patient’s hospitalisation are identified, the psychiatric institution should submit (within the next 24 hours) a petition to a local court of law, based on the commission’s decisions to sanction the subjection of a person to involuntary hospitalisation. During the course of the court hearing (set within the five day period – according to Article 34) the court must establish whether the person has any of the qualities covered by Article 29 of the Federal Law. The relevant articles of the RF domestic law on psychiatric care are listed in Appendix 8.

At the court hearing, the psychiatric institution is usually represented by the deputy chief physician, the head of the department in which the patient is resident or the doctor treating the patient. The plaintiff or his/her representative must be present (Article 34). In general, the judges specialise in this particular category of case. If the judge decides to grant permission for the patient’s further confinement in hospital, his/her decision must provide justificatory grounds.

According to Article 35 the judge’s decision (whether it grants or refuses permission for further hospitalisation) is subject to appeal within 10 days by the patient, his/her representative, the head of the clinic or an organisation entitled to protect citizens’ rights, or by a public prosecutor, in an order provisioned by the rules established in the Code of Civil Procedure of the RF.

However, the number of cassation appeals on court decisions linked to involuntary hospitalisation total only 0.01-2% of the overall number of decisions made on such cases (MHG, 2004), since patients and their relatives are not always aware of the full scope of their rights.

The annual number of written complaints from patients about the improper quality of mental help submitted to the Federal Service on Surveillance in Healthcare and Social Development of the Russian Federation¹⁰² (FSSHSD) adopted by RF Governmental Act # 323, 2004 is known to be rather low. Thus, in January-June 2006, they amounted to only 6.7 % of all complaints about

101 <http://www.gkodeks.ru/>

102 http://www.roszdravnadzor.ru/about/decrete_323/decrete_323.html

the improper quality of health care, which in turn totalled 30.1 % of all complaints (FSSHSD, 2006).

At the same time, the second largest number of petitions submitted to the European Court on Human Rights originates from Russia (MHG, 2004). This is probably a consequence of the success of the *T.Rakevich v. Russia* 2003 case on involuntary hospitalisation, filed with the European Court on Human Rights by the patient's NGO "Sutiashnik"¹⁰³ representative.

In the case of *T. Rakevich*, the European Court identified a violation of Article 34-1 of the domestic Federal Law (the court did not meet the five-day deadline) which resulted in a violation of the provisions of Paragraphs 1, 4 of Article 5 of the European Convention on Human Rights and Fundamental Freedoms, and obligated the Government of the Russian Federation to pay the plaintiff 3,000 euros to compensate for the moral damages inflicted upon her. Shortly thereafter, on December 19, 2003, the Plenum of the Supreme Court of the Russian Federation adopted a resolution specifying that court decisions in similar cases must, in future, take account of "the decisions of the European Court on Human Rights based on interpretations of provisions of the European Convention on Human Rights and Fundamental Freedoms."

However, many provisions of the Federal Law are inconsistently observed. For example, instead of obtaining legal grounds for involuntary placements through the appropriate court proceedings, a number of clinics have obtained their patients' consent to therapy by exerting pressure on them or generally misleading them, thus falsifying their voluntary consent to therapy.

In 55% of the clinics, the involuntary hospitalisation rate was below 5% instead of the natural 15–20%, whereas the rate of voluntary hospitalisation in 64% of psychiatric clinics was almost 100%, indicating falsification (MHG, 2004). It is known that many involuntarily admitted patients may later give their consent to therapy having discovered acceptable conditions in their departments, the friendly attitude of the personnel etc. But it is rather doubtful that 98-100% of patients in regular psychiatric institutions are able to express their intentions and agree to enter therapy. Thus, one should be aware that statistical data on involuntary admissions originating from local psychiatric institutions remains far from perfect.

Annual data on involuntary placements is not subject to state statistics. There is only the MRIP which, in 1994 (a year after the Federal Law "On Psychiatric Care and Guarantees of Citizens' Rights in Its Provision" came into force) began to collect relevant national and regional data. MRIP experts conduct thorough investigations into this problem as well as calculations on nationwide and regional levels. The MRIP indicators on involuntary placements in Russia constitute the following: the number of involuntary placements on the grounds of Article 29 of the Federal Law (absolute, per 100,000 population, as a % of all admissions), the number of involuntary placements confirmed by the court in accordance with Article 35 (absolute, per 100,000 population, as a % of all admissions), as well as the ratio of their absolute numbers – all figures being both regional and national. Taken together, these are certainly very informative. Russia countrywide MRIP statistical data on involuntary placements (absolute, rate per 100,000 inhabitants) corresponding with the qualities of the MINDFUL indicator # 26 is given in Tables 5.11 and 5.12. Comparison with the EU Baltic countries is not possible, due to the lack of data from these countries in the MINDFUL database.

According to the MRIP database, both the absolute numbers and rates of involuntary admissions (Art. 29; Art. 35) per 100,000 inhabitants have been gradually increasing since 1995 countrywide as well as in 43 of 89 Russian federal subjects (Gurovich et al, 2007).

MRIP-estimated statistics on the national number of cases confirmed by the court (Art. 35) as a percentage of the overall number of involuntary admitted patients (Art. 29) indicate that, from 1995, this ratio has been constantly increasing and approximately every third case is now confirmed by the court (Table 38), which is a positive development.

103 <http://www.sutyajnik.ru/>

TABLE 38. The number of involuntary placements approved by the court (Art. 35) as a percentage of all involuntary placements (Art. 29), RF for the whole country

1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
18.1	29.4	23.7	24.3	22.5	29.7	32.8	29.5	29.1	29.1	31.4	32.9

Source: The MRIP database.

On the whole, Federal Law # 3185-1, “On Psychiatric Care and Guarantees of Citizens’ Rights in Its Provision” has contributed a great deal to mental health care promotion in Russia. As the first law to do so in Russian history, it is generally believed to guarantee the rights of the patient in compliance with international democratic principles on dignity, safety and freedom.

27. “Use of out-patient services”

This indicator covers “the annual countrywide number (absolute, per 100,000 inhabitants) of visits to psychiatric out-patient care (out-patient service or unit within specialized psychiatric care) during a year” (MINDFUL, 2006).

The use of out-patient services (absolute numbers) has been covered by MHSD statistics since 1993, while rates per 100,000 inhabitants have been processed by the MRIP since 1994. Relevant MHSD and MRIP data is given in Table 5.13. The table shows that both absolute numbers and rates have been constantly increasing within the investigating period, which can be considered a positive development. The RF 1994–2005 MRIP-estimated rates per 100,000 population have thus increased by approximately 26% whereas the Estonian 1990–2003 ones have increased more strongly (by 40%). The Lithuanian 1990–2004 and Latvian 2000–2004 rates have remained constant (the MINDFUL Database).

This upward trend corresponds with the main objective of the Russian public health system – its preventive tactics and principles. The shift from inpatient to outpatient care as well as a community-based approach in Russian psychiatry has also contributed to the increasing number of visits to out-patient mental services. Such an increase is also the consequence of the construction of a proper infrastructure for the national mental health service, in particular the out-patient structure.

Currently, every third visit to an out-patient psychiatrist in Russia is aimed at prevention rather than treatment (these are mostly examinations and check-ups, either ordered by physicians of other medical specialities, or due to the need of getting driver’s or hunter’s licences, draftee’s certificates, etc.). The MRIP 1999–2005 countrywide numbers of so-called “preventive” visits to out-patient psychiatrists as a percentage of the overall number of visits to out-patient psychiatrists are shown in Table 39.

This trend is also common to adult, child and adolescent patients. Thus, in 2005 the number of adult check-up visits per psychiatric out-patient positions increased from the 1999 level by 3%, the number of child check-up visits increased by 8% and the relevant number of adolescent visits increased by 9.4% (Tables 40 and 41).

TABLE 38. Number of check-up visits to out-patient psychiatrists, RF/ whole country

1999	2000	2001	2002	2003	2004	2005
28.2	29.5	28.5	29.8	29.5	32.1	31.7

Source: The MRIP database.

TABLE 40. "Distribution of the reasons for visits to out-patient mental services (per one psychiatric position during a year) in 1999, Russia, whole country"

Age of patient	Units	Total number	Including	
			Treatment	Check-up
Adult	abs. number (thousand)	4,356.0	2,947.0	1,409.0
	as %	100	67.7	32.3
Adolescent (15–17)	abs. number (thousand)	3,472.2	2,456.7	1,015.5
	as %	100	70.8	29.2
Child (0–14)	abs. number (thousand)	2,668.7	2,126.9	541.8
	as %	100	79.7	20.3

Source: The MRIP database.

TABLE 41. "Distribution of the reasons for visits to out-patient mental services (per psychiatric position during each year) in 2005, Russia, whole country"

Age of patient	Units	Total number	Including	
			Treatment	Check-up
Adult	abs. number (thousand)	4,192.5	2,726.6	1,465.8
	as %	100	65.0	35.0
Adolescent (15-17)	abs. number (thousand)	3,401.5	2,088.5	1,313.0
	as %	100	61.4	38.6
Child (0-14)	abs. number (thousand)	2,558.2	1,820.8	737.4
	as %	100	71.2	28.8

Source: The MRIP database.

However check-up visits, though corresponding with the preventive principles of mental healthcare in Russia, result in overwork and overstrain of psychiatrists in local out-patient facilities.

The increase in the number of visits to out-patient mental facilities directly correlates with the increasing number of psychiatric positions within the out-patient branch of the mental care service in Russia. The total number of psychiatric positions within out-patient services has increased from 6,922 (3.7 per 100,000 inhabitants) in 1990 to 8,171 (5.8 per 100,000 inhabitants) in 2005 (Gurovich et al., 2007). This increase (by 18%) is mostly accounted for by the number of child psychiatric and psychotherapeutic positions (whereas the number of adolescent psychiatric positions is known to have slightly decreased, the number of adult psychiatric positions is rather stable). Table 42 below reflects the distribution of out-patient psychiatric positions occupied by psychiatrists directly involved in the patients' admissions by specialisation.

TABLE 42. Number of psychiatric positions within the out-patient mental services occupied by psychiatrists directly involved in patients' admissions, RF, whole country

		1990	1995	2000	2005
Adult	Absolute	3,520	3,791	4,019	4,130
	Per 100,000	3.3	3.5	3.6	3.6
Adolescent	Absolute	210	224	243	211
	Per 100,000	3.4	3.4	3.2	3.2
Child	Absolute	1,114	1,205	1,263	1,334
	Per 100,000	3.3	3.8	4.9	6.4
Psychotherapists	Absolute	385	731	1452	1358
	Per 100,000	0.3	0.5	1.0	1.0
Total	Absolute	5,227	5,951	6,975	7,033
	Per 100,000	3.5	4.0	4.8	5.0

Source: The MRIP database.

The increasing number of visits to out-patient mental facilities along with the increase in the number of out-patient psychiatric positions is aiding the improvement of out-patient mental services, which is highly important in the context of the recently predominating community-based approach.

33. “Disability pensions due to mental disorders”

The indicator relates to the percentage of people (16-64 years) receiving disability pensions due to mental and behavioural disorders out of all people of the same age receiving disability pensions at the end of the year (MINDFUL, 2006).

Article 4.20 of Federal Law # 181-FZ from November 1995 “On the Social Protection of Disabled Persons in the Russian Federation¹⁰⁴” established the system of monitoring demographic and socio-economic indicators related to disabled minors (0–17 years) and adults (18 and over). Article 27 of this Law regulates the procedure for providing disabled minors and adults with disability pensions and other monetary payments (which are coordinated by the Pension Fund of the Russian Federation). The RF Pension Fund¹⁰⁵ (PF) implements annual national and regional statistics on the total amount of disability pensions, regardless of the reason for the disability, on the number of disabled persons (also regardless of the reason for the disability) as well as on the number of first cases of disability status in relation to the disability reason: children, adults and total. Rosstat disseminates statistics originating from the PF (available in the “Public Health in Russia” statistical handbooks), performing no additional calculations itself.

The RF MHSD implements annual statistics on the number of disability persons (children, adults and total) related to the disability reason (due to mental and behavioural disorders, in particular). The annual 1990–2005 countrywide percentage of adults disabled due to mental and behavioural disorders out of all disabled adults based on MINDFUL indicator # 33 has been estimated by MRIP experts (Table 5.14). However, this figure relates to adults of 16 years old and older (1990–2001) or 18 years old and older (2002–2005), not to 16 to 64-year-old adults as recommended by MINDFUL, which is not crucial as far as the percentage is concerned.

Table 5.14 indicates that the percentage of disability due to mental disorders pensions out of all disability pensions in the RF has been constantly decreasing (from 13% to 7%) within the investigating period, whereas the relevant absolute number has been gradually increasing (from 563,899 to 867,791). The reason for this phenomenon is the fact that the absolute number of overall disability pensions has been increasing more rapidly within the same period (from

104 <http://ortho.zanas.ru/legal/146/150>

105 <http://pfrf.ru/>

4,183,092 to 11,971,512). This entails that, by 2005, the overall number of disability pensions (at least the reason for disability) had increased by almost three times as much as in 1990, while the number of disability pensions due to mental and behavioural disorders had increased by 1.5 over the 1990 levels. However, these correlations require careful study.

According to the SRCSPF, in 2004 88% of all people disabled due to mental and behavioural disorders were adults and 12% were children (0–17 years old); 62% being adults of working age. Some 36% of all people disabled due to mental and behavioural disorders were schizophrenic patients, 34% were patients suffering from mental retardation and 30% were patients with other mental disorders, including 10% who were epileptic patients (Churkin and Tvorogova, 2005).

Due to the lack of data in the MINDFUL database, no comparison with the Baltic EU countries is possible.

34. “Sickness allowance spells due to mental disorders”

This indicator covers “the percentage of national sickness allowance spell days per employee during a year due to mental and behavioural disorders (ICD codes F00–F99) out of all sickness allowance spells beginning each year” (MINDFUL, 2006).

Annual total and sex-adjusted national data on sickness allowance spells granted to persons of working age¹⁰⁶ (61.3% of the 2002 census’ population) is gathered by the MHSD. The MHSD records the number of days of each sickness allowance spell and the number of cases of such spells (both overall and distributed based on sickness reasons, particularly mental and behavioural disorders).

The MHSD countrywide 1994–2005 proportion of sickness allowance spells due to mental and behavioural disorders (day and case-related) is shown in Table 5.15. This table demonstrates that, within the last twelve years, both the day and case-related percentage of sickness allowance spells due to mental and behavioural disorders have decreased, although in different ways. Following a series of oscillations, the day-related percentage has decreased from 2.4% to 1.7% (1.4 times less) whereas the case-related percentage has been decreasing more constantly and consistently, from 3.3% to 1.3% (2.5 times less). Due to the lack of data in the MINDFUL database, no comparison with the Baltic EU countries is possible.

The decrease in the number of both day and case-related proportions of sickness allowance spells due to mental and behavioural disorders, compared to the overall number of sickness allowance spells, is currently viewed by major Russian psychiatrists as a phenomenon which needs to be explored. This may be connected with overall socio-economic and political changes in Russia within the last fifteen years as well as (particularly by the economically active adult population, and the young) a newly-acquired spirit of competitiveness and a mentality typical of individuals in a market economy’ who are greatly concerned about their jobs, careers and prospects. Thus, social factors may also play a somewhat restrictive if not protective (or rehabilitative) role.

¹⁰⁶ 16–59 years (men), 16–54 years (women)

Table 5.1 SUICIDE (absolute number, SDR), all ages/RF/whole country

Absolute number* (Rosstat)

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
M	30,392	30,923	36,980	46,016	51,464	50,280	48,107	45,519	42,785	47,345	47,806	48,251	46,252	43,279	41,155	38,574
F	8,758	8,465	9,145	10,120	10,422	10,673	9,705	9,512	8,985	9,931	9,128	9,033	9,078	8,470	8,223	7,489
T	39,150	39,388	46,125	56,136	61,886	60,953	57,812	55,031	51,770	57,276	56,934	57,284	55,330	51,749	49,378	46,063

* 1993–2003: data from the Chechen Republic is not included; 2003–2004 data from the Republic of Ingushetia is not included.

SDR

		1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Rosstat	M	47.6	47.8	56.1	70.2	78.0	75.5	71.8	67.5	63.0	69.5	69.7	70.2	67.1	63.1	59.4	55.5
	F	10.5	10.1	10.9	12.2	12.6	12.8	11.6	11.2	10.5	11.6	10.5	10.5	10.4	9.6	9.3	8.5
	T	27.0	27.0	31.4	38.6	42.3	41.5	39.1	36.8	34.4	37.9	37.5	37.7	36.2	33.8	32.0	29.8
MHSD	M	47.5	47.6	55.8	68.9	76.4	74.1	70.7	66.6	62.2	68.7	69.0	69.2	66.1	62.0	58.7	54.9
	F	10.5	10.1	10.9	12.1	12.5	12.7	11.5	11.2	10.4	11.5	10.5	10.5	10.4	9.6	9.3	8.5
	T	27.0	26.9	31.3	38.0	41.7	41.0	38.7	36.6	34.2	37.7	37.4	37.5	36.0	33.3	31.7	29.5
HFA-DB	M	47.5	48.2	56.8	70.8	79.1	76.2	72.3	68.1	63.4	70.0	70.3	70.6	67.4	63.9	58.7	56.1
	F	10.5	10.1	11.0	12.2	12.6	12.8	11.6	11.2	10.5	11.6	10.6	10.5	10.4	9.6	9.3	8.5
	T	27.0	27.0	31.5	38.6	42.4	41.6	39.2	40.0	34.5	38.1	37.8	37.9	36.4	33.8	31.7	29.8

Sources:

1. The Rosstat Database.
2. The CSRIOIPH (Unit for Analysis of Population Health Statistics') Database.
3. The WHO/Europe Health-for-all On-line Database (indicators #1781 "SDR, Suicide and self-inflicted injury, all ages per 100000, male"; #1782 "SDR, Suicide and self-inflicted injury, all ages per 100000, female"; and #1780 "SDR, Suicide and self-inflicted injury, all ages per 100 000" (accessed in May 2007).

Table 5.2 SUICIDE (CDR), all ages/RF/whole country

		1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Rosstat	M	43.9	44.5	53.1	66.1	73.9	72.3	69.3	65.7	61.9	69.3	70.0	71.3	68.8	64.9	61.6	58.1
	F	11.1	10.7	11.6	12.8	13.2	13.5	12.3	12.1	11.4	12.8	11.7	11.7	11.8	11.0	10.7	9.8
	T	26.5	26.5	31.1	38.2	42.1	41.4	39.3	37.5	35.3	39.2	39.1	39.5	38.4	36.1	34.3	32.2
MHSD	M	43.9	44.5	53.2	66.2	74.1	72.5	69.6	66.0	62.3	69.2	70.3	71.4	69.0	64.3	61.6	58.1
	F	11.1	10.7	11.6	12.9	13.3	13.6	12.4	12.2	11.5	12.8	11.8	11.8	11.9	11.0	10.7	9.8
	T	26.5	26.6	31.1	37.9	41.8	41.2	39.2	37.5	35.3	39.2	39.2	39.7	38.6	35.8	34.3	32.2
HFA-DB	M	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
	F	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
	T	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

Sources:

1. The Rosstat Database.
2. The CSRIOIPH (Unit for Analysis of Population Health Statistics') Database.

Table 5.3 DEATHS OF UNDETERMINED INTENTION (absolute, SDR), all ages/RF/whole country

Absolute number* (Rosstat)

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
M	12,837	15,211	22,251	34,840	40,903	39,378	34,647	30,696	32,509	33,871	33,082	33,810	35,136	35,336	36,621	38,167
F	3,764	4,285	6,102	9,392	11,049	10,784	9,697	8,815	9,266	9,292	8,715	8,942	9,253	9,580	9,909	9,964
T	16,601	19,496	28,353	44,232	51,952	50,162	44,344	39,511	41,775	43,163	41,797	42,752	44,389	44,916	46,530	48,131

* 1993–2003: data from the Chechen Republic is not included; 2003–2004 data from the Republic of Ingushetia is not included.

SDR

		1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Rosstat	M	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
	F	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
	T	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
MHSD	M	19.3	22.5	32.4	49.9	57.9	56.0	49.7	44.4	46.3	48.3	47.0	48.2	50.2	50.3	52.1	54.3
	F	4.6	5.2	7.5	11.5	13.4	13.0	11.8	10.5	11.1	11.2	10.4	10.7	11.0	11.2	11.5	11.6
	T	11.4	13.2	19.0	29.3	34.0	32.9	29.4	26.2	27.4	28.4	27.4	28.0	29.0	29.0	30.0	31.1
HFA-DB	M	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
	F	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
	T	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

Sources:

1. The Rosstat Database.
2. The CSRIOIPH (Unit for Analysis of Population Health Statistics') Database.

Table 5.4 DEATHS OF UNDETERMINED INTENTION (CDR), all ages/RF/whole country

		1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Rosstat	M	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
	F	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
	T	11.2	13.1	19.1	30.1	35.4	34.1	30.2	26.9	28.5	29.5	28.7	29.5	30.8	31.3	32.4	33.6
MHSD	M	18.5	21.9	32.0	50.1	58.9	56.8	50.1	44.5	47.3	49.5	48.7	50.1	52.4	52.5	54.8	57.5
	F	4.8	5.4	7.7	11.9	14.1	13.8	12.4	11.3	11.9	12.0	11.3	11.6	12.1	12.4	12.9	13.0
	T	11.2	13.2	19.1	29.9	35.1	33.9	30.1	26.9	28.5	29.6	28.8	29.6	30.9	31.1	32.4	33.6
HFA-DB	M	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
	F	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
	T	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

Sources:

1. The Rosstat Database.
2. The CSRIOIPH (Unit for Analysis of Population Health Statistics') Database.

Table 5.5 HAPPINESS (average score), general population/RF/whole country

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
WHS	2.5	NA	NA	NA	NA	2.5	NA	NA	NA	2.5	NA	NA	NA	NA	NA	NA
RUSSET	NA	NA	NA	2.5	NA	NA	NA	2.6	2.5	2.4	NA	NA	NA	NA	NA	NA
LLH	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	2.8	NA	NA	NA	NA
VCIOM	NA	NA	NA	NA	NA	NA	NA	NA	2.8	NA	NA	NA	NA	NA	NA	NA

WHS – The World Values Survey: <http://www.worldvaluessurvey.com>

RUSSET – The RUSSET panel study 1993 – 1999 <http://www.vanderveld.nl/russet.html>

LLH - The EU Copernikus project "Living Conditions, Lifestyle and Health": http://www.llh.at/llh_partners_start.html

VCIOM – The All-Russian Public Opinion Research Center <http://wciom.com>

Sources:

1. Veenhoven, R., World Database of Happiness, Erasmus University Rotterdam / Trends in nations / Russia: <http://worlddatabaseofhappiness.eur.nl> (accessed in May 2007).
2. The VCIOM Database (file q 82 1998_2).

Table 5.6 NUMBER OF PSYCHIATRIC BEDS/RF/whole country

Absolute number

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Rosstat	200,600	200,600	193,600	190,300	188,900	187,100	188,500	180,200	178,834	174,056	173,336	169,495	167,028	165,991	168,771	166,960
MHSD	200,192	195,961	192,043	190,060	187,493	186,347	182,906	180,087	178,145	173,474	172,394	168,693	166,194	164,752	163,384	161,748

Per 100,000 population

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Rosstat	135.0	135.1	130.3	128.3	128.4	128.0	125.0	124.0	122.0	118.9	118.9	116.6	115.5	116.0	118.6	117.9
MHSD	NA	NA	129.50	128.42	126.73	126.98	124.99	123.39	121.74	119.80	119.54	117.69	115.52	115.17	114.70	114.70
MRIP	135.1	132.1	129.5	128.4	126.7	126.2	125.0	123.4	122.4	119.0	118.6	116.7	115.5	115.2	114.8	114.2
SRCSFP	134.0	132.0	129.0	128.0	128.0	126.0	125.0	123.0	122.0	120.0	120.0	118.0	117.0	116.0	114.0	114.0
HFA-DB	135.3	132.2	129.5	129.4	127.8	126.9	124.8	123.2	122.2	119.5	119.3	117.3	116.3	114.9	113.6	113.0

Sources:

1. Goscomstat, 2001 (Table 5.2).
2. Rosstat, 2005 (Tables 3.16 and 3.17).
3. The Rosstat Database.
4. Gurovich et al., 1995 (Table 1 page 266).
5. Gurovich et al., 2000 (Table 1 page 219).
6. Gurovich et al., 2007 (in press).
7. Churkin and Tvorogova, 2005 (Table 2 page 4).
8. The WHO/Europe HFA-DB On-line Version (indicators #5071 "Number of psychiatric beds" (MHSD-submitted) and #5070 "Number of psychiatric beds/ 100000" (WHO-estimated) accessed in May 2007).

Table 5.7 NUMBER OF PSYCHIATRISTS, persons/RF/whole country

Absolute number

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Rosstat	NA	NA	NA	NA	NA	NA	NA	NA	17,019	17,408	17,986	17,914	18,044	18,106	18,352	18,361
MHSDRF	NA	NA	14,056	14,210	14,412	14,922	15,540	15,893	16,314	16,596	16,491	16,368	16,411	16,378	16,434	16,346

Per 100,000 population

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Rosstat	NA	NA	NA	NA	NA	NA	NA	NA	11.6	11.9	12.3	12.3	12.5	12.7	12.9	13.0
MHSD	NA	NA	9.5	9.6	9.7	10.2	10.6	10.9	11.1	11.5	11.4	11.4	11.4	11.4	11.5	11.5
MRIP	8.1	8.0	8.1	8.2	8.4	8.7	9.1	9.4	9.5	9.7	9.5	9.5	9.7	9.7	9.7	9.7
SRCSFP*	8.9	8.8	8.8	8.8	9.0	9.1	9.5	9.7	10.0	10.2	10.1	10.1	10.2	10.1	10.1	10.2
HFA-DB	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

* Without psychotherapists (e.g. registered psychiatrists specialising in psychotherapy).

Sources:

1. The Rosstat Database.
2. Gurovich et al., 2000 (Table 1 page7).
3. Gurovich et al., 2007 (in press).
4. Churkin and Tvorogova, 2005 (Table 3 page 6).

Table 5.8 NUMBER OF CHILD (AND ADOLESCENT) PSYCHIATRISTS/RF/whole country

Absolute number

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Rosstat	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
MHSD	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
MRIP	1,646	1,791	1,882	1,891	NA	NA	NA	NA	NA	NA	1,668	1,653	1,678	1,661	1,677	1,629

Per 100,000 population

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Rosstat	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
MHSD	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
MRIP	1,1	1,2	1,14	1,27	NA	NA	NA	NA	NA	NA	1.14	1.14	1.16	1.15	1.14	1.14
SRCSFP	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
HFA-DB	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

Source: Gurovich et al., 2007 (in press).

Table 5.9 NUMBER OF IN-PATIENT EPISODES DUE TO MENTAL CONDITIONS / RF/ whole country

Absolute number

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Rosstat	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
MHSD	1,381,399	1,309,352	1,345,540	1,500,488	1,517,129	1,467,341	1,423,614	1,366,804	1,355,501	1,417,832	1,506,066	1,502,776	1,442,289	1,447,884	1,449,800	1,436,280

Per 100,000 population

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Rosstat	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
MHSDRF	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
MRIP	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
SRCSFP*	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
HFA-DB	933.9	883.2	907.3	1,021.8	1,033.9	998.9	971.5	935.3	930.0	976.7	1,042.3	1,045.3	1,009.3	1,009.3	1,008.1	1,003.6

Source:

The WHO/Europe Health-for-all On-line Database (indicators #2382 "Number of hospital discharges, mental and behavioral disorders" (MHSD-submitted) and #2383 "Hospital discharges, mental and behavioral disorders, per 100000" (WHO-estimated) accessed in May 2007).

Table 5.10 LONG-STAY PATIENTS/RF/whole country

Absolute number

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Rosstat	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
MHSD	NA	NA	NA	39,743	39,922	39,786	36,745	34,200	34,786	32,617	31,510	32,164	32,576	32,784	32,273	32,933

Per 100,000 population

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Rosstat	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
MHSD	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
MRIP	NA	NA	NA	26.9	27.0	27.1	25.1	23.4	23.9	22.5	21.8	22.4	22.6	22.9	22.7	23.1
SRCSFP	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
HFA-DB	NA	NA	NA	27.1	27.2	27.1	25.1	23.4	23.9	22.5	21.8	22.4	22.8	22.9	22.4	23.0

Sources:

1. Gurovich et al., 2000 (Table 45, page 286).
2. Gurovich et al., 2007 (in press).
3. The WHO/Euro HFA-DB On-line Version (indicator #2381 "Number of mental patients staying in hospitals 365+ days" (MHSD-submitted) and #2380 "Number of mental patients staying in hospitals 365+ days per 100000" (WHO-estimated) accessed in May 2007).

Table 5.11 INVOLUNTARY PLACEMENTS (Art. 29 of the RF Federal Law on psychiatric care)/RF/whole country

Absolute number

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Rosstat	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
MHSD	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
MRIP	NA	NA	NA	NA	26,333	27,413	34,531	41,892	47,365	51,285	52,380	53,229	55,540	55,693	56,784	57,604

Per 100,000 population

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Rosstat	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
MHSD	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
MRIP	NA	NA	NA	NA	13.7	14.3	18.7	24.7	28.3	35.1	36.0	36.7	38.5	38.8	39.8	40.5
SRCSFP	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
HFA-DB	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

Sources:

1. Gurovich et al., 2000 (Table 70, page 197).
2. Gurovich et al., 2007 (in press).

Table 5.12 INVOLUNTARY PLACEMENTS (Art. 35 of the RF Federal Law on psychiatric care)/RF/whole country

Absolute number

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Rosstat	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
MHSD	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
MRIP	NA	NA	NA	NA	4,773	8,040	8,192	11,159	11,620	15,245	17,195	15,703	16,145	16,179	17,850	18,969

Per 100,000 population

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Rosstat	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
MHSD	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
MRIP	NA	NA	NA	NA	6.5	5.5	5.6	7.0	7.3	10.5	11.9	10.9	11.3	11.3	12.5	13.3
SRCSFP	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
HFA-DB	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

Sources:

1. Gurovich et al., 2000 (Table 72, page 202).
2. Gurovich et al., 2007 (in press).

Table 5.13 USE OF OUTPATIENT SERVICES/RF/whole country

Absolute number

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Rosstat	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
MHSD	NA	NA	NA	18,744,351	19,530,743	20,163,675	20,802,004	21,757,390	22,255,407	24,701,106	23,388,433	22,907,582	22,827,272	23,073,991	23,831,767	23,575,636

Per 100,000 population

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Rosstat	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
MHSDRF	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
MRIP	NA	NA	NA	NA	13,199	13,645	14,196	14,888	15,270	16,909	16,070	15,805	15,828	16,085	16,702	16,607
SRCSFP	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
HFA-DB	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

Sources:

1. Gurovich et al., 2000 (Table 5, page 37. Table 6, page 38),
2. Gurovich et al., 2007 (in press),

Table 5.14 DISABILITY PENSIONS DUE TO MENTAL DISORDERS¹⁰⁷/RF/whole country

Persons/absolute number, percentage

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Rosstat* (Abs.)	4,183,092	4,370,910	4,489,241	4,755,793	5,139,437	6,685,043	6,778,137	8,595,476	9,320,207	9,575,979	10,186,889	10,403,201	10,207,768	10,355,117	10,944,281	11,971,512
MHSD** (Abs.)	563,899	576,323	602,182	628,173	622,347	646,477	658,757	681,495	706,389	738,705	759,646	780,387	795,031	814,397	838,308	867,791
MRIP (%)	13.4	13.2	13.4	13.2	12.1	9.7	9.7	7.9	7.6	7.7	7.5	7.5	7.8	7.9	7.7	7.2

* Absolute number (estimated by the RF Pension Fund) of the RF disabled (anyhow the reason for disability) adults (16 years old and older – before 2002, 18 years and older from 2002 on).

** Absolute number of the RF disabled due to mental disorders adults (16 years old and older – before 2002, 18 years old and older from 2002 on).

Sources:

1. The Rosstat Database,
2. The MRIP Database,

¹⁰⁷ Estimated as proportion of disabled due to mental disorders adults out of all disabled (anyhow the disability reason) adults at the end of the year.

Table 5.15 SICKNESS ALLOWANCE SPELLS DUE TO MENTAL DISORDERS, total, all ages/RF/whole country

Cases/absolute number, percentage*

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Rosstat	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
MHSD	NA	NA	NA	NA	813,715	804,352	643,821	553,857	494,327	458,627	499,860	466,159	446,449	410,632	379,714	324,783
	NA	NA	NA	NA	2.4	2.3	2.0	1.7	1.7	1.5	1.6	1.5	1.5	1.3	1.4	1.3

* Of all sickness allowance spells (cases) beginning each year.

Days/absolute number, percentage*

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Rosstat	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
MHSD	NA	NA	NA	NA	14,608,994	14,656,641	11,971,358	11,023,570	9,822,542	8,676,316	8,798,705	8,582,116	8,226,689	7,639,130	6,847,364	6,163,260
	NA	NA	NA	NA	3.3	3.0	2.1	2.0	2.0	2.1	2.0	2.0	1.9	1.8	1.8	1.7

* Of all sickness allowance spells (days) beginning each year.

Source: The MHSD Database.

6 CONCLUSIONS AND OUTCOMES

The study indicates that data availability in the Russian Federation for the period under investigation is on a comparable level with the availability of the MINDFUL indicators in EU Member States. Some 13 out of 35 MINDFUL mental health indicators (on cause-specific mortality, prevention, health resources and health care utilisation) are available for Russia. However, the availability of data on population mental health, i.e. psychiatric morbidity and positive mental health is low.

The RF MINDFUL-related state and ministerial statistical data taken from the key national mental health statistical bodies: Federal State Statistics Service Rosstat, RF Ministry of Health and Social Development, Central Scientific and Research Institute for Organisation and Informatisation of Public Health, Moscow Research Institute of Psychiatry as well as State Research Centre for Social and Forensic Psychiatry named after V.Serbysky, proved to be reliable. However, the state's (Rosstat) and ministerial (the MHSD and its institutions) absolute numbers are non-comparable, since they cover divergent numbers of local medical bodies (MHSD data relates to Ministry-subordinated bodies while Rosstat data covers all local medical bodies, regardless of under whose authority they fall). Rosstat's absolute numbers are always greater than the relevant ministerial ones and provide a more complete picture of the mental health system in Russia. For international comparisons, preferably data from Rosstat should be used, but MHSD data on national health expenditure is more comprehensive and reliable than that of Rosstat.

The countrywide rates per 100,000 inhabitants derived from the different RF statistical bodies do not substantially differ from each other, and correspond to the relevant figures estimated by WHO EURO in the Health-For-All Database. International comparisons (with EU member states, Baltic countries in particular) of MINDFUL indicators expressed as rates per 100,000 population are thus feasible.

6.1 Mental health status

Our research showed that data on the mental health status of the living Russian population is largely lacking. The MINDFUL indicator "Happiness" constituted an exception (Table 5.5). The Russian total average scores on indicator range between 2.5 and 2.8, and tend to be somewhat lower than the corresponding figures of the three Baltic EU countries. In 1990, the scores were 2.5 in Russia and the Baltic countries (except for Estonia, which scored 2.6). In 1999, two surveys in RF reported an average score of 2.4–2.5, while the Baltic countries scored 2.6–2.8. In old EU Member States, the average score is in general over 3.0, and Finland has scored 3.1 in three consecutive surveys (in 1990, 1996, and 2000). The results indicate that, as a whole, the RF residents judge the overall quality of their life lower than people within the EU.

Suicide data confirmed the high level of suicide mortality in Russia. In 2005, 30 people of 100,000 committed suicide in Russia. However, the suicide mortality in Russia has decreased by 30% after the peak culminating in 1994 (Table 5.1). The trend has been similar in the Baltic EU members. The most successful reduction of suicides has occurred in Estonia and Latvia (over 40% reduction), but suicide prevention has been less successful in Lithuania (15% reduction since 1994). In Finland, the reduction since 1994 has been 27%. Today, when compared to EU countries, suicide mortality in Russia is higher than in any EU Member State except Lithuania.

Deaths due to undetermined intent (i.e. there is insufficient information to make the distinction between accident, self-harm and assault) are much more common in RF than in any EU country. In 2005, 31 people of 100,000 inhabitants in Russia were recorded as dead due to

undetermined intent (Table 5.3). The rate is threefold to that of the Baltic countries (8-12/100,000), which within EU evidence the highest death rates due to undetermined intent. The standardised death rate due to undetermined intent in Russia is more than tenfold the corresponding rate in EU27, which was 2.3 in 2004.

6.2 Health systems

The study revealed that in 1990, at time of the breakdown of the Soviet Union, the Baltic states were better equipped with psychiatric beds and with psychiatrists than Russia. Since 1990, the basic trend in the number of psychiatric beds and number of long-stay patients has been a decrease of rates per 100,000 inhabitants in Russia and the EU Baltic countries (figures on long-term patients are not available from Estonia). However, the decrease of beds in RF has been 13% from the 1990 level (Table 5.6), whereas the beds in the Baltic countries have decreased more clearly: by 72%, 35% and 31% for Estonia, Lithuania and Latvia, respectively. Thus, of the four countries, Estonia is the leader in terms of the decline in the number of psychiatric beds. International comparability of numbers of psychiatric beds is low (Lavikainen et al, 2007), but current numbers from RF indicate that there still is overemphasis on institutional psychiatric care in Russia when compared to many Western European EU Member States.

The number of in-patient episodes due to mental health conditions has increased in Russia by 7% since 1990 (Table 5.9). This trend is similar to that of a major part of the EU member states (except Denmark, Italy, Luxembourg, Poland, and Sweden). In Lithuania the rate has increased grossly (by almost 50%) since 1990, whereas in Estonia and Latvia the increase is minor (by 3% and 2% respectively) throughout 1998 – 2004 for which the data is available. When compared with the Baltic countries and Finland (1,806/100,000 inh. in 2004) the RF 2005 rate of in-patient episodes due to mental conditions is the lowest (1,004/100,000 inh.).

The number of long-stay patients in RF has decreased with 17 % from 1994 to 2005 (Table 5.10). During the same time period, the corresponding figure from Finland has decreased with 31 % but the number of long-stay in-patients remains high in Finland (30/100,000 inh. in 2004) and indicates that development of community-based services for people with long-term remains a major challenge in Finland. In RF, there were 23 long stay patients per 100,000 inhabitants in 2005. In Lithuania, the number of long-stay inpatients has dramatically decreased (from 21/100,000 inh. in 1991 to 6/100,000 inh. in 2004) but in Latvia numbers remain at an extraordinary high level (39 per 100,000 inh. in 2005). Numbers from Estonia are not available. The figures indicate that in many EU countries, including Finland, deinstitutionalisation of psychiatric care remains a challenge. However, caution should be used in comparing countries, since the role of long-stay social care institutions vary from country to country, and these may not be included in the statistics.

Unlike Russia, the Baltic EU countries do not gather statistics on indicators # 26, “Involuntary treatment,” and # 34 “Sickness allowance spells due to mental disorders”.

Like in most EU Member States, the rate of out-patient psychiatric visits in Russia has increased since early 1990s (Table 5.13). Although the trend is similar in the EU countries and Russia, there are considerable comparability problems between countries due to differences in health care systems. Current rates of out-patient visits are considerably lower in all the Baltic countries than in Russia, but this may reflect variations in health statistics methods rather than real differences.

Like in the EU Member States, the number of psychiatrists has increased in Russia (Table 5.7). Today, the density of psychiatrists in Russia is equivalent to many EU Member States, but clearly lower than in UK, France, or the Nordic welfare states (Denmark, Finland, and Sweden). In the

Baltic states, a clear increase in the number of psychiatrists to the same level as the Nordic countries can be seen in Lithuania (18 psychiatrists/100,000 inh. in 2005), but no increase since 1990 can be seen in Latvia (11 psychiatrists/100,000 inh. in 2006), indicating that density of psychiatrists in Latvia today is lower than the density in Russia (13 psychiatrists/100,000 inh. in 2005).

However, figures from MRIP indicate that there has been no increase in number of child psychiatrists in RF since 1990 (Table 5.8). In 2005, there were 1,1 child psychiatrists for 100,000 inhabitants. During the same time period, there has been a considerable increase in many EU Member States (e.g. Germany, France, UK, Denmark, and Finland), but not in the Baltic countries (Lithuania: 1.5 child psychiatrist/ 100,000 inh. in 2005, Latvia: 1.0 child psychiatrist /100,000 inh. in 2006).

Since 1990, the absolute number of disability pensions due to mental disorders has been constantly increasing in Russia whereas the percentage of disability due to mental disorders pensions of all disability pensions (MINDFUL indicator # 33) has been constantly decreasing (from 13.4% to 7.2 %). This is due to the fact the overall number of disability pensions has been increasing far more rapidly than the number of disability pensions due to mental disorders. Currently, the ratio of disability pensions due to mental disorders of all disability pensions is lower in Russia than in any country available in the MINDFUL database. The range in the MINDFUL database goes from 11% for Austria in 2000 to 43% for Finland in 2004. Data on ratio of disability pension are not available for the Baltic countries.

6.3 Final words

The study also demonstrates development needs within the mental health information system in Russia. Challenges exist mainly with respect to measurement of population mental health status in nationally representative population surveys. Development of automated mortality-based indicators, which were obtainable for 17 federal subjects of Russia, remains a challenge too.

The large volumes of RF statistics on European mental health indicators obtained during the study have enriched the MINDFUL project database and will probably serve in comparisons with corresponding data across the EU member states. The authors hope that the joint Finnish-Russian pilot study on the availability of the MINDFUL-related Russian statistics will initiate dialogue and further cooperation between the EU and the Russian Federation on mental health-related issues.

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Appendix 1. LIST OF THE MINDFUL MENTAL HEALTH INDICATORS

GROUP: HEALTH STATUS (1–13)

Domain: Cause specific mortality

- 1a. Suicide (SDR)
- 1b. Suicide (CD)
- 2a. Deaths of undetermined intent (SDR)
- 2b. Deaths of undetermined intent (CDR)
3. Drug related deaths
4. Alcohol related deaths

Domain: Morbidity, disease specific

5. Any anxiety disorder
6. Major depression
7. Hazardous and harmful drinking
8. Suicide attempts

Domain: Morbidity, generic

9. Psychological distress
10. Mental disorders and adjustment among children and adolescents
11. Energy, vitality
12. Happiness
13. Psychological impairment

GROUP: DETERMINANTS OF HEALTH (14–18)

Domain: Personal conditions

14. Sense of mastery
15. Self-Esteem

Domain: Social and cultural environment

16. Social support
17. Negative life events
18. Childhood adversities

GROUP: HEALTH SYSTEMS GROUP (19–35)

Domain: Prevention, health protection and promotion

19. Suicide prevention
20. Mental health promotion

Domain: Health resources (domain)

21. Number of psychiatric beds
22. Number of psychiatrists
23. Number of child (and adolescent) psychiatrists

Domain: Health care utilisation; psychiatric care and social services

24. Number of in-patient episodes due to mental conditions
25. Number of long-stay patients
26. Involuntary placements
27. Use of out-patient services
28. Self-reported use of mental health services
29. Use of antidepressants
30. Use of antipsychotics
31. Use of anxiolytics

- 32. Use of hypnotics
 - 33. Disability pensions due to mental disorders
 - 34. Sickness allowance spells due to mental disorders
- Domain: Expenditure (domain)
- 35. Expenditure on mental health services

Source: MINDFUL, 2006.

Appendix 2. LIST OF THE MINDFUL SURVEY INSTRUMENTS

1. CIDI-SF

The World Health Organization Composite International Diagnostic Interview – Short Form (Kessler et al., 1998). CIDI-SF 12 Month DSM-IV Version 1.1, December 2002.

Indicators: # 5. “Any anxiety disorder” and # 6. “Major depression”.

2. AUDIT-5

5 items (1, 2, 4, 5, 10) from the original AUDIT (Alcohol Use Disorders Identification Test) version (Saunders et al., 1993).

Indicator # 7. “Hazardous and harmful drinking”.

3. Specific question: “Have you ever attempted suicide?” from the CIDI-SF (Kessler et al., 1998).

Indicator # 8. “Suicide attempts”.

4. SF-36 (RAND-36)

Medical Outcome Study Short-Form Health Survey; Syn.: 36-item Generic Health Measure Survey (Ware et al, 1993). (Hays, Sherbourne and Mazel., 1993).

Indicators: # 9. “Psychological distress,” # 11. “Energy, vitality” and # 13. “Psychological impairment”.

5. SDQ

Strengths and Difficulties Questionnaire (Goodman, 1997).

Indicator # 10. Mental disorders and adjustment among children and adolescents.

6. Andrews 4-step verbal question on happiness (Andrews and Witney, 1976).

Indicator # 12. “Happiness”.

7. SOM-7

The 7-item version of the Sense of Mastery questionnaire (Personal Mastery Scale) (Pearlin et al., 1981).

Indicator # 14. “Sense of mastery”.

8. RSES

The 10-item Rosenberg Self-Esteem Scale (Rosenberg, 1965)

Indicator # 15. “Self-esteem”.

9. BSSQ (SSQ6)

The 6- item Brief Social Support Questionnaire (Van Sonderen, 1991)

Indicator # 16. “Social support”.

10. LTE

The List of Threatening Events (Brugha et al., 1985)

Indicator # 17. “Negative life events”.

11. Childhood adversities

National Comorbidity Survey (Kessler R.C. National Comorbidity Survey: Baseline (NCS-1), 1990–1992, University of Michigan, Institute of Social Research Survey Research Center): Life event history section.

Indicator # 18. Childhood adversities.

12. Help-seeking

Specific question (Eurobarometer 58.2, 2003. Q.46) about seeking help from somebody in relation of a mental health problem during the last 12 months.

Indicator # 28. “Self-reported use of mental health services”.

Source: MINDFUL, 2006.

Appendix 3. MENTAL HEALTH DATA SOURCES IN RUSSIA

1. **Rosstat** – Federal State Statistics Service
<http://www.gks.ru/wps/portal/english>
1.1 Rosstat IPC “Statistics of Russia”
 The Rosstat Informational and Publishing Centre “Statistics of Russia”
<http://www.infostat.ru/eng/index.html>

2. **MHSD** – The Ministry of Health and Social Development of the Russian Federation
 (<http://www.mzsrrf.ru/main/>)
2.1 CSRIOIPH
 The Central Scientific and Research Institute for Organization and Informatisation of Public Health under the Federal Agency of Health and Social Development within the RF Ministry of Health and Social Development
<http://www.mednet.ru/main/>

3. **MRIP**
 The Moscow Research Institute of Psychiatry under the Ministry of Health and Social Development of the Russian Federation
<http://www.psychiatr.ru/inst/instit.shtml>

4. **SRCSEFP**
 State Research Centre for Social and Forensic Psychiatry named after V.Serbysky under the Federal Agency of Health and Social Development within the RF Ministry of Health and Social Development
<http://www.medportal.ru/clinics/guide/213/>

Appendix 4. The list of items of the Russia's 1997 classification of causes of death based on the International Statistical classification of Diseases and Related Health Problems, 10th revision (1989)

1–55	CHAPTER I. Certain infectious and parasitic diseases	Items A00–A99, B00–B99
1	Cholera	A00
2	Typhoid fever	A01.0
3	Paratyphoid fever	A01.1, A01.2, A01.3, A01.4
4	Other salmonella infections	A02
5	Shigellosis	A03
6	Other bacterial foodborne intoxications	A05
7	Other bacterial intestinal infections including amoebiasis and other protozoal intestinal diseases	A04, A06–A08
8	Diarrhoea and gastroenteritis of presumed infectious origin	A09
9	Respiratory tuberculosis, bacteriologically and histologically confirmed	A15
10	Respiratory tuberculosis, not confirmed bacteriologically or histologically	A16
11	Tuberculosis of nervous system	A17
12	Tuberculosis of intestines, peritoneum and mesenteric glands	A18.3
13	Tuberculosis of bones and joints	A18.0
14	Tuberculosis of genitourinary system	A18.1
15	Other tuberculosis excluding late effects	A18.2–8, A19
16	Plague	A20
17	Anthrax	A22
18	Brucellosis	A23
19	Leprosy [Hansen's disease]	A30
20	Tetanus neonatorum	A33
21	Obstetrical tetanus	A34
22	Other tetanus	A35
23	Diphtheria	A36
24	Whooping cough	A37
25	Scarlet fever	A38
26	Meningococcal infection	A39
27	Septicaemia	A40, A41
28	Erysipelas	A46
29	Other bacterial infections excluding foodborne intoxications	A21, A24–A28, A31, A32, A42, A43, A44, A48, A49
30	Syphilis (all forms)	A50–A53
31	Other predominantly sexually transmitted diseases	A54–A64
32	Relapsing fevers	A68
33	Typhus fever	A75
34	Other rickettsioses	A77–A79
35	Acute poliomyelitis	A80
36	Rabies	A82
37	Viral encephalitis	A83–A86
38	Yellow fever	A95
39	Other arthropod-borne viral fevers and viral haemorrhagic fevers	A90–A94, A96–A99
40	Measles	B05
41	Acute hepatitis A	B15
42	Acute hepatitis B	B16
43	Other acute and chronic viral hepatitis	B17–B19

44	Human immunodeficiency virus [HIV] disease (B20-B24)	B20–B24
45	All other viral diseases	A81, A87–A89, B00–B04, B06–B09, B25–B34
46	Protozoal diseases (Malaria)	B50–B54
47	Leishmaniasis	B55
48	Trypanosomiasis	B56–B57
49	Schistosomiasis [bilharziasis]	B65
50	Echinococcosis	B67
51	Dracunculiasis and filariasis	B72, B74
52	Other helminthiasis	B66, B68–B71, B73, B75–B83
53	Other and unspecified infectious and parasitic diseases	A65–A67, A69–A74, B35–B49, B58–B60, B64, B85–B89, B95–B97, B99
54	Sequelae of tuberculosis	B90
55	Late effects of other infectious and parasitic disease, including late effects of poliomyelitis	B91–B94
56–89	CHAPTER II. Neoplasms	Items C00–C97, D00–D48
56	Malignant neoplasm of lip, oral cavity and pharynx	C00–C14
57	Malignant neoplasm of oesophagus	C15
58	Malignant neoplasm of stomach	C16
59	Malignant neoplasm of small intestine	C17
60	Malignant neoplasm of colon	C18
61	Malignant neoplasm of rectum, rectosigmoid junction and anus	C19–C21
62	Malignant neoplasm of liver and intrahepatic bile ducts	C22
63	Malignant neoplasm of pancreas	C25
64	Malignant neoplasm of other and ill-defined digestive organs	C23, C24, C26
65	Malignant neoplasm of larynx	C32
66	Malignant neoplasm of trachea, bronchus and lung	C33, C34
67	Malignant neoplasm of other and ill-defined sites respiratory and intrathoracic organs	C30, C31C37–C39
68	Malignant neoplasm of bone and articular cartilage of limbs and other and unspecified sites	C40, C41
69	Malignant melanoma of skin	C43
70	Other malignant neoplasms of skin	C44
71	Mesothelioma, Kaposi's sarcoma, malignant neoplasm of peripheral nerves and autonomic nervous system, retroperitoneum, peritoneum and other connective and soft tissue	C45–C49
72	Malignant neoplasm of breast	C50
73	Malignant neoplasm of cervix uteri	C53
74	Malignant neoplasm of corpus uteri and of uterus, part unspecified	C54, C55
75	Malignant neoplasm of ovary	C56
76	Malignant neoplasm of other and unspecified female genital organs	C51, C52, C57, C58
77	Malignant neoplasm of prostate	C61
78	Malignant neoplasm of other male genital organs	C60, C62, C63
79	Malignant neoplasm of kidney, except renal pelvis	C64
80	Malignant neoplasm of bladder	C67
81	Malignant neoplasm of other and unspecified urinary organs	C65, C66, C68
82	Malignant neoplasm of meninges, brain, spinal cord, cranial nerves and other parts of central nervous system	C70–C72
83	Malignant neoplasms of other and independent (primary) multiple sites	C69, C73–C80, C97

84	Hodgkin's disease	C81
85	Non-Hodgkin's lymphoma	C82–C85
86	Multiple myeloma and malignant plasma cell neoplasms	C90
87	Leukaemia	C91–C95
88	Other and unspecified malignant neoplasms of lymphoid, haematopoietic, related tissue and malignant immunoproliferative diseases	C88, C96
89	In situ neoplasms benign and unspecified neoplasms	D00–D48
90–92	CHAPTER III. Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	Items D50–D89
90	Haemolytic anaemias	D55–D59
91	Other anaemias	D50–D53, D60–D64
92	Other diseases of blood and blood-forming organs	D65–D89
93–96	CHAPTER IV. Endocrine, nutritional and metabolic diseases	Items E00–E90
93	Diabetes mellitus	E10–E14
94	Diseases of other endocrinous glands	E00–E07, E15–E16, E20–E35
95	Malnutrition	E40–E46
96	Other nutritional and metabolic disorders	E50–E90
97–103	CHAPTER V. Mental and behavioural disorders	Items F01–F99
97	Chronic alcoholism	F10.0–3, F10.6 (part) F10.8, 9
98	Alcoholic psychosis, encephalopathy, dementia	F10.4–5, F10.6 (part) F10.7
99	Other psychoses	F00–F09, F20–F29
100	Mental and behavioural disorders due to drug use and use of other psychoactive substances	F11, F12, F14, F13 (part), F15 (part), F16 (part), F19 (part)
101	Mental and behavioural disorders due to use of other psychoactive substances	F17, F13 (part), F15 (part), F16 (part), F19 (part)
102	Mental retardation	F70–F79
103	Other mental and behavioural disorders	F30–F69, F80–F99
104–111	CHAPTER VI. Diseases of the nervous system	Items G00–G98
104	Meningitis, excluding infectious and parasitic meningites	G00, G03
105	Other inflammatory diseases of the central nervous system	G04, G06, G08, G09
106	Parkinson's disease and secondary parkinsonism	G20, G21
107	Alzheimer's disease	G30
108	Multiple sclerosis	G35
109	Epilepsy	G40, G41
110	Infantile cerebral palsy	G80
111	Other diseases of the nervous system	G10–G12, G23–G25, G31, G36, G37, G43–G45, G47, G50–G72, G81–G98
112	CHAPTER VII. Diseases of the eye and adnexa	Items H00–H59
113–114	CHAPTER VIII. Diseases of the ear and mastoid process	Items H60–H95
113	Otitis media	H65–H66
114	Other diseases of the ear and mastoid process	H60–H62, H70–H95
115–147	CHAPTER IX. Diseases of the circulatory system	Items I00–I99
115	Acute rheumatic fever	I00–I02

116	Chronic rheumatic heart diseases	I05–I09
117	Hypertensive heart disease	I11
118	Hypertensive renal disease	I12
119	Hypertensive heart and renal disease	I13
120	Other and unspecified hypertensive disease	I10, I15
121	Acute myocardial infarction including certain current complications following acute myocardial infarction	I21, I23
123	Subsequent myocardial infarction	I22
125	Atherosclerotic heart disease	I25.1
127	Other forms of chronic ischaemic heart diseases	I25.2–9
129	Other forms of acute ischaemic heart diseases	I20, I24.1–9
131	Pulmonary heart disease and diseases of pulmonary circulation	I26–I28
132	Other forms of heart disease	I30–I51
133	Subarachnoid haemorrhage	I60
135	Intracerebral haemorrhage and other nontraumatic intracranial haemorrhage	I61–I62
137	Cerebral infarction	I63
139	Stroke, not specified as haemorrhage or infarction	I64
141	Other cerebrovascular diseases	I67–I69
143	Atherosclerosis	I70
144	Other diseases of arteries, arterioles and capillaries	I71–I79
145	Phlebitis and thrombophlebitis, venous embolism and thrombosis	I80–I82
146	Other disorders of veins and lymphatic vessels	I83–I89
147	Other and unspecified diseases of circulatory system	I95–I99
148–164	CHAPTER X. Diseases of the respiratory system	Items J00–J99
148	Acute upper respiratory infections	J00–J01, J02.8–9, J03–J06
149	Streptococcal pharyngitis	J02.0
150	Influenza	J10–J11
151	Viral pneumonia, not elsewhere classified	J12
152	Bacterial pneumonia	J13–J15
153	Pneumonia due to other infectious organisms, not elsewhere classified	J16
154	Pneumonia, organism unspecified	J18
155	Acute lower respiratory infections	J20–J22
156	Bronchitis, not specified as acute or chronic	J40
157	Emphysema	J43
158	Other chronic obstructive pulmonary disease	J42, J41, J44
159	Asthma	J45–J46
160	Bronchiectasis	J47
161	Pneumoconiosis and other lung diseases due to external agents	J60–J70
162	Other respiratory diseases principally affecting the interstitium	J80–J84
163	Suppurative and necrotic conditions of lower respiratory tract	J85–J86
164	Other diseases of respiratory system	J30–J39, J90–J99
165–179	CHAPTER XI. Diseases of the digestive system	Items K00–K93
165	Gastric ulcer	K25
166	Duodenal ulcer	K26
167	Peptic ulcer, site unspecified	K27
168	Gastritis and duodenitis	K29
169	Diseases of appendix	K35–K38
170	Hernia	K40–K46
171	Noninfective enteritis and colitis	K50–K52
172	Paralytic ileus and intestinal obstruction without hernia	K56

173	Alcoholic liver disease	K70
174	Fibrosis and cirrhosis of liver	K74
175	Other diseases of liver	K71–K73, K75–K76
176	Cholelithiasis	K80
177	Cholecystitis	K81
178	Acute pancreatitis and other diseases of pancreas	K85–K86
179	Other diseases of the digestive system	K00–K14, K20–K24, R28, K30–K31, K55, R57–K66, K82, K83, K90–K93
180	CHAPTER XII. Diseases of the skin and subcutaneous tissue	Items L00–L98
181–184	CHAPTER XIII Diseases of the musculoskeletal system and connective tissue	Items M00–M99
181	Rheumatoid arthritis	M05–M06
182	Systemic lupus erythematosus	M32
183	Osteomyelitis	M86
184	Other diseases of the musculoskeletal system and connective tissue	M00–M03, M08, M10–M31, M33–M85, M87–M99
185–193	CHAPTER XIV. Diseases of the genitourinary system	Items N00–N99
185	Acute and rapidly progressive nephritic syndrome	N00–N01
186	Chronic nephritic syndrome	N03
187	Other glomerular disorders (nephritic syndromes isolated, hereditary nephropathy, nephrotic syndrome unspecified)	N02, N04N05–N08
188	Acute tubulo-interstitial nephritis	N10
189	Other renal tubulo-interstitial diseases	N11–N15
190	Urolithiasis (Calculus of urinary tract)	N20–N23
191	Other diseases of urinary system	N17–N19, N25–N39
192	Hyperplasia of prostate	N40
193	Other diseases of genital organs	N41–N99
194–205	CHAPTER XV. Pregnancy, childbirth and the puerperium	Items O00–O99
	Pregnancy with abortive outcome:	
194	Ectopic pregnancy	O00
195	Legally induced abortion (Medical abortion and failed attempted abortion)	O04, O07
196	Abortion started out of the hospital and unspecified	O01–O03, O05, O06, O08
	Direct obstetric causes:	
197	Toxaemia in pregnancy	O10, O11, O13–O15, O21
198	Haemorrhage due to placenta praevia and separation of placenta	O44.1, O45, O20
199	Antepartum and postpartum haemorrhage	O46, O72.0–3, O67.0, 8, 9
200	Complications of anaesthesia during pregnancy, labour and delivery, the puerperium	O29, O74, O89
201	Septicaemia in childbirth and the puerperium	O85, O86.O088.3, O91.1
202	Obstetric embolism	O88.0–2, O88.8
203	Other direct obstetric causes	O12, O22–O28, O30–O43, O44.0, O47, O48, O60–O66, O68–O71, O73, O75, O80–O84, O86.1–4,8 O87, O90, O91.2, O92
204	Indirect obstetric causes	O98, O99
205	Other complicating pregnancy, childbirth and the puerperium	O95–O97
206–216	CHAPTER XVI. Certain conditions originating in the perinatal period	Items P05–P96
206	Birth trauma	P10–P15
207	Intrauterine hypoxia and birth asphyxia	P20–P21

208	Respiratory distress of newborn	P22
209	Congenital pneumonia	P23
210	Other respiratory disorders specific to the perinatal period (P20-P29)	P24–P28
211	Bacterial sepsis of newborn	P36
212	Omphalitis of newborn with or without mild haemorrhage	P38
213	Haemorrhagic disorders of newborn	P50–P54
214	Haemolytic disease and other perinatal jaundices	P55–P61
215	Transitory endocrine and metabolic disorders specific to newborn	P70–P74
216	Other conditions originating in the perinatal period	P29, P35, P37, P39, P75–P96, P05–P08
217–225	CHAPTER XVII. Congenital malformations, deformations and chromosomal abnormalities	Items Q00–Q99
217	Spina bifida and congenital hydrocephalus	Q03, Q05
218	Other congenital anomalies of central nervous system	Q00–Q02, Q04, Q06–Q07
219	Congenital anomalies of heart	Q20–Q24
220	Other congenital anomalies of circulatory system	Q25–Q28
221	Congenital malformations of the respiratory system	Q30–Q34
222	Congenital anomalies of digestive system	Q35–Q45
223	Congenital malformations of the urinary system	Q60–Q64
224	Down's syndrome and other chromosomal abnormalities, not elsewhere classified	Q90–Q99
225	Other congenital malformations, deformations and chromosomal abnormalities	Q10–Q18, Q50–Q56, Q65–Q89
226–228	CHAPTER XVIII. Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	Items R00–R99
226	Senility	R54
227	Sudden infant death syndrome	R95
228	Other ill-defined and unspecified causes of mortality	R00–R53, R55–R94, R96–R99
229–238	CHAPTER XIX. Injury, poisoning and certain other consequences of external causes	Items S00–S09, T00–T98
229	Injuries to the head	S00–S09
230	Injuries to the neck	S10–S19
231	Injuries to the thorax	S20–S29
232	Injuries to the abdomen, lower back, lumbar spine and pelvis	S30–S39
233	Injuries to the limbs	S40–S99
234	Effects of foreign body entering through natural orifice	T15–T19
235	Burns and corrosions	T20–T32
236	Frostbite	T33–T35
237	Poisoning by drugs, medicaments and biological substances, toxic effects of substances chiefly nonmedicinal as to source	T36–T65
238	Other injury, poisoning and consequences of external causes	T00–T14, T66–T98
239–254	CHAPTER XX. External causes of morbidity and mortality	Items V01–V89
239	Pedestrian injured in transport accident	V01–V09
240	Car occupant injured in transport accident	V40–V49
241	Other and unspecified transport accidents	V10–V39V50–V99
242	Accidental fall	W00–W19
243	Accidental drowning and submersion	W65–W74
244	Accidental inhalation and ingestion causing obstruction of respiratory tract, foreign body entering other orifices	W75–W84

245	Accident caused by electric current	W85–W99
246	Accident caused by fire	X00–X09
247	Accidental poisoning by and exposure to alcohol	X45
248	Other accidental poisoning	X40–X44X46–X49
249	Suicide and selfinflicted injury	X60–X84
250	Homicide and injury purposely inflicted by other persons, including legal execution	X85–V09
251	Injury undetermined whether accidentally or purposely inflicted	Y10–Y34
252	Operations of war	Y36
253	Misadventures to patients during medical care	Y40–Y84
255	Accident caused by firearm missile	W32–W34
254	Other and unspecified external causes late effects of external causes	W20–W31,W35–W64, X10–V39, X50–V59, Y35Y85–Y89

Source: The CSRIOIPH (Unit on Analysis of the Population Health Statistics') Documentation.

Appendix 5. ADMINISTRATIVE MAP OF THE RUSSIAN FEDERATION



Appendix 6. Federal Districts of the Russian Federation

1. CENTRAL FEDERAL DISTRICT
 - Belgorod Oblast
 - Bryansk Oblast
 - Vladimir Oblast
 - Voronezh Oblast
 - Ivanovo Oblast
 - Kaluga Oblast
 - Kostroma Oblast
 - Kursk Oblast
 - Lipetsk Oblast
 - Moscow Oblast
 - Oryol Oblast
 - Ryazan Oblast
 - Smolensk Oblast
 - Tambov Oblast
 - Tver Oblast
 - Tula Oblast
 - Yaroslavl Oblast
 - Moscow
2. SOUTHERN FEDERAL DISTRICT
 - Republic of Adygeya
 - Republic of Daghestan
 - Republic of Ingushetia
 - Kabardino-Balkar Republic
 - Republic of Kalmykiya
 - Karachayevo-Cherkess Republic
 - Republic of North Ossetiya-Alania
 - Chechen Republic
 - Krasnodar Krai
 - Stavropol Krai
 - Astrakhan Oblast
 - Volgograd Oblast
 - Rostov Oblast
3. NORTH-WESTERN FEDERAL DISTRICT
 - Republic of Karelia
 - Republic of Komi
 - Arkhangelsk Oblast
 - incl. Nenets Autonomous Okrug
 - Vologda Oblast
 - Kaliningrad oblast
 - Leningrad Oblast
 - Murmansk Oblast
 - Novgorod Oblast
 - Pskov Oblast
 - St. Petersburg
4. FAR-EASTERN FEDERAL DISTRICT
 - Republic of Sakha (Yakutiya)
 - Primorsk Krai
 - Khabarovsk Krai
 - Amur Oblast
 - Kamchatka Oblast
 - incl. Koryak Autonomous Okrug
 - Magadan Oblast
 - Sakhalin Oblast
 - Jewish Autonomous Oblast
 - Chukotka Autonomous Okrug
5. SIBERIAN FEDERAL DISTRICT
 - Republic of Altai
 - Republic of Buryatiya
 - Republic of Tyva
 - Republic of Khakassiya
 - Altai Krai
 - Krasnoyarsk Krai
 - incl. Taimyr (Dolgano-Nenets) Autonomous Okrug
 - incl. Evenk Autonomous Okrug
 - Irkutsk Oblast
 - incl. Ust-Ordynsk Buryat Autonomous Okrug
 - Kemerovo Oblast
 - Novosibirsk Oblast
 - Omsk Oblast
 - Tomsk Oblast
 - Chita Oblast
 - incl. Aginsk-Buryat Autonomous Okrug
6. URALS FEDERAL DISTRICT
 - Kurgan Oblast
 - Sverdlovsk Oblast
 - Tyumen Oblast
 - incl. Khanty-Mansi Autonomous Okrug-Yugra
 - incl. Yamal-Nenets Autonomous Okrug
 - Chelyabinsk Oblast
7. VOLGA FEDERAL DISTRICT
 - Republic of Bashkortostan
 - Republic Mari El
 - Republic of Mordovia
 - Republic of Tatarstan
 - Udmurt Republic
 - Chuvash Republic

Kirov Oblast
Nizhniy Novgorod Oblast
Orenburg Oblast
Penza Oblast
Perm Oblast
 incl. Komi-Permyak Autonomous
 Okrug
Samara Oblast
Saratov Oblast
Ulyanovsk Oblast

Source: http://en.wikipedia.org/wiki/Federal_districts_of_Russia

Appendix 7. Economic Regions of the Russian Federation

1. NORTHERN ECONOMIC REGION
 - Republic of Karelia
 - Republic of Komi
 - Arkhangelsk Oblast
 - incl. Nenets Autonomous Okrug
 - Vologda Oblast
 - Murmansk Oblast
2. NORTHWESTERN ECONOMIC REGION
 - St. Petersburg
 - Leningrad Oblast
 - Novgorod Oblast
 - Pskov Oblast
3. CENTRAL ECONOMIC REGION
 - Bryansk Oblast
 - Vladimir Oblast
 - Ivanovo Oblast
 - Kaluga Oblast
 - Kostroma Oblast
 - Moscow
 - Moscow Oblast
 - Oryol Oblast
 - Ryazan Oblast
 - Smolensk Oblast
 - Tver Oblast
 - Tula Oblast
 - Yaroslavl Oblast
4. VOLGA-VYATKA ECONOMIC REGION
 - Republic Mari El
 - Republic of Mordovia
 - Chuvash Republic
 - Kirov Oblast
 - Nizhniy Novgorod Oblast
5. CENTRAL-CHERNOZYOM ECONOMIC REGION
 - Belgorod Oblast
 - Voronezh Oblast
 - Kursk Oblast
 - Lipetsk Oblast
 - Tambov Oblast
6. VOLGA ECONOMIC REGION
 - Republic of Kalmykiya
 - Republic of Tatarstan
7. NORTH-CAUCASIAN ECONOMIC REGION
 - Astrakhan Oblast
 - Volgograd Oblast
 - Penza Oblast
 - Samara Oblast
 - Saratov Oblast
 - Ulyanovsk Oblast
8. URALS ECONOMIC REGION
 - Republic of Bashkortostan
 - Udmurt Republic
 - Kurgan Oblast
 - Orenburg Oblast
 - Perm Oblast
 - incl. Komi-Permyak Autonomous Okrug
 - Sverdlovsk Oblast
 - Chelyabinsk Oblast
9. WEST-SIBERIAN ECONOMIC REGION
 - Republic of Altai
 - Altai Krai
 - Kemerovo Oblast
 - Novosibirsk Oblast
 - Omsk Oblast
 - Tomsk Oblast
 - Tyumen Oblast
 - incl. Khanty-Mansi Autonomous Okrug-Yugra
 - incl. Yamal-Nenets Autonomous Okrug
10. EAST-SIBERIAN ECONOMIC REGION
 - Republic of Buryatiya
 - Republic of Tyva
 - Republic of Khakassiya

- | | |
|--|--|
| <p>Krasnoyarsk Krai
 incl. Taimyr (Dolgano-Nenets)
 Autonomous Okrug
 incl. Evenk Autonomous Okrug</p> <p>Irkutsk Oblast
 incl. Ust-Ordynsk Buryat Autonomous
 Okrug</p> <p>Chita Oblast
 incl. Aginsk-Buryat Autonomous
 Okrug</p> <p>11. FAR EASTERN ECONOMIC REGION
 Republic of Sakha (Yakutiya)
 Jewish Autonomous Oblast</p> | <p>Chukotka Autonomous Okrug
 Primorsk Krai
 Khabarovsk Krai
 Amur Oblast
 Kamchatka Oblast
 incl. Koryak Autonomous Okrug
 Magadan Oblast
 Sakhalin Oblast</p> <p>12. KALININGRAD ECONOMIC REGION
 Kaliningrad Oblast</p> |
|--|--|

Source: http://en.wikipedia.org/wiki/Image:Economic_regions_of_Russia.png

Appendix 8. SECTIONS OF THE RF DOMESTIC LAW ON PSYCHIATRIC CARE

(relevant to the MINDFUL indicator # 26, “Involuntary placements”)

The basic principles of psychiatric medical care in Russia are governed by the Federal Law # 3185-1, enacted in 1992 “On Psychiatric Care and Guarantees of Citizens’ Rights in Its Provision” (hereinafter “the Law”).

Section 29 of the Law sets out the grounds for an involuntary placement in a psychiatric hospital:

Section 29

“A mentally disturbed individual may be hospitalized in a psychiatric hospital against his will or the will of his legal representative and without a court decision having been taken, if the individual’s examination or treatment can only be carried out by in-patient care, and the mental disorder is severe enough to give rise to:

- a) a direct danger to the person or to others, or
- b) the individual’s helplessness, i.e. an inability to take care of himself, or
- c) a significant impairment in health as a result of a deteriorating mental condition, if the affected person were to be left without psychiatric care.”

Section 32 of the Law specifies the procedure for the examination of patients compulsorily confined in a hospital:

Section 32

- “1. A person placed in a psychiatric hospital on the grounds defined by section 29 of the present Law shall be subject to compulsory examination within 48 hours by a commission of psychiatrists of the hospital, which commission shall take a decision as to the necessity of hospitalization. If no reasons for hospitalization are established and the hospitalized person expresses no intention of remaining in the hospital, the person shall be released immediately.
2. If hospitalization is considered necessary, the conclusion of the commission of psychiatrists shall be forwarded to the court having territorial jurisdiction over the hospital, within 24 hours, for a decision as to the person’s further confinement in the hospital.”

Sections 33–35 set out in detail the procedure for judicial review of applications for the compulsory treatment of mentally ill persons:

Section 33

- “1. Involuntary hospitalization for in-patient psychiatric care on the grounds defined by Section 29 of the present Law shall be subject to review by the court having territorial jurisdiction over the hospital.
2. An application for the involuntary placement of a person in a psychiatric hospital shall be filed by a representative of the hospital where the person is detained.

The application containing the grounds for involuntary psychiatric hospitalization shall be accompanied by a reasoned conclusion of a commission of psychiatrists as to the further necessity of the person’s in-patient treatment in a psychiatric hospital.

3. A judge who accepts the application for review shall simultaneously order the person's detention in a psychiatric hospital for the term necessary for that review."

Section 34

- "1. An application for the involuntary placement of a person in a psychiatric hospital shall be reviewed by a judge on the premises of the court or hospital within five days after receipt of the application.
2. The person shall be allowed to participate personally in the hearing in order to determine whether he should be hospitalized. If, on the information provided by a representative of the psychiatric hospital, the person's mental state does not allow him to participate personally in the hearing, the application shall be reviewed by the judge on the hospital's premises.
3. The presence at the hearing of a public prosecutor, a representative of the psychiatric institution requesting hospitalization, and a representative of the person, whom it is intended to detain, shall be mandatory."

Section 35

- "1. Upon examination of the application on the merits, the judge shall either grant or refuse it.
2. The judge's grant of the application shall justify the person's hospitalization and further confinement in the hospital.
3. The judge's decision shall be subject to appeal within ten days by the person placed in the psychiatric hospital, his representative, the head of the psychiatric hospital as well as by an organization entitled by virtue of law or by its charter to protect citizens' rights, or by a public prosecutor. The appeal shall be made in accordance with the rules established in the Code of Civil Procedure of the RF."

Sections 47-1 and 48-1 of the Law provide a patient with the right to complain about the unlawful actions of medical staff:

Section 47

- "1. Unlawful actions of medical, social, educational and other staff and of medical commissions involved in psychiatric care may be complained about ... to a court, a supervising authority or a public prosecutor..."

Section 48

- "1. The complaints [defined in section 47-1] shall be considered by a court in accordance with the Code of Civil Procedure of the RF."

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