

CHAPTER 12

RUSSIAN FEDERATION

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12.1. Introduction

12.1.1. Description of local area

St. Petersburg is one of the largest metropolitan areas in Europe, being the 4th largest city (after London, Paris and Moscow). It is situated at latitude 59° 57' North and longitude 30°19' East. St. Petersburg was created in 1703 by Tsar Peter the Great (1672–1725). The city is situated at the east coast of Finnish gulf on 42 islands of the river Neva delta. St. Petersburg was a capital of Russia in 1712–1728 and 1732–1918.

The total area of the city is 1400 sq. km. The population on 1 January 2001 was 4.5 million. Density of population is 3479 per 1 km². St-Petersburg is situated at the crossing of naval, river, railway and auto ways and is a European gate to Russia. It is connected with direct international flights to 27 cities of Europe, Asia and America. The seaport of St-Petersburg is the largest port in north-west Russia.

Kalininsky district, in which the project was mainly located, is situated in 39.7 km² of territory and includes 7 municipalities.

12.1.2. Medical care

Medical care in the district is provided in the following departments of primary health care:

- 2 centres of family medicine: the Family Medicine Centre with 5 GPs and 6 family nurses, and the Family Medicine Office with 3 GPs and 5 nurses
- Out-patient clinics (for adults): Nos 10, 16, 76, 86, 90, 96,
- Out-patient clinics (for children): Nos 9, 41, 42, 54, 55, 57, 59, 61,
- Maternity welfare centres: Nos 10, 29, 32, 39,

The total number of doctors is approximately 1500 and nurses nearly 2000. The population of the Kalininsky district of St-Petersburg on 1 January 2000 was 462,389 (men 207,937, women 254,452).

Medical care for adolescents and young people in the district follows the structure applying to the Russian Federation as a whole and is displayed in Figure 12.1.

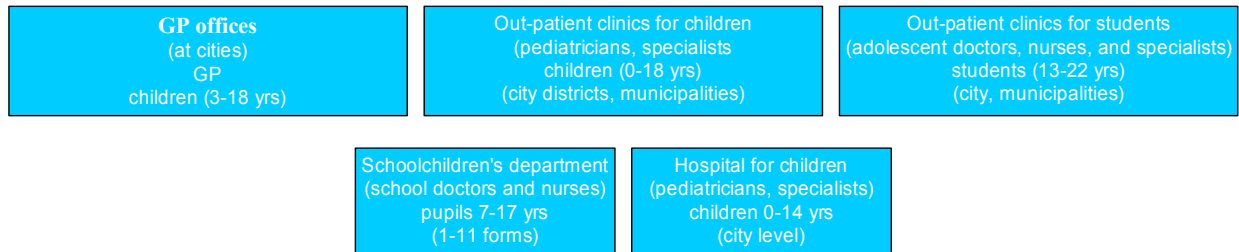
12.1.3. Alcohol consumption and alcohol-related problems

To place the project in context, this section will summarise, as far as possible, the level of alcohol consumption and the extent of alcohol-related problems in the Russian Federation.

Over two million people (2.4 million) were registered as alcoholics in 1999 in Russia (15% female). This official figure is almost certainly an under-estimate and

the true number is probably much more than this. In 1998, 24,000 people died in Russia as a result of poisoning by low-grade alcohol.

**FIGURE 12.1:
Medical Care For Adolescents In the Russian Federation**



Per capita sales of alcohol in litres in Russia from 1992 to 1999 were as follows:

1992 - 5.0	1996 - 7.2
1993 - 5.0	1997 - 7.5
1994 - 6.8	1998 - 7.3
1995 - 9.3	1999 - 7.6

If home-produced alcohol is included, the figure for 1999 increases to 14.3 litres per capita. This is significantly more than other European countries and is exceeded only in Latvia, Slovenia and Estonia¹.

Liver cirrhosis mortality (per 100,000 inhabitants) was recorded as follows:

1984 – 0.70	1994 – 1.52
1986 – 0.20	1995 – 1.80
1992 – 0.33	1998 – 1.23

The decrease in liver cirrhosis mortality from 1985 to 1993 was a consequence of a rigorous anti-alcohol policy by the state. The sharp rise in 1994 was a result of the abolition of the state monopoly and the introduction of market reforms, together with the importation of a large amount of low-grade spirits from abroad². Reasons for the decrease from 1995 to 1998 are unclear but, even taking this decrease into account, the 1998 level of cirrhosis mortality was well above that recorded before the anti-alcohol measures were introduced in the mid-1980s.

Alcoholic psychoses per 100,000 inhabitants (an index of severe alcohol dependence) were recorded as:

1984 – 20.4	1992 – 13.3
1986 – 6.9	1995 – 49.0
1988 – 5.1	1998 – 28.6

Nemtsov² has documented a new growth in alcohol-related mortality, fatal alcohol poisonings and incidence of alcoholic psychoses beginning in 1999-2000. Excessive consumption of alcohol is a significant factor, or possibly the leading factor, in the low life expectancy in Russia compared with other European populations.

As part of this project, a survey was carried out in 2000 among patients of three PHC centres, two in the Kalininsky district and one in the Petrogradsky district of St. Petersburg. All patients who agreed to take part were included. The survey used the AUDIT screening questionnaire³ to establish levels of hazardous and harmful drinking and the CIDI⁴ to establish diagnosis according to ICD-10. The AUDIT questionnaire and scoring template were translated into Russian, together with an information sheet for patients, for the purposes of this survey. Breakdown of categories of alcohol consumption and alcohol-related harm in this sample is shown in Table 12.1.

It will be seen that there is a very small proportion of total abstainers in this sample (2.4%). There is also a very high proportion of patients drinking at dependent or harmful levels or at increased risk of alcohol-related harm (31.5% in total). This is mainly attributable to the drinking of male patients, among whom more than one quarter are either “harmful drinkers” or “alcohol dependent”.

With specific regard to adolescent drinking and illicit drug-taking, registered alcoholism and “narcomania” (i.e. dependence on illicit drugs) morbidity among adolescents (per 100,000 adolescents 15–18) from 1991-98 is shown in Table 12.2. This shows an enormous increase in the incidence of illicit drug problems during the 1990s but there is also a substantial increase in alcohol-related problems among adolescents. The mean age of first using alcohol is 12.7 years.

TABLE 12.1

**Breakdown of categories of alcohol consumption and alcohol-related harm
among patients in three PHC centres in St. Petersburg**

<u>Category</u>	Total (%)	Males (%)	Females (%)
Abstainers	11 (2.4)	5 (2.4)	6 (2.4)
Low risk drinkers (equal or less than 4 U/day/M and 2 U/day/F; less than 5U×1 occasion/M and less than 3U×1 occasion/F)	304 (66.1)	98 (46.2)	206 (83.1)
Hazardous drinkers (more than the above without any detectable drinking problem)	75 (16.3)	52 (24.5)	23 (9.3)
Harmful drinkers (showing physical, emotional, social etc. signs of alcohol-related harm)	42 (9.1)	34 (16.0)	8 (3.2)
Alcohol dependent (according to ICD-10)	28 (6.1)	23 (10.8)	5 (2.0)
Total	460 (100.0)	212 (100.0)	248 (100.0)

TABLE 12.2

**Registered alcoholism and narcomania in adolescents in Russian Federation,
1991-1998**

	1991	1992	1993	1994	1995	1996	1997	1998
Alcoholism	7.6	9.2	7.6	11.3	12.2	11.7	10.8	11.5
Narcomania	4.6	4.5	9.5	19.5	40.8	59.8	67.5	71.4

12.2. The Phase IV Study in St. Petersburg

Owing to the location of the Chief Investigators (VM, TK) in a Department of Adolescent Medicine at the Medical Academy of Postgraduate Studies (MAPS) in St. Petersburg and to the particular problem of excessive alcohol consumption by young people in St. Petersburg, it was decided to focus the Russian arm of the Phase IV study on adolescents and young people. However, the structure of Phase IV components described in Chapter 1 was applied to this target population. While the eventual aim was to disseminate early identification and alcohol brief intervention (EIBI) throughout the Russian Federation, the Phase IV Project was confined to the St. Petersburg and the North-west region of Russia.

The Phase IV project in Russia was supported by two grants from the Know-How Fund (Health Sector Small Partnership Scheme) in London. The first, awarded in February 1998, enabled the Phase IV Technical Focal Point, Professor Nick Heather, to visit St. Petersburg to discuss with Russian partners at MAPS the feasibility of carrying out a collaborative study and to develop an application for full funding. This was submitted in September 1998 and awarded in November of that year. A request for an extension, required mainly because of changes to personnel at MAPS, was agreed in January 2001, with a revised completion date of June 2002. A further extension was allowed in May 2002, with a final completion date of 31/12/2002. This funding enabled Professor Heather to make three further visits to St. Petersburg and contributed to various expenses of the project (printing costs, translation of materials, local travel).

A list of personnel and collaborating organisations will be found in Appendix 12.1.

12.3. Customisation of EIBI materials and services

This part of the project was assisted by a grant from the European Union (the ECATOD project), administered by Dr. Pierluigi Struzzo in Udine, Italy and Dr. Leo Pas in Brussels, Belgium. The ECATOD funding was intended to help investigators from eastern European countries to carry out the customisation component of the WHO Phase IV study by providing training in focus group and Delphi study methodology.

12.3.1. Focus groups with health professionals

To investigate the attitudes of health professionals to implementing EIBI in PHC, 4 focus groups (FGs) were run, composed of 6–9 participants each. All participants were women under 50 years of age. There were no problems with recruitment because all participants were teachers at MAPS. Venues for the groups were the Department of Adolescent Medicine and the Department of Nurse Training at MAPS. Moderators and observers were:

T. Krishtal CM, Assistant, Department of Adolescent Medicine and Valeology.
 M. Oganova CM, Assistant, Department of Adolescent Medicine and Valeology.
 L. Yaremenko, Assistant, Department of Family Medicine
 V. Medvedev MD, Professor, Department of Adolescent Medicine and Valeology

In summary, the group discussions indicated that very few general practitioners or nurses in Russia pay attention to the drinking habits of their patients. Most believe that screening and diagnosis of alcohol problems are not their responsibility and that, in any case, excessive alcohol consumption is a widespread national characteristic.

Thus responding to drinking problems is not an area in which GPs and nurses normally work. The findings suggest that to change doctors' passive attitudes to the identification of drinking problems will be very difficult. This may be easier in nurses, but nurses in Russia are closely dependent on doctors and have no autonomous decision-making capacity. Effective incentives for changing doctors' attitudes and encouraging active intervention are not yet known.

Most group participants did believe they could modify the patient's drinking habits by simple advice. They were shown the "Helping People Change"⁵ or "Skills for Change"⁶ packages during the groups but stated they had never used them or heard about them and only a minority thought they would be prepared to use them. Nevertheless, discussion of how to change the attitudes of GPs and nurses had some effect. The expectation that discussions would facilitate and motivate doctors and nurses to use methods to identify and classify alcohol problems in general practice was partly confirmed. The actual knowledge of health professionals about the harms of drinking was shown to be very low.

Many of the nurses appeared to have difficulty in discussing the topic of the focus group and were not prepared to interact or discuss the relevant issues. GPs, however, interacted well but there was little flexibility in their attitudes. Participants seemed to have a rigid orientation towards teaching programs. In general terms, participants were simply not ready for the identification and classification of alcohol problems among their patients. They were not familiar with the stages of change model⁷. There were very few written materials available in this area for doctors and nurses in Russia at the beginning the project.

The main conclusions of this investigation were that, in order to change attitudes, it would be necessary to create legislation, organize intersectoral cooperation and begin adequate education of health professionals and young people themselves. These possibilities will be returned to below.

12.3.2. Focus groups with young people

Two FGs were run to investigate the attitudes and beliefs of young people to alcohol consumption. Participants were university students. Groups were held at MAPS on 23-24 July 2002. The moderator for both groups was T. Krishtal and the observer was V. Medvedev. Both groups consisted of 10 young people. In the first group (3 men, 7 women), the mean age was 18.1 (range 17-20); in the second group (8 men, 2 women), the mean age was 18.1 (range 17-19).

Most participants said that they mostly used alcohol to relax at the end of a working week or a busy day, especially beer and gin-tonic. On holidays, it was traditional and expected to drink champagne. They also sometimes used alcohol, usually gin or some other form of spirits, if they were in a bad mood.

For the majority of participants, the age of first drinking was between 12 and 14 years but was usually later in girls. If a friend began drinking heavily, most participants said they would have a “hear-to-heart” talk with them and try to help make decisions about solving the problem. There was no suggestion that the friend should seek help from a doctor.

Most of the students defined heavy drinking in terms of negative effects on studying or on health. No consensus about a “normal” amount of alcohol emerged; this was considered to be a matter of individual choice. Some participants had heard of the concept of a “standard unit” of alcohol but were not sure how much alcohol this represented.

All participants said they would reduce their intake of alcohol in the event of illness and if advised to do so by a doctor. They would consider abstaining only in the event of serious illness. This topic caused intense discussion but most students were not convinced that their own drinking could cause or aggravate serious illness. However, they all agreed that alcohol should not be used during pregnancy.

Participants believed it was necessary to educate schoolchildren about alcohol, beginning at age 11-12, and to educate students during their first semester. This should be aimed especially at those who had left home and were living in hostels. It was thought that such education would help to avoid alcohol problems in the conditions of independent living outside the control of parents.

The advertising of beer on TV was thought to influence only those who had not yet acquired a taste for beer. Advertising produced a desire to drink beer as “something tasty” or thirst-quenching. However, all agreed that beer advertising should be banned from TV.

All participants had visited a beer festival. On these occasions, a mood of celebration was caused by the feeling of being on holiday and by music but the high price of beer during festivals and the presence of many drunk young people were unpleasant. Festivals also produced large amounts of litter and this detracted from the holiday mood.

Participants thought it was essential to strictly supervise the sale of spirits and ensure that only those over 18 years could buy it. For beer and wine, however, those over 14 who had obtained a passport should be allowed to purchase. It would be ineffective to forbid the use of alcohol among schoolchildren and to promote the idea that they should not drink but it was essential that training in a culturally acceptable way of drinking should be provided. The recommended amount should be between 1 and 6 units, with larger amounts being reserved for holidays, birthdays and other special occasions.

12.3.3. Delphi survey

Because of the unreliability of mail in Russia, it was not possible to use the postal system. We therefore had to modify our work with the Delphi. It was carried out at meetings during sessions of Baltic Summer School of Health Care in 2001. At the beginning, participants were given a 1st round questionnaire and responded to items on 5-point scales. The 2nd round was completed orally. After one month participants were interviewed again in a 3rd round. GPs and general nurses (GNs) were interviewed at meeting of the Association of Family Medicine at 2-monthly intervals. Social workers were interviewed at monthly intervals while completing postgraduate studies.

The composition of the expert group was: Health service managers = 6; Social workers = 14; GPs = 20; Pediatricians = 11; School psychologists = 13; Nurses = 10. All these experts had considerable experience in working with young people but not necessarily with alcohol problems.

The results were not encouraging for the implementation of EIBI. Managers and nurses believed that the most effective policy against alcohol-related harm would be the introduction of prohibition measures at the state level, despite the fact that such measures had been rescinded in Russia in the early 1990s.

Neither intervention methods nor community action were included as proposals in responses to Delphi items. At the same time, respondents agreed that, in view of present living and cultural standards, preventive programmes would be ineffective. In answer to the question, "Are your doctors ready for prevention work and do they need special training?", they replied: "They never will work in this field."

Nurses' responses revealed a lack of motivation for independent work with patients. The reason for this situation is no doubt the specific role of the nurse in Russia, where nurses work only as the doctor's assistant. This may be the reason they feel powerless in regard to alcohol-related problems and believe in prohibition measures at the state level.

GPs appeared much better motivated for preventive work with their patients and attached great importance to healthy life-style promotion. They understood their role in the mass media in influencing priorities for children, adolescents and youth. The more positive attitudes of GPs' may be accounted for by the fact that they had been trained in healthy life-style promotion. In addition, GPs are more active and skilful in their relationships with patients than outpatient clinic doctors. In the latter case, we found misunderstanding, lack of knowledge and unwillingness to discuss health promotion and disease prevention.

12.3.4. Conclusions regarding customisation and implications for future work

The overall conclusion of this investigation is that the implementation of EIBI in PHC in Russia is a great challenge. The findings of both focus groups and the Delphi survey reflected the fact that drinking problems are not an area in which doctors and nurses of ordinary outpatient clinics normally work or are expected, at

least by young people, to work. The extent of outpatient clinics doctors' (therapists) knowledge about alcohol-related harm was found to be low in St. Petersburg. It is clearly better among social workers and, especially, among GPs. The ascending order of knowledge was: nurses, therapists, social workers and GPs. Effective incentives for changing doctors' and other health professionals' attitudes are unknown but a strategy with this aim would need to involve the following:

- (i) Legislation. Important here is the introduction of controls on alcohol advertising in Russia, especially advertising on TV, and we note that this would have the support of young people. We hope for a definite improvement in this connection from the fact that the State Duma of the Russian Federation is currently considering new legislation regarding limitations on alcohol and tobacco advertising. Another essential improvement would be stricter enforcement of existing legislation regarding the sales of alcohol to minors. It is essential that State Laws regarding alcohol advertising and sales are duplicated at the local level. These measures would encourage health professionals to believe that their efforts to reduce alcohol-related harm among their patients are being supported by government action.
- (ii) Clinical guidelines on EIBI for doctors and nurses separately will be developed at MAPS. We note that an EU-funded project in Barcelona, under the control of Dr. Peter Anderson, Dr. Antoni Gual and Dr. Joan Colom, includes plans to develop clinical guidelines for EIBI for use in the European region (PHEPA). We hope that these guidelines can be adapted for use in Russia.
- (iii) Education of health professionals. Better education of health professionals concerning the harmful effects of alcohol is urgently needed. As a result of work on the customisation component of the project, we have organized at MAPS a range of new training courses on alcohol intervention. These will be described in the section on Reframing (12.4.) below.
- (iv) Intersectoral co-operation and coalition building. Of particular importance for the secondary prevention of alcohol-related harm among young people is co-operation between the health and education sectors which is at present poor. The formation of a Strategic Alliance in St. Petersburg as part of the project was an attempt to make progress in this direction (see section 12.5.).
- (v) Mass media involvement. Probably the most important development in support of reducing alcohol-related harm in Russia is a change in the currently favourable public attitudes to drinking and drunkenness, attitudes that are deeply embedded in the culture. This would obviously require government commitment and expensive mass media campaigns that are well beyond the scope of the present project.
- (vi) Early, active and adequate education of children and adolescents. This will be ineffective if it only involves the input of PHC professionals. Intersectoral co-operation will be essential for the following reasons:
 - a) Alcohol education should begin as early as possible as part of comprehensive health promotion programmes;

- b) Schools and colleges have a suitable infrastructure to allow a comprehensive intervention;
- c) A new methodology is needed that can help to move from knowledge to attitude and behaviour change;
- d) The proportion of health professionals with good or acceptable levels of knowledge, attitudes, skills and behaviour regarding alcohol must be raised. It will be necessary to train intervention teams of doctors, nurses, teachers, social workers, psychologists and volunteers (students of senior schools or institutions);
- e) The proportion of schoolchildren, parents, teachers, physicians, nurses with good or acceptable level of knowledge, attitudes and skills regarding alcohol must be increased;
- f) Experience in other countries should be adapted for use in Russia.

12.4. Reframing Understandings of Alcohol Issues

The aim of this component of the project is to bring about a better understanding of the concept of "risky drinking" and of the practice of EIBI among relevant professional groups and among young people.

12.4.1. Training health professionals

As a result of work in this project and following requests from health professionals during the focus groups described above, we organized new training courses or modified existing courses on health promotion in St. Petersburg MAPS:

Family doctors: Education on Preventive Medicine is a part of the post-graduate course for family doctors at MAPS and since 1999 has included all family doctors in St. Petersburg and the North-west region of Russia. The course is situated in the Department of Family Medicine at MAPS. The Helping People Change package⁵ is now an obligatory part of this course and we have increased the emphasis on training doctors to enquire about alcohol consumption and intervene when necessary. These additions include statistical data and other information on young people's alcohol consumption and improvements in skills related to increasing young people's motivation to discuss alcohol problems.

We have also introduced regular focus group discussions to monitor changes in doctors' attitudes to the difficulties and resources needed to work in this area. The time devoted to the study of adolescent and young people's drinking has been increased and now takes 4 hours in total. In the current year, trainees include 8 GPs working in two centres of family medicine in the Kalininsky district.

Family nurses: Family nurses are also included in the course on Preventive Medicine just described. Trainees currently include 11 nurses working in the Kalininsky district.

School doctors, Pediatricians, Doctors for adolescents: These doctors are trained in the Department of Adolescent Medicine of MAPS. A workshop on "Principles of Preventive Medicine for Young people" includes the theme "Teenagers and Alcohol" and alcohol training passages from *Helping People Change*. This part of

the syllabus is also obligatory. Trainees include 28 doctors working with teenagers in the Kalininsky district in 2000-02.

Also, training of doctors at 10 Youth Consulting Centres and the City Diagnostic Centres for Children and Adolescents is being undertaken on the themes of preventive medicine, including “Alcohol, Drugs and Smoking”. The first of these courses was completed in March 2002 and 32 doctors were included. In future, all doctors in these centres will receive training on alcohol issues on a yearly basis at the Department of Adolescent Medicine.

School nurses: All school nurses (46 persons) were trained in the Kalininsky district. Fifty-two percent (52%) of the nurses responded that they were ready to carry out preventive work on alcohol.

Social workers: A new training course for social workers began in March 2003. This course was dedicated to medical-social care for teenagers and focussed on aspects of preventive medicine, including “Alcohol, Drugs and Smoking”. Material on alcohol was emphasised and included EIBI training.

12.4.2. Training volunteers

In addition to the above changes in the syllabus at MAPS, we have recruited students to work as volunteers in visiting schools to educate adolescents about excessive drinking and other high-risk behaviours. There is a public organization called “Looking to the Future” which has developed the organization, training and implementation of volunteer activity in schools. This programme touches on all risk factors of teenage life, including alcohol, and attempts to train skills for non-risky behaviour. The work of the volunteers is coordinated by adults – teachers, psychologists, heads of teenage clubs. In the last two years, youth organizations working in different preventive programs have been united in an umbrella organization called “ECHO” and this will carry out community action, meetings, conferences and training. This project is supported by UNISEF.

The Department of Adolescent Medicine works together with volunteers and acts as the centre for training team-leaders and developing tutorials. At an ECHO conference, T. Krishtal and V. Medvedev led a Round Table for team-leaders on the prevention of excessive alcohol consumption and the training of volunteers using the *Helping People Change* model. The Department of Adolescent Medicine is currently producing a printed tutorial for volunteers, and will design and develop a poster and a booklet for young people called “Drink Less but Better”.

There now exists one team of volunteers organised by the Department of Adolescent Medicine to carry out training with teenagers in city schools and at the Technical University. The leader of the team of volunteers is T. Krishtal. This group of volunteers consists of 4 young women and 3 young men who are all university students and have been working on the prevention of high-risk behaviour for two years. The program delivered consists of 10 2-hour lessons on the problems of teenagers, including one lesson on alcohol. The contents of this lesson are as follows:

- to show how alcohol can affect the life of a teenager and how alcohol and tobacco can go together in teenage behaviour;

- to explain pros and cons of drinking;
- to define the difference between normal consumption and abuse;
- to impart skills in how to refuse drinks;
- to learn first-aid treatment for acute alcohol intoxication

The techniques used include brain-storming, small group work, role-play, didactic instruction and plenary discussions. So far a total of 9 sessions have been completed in the Kalininsky district, including 158 students. Plans for the future include the creation of a team of volunteers at the University outpatients department № 76. The setting up of the team and the initial training is planned for February 2003. Volunteers are considered to be an important resource for the dissemination of knowledge on risk factors of teenage life. Training by the peer-led method is acknowledged to be effective and to produce positive results in the primary and secondary prevention of excessive drinking.

12.4.3. Introduction of alcohol information in medical records

From January 2003, information on alcohol consumption and risky drinking was inserted into medical documents (patients' registration cards) in two Youth Clinics in Kalininsky. These measures were discussed and accepted at the meeting of Health Care managers in the Kalininsky district in March 2002. There are plans to extend this initiative to other clinics in the district and elsewhere. This will help to disseminate information about recommended consumption levels and the concept of risky drinking among health professionals and adolescent patients.

12.5. Strategic Alliance

Figure 12.2 displays the strategic alliance that has been established in the Kalininsky District of St. Petersburg to further the aims of the project. In the figure, solid lines represent links to organisations that have agreed to contribute to the project and lines with arrows at each end represent instances where mutual co-operative work has been undertaken. Dotted lines represent instances in which it has not been possible to develop co-operation or to elicit a commitment to the aims of the project.

It will be seen from the figure that it has been possible, via the Department of Health in the Kalininsky District, to influence the work of a range of health care facilities, i.e., Adolescent Health Care Centres, Outpatient Clinics for Children and for Students, and GP offices. In addition, there has been direct contact with the City Health Care Centre for Adolescents (Juventa). However, it has not proved possible to develop similar links via the Education Department and contacts with schools, universities and with an NGO organisation for volunteers (see above) have been direct. In addition to the failure to achieve co-operation from the Department of Education, it has also been impossible to establish collaborative links with the municipalities and mass media organisations. The formation of such links represents a challenge for the future.

FIGURE 12.2 ABOUT HERE (See this figure on page 18)

12.6. Demonstration Project

The demonstration project is intended to show that dissemination of screening and brief alcohol intervention in primary health care in a local area is possible, and will hopefully serve as a model for similar applications throughout Russia. The aim is to provide a practical demonstration of how implementation can be achieved, with some evidence of the impact on alcohol-related harm and its cost to the community.

The specific objectives are:

- i) To measure adolescents' and young people's alcohol consumption and knowledge of acceptable levels of consumption;
- ii) To assess motivational changes in doctors (GPs and outpatient doctors) in a local district;
- iii) To assess the implementation of EIBI among young people and professional skills in carrying out brief alcohol intervention.

12.6.1. Surveys of young people's alcohol consumption and knowledge of acceptable levels

Schoolchildren: Eighty-five (85) pupils from 8th–10th forms (14–15 years old) were interviewed by means of a special questionnaire in two schools. The area covered by the questionnaire was smoking, illicit drug-taking and alcohol consumption. With regard to alcohol, the main questions concerned: age of first drinking alcohol; alcoholic beverage preferences; experience of intoxication; interest in information on alcohol effects; preferences for discussion of alcohol problems (parents, teacher, friend, psychologist, specialist).

Results can be found in a report to the Know-How Fund⁸. The data gathered in this survey can serve as a baseline from which to measure any changes alcohol consumption and attitudes to alcohol among schoolchildren that may occur in future.

Students of Universities and Academies: A questionnaire on the same topics as given to schoolchildren (see above) was given to 666 university undergraduates (age 16-18). Once more, the data collected in this survey of students can serve as a baseline with which similar data collected in future surveys may be compared to determine whether changes in alcohol-related behaviour or attitudes have taken place. Detailed findings are available in the report to the Know-How Fund⁸.

12.6.2. Assessment of motivational changes in doctors

Interviews to assess motivational changes with regard to preventive work in general and brief alcohol interventions in particular are currently in progress at MAPS. Doctors attending courses at MAPS will be interviewed before the commencement of their studies and two months after the course has been completed.

12.6.3. Assessing the implementation of EIBI among young people and professional skills in carrying out brief alcohol intervention

A questionnaire developed by the Finnish investigators in the WHO Phase IV project⁹ was translated into Russian for this purpose. This instrument, known as the "exit poll", measures the extent to which patients leaving a health care centre were

asked about their alcohol consumption, whether they received any advice about their drinking and the nature and quality of this advice.

The exit poll survey in St. Petersburg was carried out in an outpatient clinic for students (No. 76) and involved 489 students. These were all first-year students of the Technical University and two technical secondary schools. Students were questioned after receiving a medical examination prior to the commencement of their studies. The survey involved the work of 3 nurse researchers and was carried out over a 3-day period.

Results were analysed by age and gender and are presented in Appendix 12.2. It will be seen that, among male students, very few had been asked about their alcohol consumption. In anything, younger students were more likely to have been asked. Fully three-quarters of the sample had never been asked about their alcohol consumption at any time. Rather more of the younger students were counselled about their drinking, presumably in the form of general warning about the dangers of excess without specific enquiry about their drinking habits. Nevertheless, over 90% of the total sample received no counselling about alcohol and this must have included a substantial number of heavy drinkers. Disappointingly perhaps, three-quarters of the sample said they would not be interested in receiving further information on alcohol. This indicates the need for education among the patients themselves, as well as among health professionals.

Much the same patterns were evident in the data for female students. Somewhat more of the younger girls than boys were asked about their drinking and received counselling about it, although again the great majority of the sample as a whole had never been asked about drinking or received any counselling. Roughly the same proportion as among the young men (one-quarter) were interested in receiving further information.

These useful data represent a baseline for assessing the effects of attempts to encourage health professionals to deliver EIBI to young people and the success of efforts to formally implement EIBI.

12.7. General Conclusions

As with the experience in other countries involved in the WHO Phase IV project, the findings of the Russian arm indicate that the attempt to implement EIBI among young people attending health care facilities presents a formidable challenge. It took over 20 years from the first widespread knowledge of the harmful effects of cigarette smoking to the time when smoking was routinely enquired about in primary health care and intervention given when necessary, and even this is still imperfectly delivered in many countries. It follows that the effort to implement EIBI regarding excessive drinking will be an ongoing task with many drawbacks and little evidence of obvious progress. Yet this task must be undertaken if the harmful effects of excessive alcohol consumption are to be reduced, especially in a country like Russia where the extent of this harm is enormous.

A beginning to this task has been made in the current project. In particular: a) a screening instrument has been developed and intervention materials with accompanying guidelines are being developed; b) attitudes of health professionals to this work have been investigated and the main obstacles to progress identified, with

some suggestions for how these obstacles might be overcome; c) behaviour and attitudes of young people themselves have been investigated using both qualitative and quantitative methods; d) a database has been established by means of which changes in implementation practice and the alcohol-related behaviour and consumption of young people can be assessed; e) a beginning has been made in the attempt to educate both health professionals and young people about the concept of risky drinking; f) lastly, a strategic alliance of individuals and organisations sharing the aim of widespread implementation of EIBI among young people in the St. Petersburg area has been established and will be carried forward.

12.8. References

1. Harkin AM, Anderson P, Goos C. *Smoking, Drinking and Drug Taking in the European Region*. Copenhagen: WHO Regional Office for Europe, 1997.
2. Nemstov AV. Alcohol-related human losses in Russia in the 1980s and 1990s. *Addiction* 2002; 97: 1413-1425.
3. Saunders JB, Aasland OG, Babor TF, de la Fuente JR, Grant M. Development of the Alcohol Use Disorders Identification Test (AUDIT): WHO Collaborative Project on Early Detection of Persons with Harmful Alcohol Consumption - II. *Addiction* 1993; 88: 791-804.
4. Robins LN, Wing J, Wittchen H-U *et al.* The Composite International Diagnostic Interview: an epidemiologic instrument suitable for use in conjunction with different diagnostic systems and in different countries. *Archives of General Psychiatry* 1989; 45: 1069-1077.
5. Mason P, Hunt H, Raw M, Sills M. *Helping People Change: Trainer's Manual*. London: Health Education Authority, 1994.
6. Mason P, Hunt H. *Skills for Change*. Copenhagen: WHO Regional Office for Europe, 1997.
7. Prochaska JO, DiClemente CC. Stages of change in the modification of problem behaviors, in: Hersen M, Eisler RM, Miller PM, eds, *Progress in Behavior Modification*. Newbury Park CA: Sage, 1992.
8. Medvedev V, Kryshstal T, Heather N. *Implementing Early Identification and Brief Alcohol Intervention in Primary Health Care in St. Petersburg, Russian Federation*. Final Report to HLSP Consulting on work carried out under Project SPS 174. Newcastle upon Tyne: Centre for Alcohol & Drug Studies, 2003.
9. Aalto M, Pekuri P, Seppä K. Primary health care professionals' activity in intervening in patients' alcohol drinking: a patient perspective. *Drug & Alcohol Dependence* 2002; 66: 39-43.

APPENDIX 12.1

PERSONNEL AND COLLABORATING ORGANISATIONS

Russian partners:

Vladislav Medvedev MD, Professor, Department of Adolescent Medicine, MAPS - Principal Investigator from July 2000

Tatiana Krishtal CM, Assistant Professor, Department of Adolescent Medicine, MAPS - Program Coordinator from July 2000

Alexander Koulikov MD, Head of Department of Adolescent Medicine, MAPS

Karina Pokhis MD, Head of Department of Nurse Training, MAPS - Principal Investigator 1998–1999

UK partner:

Nick Heather PhD, Professor of Alcohol & Other Drug Studies, Newcastle, North Tyneside & Northumberland Mental Health NHS Trust & University of Northumbria - Technical Focal Point for Phase IV Project from 1998

Collaborating organisations:

St. Petersburg Medical Academy of Postgraduate Studies
41 Kirotnaya str., St-Petersburg, 193015, Russian Federation

Centre for Alcohol & Drug Studies, Newcastle, North Tyneside & Northumberland Mental Health NHS Trust and University of Northumbria at Newcastle
Plummer Court, Carlisle Place, Newcastle upon Tyne, NE1 6UR, UK

APPENDIX 12.2

RESULTS OF “EXIT POLL” SURVEY

SURVEY – men

Questions	15 years	16 years	17 years	18 years	More than 18	Total	TOTAL %
1. NUMBER OF STUDENTS	32	51	82	69	75	309	
2. WHEN have you been asked about alcohol consumption by a doctor or a nurse in this clinic recently?							
Today	6,3%	7,8%	8,5%	4,3%	4,0%	19	6,1%
During last year	9,4%	17,6%	10,9%	4,3%	14,6%	35	11,3%
More than year back	3,1%	11,8%	7,3%	1,4%	9,3	21	6,8%
Never	81,3%	62,7%	72%	91,3%	72%	234	75,7%
3. Have you been counselled on a question of alcohol consumption by a doctor or a nurse IN THIS VISIT?							
YES	12,5%	15,7%	6,1%	4,3%	5,3%	24	7,7%
NO	84,4%	86,3%	90,2%	95,6%	94,7%	282	91,3%
4. How often do you use alcoholic drinks?							
- Never	18,7%	7,8%	14,6%	10,1%	5,3%	33	10,6%
- Less than once a month	28,1%	21,6%	22%	14,4%	6,7%	53	17,1%
- Once a month	9,4%	9,8%	17,1%	30,4%	21,3%	59	19,1%
- Once a week	6,3%	25,5%	24,4%	18,8%	29,3%	70	22,6%
2-4 times a week	15,6%	21,6%	9,7%	15,9%	22,6%	52	16,8%
5 or more times a week	21,8%	13,7%	9,7%	7,2%	10,6%	35	11,3%
5. What do you usually prefer drinking?							
Beer	71,8%	72,5%	50%	71%	78,7%	209	67,6%
Wine	25,6%	25,5%	35,4%	21,7%	14,6%	76	24,6%
Spirits	15,6%	15,7%	12,2%	31,9%	6,6%	50	16,2%
6. What is your usual dose? Vodka (in gram); a wine glass ml Beer a bottle ml M – mean grams	M=250,0 M=1,2 (180 ml) M=3,8 (1,9 l)	M=256,7gr M=3,25 (406ml) M=2,9 (1460ml)	M=285,7gr M=3,8 (480ml) M=3,3 (1165ml)	M=261,6 M=4,2 (522,4ml) M=3,6 (1800ml)	M=268,2 M=4,3 (537,5ML) M=4,3 (2150 ml)		
7. Would you like to more information on alcohol consumption?							
YES	77,0%	31,4%	29,3%	18,8%	14,6%	82	26,5%
NO	23,0%	70,6%	68,3%	81,1%	85,3%	235	76,1%

SURVEY– women

Questions	15 years	16 years	17 years	18 years	More than 18	Total	Total %
1.NO.STUDENTS	14	35	69	53	9	180	100%
2. WHEN have you been asked about alcohol consumption by a doctor or a nurse in this clinic recently?							
Today	7,1	14,3	2,9	1,9	-	9	5
During this year	14,3	5,7	8,6	7,5	11,0	15	8,3
More than year back	-	11,4	5,8	3,8	-	10	5,5
Never	78,6	68,6	82,6	86,8	88,0	146	81,1
3. Have you been counselled on alcohol consumption by a doctor or a nurse IN THIS VISIT?							
YES	7,1	17,1	4,3	9,4	11	16	8,8
NO	92,8	82,8	94,2	90,5	88	163	90,5
4. How often do you use alcoholic drinks?							
Never	7,1	5,7	11,6	9,4	22,0	78	43,3
Less than once a month	7,1	14,3	11,6	30,2	22,0	32	17,7
Once a month	50	28,6	42	43,4	-	69	38,3
Once a week	21,4	31,4	23,2	11,3	33	39	21,6
2-4 times a week	7,1	11,4	7,2	5,7	-	13	7,2
5 or more times a week	7,1	8,6	4,3	0	-	7	3,8
5. What do you usually prefer drinking?							
Beer	64,3	54,3	31,8	66,1	22,0	87	48,3
Wine	50,0	48,6	62,3	49,1	44,0	97	53,9
Spirits	7,1	17,1	8,7	3,8	11,0	16	8,9
6. What is your usual dose? Vodka (in gram); a wine glass Ml Beer a bottle ml M – mean grams	M =108.3 M=3.0 (375 ml) M=2.4 (1.2 l)	M=137.5r M=7.9 (992 ml) M=1.95 (978.3ml)	M=206g M=2.0 (250ml) M=2.8 (1400ml)	M=128.7 M=2.4 (302ml) M=2.6 (1300ML)	M=133.3 M=2.4 (303.5 ml) M=3.2 (1611ml)		
7. You would like to receive more information on alcohol consumption?							
YES	21.4	31.4	26.1	9.4	44.4	41	22.8
NO	71.4	68.6	72.5	90.6	44.4	136	75.6

WHO COLLABORATIVE PROJECT ON IDENTIFICATION AND MANAGEMENT OF ALCOHOL-RELATED PROBLEMS IN PRIMARY HEALTH CARE: PHASE IV - DEVELOPMENT OF COUNTRY-WIDE STRATEGIES FOR IMPLEMENTING EARLY IDENTIFICATION AND BRIEF INTERVENTION IN PRIMARY HEALTH CARE

FIGURE 12.2

THE STRATEGIC ALLIANCE

