ASTRAKHAN STATE MEDICAL UNIVERSITY

As a manuscript

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SCIENTIFIC RATIONALE FOR IMPROVING MECHANISMS FOR ORGANIZING PSYCHIATRIC CARE FOR THE POPULATION

3.2.3. Public health, health organization and sociology, medical and social expertise

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HEADLINE

INTRODUCTION

Relevance of the research topic.

High rhythm of life, decrease in stress resistance, emotional burnout and the consequences of pandemic significantly affect the conditionally healthy group of population, especially of working age, causing neurotic, anxiety-phobic, affective and other reactions, which determines the increasing risk of forming addictions, especially to alcohol and tobacco, and, in the aggregate, leads to irreversible consequences: impaired social functioning, intra-family conflicts, etc., as well as to the development of psychological and psychiatric help. Any kind of psychological and psychiatric help can be ineffective because of the delayed address to a specialist, when gross irreversible disorders have already been formed. In the general medical network, medical care is provided to patients by specialist doctors without taking into account their current mental state, as its degree does not reach the need for transfer to a psychiatric hospital, and there is often no consent to see a psychiatrist due to the stigmatization barrier.

Despite the significant legislative formalization of the work of the psychiatric service, defects in its organization remain.

At present, conditions related to psychosomatic disorders, mild or borderline disorders are out of sight. A significant number of patients who need the help of a psychiatrist, psychotherapist, psychologist in the process of getting out of a difficult life situation or within the framework of psychosomatic disorders are forced to turn to private practitioners or receive help in the conditions of the psychiatric service of the city, which significantly worsens the availability and quality of care.

The number of non-psychotic mental disorders has increased among various contingents of the population. At the same time, a significant part of patients with various manifestations of mental pathology "moved" from the strictly specialized sphere - psychiatry - to the sphere of other medical specialties: neurology, therapy, gynecology, cardiology, endocrinology, becoming patients of general medical institutions (territorial polyclinics, medical unit, multidisciplinary hospitals, etc.).

According to various studies (Labrum T. 2018. Molina-lópez A., Cruz-islas J.B., Palma-cortés M., Guizar-sánchez D.P., Garfias-rau C.Ye., Ontiveros-uribe M.P., Fresán-orellana A. 2016. Stuhec M., Tement V. 2021), the number of patients with mental disorders in the general systemic network varies widely - 10-50% of all those seeking medical care. High prevalence of psychiatric pathology is also noted among the population of outpatient institutions (Iachina M., NØrgÅrd B.M., Garvik O., Ljungdalh P., SchiØttz-Christensen B., Stenager E. 2022).

A significant increase in the number of mentally ill patients in general medical institutions indicates the urgency of creating a system of specialized care for these contingents. This situation is fraught with the danger of untimely detection of numerous mental disorders, which is reflected in an increase in the number of cases "neglected" in terms of diagnosis and treatment, reduced ability to work, deterioration in the quality of life, and unjustified economic expenditures of the health care service.

These circumstances were the basis for the present study.

Degree of development of the research topic.

A number of works are devoted to the study of various aspects of the organization of psychiatric care for the population, determinants of mental health, legal aspects of regulation of the processes of psychiatric care: Tolmachev V.A. 2015, Usacheva E.L. 2016, Yastrebova V.S. 2016, Uskov V.M. 2017, Sheremetieva I.I. 2017, Filatov D.S. 2018, Roberts L.W. 2018, Ter-Israelyan A.Yu. 2020 , Phillipova N.V. 2021 , Stupina O.P. 2021 , Liu H., Zhu 2021 , Steardo L.Jr. 2023. At the same time, earlier studies addressed the problems of organizing psychiatric care in other socio-economic and political conditions. The high urgency of the problem, the presence of a negative trend in the morbidity of the population due to mental disorders, aggressive socio-political determinants for mental health, the need to create a methodological basis for the management of psychiatric care and resources in it, necessitated the present study. The high scientific managerial value of this problem for the theory and practice of health care organization served as the basis for the present study.

Purpose of the study: Development of mechanisms to improve the organization of psychiatric care for the population.

In order to achieve the goal, the following tasks were set:

1. To substantiate the necessity of improving the mechanisms of organization of psychological and psychotherapeutic and psychiatric assistance to the population based on the assessment of the regulatory and legal framework and the data of literary sources.

2. To analyze the need for psychological-psychotherapeutic and psychiatric care according to the data of network requests and sociological survey of the population.

3. To analyze the dynamics and structure of disability of mental disorders of the population for 2004 - 2021.

4. To determine the socio-medical determinants of the process of providing psychological, psychotherapeutic and psychiatric assistance

5. To build an organizational and management model of effective psychiatric care to the population.

Object of the study:

Population, medical workers providing psychological-psychotherapeutic and psychiatric care, patients receiving psychiatric care in Moscow.

Research methods:

Sociological survey, analytical, statistical, expert evaluations, mathematical modeling, organizational experiment.

Tools used:

Software products: database, spreadsheets.

Scientific novelty

For the first time:

1. The strategic trends of mental disorders of the population and their determinants are revealed;

2. The dynamics and structure of disability of mental disorders of the population were determined;

3. The organizational and management model of effective psychiatric care for the population has been developed;

4. The effectiveness of organizational measures aimed at reducing morbidity and increasing the effectiveness of psychiatric care to the population has been evaluated.

Theoretical and practical significance

The theoretical and practical significance of the work is determined by the results of the conducted research, which allowed to provide health care organizers with objective information about the possibility of using the organizational and management model of effective organization of psychiatric care to reduce the hospitalized morbidity of mental disorders, improving the quality and efficiency of psychiatric care to the population.

Implementation in practice.

The results of the study are applied in the work:

- GBUZ «Botkin City Clinical Hospital of S.P. Botkin DZM» algorithm for the organization of psychiatric and psychological-psychotherapeutic care for patients who apply to a medical organization for somatic disease, to identify the real need for psychological-psychotherapeutic and psychiatric care to the population and effective organization of the health care system (Act of implementation № 852-11 from 25.07.2023g.);

- State Budgetary Institution «L.A. Vorokhobov City Clinical Hospital No. 67 named after L.A. Vorokhobov DZM», the algorithm of organization of psychiatric and psychological-psychotherapeutic assistance to patients who apply to the medical organization for somatic disease, to identify the real need for psychological-psychotherapeutic and psychiatric assistance to the population and effective organization of the health care system (Act of implementation № 2786-01-012 01.12.2023g.);

- GBUZ «Municipal Polyclinic 180 DZM» algorithm for the organization of psychiatric and psychological-psychotherapeutic assistance to patients who apply to a medical organization for somatic disease, to identify the real need for

psychological-psychotherapeutic and psychiatric assistance to the population and the effective organization of the primary health care system (Act of implementation № 2786-01-012 01.12.2023g.);

- GBUZ «GP 115 DZM» algorithm for the organization of psychiatric and psychological-psychotherapeutic assistance to patients who apply to a medical organization for somatic disease, to identify the real need for psychological-psychotherapeutic and psychiatric care to the population and the effective organization of primary health care system (Act of implementation № 2786-01-012 01.12.2023g).

- Department of Economics and Health Management with a course of postgraduate education of the Federal State Budgetary Educational Institution of Higher Professional Education Astrakhan State Medical University of the Ministry of Health of Russia (in the part of data on the assessment of the organization of psychological and psychotherapeutic and psychiatric care and its medical and social determinants) (Act of implementation 0123/20 from 19.06.2023).

Degree of reliability of the results.

The reliability of the obtained research results is confirmed by the data of official statistical observation, a sufficient number of observation units, the use of modern research methods and statistical processing. Correlation and regression analysis was used to analyze the strength and direction of the relationship between quantitative variables.

Approbation of the results.

The main results of the study were reported and discussed at:

- VII International Conference of the Caspian States «Actual issues of modern medicine» (Astrakhan, 2023);

- Interdepartmental conference devoted to the discussion of the results of the completed dissertation on the theme: «Scientific substantiation of improvement of mechanisms of organization of psychiatric care to the population» (Astrakhan, 2023).

- VIII International Conference of the Caspian States «Actual issues of modern medicine» (Astrakhan, 2024).

Relation of the work with scientific programs.

The dissertation was carried out in accordance with the plan of research works of FGBOU VO Astrakhan State Medical University of the Ministry of Health of the Russian Federation within the framework of the problem «Habitat, occupational medicine and health status». Preliminary discussion of the thesis was held at the joint conference of the departments of FGBOU VO Astrakhan State Medical University of the Ministry of Health of the Russian Federation.

Publications.

The main provisions of the dissertation are published in 10 publications, 4 of which are in publications recommended by the Higher Attestation Commission of the Ministry of Education and Science of the Russian Federation for publishing the main scientific results of dissertations for the degree of candidate of medical sciences, 1 in publications indexed in scientometric databases Scopus.

The author's personal contribution to the study.

The author defined the purpose and formulated the objectives of the study, developed the program, determined the stages and tactics of the study, performed an analytical review of the literature and normative acts regulating the issues of prevention on the topic under study, developed questionnaires for conducting a sociological survey, collected and processed the material, generalized the material and analyzed the results of the study. The share of the author's participation in the collection and accumulation of material - 90%, in the processing of material - 80%, in the generalization and analysis of the results of the study - 100%.

Correspondence of the thesis to the passport of scientific specialty.

Scientific provisions of the thesis correspond to the passport of specialty 3.2.3. Public health, organization and sociology of health care, medical and social expertise, 5, 7, 8 points

Structure and volume of the thesis.

The work consists of an introduction, 6 chapters, conclusion, conclusions, practical recommendations, and a list of references. The dissertation is outlined on 206 pages of typewritten text.

The text is illustrated with 1 table and 157 figures. The index of literature includes 205 sources (184 domestic and 21 foreign authors).

Main scientific results

Disability of patients with mental disorders in the city of Moscow, see works [98] (personal contribution is at least 80%).

Topical issues of improving psychiatric care for patients with schizophrenic spectrum disorders in the context of healthcare modernization, see works [16] (personal contribution is at least 80%).

Clinical and social aspects of the dynamics of the registered contingent of patients with schizophrenic spectrum disorders and some issues of optimizing the provision of psychiatric care, see work [17] (personal contribution is at least 80%).

The updated structure of the social service of the psychiatric association, see works [27] (personal contribution is at least 80%).

The organizational model of the two-component diagnostic department with a block of short-term round-the-clock stay, see works [28] (personal contribution is at least 80%).

The experience of organizing the Center for Psychological and Psychotherapeutic Assistance at PB Gannushkin PKB No. 4, see works [29] (personal contribution is at least 80%).

A new stage in the development of the system of treatment and rehabilitation of patients with disorders of the schizophrenic spectrum, see works [20] (personal contribution is at least 80%).

The social and medical profile of the population in the organization of psychological, psychotherapeutic and psychiatric care, see works [171] (personal contribution is at least 80%).

Disability of the population in mental disorders, see works [172] (personal contribution is at least 80%).

Organizational and management model for improving the mechanisms for providing psychological, psychotherapeutic and psychiatric care, see works [173] (personal contribution is at least 80%).

Provisions for defense:

1. Determination of socio-medical determinants of the need for psychological-psychotherapeutic and psychiatric care of the population is the basis for the formation of adequate mechanisms for the organization of medical care and cost planning.

2. The dynamic growth of the population's need for psychological-psychotherapeutic and psychiatric care is the basis for the need to form a system of routing the population in providing adequate targeted psychological-psychotherapeutic and psychiatric care.

3. The construction and use of an organizational model of management of psychological, psychotherapeutic and psychiatric care will allow for effective preventive measures and control of morbidity and disability indicators.

CHAPTER 1. ANALYSIS OF THE STATE OF THE PROBLEM OF ORGANIZATION OF PSYCHIATRIC CARE FOR THE POPULATION (ACCORDING TO THE LITERATURE)

1.1 Morbidity and disability of the population with mental disorders.

Mental health is the basis of human well-being and the life of society. According to the WHO, every fourth-fifth inhabitant of the Earth suffers from a mental disorder, and every second person has a chance to suffer from it during his or her life. More than half of individuals have borderline mental disorders. Among children mentally unhealthy make up 20% [17, 53, 71, 73, 102, 116, 117, 119, 120, 123, 126, 127, 137, 138].

Despite the official statistics in Russia reflecting a decrease in the incidence of mental disorders, there is an increase in mental conditions of a non-psychotic nature, psychosis and dementia, a twofold prevalence of mental disorders in men, an increase in the prevalence of mental disorders among persons over 60 years of age, and an increase in mental disorders in individual territories [4,6,7, 9, 25, 35, 47, 48, 49, 50, 52, 53, 71, 75, 78, 112, 115, 143].

At present, the formation of statistical data on mental disorders is extremely difficult. The statistics of morbidity on turnover has lost the comprehensive character that it had in Soviet times. "Accounting of morbidity in the system of compulsory health insurance is only emerging, but it will not be able to cover the totality of diseases due to the expansion of the sphere of medical care by private medical organizations" [33].

The study of the influence of medical and organizational factors on the morbidity of mental disorders showed the role of provision with psychiatrists in the dynamics of the prevalence of this disease. The analysis of the morbidity rate of mental disorders and the influence of the availability of psychiatrists on its dynamics made obvious the problem of imbalance between the introduction of modern approaches to treatment and the resource availability of psychiatric services [27, 37].

No connection between the introduction of regulations aimed at changing the organization of medical care for children and adolescents, changes in medical birth criteria and the dynamics of morbidity of mental disorders and behavioral disorders, as well as indicators of chronicization of this pathology in children aged 0-14 years has been identified. "The above observation is verified by conducting a study in the territory of the Arkhangelsk region, the Northwestern Federal District and, in general, the Russian Federation in 2009-2019" [34, 44, 103, 108, 161, 166].

The occurrence of mental disorders in children with severe pneumonia has been determined [62, 67].

Etiopathogenetically, mental retardation in children is largely due to somatogenic causes. In the structure of disorders of psychological (mental) development in children, the largest share was occupied by disorders of expressive speech [15].

A key role is given to the problem of protecting the health of the adolescent generation. In this regard, the issue of preparation for military service and examination of persons of conscription age, of which military psychiatric expertise is a significant component, is important. Mental disorders occupy a leading place in the structure of the general morbidity of conscripts. The specific weight of mental pathology in the overall structure of the causes of limited fitness for military service is increasing, there is an increase in the number of adolescents under dynamic dispensary observation, the number of persons of draft age with alcohol and drug dependence is increasing [10, 91, 145].

The predictors of morbidity of military cadets included a combination of indicators of mental states: excitement, cheerfulness, relaxedness, thoughtfulness, fear, laziness. At the same time for the cadets who have diseases during the year are characterized by laziness, desire for entertainment and excitement; they are less relaxed, more thoughtful, inclined to introspection, analysis of their physical condition, critical of the environment, do not experience the state of fear, associated with it a sense of respect for the team, because receiving an exemption from duty for

a "non-serious" disease in the military team is perceived as a desire to evade their duties[59].

The forecast of the general and primary morbidity of mental disorders, calculated using the second-order polynomial trend, showed that in 2022-2023, the general morbidity of internal affairs officers of the Russian Federation is expected to increase with neurotic stress-related diseases and somatoform disorders [66, 147].

The incidence of mental disorders and behavioral disorders associated with substance use remains high in the Russian population, despite a steady downward trend. In the majority of cases, such mental and behavioral disorders are associated with alcohol abuse in Russia. In the constituent entities of the Russian Federation, the incidence varied from 0 in the republics of Ingushetia and North Ossetia-Alania to 34 per 100,000 people in Ivanovo Oblast. High incidence rates of substance abuse were observed in Sakhalin Oblast (28 per 100,000 people), Nenets Autonomous Okrug, Arkhangelsk Oblast and Kamchatka Krai (20-21). In another 13 regions of the Russian Federation, the value of this indicator ranged from 10 to 18 per 100,000 people [12, 23, 24, 26, 43, 132, 150, 162].

Mental disorders in persons exposed to accidental radiation in the remote period more than half a century later have aroused great scientific interest. A wide range of mental pathology was observed in liquidators of the Chernobyl NPP accident, in victims of the accident at the Fukushima Daiichi NPP (Japan). Taking into account the distribution of irradiated residents and their descendants in the Chelyabinsk region, the incidence of mental retardation deserves in-depth attention [27].

Given the numerous data indicating a high comorbidity of mental disorders and malignant neoplasms, the registration of mental disorders in cancer is recognized as necessary [74].

Some authors have studied the influence of combined pathology - organic personality disorder and affective disorders - on the regulation of legally significant behavior of the subject during forensic psychiatric examination in criminal and civil proceedings. The great importance of the modifying influence of a set of

psychogenic factors caused in criminal proceedings by bringing to responsibility, in civil proceedings - by problems of adaptation, deterioration of social status, somatic disadvantage was established. The unfavorable dynamics of organic mental disorder was manifested by decompensation of personality and cognitive disorders, and the accession of comorbid depressive disorders. The addition of affective pathology to the existing organic pathology in 48.7% of cases significantly increased the impairment of cognitive functions, critical and prognostic abilities, and volitional control of activity, which led to the inability of patients to understand the meaning of their actions [30].

1.2 Challenges of organizing mental health care in health care practice.

Accessibility and quality of medical care to the population are the most important strategic tasks of the national health care. Public health is determined by 45-53% by the lifestyle of the population, 18-22% by hereditary factors, 17-20% by environmental factors, and 8-10% by the level of development of the health care system.

Despite the insignificant share of the health care system factor in the structure of public health, the socio-political role of the health care system remains highly significant, strategically important, determining both the regulatory support of the industry, the conditions of work in the system, and the level of public health, socio-economic support to the economically active population receiving medical care and participating in the formation of the gross national product, used in the financing of the health care system, support for children and adolescents. That is why state support of the health care sector, effective state regulation in the system are extremely necessary, require detailed study, scientific elaboration and practical implementation. At present, objective prerequisites for serious state support of the organization of psychological and psychotherapeutic and psychiatric services have been formed.

In the Russian Federation, the incidence of mental disorders have increased by more than 40% over the past two decades.

Alcoholism and drug addiction, depression and suicides, personality disorders, post-traumatic stress disorders retain a high share in the structure of mental illnesses. In Europe, mental disorders account for about 20% of all diseases, and 60-80% of the losses due to temporary and permanent disability, reduced productivity and early retirement. In the U.S., the annual direct cost of mental disorders is $148 billion, or 2.5% of gross national product.

"In most countries, a large share of indirect costs fall on the families of patients with mental disorders. According to official figures, in Germany in 2012, 22.44 billion euros (270 euros per capita) were spent on mental and behavioral disorders by the health system alone. The largest expenditures were spent on care for patients with depression (4.025 billion euros), schizophrenia and similar disorders (2.756 billion euros) and neuroses (2.825 billion euros). In England, the cost of depression amounted to €15.46 billion.

Of this, €636 million was spent on treating depression and the remaining losses were due to incapacity for work and premature deaths." Other economic losses caused by mental disorders include: uncollected taxes from premature retirement or disability, and losses related to caregiving. For example, relatives of a schizophrenia patient spend about 6 hours a day, while dementia care requires 24-hour presence and accounts for 70% of all economic losses [70, 85].

Many countries in the world currently allocate less than 2% of the health budget to the treatment and prevention of neuropsychiatric disorders, and the majority of funding is directed towards psychiatric hospital costs. In African countries, there is one psychiatrist per 1.7 million inhabitants and one psychiatric bed per 42,000 people. In many African countries, patients with severe mental disorders receive no treatment in 76-85% of cases [128].

Mental disorders affect all aspects of a person's life: they "can undermine physical health, disrupt family and social life, ruin careers, and lead to crime and suicide. People suffering from mental disorders are often victims of discrimination and lose their self-esteem. It is difficult for them to get an education and a job. The family has to bear the social costs: emotional burden, reduced quality of life for

caregivers, social isolation, stigmatization, and loss of future opportunities for self-improvement [122].

Historically, there has been an uneven distribution of resources aimed at organizing psychiatric care, non-systematic provision of conditions for providing assistance to the population in need, staff shortages and low wages, lack of mechanisms for effective state regulation, while the social specificity of mental illnesses creates tension in society, violates the safety of citizens, and can lead to irreversible consequences [31, 32, 36, 56, 111, 113, 133, 168].

The modern stage of psychiatry development is characterized by the wide introduction of social services into the work of medical organizations providing medical care to patients with mental disorders and behavioral disorders [1-3].

It has been established that with a general reduction in the number of psychiatric services, the network of psychiatric units of multidisciplinary medical organizations in rural areas has been preserved. There was a regrouping of the number of occupied positions of psychiatrists and psychotherapists in favor of the outpatient sector of psychiatric organizations. The introduction of team technologies in working with patients contributed to the growth in the capacity of semi-inpatient units, intensive home-based psychiatric care units, and medical rehabilitation units [73].

The main legal act regulating the organization of social assistance for patients with mental disorders is the Law of the Russian Federation from 02.07.1992 № 3185-1 "On psychiatric care and guarantees of citizens' rights in its provision" (hereinafter referred to as the Law of the Russian Federation 3185-1), which defines the legal, organizational and economic principles of psychiatric care in the Russian Federation.

Another legal document regulating the organization of medical care for mental disorders is the Order of the Ministry of Health and Social Development of the Russian Federation of May 17, 2012, No. 566n "On Approval of the Procedure for Providing Medical Care for Mental and Behavioral Disorders", which includes the rules for providing medical care for mental and behavioral disorders in medical

organizations. According to the Order, the functions of a psychoneurological dispensary (hospital) include not only the provision of medical care but also social assistance: the development and implementation of individual medical and social rehabilitation programmes, the resolution of medical and social problems, assistance in the employment of persons suffering from mental disorders, the resolution of guardianship issues, consultations on the realization of the rights and legitimate interests of persons suffering from mental disorders, medical and social and domestic arrangements for disabled persons and the elderly suffering from mental disorders, and the provision of medical and social assistance to persons suffering from mental disorders.

The increasing role of social work among patients with mental disorders requires the adaptation of the previously functioning system for organizing psychiatric care at the regional level.

Practice shows that there are serious problems in staffing the structure of neuropsychiatric institutions with specialists in medical and social work. The number of posts of social work specialists is calculated at the ratio of 1 specialist per 75,000 adults. The number of social workers is calculated by one per approved area of a psychiatrist and amounts to 27 estimated rates. And the number of medical and social assistance nurse is calculated as 2 rates per 5 posts of district psychiatrists and amounts to 10.8 estimated rates.

The actual rate of staffing of social work specialists in the psychoneurological dispensary is only 33.8% or 5 rates of specialists per psychoneurological dispensary and its branches; the rate of staffing of social workers is 24.1% or 6.5 rates. The post of medical and social assistance nurse is staffed at 27.8% of the required level. At this level of staffing of social service specialists in psychoneurological institutions, it is obvious that it is impossible to provide the necessary amount of medical and social assistance to patients with mental disorders [8, 105, 106, 107, 136, 142, 142, 148, 149, 149, 152, 152, 171, 172, 174].

The problem of organization of psychiatric care was intensified in severe forms of mental disorders by hospitalism due to the need for a long stay of patients

in hospital. The introduction of a new organizational form - an outpatient psychiatric module - made it possible to solve the problem of the duration of hospitalization and reduce the development of hospitalism in patients [11, 139, 140, 157, 158, 159].

Some researchers stated that intensive activity of the day hospital in the structure of the dispensary department reduced the length of stay of psychiatric patients in hospital, led to less pronounced exacerbations of the disease, accelerated the development of inpatient-substitute forms of psychiatric care, reduced the level of hospitalism, improved the level of socialization of the patient, his/her work, family functioning, and social interaction [18].

Expert evaluation of hospitalized patients depending on the main diagnosis at hospitalization, recommended terms and volumes of therapeutic and diagnostic measures showed the need for a more careful selection of patients for specialized psychiatric beds [19,21, 44].

The issues of effective organization of psychiatric care are related to the interdisciplinary component, the organization of emergency medical care. An important problem in the organization of psychiatric care includes the provision of emergency care for suicides. Of the number of calls to the ambulance station, 3-5% are due to drug poisoning, of which 30% are accidental and 70% are intentional. In the psychiatric population, the suicide rate was 59%. The definition of suicide attempts is complex, as not all suicidal behaviors represent failed suicides [130, 135, 151, 153, 154].

The need to actualize the system of medical care for the population over working age and to develop the clinical direction of gerontopsychiatry has been confirmed [83, 92].

Some authors note insufficient attention to the issues of organization of out-of-hospital care. The analysis of the legal framework regulating the organization and provision of medical, including inpatient substitute care for the mentally ill, has shown that an integral part of the legal system of the Russian Federation are generally recognized principles and norms of international law, as well as international treaties. Ratification of the described international documents imposes

obligations for their fulfillment and implementation in the policy and social life of the RF society [22]. The issue of criminal-legal regulation of illegal hospitalization in a medical organization providing inpatient psychiatric care needs effective legal support [14, 16, 134].

The International Classification of Diseases 11th revision will provide an opportunity not only to ensure statistical reporting, but also legal regulation, serve as a basis for financing health care, social services, determination of disability benefits [14].

The specific load in the system of mental health care provision has been increasing due to the steady tendencies of redistribution of mental disorders into childhood and adolescence, caused by the growth of developmental pathology [1, 156].

The issue of mental health support in schoolchildren is extremely important. Taking into account the specifics of the adolescent period, the presence of external challenges of political, economic, and psychological nature, the need for the active activity of psychologists at school is very high, but the staffing deficit in health care, the lack of knowledge of pedagogical staff, and resource provision does not allow schools and educational authorities to carry out full-fledged activities to ensure the mental health of children and adolescents [22, 41, 82, 163].

Currently, the system of assistance to children with disabilities is actively developing within the framework of educational institutions, psychological and pedagogical centers, and outpatient appointments. However, for certain categories of children, only inpatient care may be sufficient and optimal to preserve and restore mental health [94, 98, 100, 101, 131].

Of particular importance is the organization of psychological, psychotherapeutic and psychiatric care in emergency situations. Its effective organization allows to consistently and quickly eliminate the consequences of emergencies. To maximize the effectiveness of the activities carried out, it is advisable to adhere to a certain order of involvement of specialists and assistance to the affected population [13, 80, 90, 129, 164, 168, 175].

Psychiatric service should be developed in the departmental aspect, in the system of the Ministry of Internal Affairs of Russia to assist both personnel and pensioners in terms of corrective measures, diagnosis of borderline mental disorders arising in connection with organic disorders associated with the consequences of closed craniocerebral traumas of mine-explosive etiology, pronounced neurotization and the formation of chemical dependencies. When working out a plan of measures to eliminate the consequences of the war in the field of neuropsychiatric morbidity, it is necessary to involve not only the institutions of the Ministry of Health, but also the institutions of social security, the All-Union Central Committee of the Soviet Union (through the organization of sanatoriums and rationalization of the examination of temporary disability) and the Ministry of Education (to provide assistance to children and adolescents). The integrated work of all these agencies will make it possible to carry out effective measures to improve the neuropsychiatric condition of the population affected during the war [20, 141, 173].

Patients had complaints about the organization of psychiatric care, which was confirmed by a number of studies conducted by health care organizers and lawyers. The main claims of citizens addressing human rights defenders protecting human rights in psychiatry included: coercion to consent to hospitalization and treatment; failure to inform about rights, diagnosis, treatment methods, prescribed drugs; damage to health due to high dosages of drugs and prolonged use; numerous violations during involuntary hospitalization and treatment, cruel or insulting treatment, including beatings by orderlies, fatalities due to negligent treatment; involuntary hospitalization of citizens in psychiatric institutions; and the use of drugs and medications.

Assessment and analysis of the ways of committing crimes related to illegal hospitalization in a medical organization providing inpatient psychiatric care made it possible to identify the dependence of the perpetrators' criminal actions on the procedure for hospitalization in a psychiatric hospital established by the State. The regularities of the method of committing illegal hospitalization in a medical organization providing inpatient psychiatric care are related to the activities of

medical workers (psychiatrists, heads of departments, chief physicians of hospitals or inpatient units, etc.).

Medical personnel, brought to criminal responsibility for illegal hospitalization in a medical organization providing psychiatric care in inpatient settings, are self-interested and acted in the interests of third parties: relatives, close to the victim, guardians, custodians, other persons providing "care" for the victim. The latter acted as initiators of criminal actions, induced officials authorized by law to make unjustified and illegal decisions on hospitalization, being accomplices of the criminal activity under study [2,3,5,8, 29, 54, 55, 57, 76, 77, 79, 79, 81, 93, 97, 97, 104, 110, 146, 165, 167].

The problem of organizing psychiatric care for convicts with mental disorders turned out to be no less serious. The disadvantages in its organization should include a low level of diagnosis of mental disorders in criminals before committing a crime and conviction, insufficiently frequent appointment of forensic psychiatric studies, the absence of a diagnosis of a mental disorder in the conclusion of forensic psychiatric examinations, records of the presence of a comorbid narcological pathology in the offender; a shortage or complete absence of a psychiatrist in penitentiary conditions; frequent refusals of people with mental disorders from therapy, lack of development of practical measures for the implementation of outpatient compulsory treatment and supervision by a psychiatrist in penitentiary institutions; lack of developed programs with targeted and prolonged use of neuroleptics for the correction of non-psychotic disorders, including aggression, decompensation in persons with personality disorders; insufficient effective interaction with psychiatric by the health care system's succession service in the management of such patients; the lack of a joint accessible database on criminals and persons who have committed socially dangerous acts[46].

The organization of psychiatric care is also associated with legal uncertainty of placement and detention of a suspect (accused), in respect of whom during the preliminary investigation a preventive measure in the form of detention in a medical organization providing psychiatric care was chosen. Based on the analysis of the

norms of criminal procedural legislation and judicial and investigative practice, amendments to certain norms of the CPC of the RF were proposed to ensure that the suspect (accused) is in a medical organization providing psychiatric assistance within a reasonable time [114, 121, 124, 155, 176, 177, 179].

The objective need to organize psychosocial rehabilitation at the outpatient stage was accompanied by the introduction of programs that allow planning and controlling the necessary forms of legal, social, and psychological assistance, and at the inpatient stage - to form a full cycle of assistance with the continuation of observation and treatment of patients in the dormitory [38].

Serious attention is paid to the protection of patients' rights by patient public organizations, which ensure group and individual meetings with relatives of mentally ill people within the framework of psychological counseling and group psycho-educational programs by doctors, medical psychologists and social work specialists, informing and coordinating relatives of mentally ill people on social, labor, legal issues by volunteers of the organization, activation of charitable activities, raising funds from charitable foundations and grants for practical solutions to the problems of the mentally ill and their family members; conducting leisure activities, establishing contacts with relevant health authorities and other government agencies on the protection of the rights of persons suffering from mental disorders [39, 40, 178].

The international experience of the organization of psychiatric care testified to the need for its integration with general medicine, the transition to providing psychiatric care in the locations of other medical institutions, in psychiatric departments of ordinary somatic hospitals, however, there was no complete abandonment of psychiatric hospitals due to the specifics of providing psychiatric care. The replacement of the previous model of the organization of psychiatric care with a socially oriented one is due to the social deprivation of persons with mental disorders who are in long-term inpatient treatment, the need for patients to receive public support, the need for society to comply with social guarantees and human rights, and the involvement of society's resources at the stage of social recovery.

The considered model of assertive care as an organizational model of psychiatric care included supported employment as an effective competitive one with an increase in working hours, often combined with cognitive techniques, training of social skills and cognitive behavioral psychotherapy; training of social interaction skills, independent living, functioning within society. training of family members as "generalizing agents"; cognitive behavioral therapy in both group and individual formats; methods of the token reward system; connection of family services; psychosocial interventions in relation to alcohol and drug use disorders; psychosocial interventions for overweight; cognitive recovery; "cognitive correction"; support from patients and services with their participation; interventions that increase compliance with psychotropic therapy (compliance therapy); psychosocial methods for recently started schizophrenia. When comparing the cost of providing assistance in these two systems - institution-oriented and community-oriented - the authors pointed out the complexity of the countless relationships between budget, staff and other hired resources [45, 72, 118, 128].

Domestic authors proposed to go a different way of organizing psychiatric care: through emphasis on the primary link in the health care system, professional development of doctors of somatic specialties on mental health issues, which, in their opinion, will increase the effectiveness of psychotherapists, psychiatrists, connect doctors of somatic specialties to provide psychiatric care to patients with non-psychotic mental disorders [51, 125].

Domestic researchers paid attention to the continuous education of psychiatric hospital staff through endowing them with flexible skills of critical thinking, problem solving, building effective communication, public speaking and public speaking, digital and business communication, teamwork, work in conditions of uncertainty, introspection and self-reflection in the organization of psychiatric care [28, 29, 60, 65, 68, 95].

The main directions of development of regional and municipal mental health services in Russia included changing the content and increasing the availability of psychiatric, psychotherapeutic, psychological and social care due to the gradual

renewal of functional duties of psychiatrists, psychotherapists, psychologists, social work specialists and social workers as human resources accumulate, balanced distribution of volumes and quality of multiprofessional and interdepartmental brigade forms of work in primary care (in polyclinics), in hospitals, in the community at the place of residence (in neuropsychiatric dispensaries, psychiatric and psychotherapeutic offices), in state and municipal social service institutions [68, 70, 72, 86, 87, 88, 89].

Given the fact that most people with mental disorders go to primary health care institutions, where they prefer to receive treatment, and primary health care doctors meet almost twice as many patients with mental disorders as psychiatrists, largely due to the "barriers" of the psychiatric service, it is necessary to create diagnostic training programs and drug treatment of anxiety and depressive disorders for primary care physicians, development of treatment protocols and indications for referral of persons with mental disorders to psychiatric specialists [84].

Given the high demand for social work in the activities of psychiatric and psychotherapeutic services, it is necessary to intensify postgraduate training of specialists in social work and expand the training of social workers in medical colleges according to educational programs already developed and used in the country [69].

Thus, the presence of problems in the organization of medical care for mental disorders, the growth of real morbidity and disability, the high degree of social and political significance of this category of pathology led to the objective need to organize and conduct this study with a detailed assessment and scientific analysis of the existing organizational and medical problems of psychiatric care for the introduction of innovative management technologies in the practice of organizing adequate timely psychiatric care to the population, solving problems at the level of primary prevention of mental illness, reducing morbidity and disability of the population, improving the level of mental health of society and strengthening national security.

CHAPTER 2. PROGRAM, MATERIALS AND SCOPE OF INVESTIGATION

The study was conducted on the basis of GBUZ L.A. Vorokhobov City Clinical Hospital No. 67 of the Moscow Department of Health. The bed capacity is 1,348 beds, where 89,000 people receive medical care annually. Medical care is provided by 1300 medical workers (including 44 candidates of medical sciences, 4 doctors of medical sciences, 3 honored doctors) on the basis of 50 departments, including the psychiatric service.

The peculiarity of the study was to study the needs of the population for psychiatric and psychological-psychotherapeutic care and its organization on the basis of medical organizations of the primary level of the health care system.

Currently, the psychiatric care system provides it to specialized patients on the basis of psychiatric hospitals and dispensaries. About 24,000 patients receive treatment there every year. In neuropsychiatric dispensaries, 2.7 – 2.8 million medical examinations are carried out per year. Those who have been treated in a hospital and are under observation at a neuropsychiatric dispensary or are already being observed at a neuropsychiatric dispensary are subject to examination. To the somato-psychiatric department of the multidisciplinary hospital GBUZ City Clinical Hospital No. 67 named after L.A. Vorokhobov Department of Health of the city of Moscow receives patients, 60-70 percent of whom have not previously been seen by a psychiatrist and have not been treated in a psychiatric hospital. These patients did not come to the attention of a psychiatrist, psychotherapist and psychologist, they were treated in polyclinics and somatic hospitals. It is for this category of patients that an innovative technology for the organization of specialized psychiatric care is required for the effective use of resources of medical organizations, the quality of provision and patient satisfaction with medical care.

Statistical reporting was generated using the program "Medkarta Pro". The study involved information from forms No. 30, 36, 10, registry data, doctor's appointments, and medical commissions.

The object of the study were patients who received psychological, psychotherapeutic and psychiatric care, the population ready to seek psychological, psychotherapeutic and psychiatric help, medical specialists involved in the provision of psychological, psychotherapeutic and psychiatric care, medical experts-psychiatrists, psychotherapists and medical psychologists who assessed the nature of morbidity, the evaluation system for the provision of psychiatric, psychological and psychotherapeutic care help.

The subject of the study was a set of theoretical, methodological and practical issues related to the medical and social assessment of the population's need for psychological, psychotherapeutic and psychiatric care, the processes of its receipt by patients and provision by medical specialists and the development of a management model for psychological, psychotherapeutic and psychiatric care.

The hypothesis of the study. The functioning of an innovative model of the organization of psychological, psychotherapeutic and psychiatric care reduces the burden on the healthcare system, increases the efficiency, quality and accessibility of medical care to the population.

The goal is to develop mechanisms for improving the organization of psychiatric care for the population.

The work was carried out in stages, according to a pre-developed program using various methods of collecting information, depending on the purpose and objectives (Table 2.1).

Table 2.1. - Research program

Research objectives	Research methods	Units of observation and scope of the study	Sources of information	Deadlines
1. To substantiate the need to improve the mechanisms for organizing psychological, psychotherapeutic and psychiatric care for the population based on an assessment of the regulatory framework and data from literary sources.	Analytical, statistical	Patients who sought medical help at the State Medical Institution L.A. Vorokhobov City Clinical Hospital No. 67 of the Moscow Department of Health (145,000 people).	Literature data (205 sources). Statistical reporting data of the psychiatric service (forms No. 30, 36, 10) of the DZM for 2004-2021	2023г.
2. To analyze the need for psychological, psychotherapeutic and psychiatric care according to network queries and a sociological survey of the population.	Analytical, statistical	The population expressing the need to receive psychological, psychotherapeutic and psychiatric care on the Internet (200,000 people)	The data of public appeals on the Internet for 2021.	2023г.
3. To analyze the dynamics and structure of disability of mental disorders of the population for 2004-2021	Analytical, statistical	Cases of providing psychiatric care to the population	Statistical reporting data of the psychiatric service (Forms No. 30, 36, 10) of the DZM for 2004-2021	2023г.
4. To determine the medical and social determinants of the provision of psychological, psychotherapeutic and psychiatric care.	Analytical, statistical, sociological survey, organizational experiment	Questionnaires for the public (20 questions), medical staff (34 questions), patients (40 questions)	Materials of the conducted research:	2023г.
5. To build an organizational and managerial model of effective psychiatric care for the population.	Analytical, statistical, organizational experiment	Organizational-medical, medical-demographic and medical-social determinants	Materials of the conducted research:	2023г.

At the first stage, the study of literary sources on the problem of the organization of psychological, psychotherapeutic and psychiatric care to the population was carried out on the basis of an assessment of the regulatory framework and data from literary sources.

At the second stage, online data was collected on the need for psychological, psychotherapeutic and psychiatric care of the population, statistical data in the State Clinical Hospital 67 in Moscow based on the materials of market reports for 2004-2021, statistical data on general and newly identified disability of mental disorders, the demographic structure of disability.

At the third stage, a sociological survey of the population was conducted to identify the willingness to seek psychological, psychotherapeutic and psychiatric help, medical specialists providing psychological, psychotherapeutic and psychiatric care, patients receiving psychological, psychotherapeutic and psychiatric care.

At the fourth stage, the medical and social determinants of the provision of psychological, psychotherapeutic and psychiatric care were determined.

At the fifth stage, an organizational and managerial model of effective psychiatric care for the population was built. The following methods were used: analytical, sociological survey, dynamic series, correlation and regression analysis, organizational experiment.

The data obtained as a result of the study were subjected to statistical processing using the 13th version of the STATISTICA program from StatSoft (serial number JPZ807I452917ARCN20ACD-9) installed on a personal computer with the Microsoft Windows 10 operating system.

2.1. Indicators of morbidity and disability of mental diseases and their determinants.

The indicators of general and newly identified disability, the demographic structure of disability in mental disorders are calculated, the strength of the influence of medical and social factors on them is estimated, medical and social determinants

are identified to build an effective model for the organization of targeted psychological, psychotherapeutic and psychiatric care to the population.

Extensive indicators were presented graphically in the form of intra-column, sector diagrams.

The work uses nonparametric statistical methods, which were used to assess disability. Disability indicators for individual nosological forms were calculated, dynamic series analysis was carried out, regression coefficients, determinations, angular coefficients, and error-free prediction probabilities were calculated to confirm the presence of trends in dynamic series.

The identification of trends in indicators created the basis for forecasting – a probabilistic assessment obtained by promising extrapolation of a series (extending into the future the trend observed in the past).

The extrapolation of the dynamics series was carried out by analytical alignment, substituting $y = a_0 + a_1 \cdot t$ values of t outside the studied series into the equation and calculating probabilistic t for t.

2.2. The sociological survey. Statistical conditions for the formation of a sample population.

3 types of questionnaires have been developed for:

• the population ready to seek psychological, psychotherapeutic and psychiatric help - 20 questions,

• medical specialists providing psychological, psychotherapeutic and psychiatric care 34 questions,

• patients receiving psychological, psychotherapeutic and psychiatric care - 41 questions,

• Expert psychiatrists, psychotherapists and medical psychologists - 14.

To determine the confidence number (t), we proceeded from the knowledge that at t = 2, the probability of a statement about the discrepancy between the sample and the general population is 0.954. When conducting sociological research, it is

sufficient to ensure the probability of displaying a sample of the data of the general population (representativeness). The maximum discrepancy between the data of the sample and the general population is Δ= 5% or 0.05. Thus, with these parameters, the minimum sample size should be at least 400.

variance (a measure of variation of a feature in the general population), Δ is the marginal sampling error. The signs recorded in the sociological survey are of an attributive nature, and therefore the variance of the alternative feature pq acts as a measure of fluctuation, where

p is the proportion of this feature established in advance

q = 1 – p

when calculating the required number of random samples, the maximum value of the variance G2 = pq = 0.5 * 0 was used.

2.3. Modeling the organization of psychiatric care for patients applying to a polyclinic and a multidisciplinary hospital

Building an algorithm for organizing psychiatric care for patients applying to a polyclinic and a multidisciplinary hospital to reduce the burden on the general somatic network, form groups of specialized patients who avoid contacting specialized institutions to provide them with targeted specialized timely psychiatric care, form a commitment to a healthy lifestyle among the population, reduce the socio-economic burden on healthcare and professional burnout of medical specialists, ensuring the safety of mentally healthy citizens, objectification of morbidity and disability to justify adequate financing of psychiatric services, the elimination of the shadow market of medical services for the provision of psychiatric, psychological and psychotherapeutic care.

2.4. Assessment of the effectiveness of the model for organizing psychological, psychotherapeutic and psychiatric care.

1. The level of satisfaction with medical care: it was assessed according to a five-point system based on data from a sociological survey of women in childbirth (1,500 questionnaires). A sampling method was used, the required number of the sample population was determined according to the formula:

n = t2 *G2/ 2, where

n is the number of necessary observations,

t is the confidence criterion,

G is the variance (a measure of variation of a trait in the general population),

Δ is the marginal sampling error. The signs recorded in the sociological survey are of an attributive nature, and therefore the variance of the alternative feature pq acts as a measure of fluctuation, where

p - is the proportion of this feature established in advance

q = 1 – p

when calculating the required number of random samples, the maximum value of the variance G2 = pq = 0.5 * 0.5 was used.

1. Medical effectiveness:

$$K_{MP} = \frac{MP_{\phi}}{n}$$, where

MRf – the number of patients with a positive medical result (positive health dynamics on the day of discharge) for the reporting period;

n - is the total number of patients who left the institutions during the same period.

The organizational model of psychological, psychotherapeutic and psychiatric care is based on the key medical and social determinants of morbidity and disability with mental disorders, determined by the method of correlation and regression analysis, measures to control their changes and effective management, medical, socio-economic efficiency.

CHAPTER 3. SOCIO-MEDICAL DETERMINANTS OF THE NEED FOR PSYCHOLOGICAL, PSYCHOTHERAPEUTIC AND PSYCHIATRIC CARE OF THE POPULATION

3.1. Analysis and assessment of the population's appeal for psychological, psychotherapeutic and psychiatric care according to network requests.

According to statistics from the World Health Organization, one in eight people in the world lives with a mental disorder. In 2020, the number of people with anxiety and depressive disorders increased by 26% and 28%, respectively[1]. According to the data[2], in 2017, depression was detected in 264 million people, anxiety disorders in 284, and in 2019 in 280 million and 301 million, respectively.

In the last few years, there has been an increase in demand for psychological assistance, both from citizens[3] and from employers. The COVID-19 pandemic and the postcovid syndrome, as well as the socio-political context, have led to an increase in the level of neuroticism and an increase in anxiety-depressive states[4] [5] [6] [7] [8]. Thus, in 2022, the demand for psychological consultations increased by 62.87% compared to 2021[9], and there was an increase in referrals to psychiatrists and psychotherapists in private clinics[10]. According to the HeadHunter resource, the number of vacancies for psychologists increased by 111%[11] compared to 2021.

The COVID-19 pandemic has revealed the insufficiency of psychological support groups for the population in situations where a large number of people need it at once, namely, doctors, patients, emergency services personnel, vulnerable

[1] https://www.who.int/ru/news-room/fact-sheets/detail/mental-disorders
[2] https://ourworldindata.org/mental-health
[3] https://www.gazeta.ru/business/2022/05/24/14898320.shtml?updated
[4] https://psychiatr.ru/files/magazines/2022_04_obozr_2158.pdf
[5] https://www.who.int/ru/news/item/02-03-2022-covid-19-pandemic-triggers-25-increase-in-prevalence-of-anxiety-and-depression-worldwide
[6] https://tass.ru/obschestvo/10993575
[7] https://www.forbes.ru/society/483190-eksperty-svazali-rost-sprosa-na-uslugi-psihologov-so-specoperaciej-i-mobilizaciej
[8] https://secretmag.ru/news/v-rossii-stalo-bolshe-depressivnykh-21-07-2022.htm;
[9] https://www.kommersant.ru/doc/5748777
[10] https://www.kommersant.ru/doc/5758780
[11] https://www.rbc.ru/spb_sz/03/03/2022/622077c39a794779aceb34da

categories such as the elderly and children [1-7]. The need for the prevention and correction of adverse psychological conditions was established [8-10], as well as the lack of information materials as psychological self-help. There is an obvious need for psychological, psychotherapeutic and psychiatric care, since psychotherapy as a field of professional activity is defined as a form of interaction for the preservation and development of individual physical, psychological, social health and emotional well-being, and there has been a growing trend in the need for this type of assistance. According to Google search query statistics, from 2006 to the present, there has been an overall increase in the number of "Psychologist" search queries[12]. Among the regions, St. Petersburg and Moscow turned out to be the leaders in the search for psychologists (Figure 3.1-3.2).

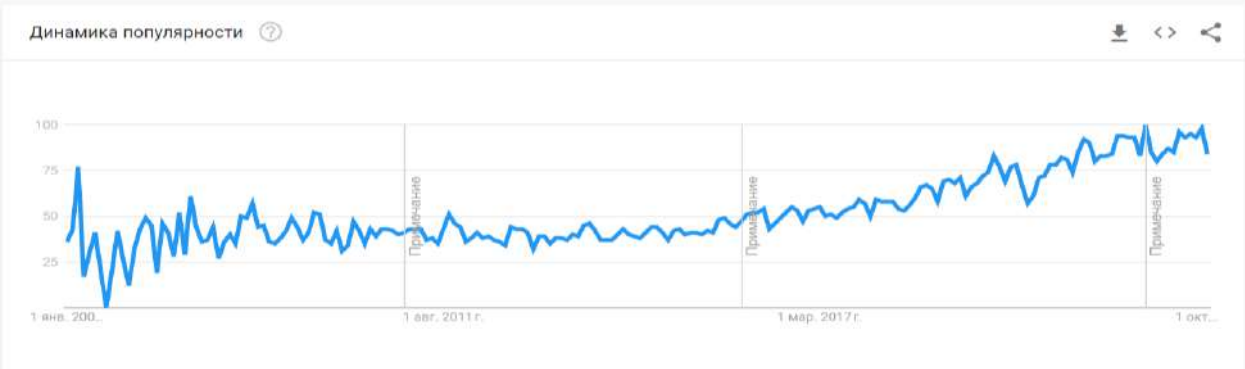

Figure 3.1. Dynamics of popularity of search queries "Psychologist" (%)

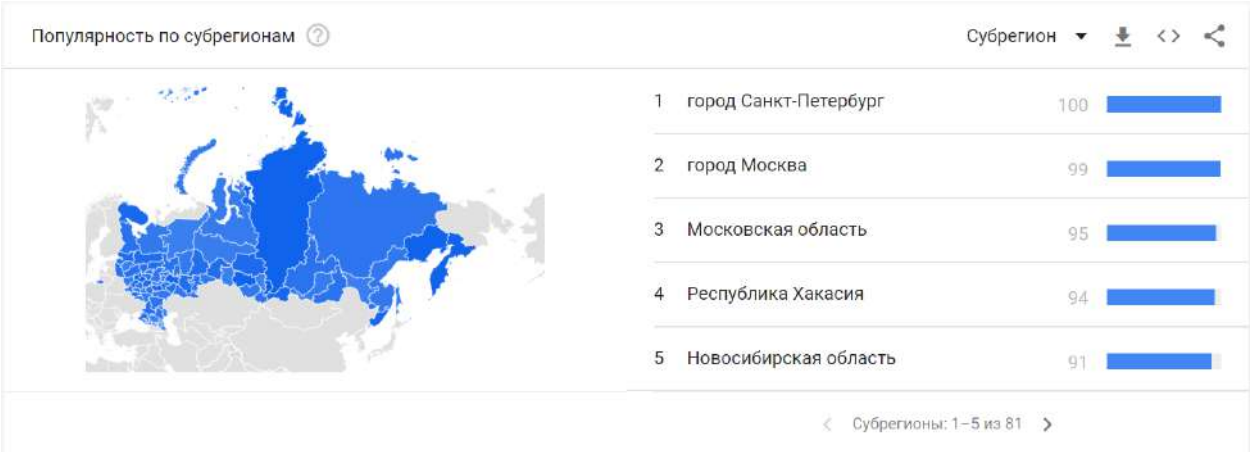

Figure 3.2. Dynamics of popularity of search queries "Psychologist"

[12] https://trends.google.ru/trends/explore?date=2006-01-01%202022-12-27&geo=RU&q=психолог

The growth of requests over the past year has also been noted, according to Yandex statistics (2,176,315 requests at the beginning of 2021, 3,322,199 in November 2022). There is a general trend of an increase in the number of requests. Increased interest in the query "Psychologist" was noted in Moscow (108%) and St. Petersburg (112%)[13] (Figure 3.3).

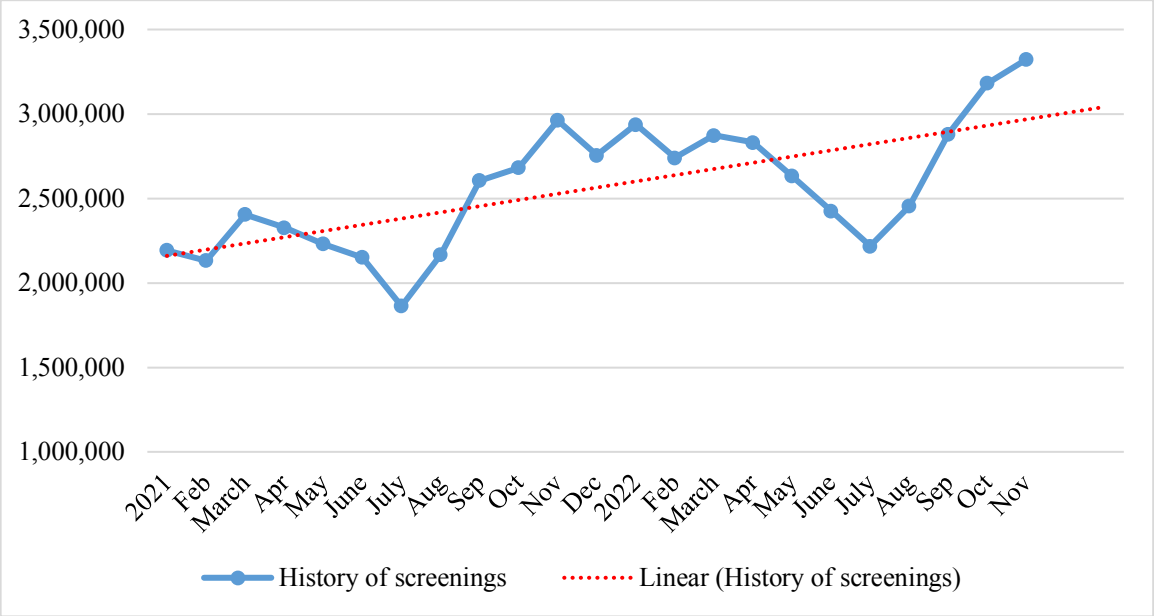

Figure 3.3. The history of impressions for the query "Psychologist"

A similar interest in terms of queries has been noted since 2007 when searching for the word "psychiatrist"[14].

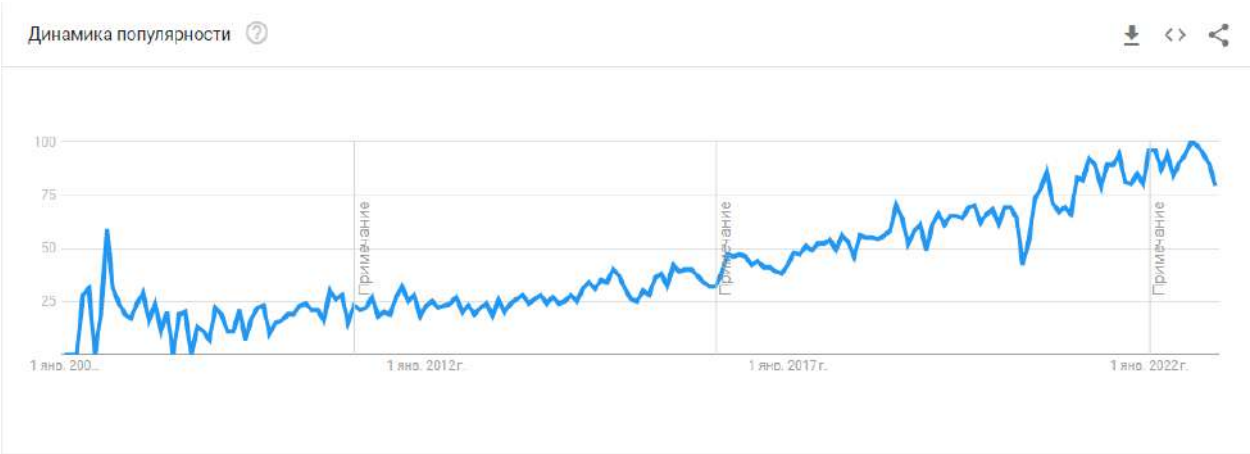

Figure 3.4. The history of impressions for the query "Psychiatrist"

[13] https://wordstat.yandex.ru/#!/regions?filter=cities&words=психолог
[14] https://trends.google.ru/trends/explore?date=2007-01-01%202022-12-27&geo=RU&q=Психиатр

From January 2021 to the present, there has been an increase in the popularity of the search query "psychiatrist" according to Yandex[15] statistics, and with a similar tendency to increase interest, as in the case of the query "psychologist". The analysis of regional queries revealed the greatest interest in this query in Moscow (125%), St. Petersburg (118%) and Novosibirsk (113%)[16] (Figure 3.4-3.5).

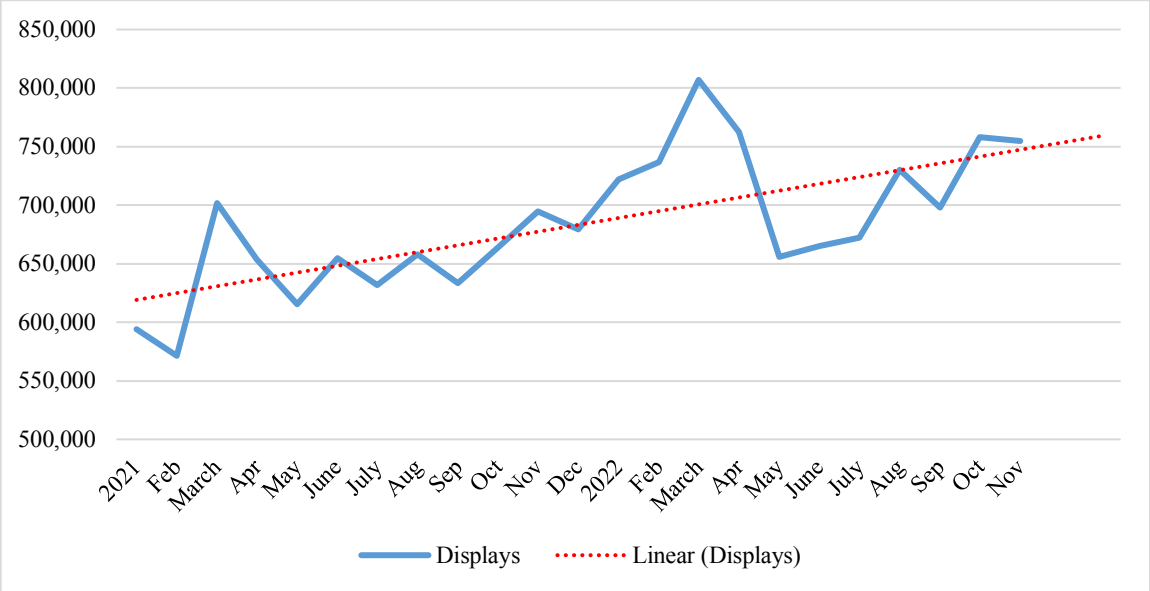

Figure 3.5. The history of impressions for the query «Psychiatrist»

Interest in psychotherapists was also growing.

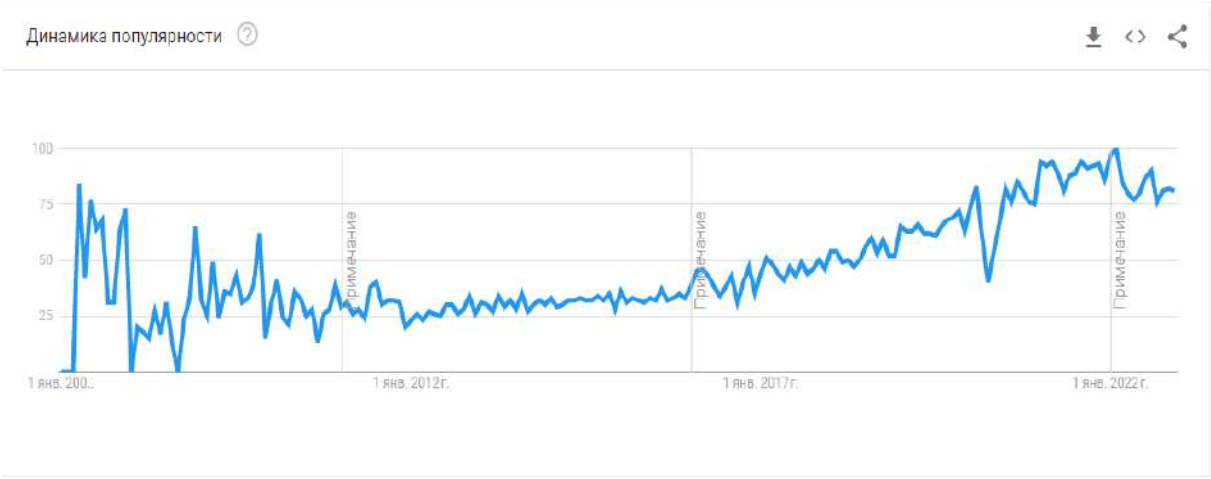

Figure 3.6. Dynamics of popularity for the query "Psychotherapist"

[15] https://wordstat.yandex.ru/#!/history?words=психиатр
[16] https://wordstat.yandex.ru/#!/regions?filter=cities&words=психиатр

Since 2021, there has been an increase in the popularity of this query with a growing trend[17]. The most popular search query is "psychotherapist" in Moscow (115%) and St. Petersburg (156%)[18] (Figure 3.6-3.7).

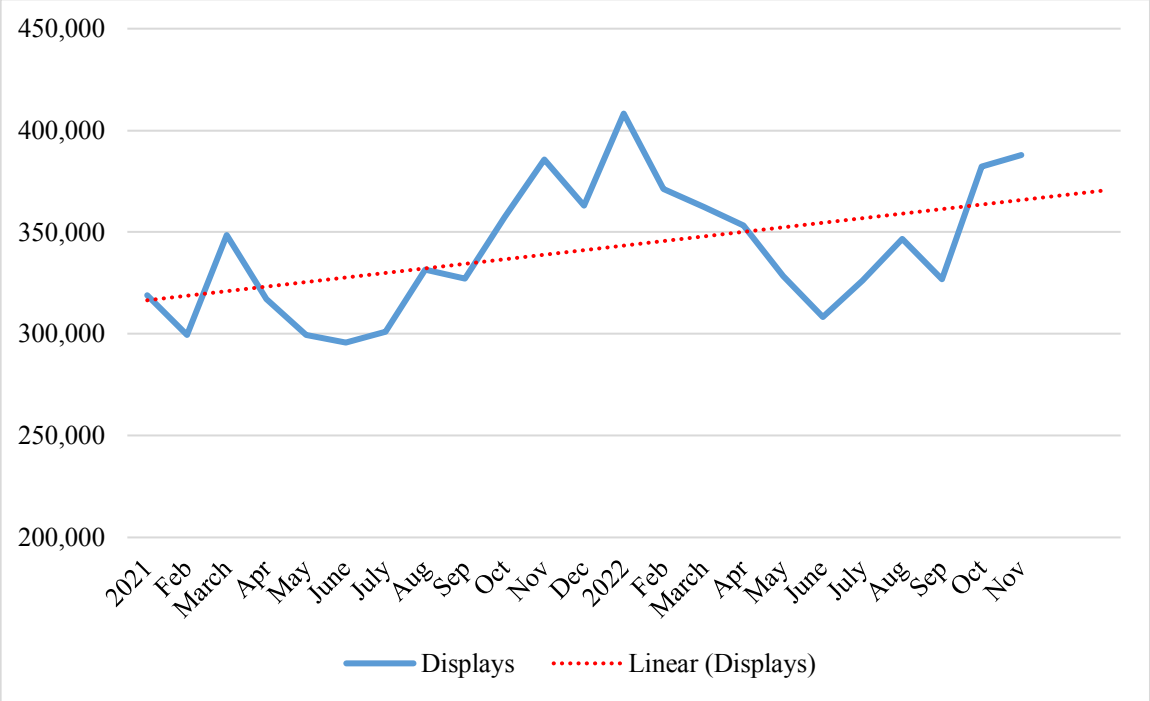

Figure 3.7. Dynamics of popularity for the query "Psychotherapist"

Since the beginning of 2022, the demand for sedatives in Russia has increased by 44% and for antidepressants by 48% compared to 2021[19]. The growth trend is recorded by Google search query statistics[20] (Figure 3.8-3.10).

[17] https://wordstat.yandex.ru/#!/history?words=психотерапевт
[18] https://wordstat.yandex.ru/#!/regions?filter=cities&words=психотерапевт
[19] https://vademec.ru/news/2022/12/02/murashko-dostupnost-psikhologo-psikhiatricheskoy-pomoshchi-v-rossii-povysitsya/
[20] https://trends.google.ru/trends/explore?date=2012-01-01%202022-12-20&geo=RU&q=депрессия,антидепрессанты

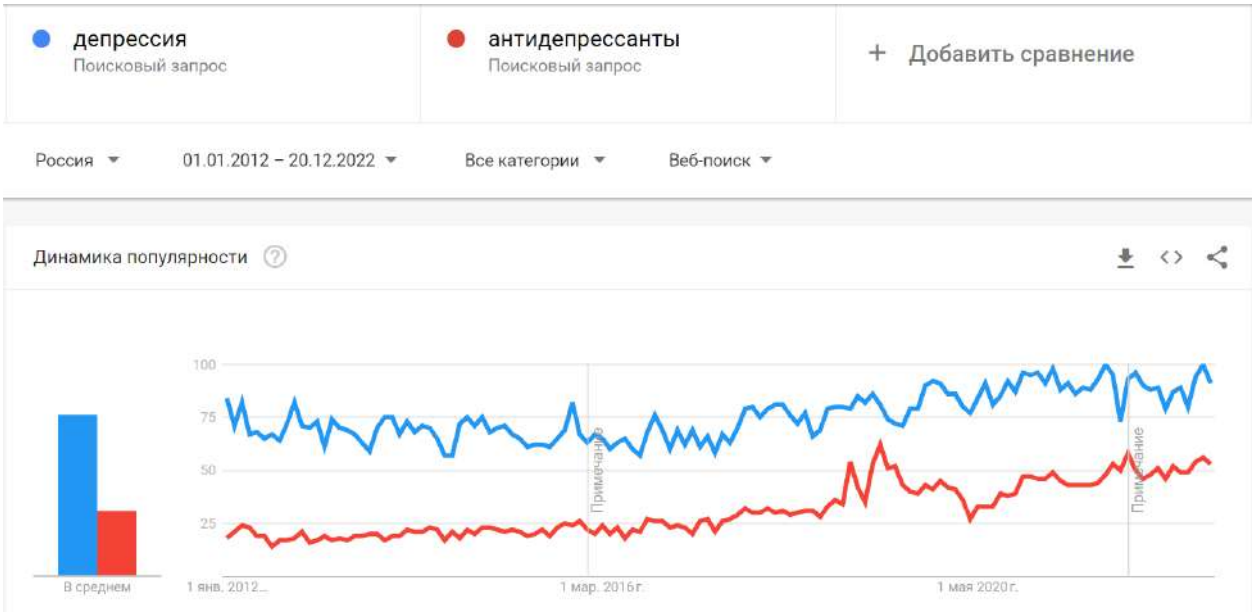

Figure 3.8. Dynamics of popularity for the query "Depression" and "Antidepressants"

The projected increase in the number of requests was also observed according to Yandex data for the period from 2021 to the end of 2022[21] [22].

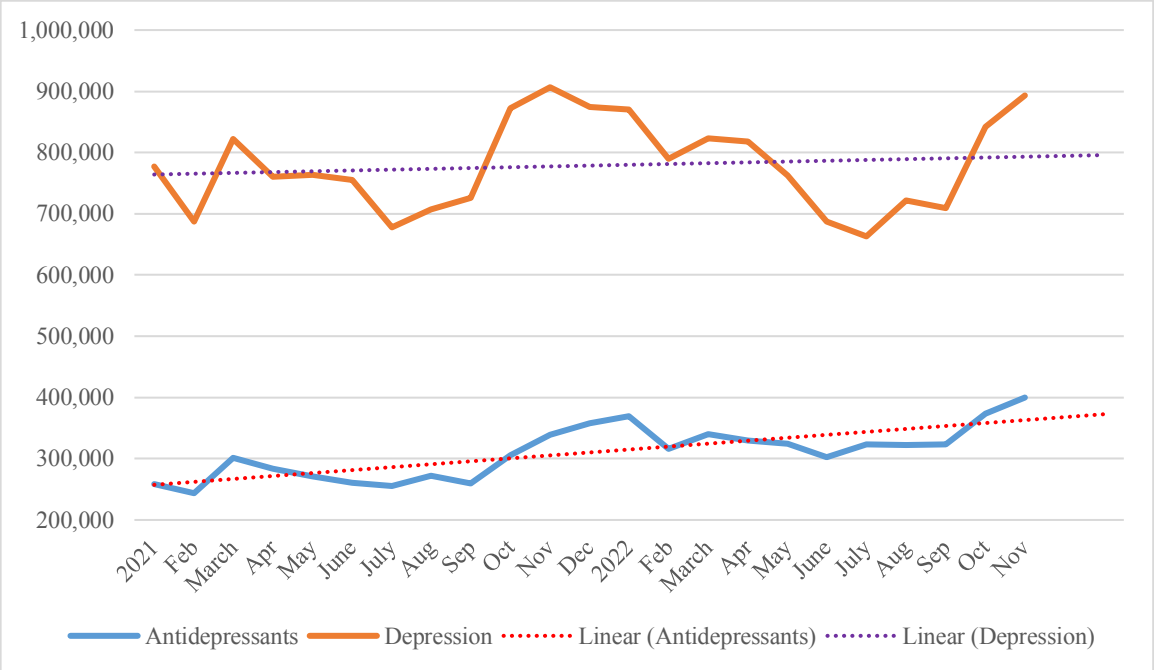

Figure 3.9. The history of impressions for the query "Depression" and "Antidepressants"

[21]https://wordstat.yandex.ru/#!/history?words=антидепрессанты
[22]https://wordstat.yandex.ru/#!/history?words=депрессия

The increase in the level of anxiety of the population was confirmed by the dynamics of the growth in the popularity of Google search queries[23] (Figure 3.10).

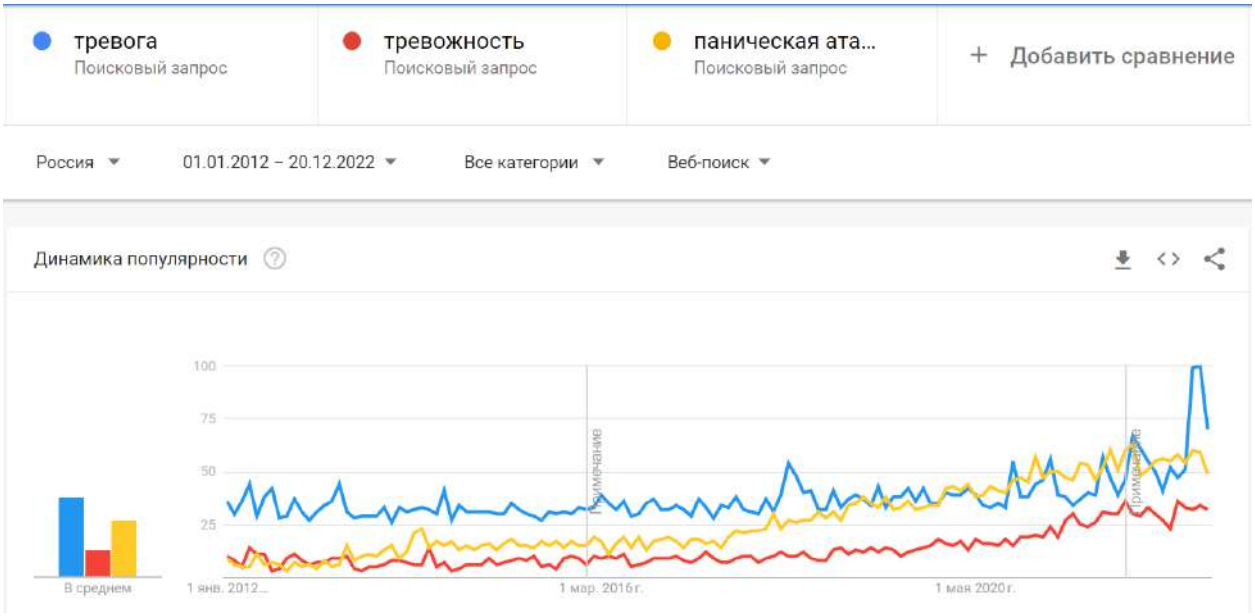

Figure 3.10. The dynamics of popularity at the request of psychoemotional disorders.

A similar increase in the number of queries on the topic of panic attacks[24], anxiety[25] and anxiety[26] was confirmed by the analysis and evaluation of Yandex statistics (Figure 3.11).

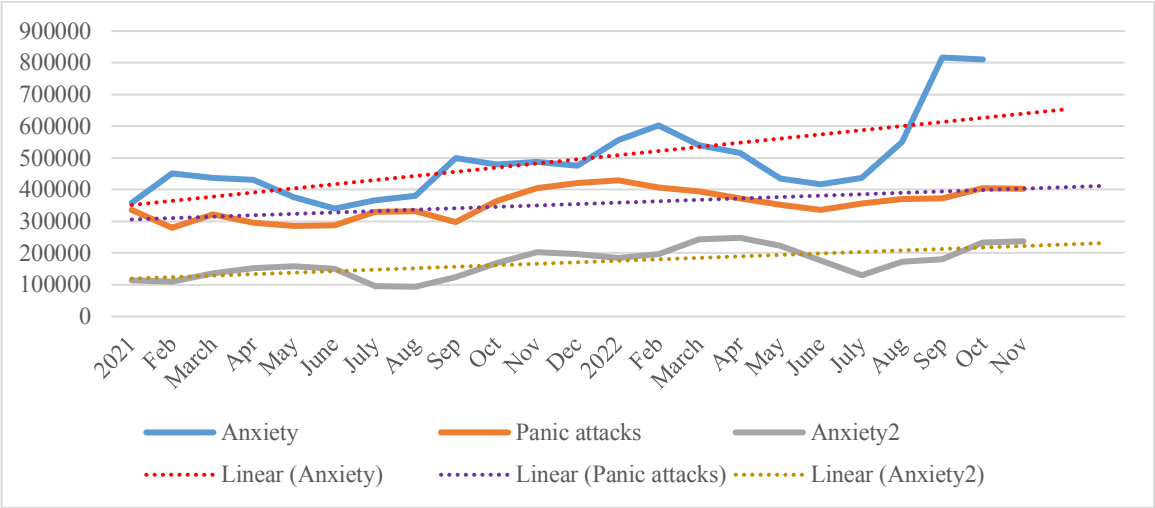

Figure 3.11. The history of impressions based on requests for psychoemotional disorders.

[23] https://trends.google.ru/trends/explore?date=2012-01-01%202022-12-20&geo=RU&q=тревога,тревожность,паническая%20атака
[24] https://wordstat.yandex.ru/#!/history?words=панические%20
[25] https://wordstat.yandex.ru/#!/history?words=тревога
[26] https://wordstat.yandex.ru/#!/history?words=тревожность

As part of the study, an analysis of the demand for consultations of medical psychologists in a hospital on the basis of GKB 67 in Moscow was carried out. Since 2020, there has been an increase in the number of consultations by 386% (Figure 3.12).

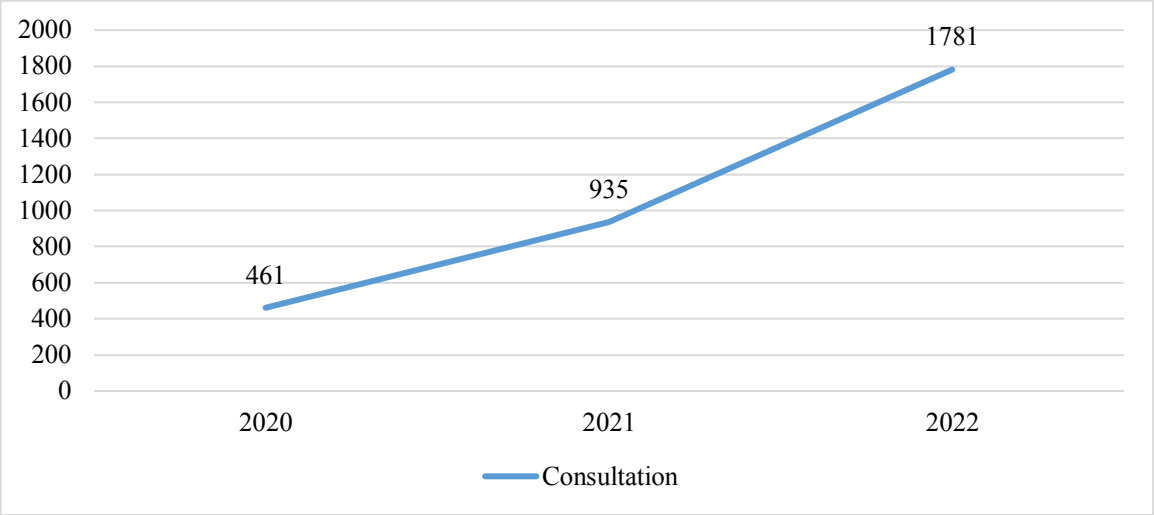

Figure 3.12. Analysis of the demand for consultations of medical psychologists in the hospital

Based on the analysis of requests, work with the problem of anxiety came to the fore. During the pandemic, moderate anxiety accounted for 52% of the total number of requests, acute anxiety – 23%. In 2022, anxiety (44% of the total number of requests), as well as depression (20%) and emotional and personal characteristics (16%) were the main reasons for seeking medical psychologist's advice at the GKB 67 hospital (Figure 3.13-3.14).

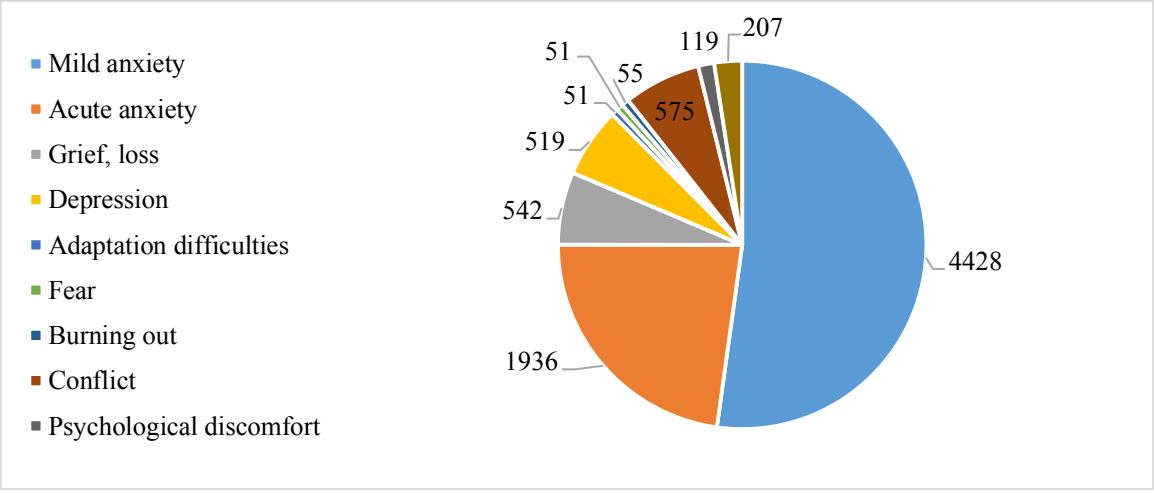

Figure 3.13. Areas of work of psychologists in the IVF prominent hospital

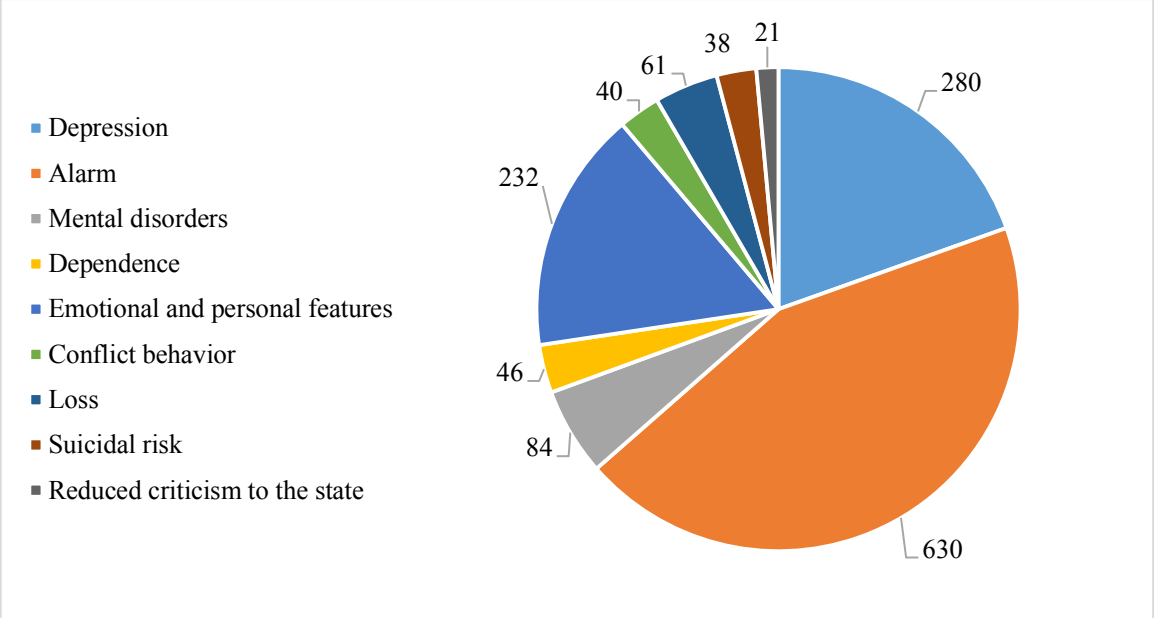

Figure 3.14. The directions of work of psychologists in GKB 67 in 2022

In addition, a survey was conducted of patients of the GKB 67 perinatal center aged 18 to 44 years. 95% of the patients were married and lived with their spouse and children, 63% had a permanent job. The study revealed that 44% of patients periodically experienced anxiety, anxiety or fear, 24% noted a decreased mood, 31% increased irritability, 38% increased fatigue (Figure 3.15).

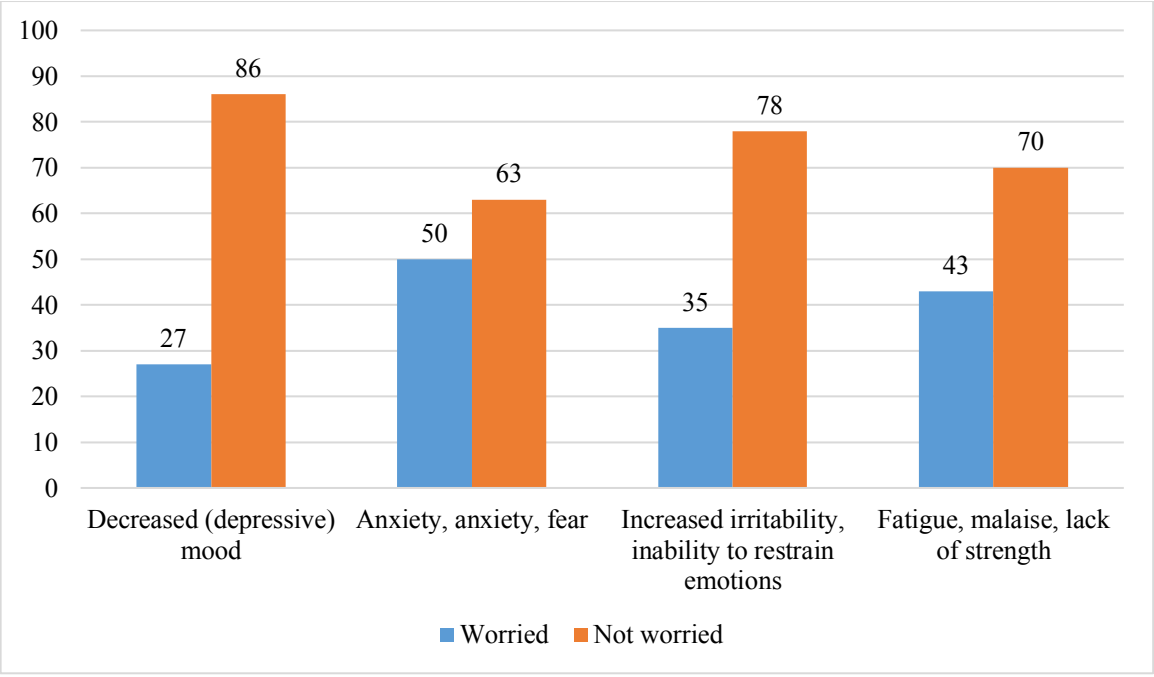

Figure 3.15. The structure of the causes of psychoemotional disorders in patients of the perinatal center GKB 67, %.

Patients interested in specialized care made up the majority. 75% of the patients were ready to consult a psychologist if necessary, 64% - a psychotherapist, 62% - a psychiatrist (Figure 3.16).

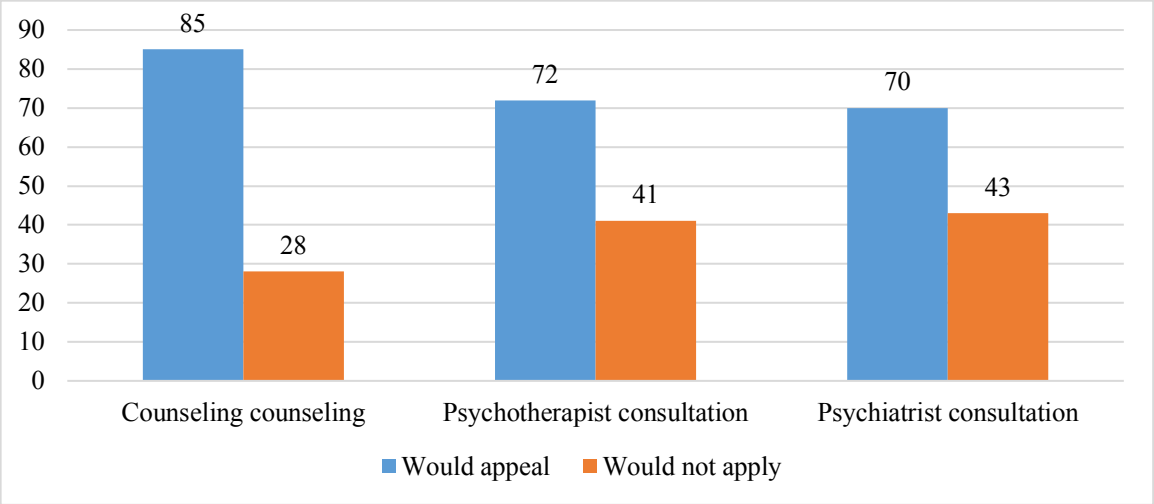

Figure 3.16. The structure of the patients of the perinatal center GKB 67 interested in specialized care, %.

3.2. Social and medical profile of the population in the organization of psychological, psychotherapeutic and psychiatric care.

In the sexual structure of the population ready to seek psychological, psychotherapeutic and psychiatric care of the population was dominated by women, amounting to 61.96%, men occupied a smaller share – 38.04% (Fig. 3.17).

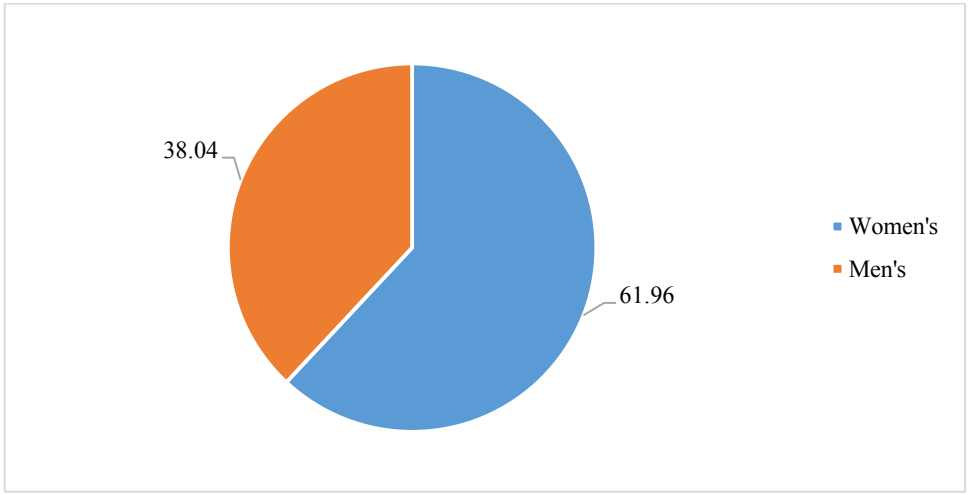

Figure 3.17. Gender distribution of persons who are ready to seek psychological, psychotherapeutic and psychiatric help. %.

The age structure of the respondents was mainly represented by persons 35-39 years old (20.57%), 40-44 years old (16.14%), 30-34 years old (15.38%), 25-29 years old (11.29%) (Figure 3.18).

Among the respondents willing to seek psychological, psychotherapeutic and psychiatric help, 65.89% were married and married, 20.57% were divorced, 10.79% were single (not married), 2.76% were widows (Figure 3.19).

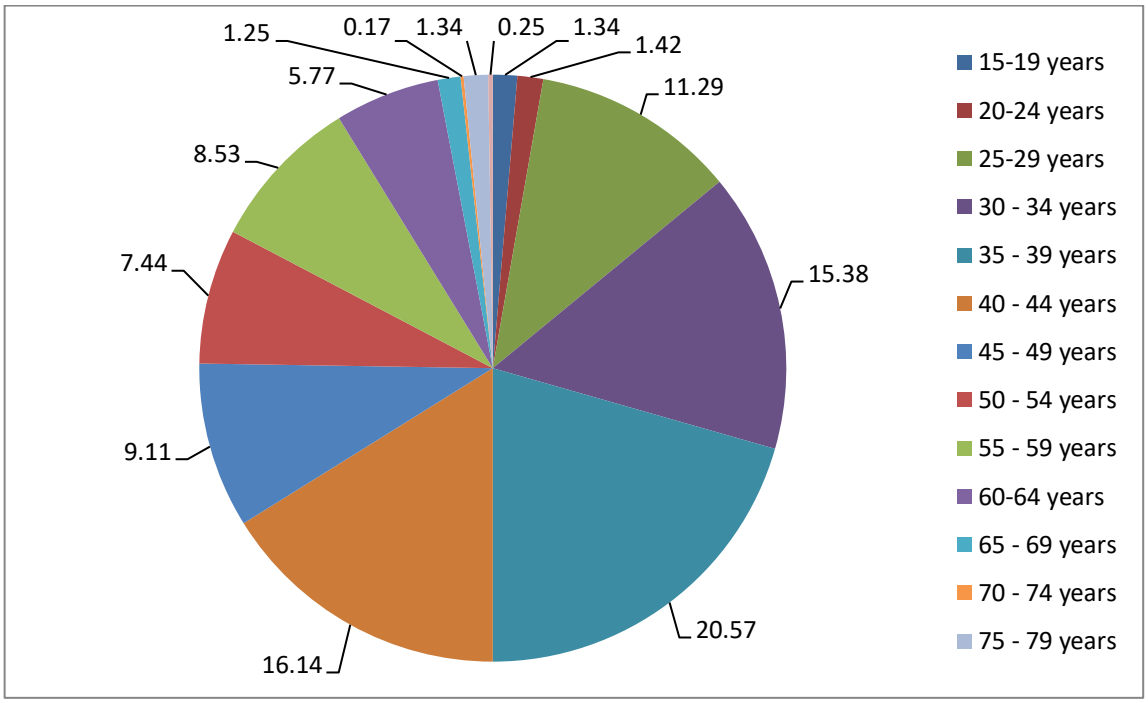

Figure 3.18. Age distribution of persons who are ready to seek psychological, psychotherapeutic and psychiatric help.

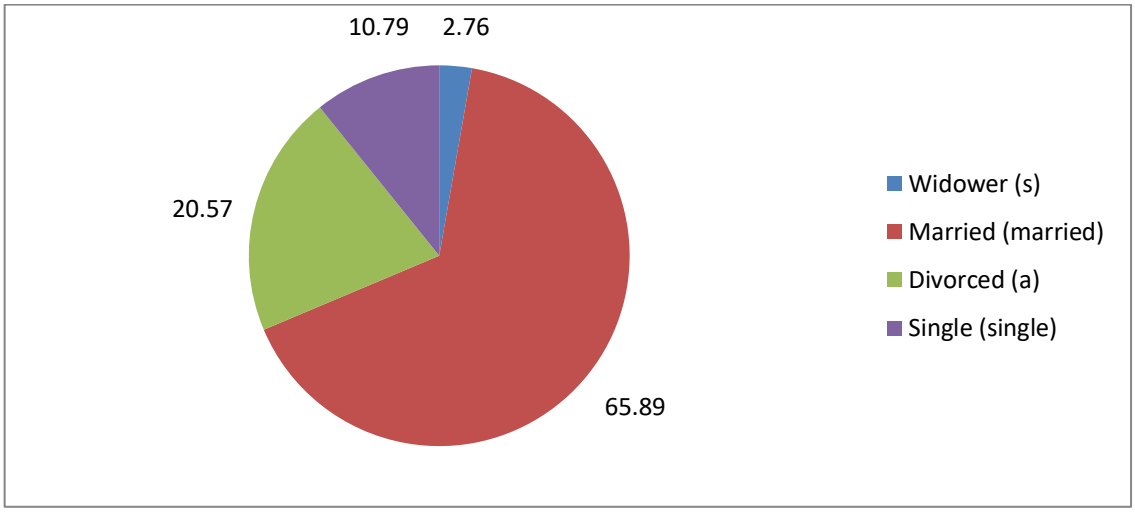

Figure 3.19. Distribution by marital status of persons who are ready to seek psychological, psychotherapeutic and psychiatric help. %

Among those who are ready to seek psychological, psychotherapeutic and psychiatric help, 47.41% worked in public institutions, 39.21% worked in private institutions and enterprises, 7.44% did not work, 3.6% were old-age pensioners, 2.34% were pensioners, disabled people (Figure 3.20).

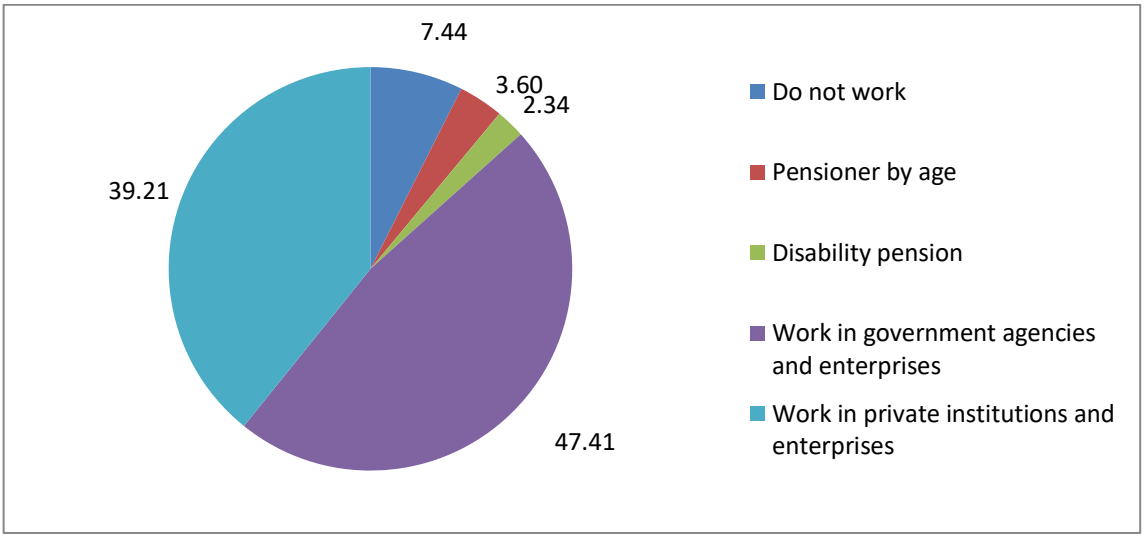

Figure 3.20. Distribution by social status of persons who are ready to seek psychological, psychotherapeutic and psychiatric help.

The distribution of persons ready to seek psychological, psychotherapeutic and psychiatric help by family composition showed that 52.17% lived with their spouse and children, 13.04% lived alone, 12.96% lived with their parents, 9.45% lived with their parents, 8.11% lived with children (Figure 3.21).

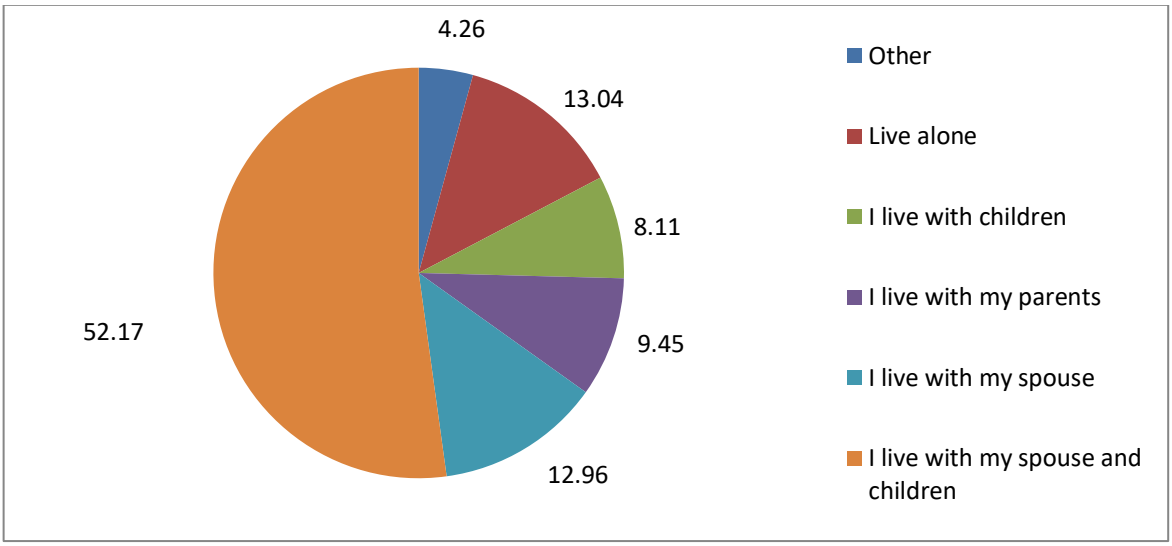

Figure 3.21. Distribution by family composition of persons who are ready to seek psychological, psychotherapeutic and psychiatric help. %

Among the respondents had chronic diseases 34.7%, did not have - 65.3% (Figure 3.22).

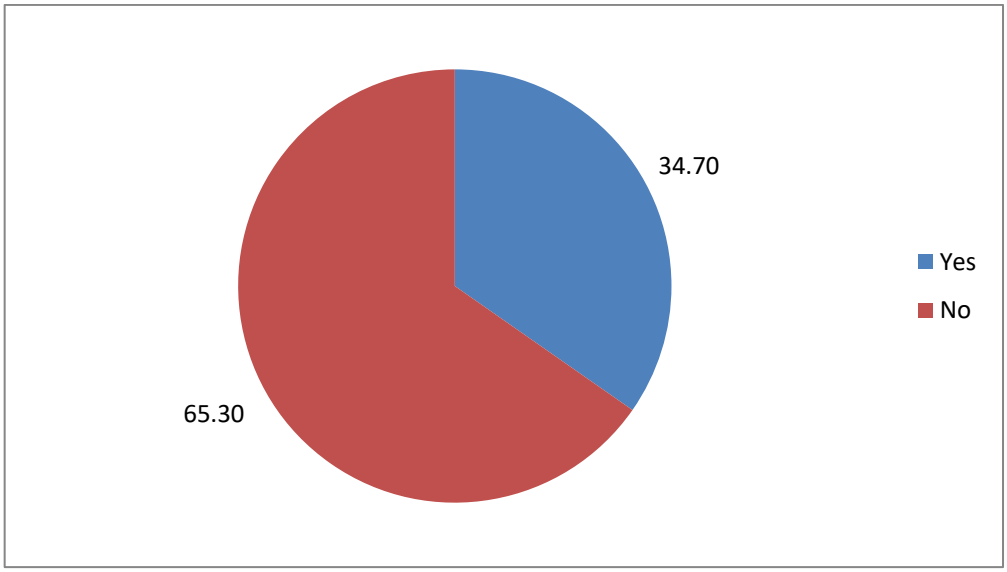

Figure 3.22. Distribution by the presence of chronic diseases of persons who are ready to seek psychological, psychotherapeutic and psychiatric help. %

Among the respondents, 91.47% of people were sick with coronavirus infection, and only 8.53% were not sick (Figure 3.23).

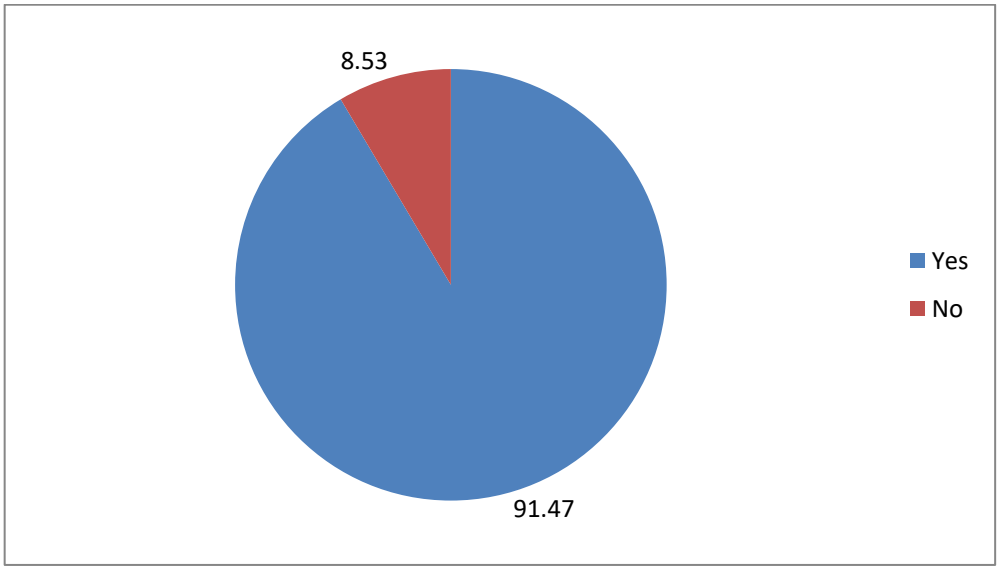

Figure 3.23. Distribution of persons who are ready to seek psychological, psychotherapeutic and psychiatric help, based on "Have you had a coronavirus infection" %

According to the course of coronavirus infection, all respondents were divided into groups with a mild course (58.78%), moderate severity (35.56%), severe course (5.21%) (Figure 3.24)

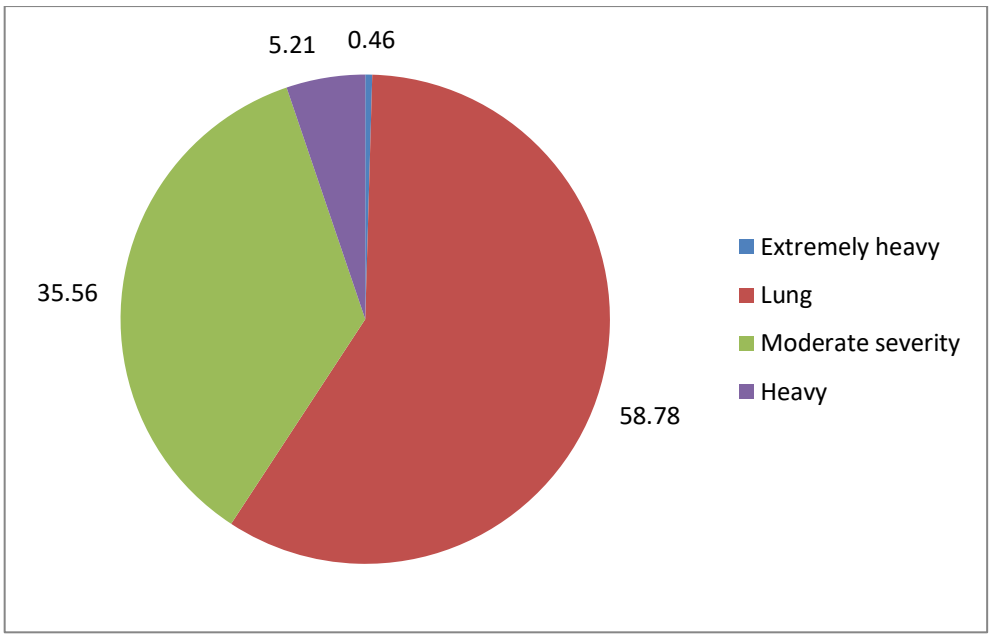

Figure 3.24. Distribution of persons who are ready to seek psychological, psychotherapeutic and psychiatric help, based on the "Form of the course of coronavirus infection" %

Among the respondents, 77.68% noted a depressive mood, 22.32% had a normal mood (Figure 3.25)

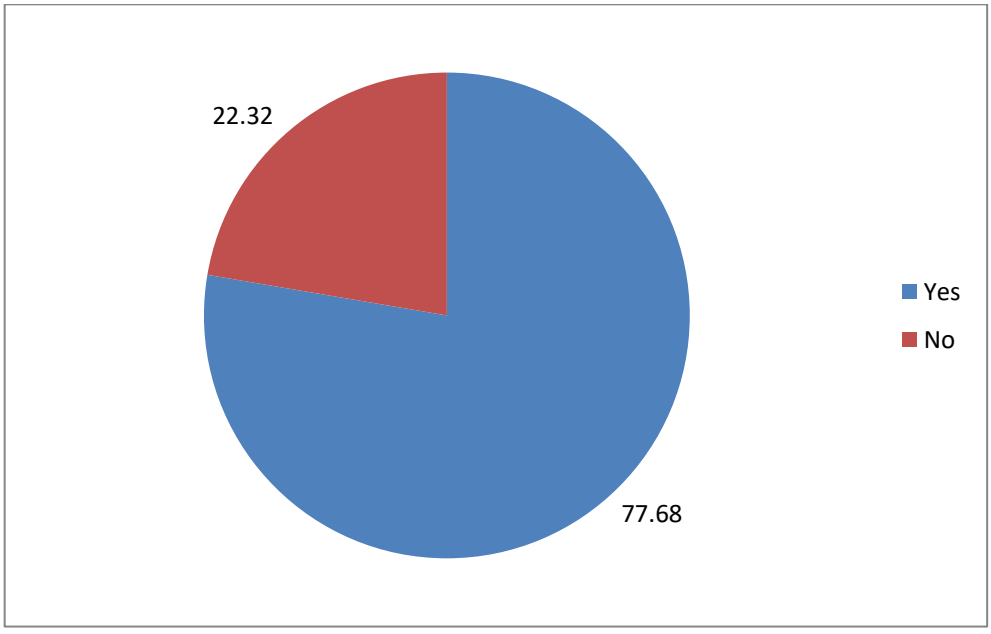

Figure 3.25. The distribution of persons who are ready to seek psychological, psychotherapeutic and psychiatric help, based on "Do you notice yourself: (Reduced (depressive) mood" %

Among the respondents who are ready to seek psychological, psychotherapeutic and psychiatric help, 38.38% noted the presence of fear, anxiety, anxiety, 61,62% did not experience such feelings (Figure.3.26).

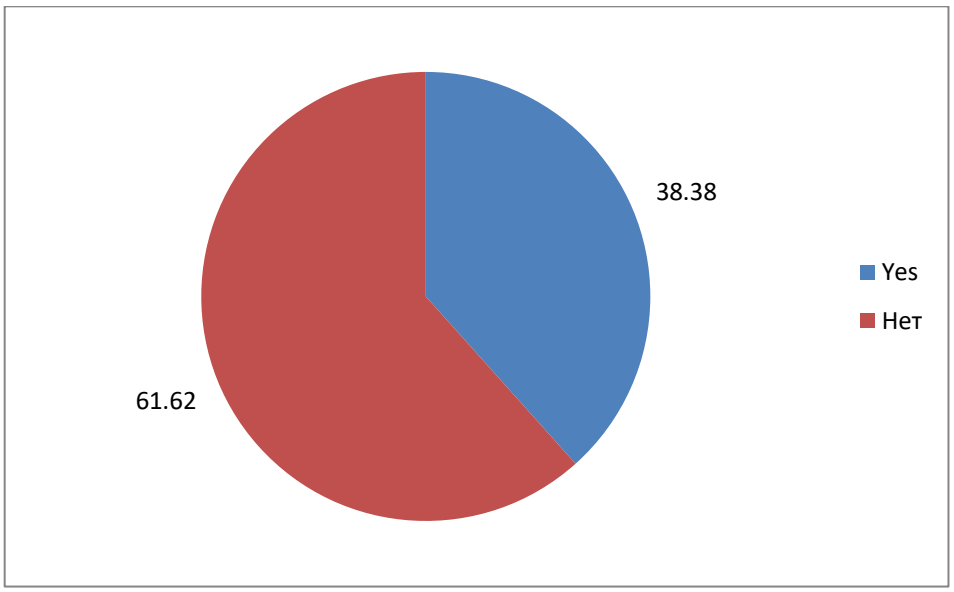

Figure 3.26. Distribution of persons who are ready to seek psychological, psychotherapeutic and psychiatric help, according to "Do you notice in yourself: Anxiety, anxiety, fear" %

The distribution of persons ready to seek psychological, psychotherapeutic and psychiatric help on the basis of "Do you notice a periodic feeling of panic" was as follows: 79.43% did not notice a periodic feeling of panic, 20.57% - on the contrary, noted this condition (Figure. 3.27).

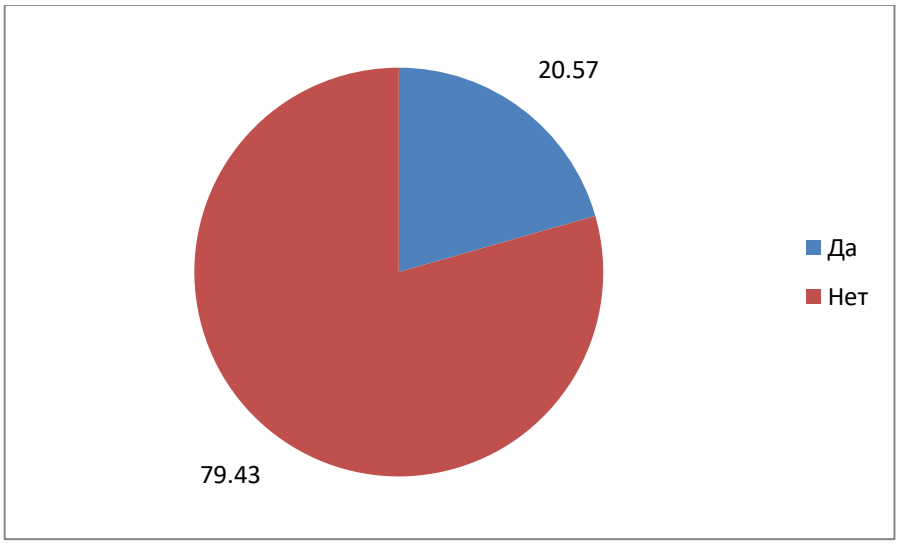

Figure 3.27. The distribution of people who are ready to seek psychological, psychotherapeutic and psychiatric help, based on "Do you notice yourself: A periodic feeling of panic" %

When asking the question "Do you notice a decrease in memory, difficulties in assimilating new information", 76.7% of respondents confirmed the fact of memory loss and difficulty in assimilating information, 23.33% rejected this fact (Figure 3.28).

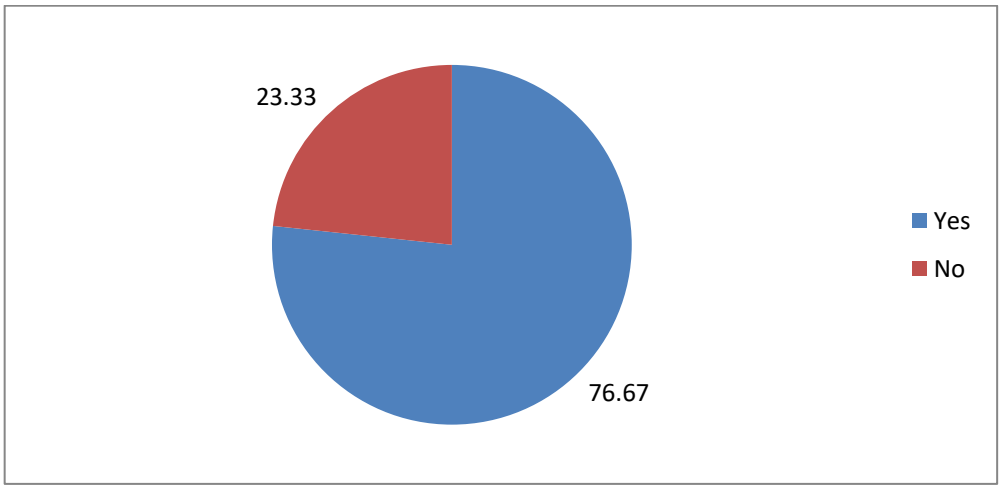

Figure 3.28. Distribution of people who are ready to seek psychological, psychotherapeutic and psychiatric help, based on "Do you notice a decrease in memory, difficulty assimilating new information" %

To the question "Do you notice difficulties in communicating with others?" only 11.87% responded positively, and 88.13% denied this fact (Figure 3.29).

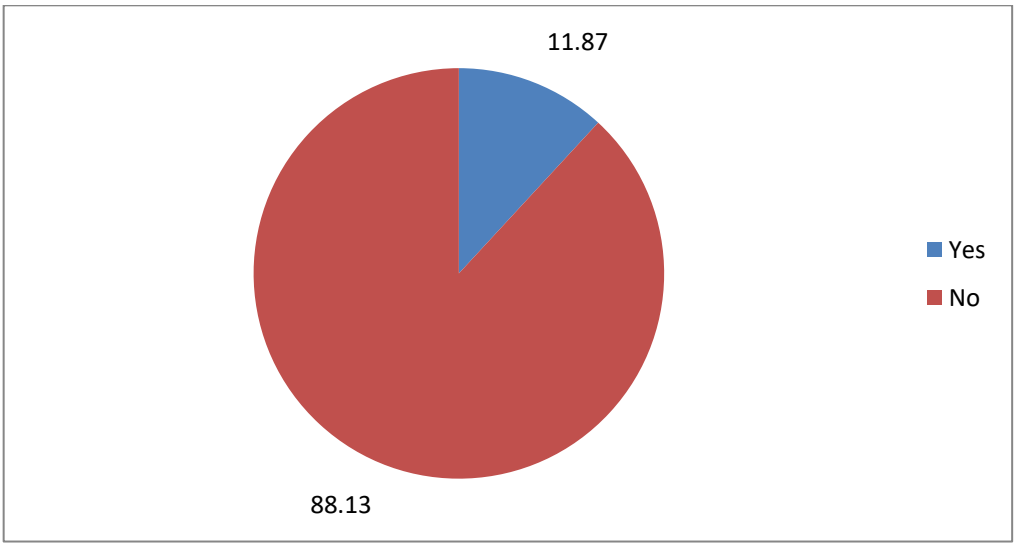

Figure 3.29. The distribution of people who are ready to seek psychological, psychotherapeutic and psychiatric help, based on "Do you notice difficulties in communicating with others?" %

To the question "Do you notice malaise, lack of strength, increased fatigue", 50.17% answered positively, and 49.83% - negatively (Figure 3.30).

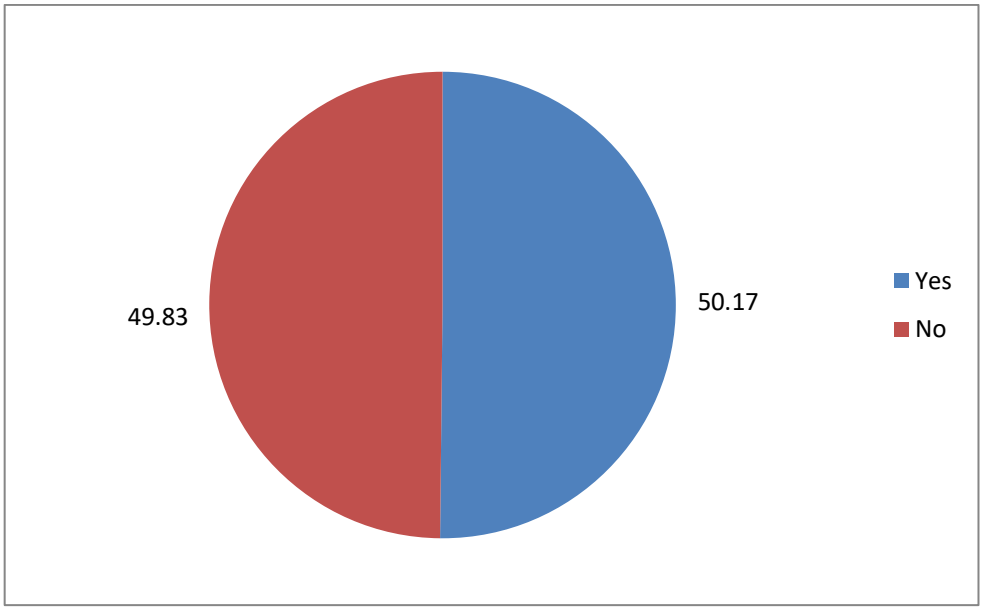

Figure 3.30. The distribution of people who are ready to seek psychological, psychotherapeutic and psychiatric help, based on "Do you notice malaise, lack of strength, increased fatigue?" %

To the question "Do you notice a decrease in performance" 81.69% answered positively, and 18.31% - negatively (Figure 3.31).

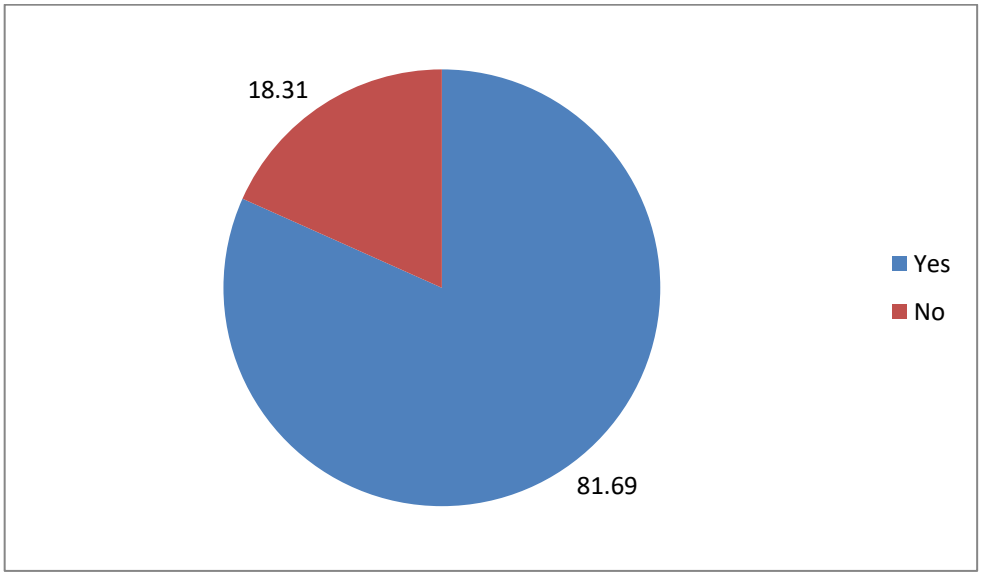

Figure 3/31. Distribution of persons who are ready to seek psychological, psychotherapeutic and psychiatric help, based on "Do you notice a decrease in your working capacity?" %

To the question "Do you have complaints about pain or discomfort in internal organs and muscles that do not subside after taking medications? The doctor's treatment does not bring relief" 11.87% of the respondents confirmed this fact, and 88.13% did not confirm it (Figure 3.32).

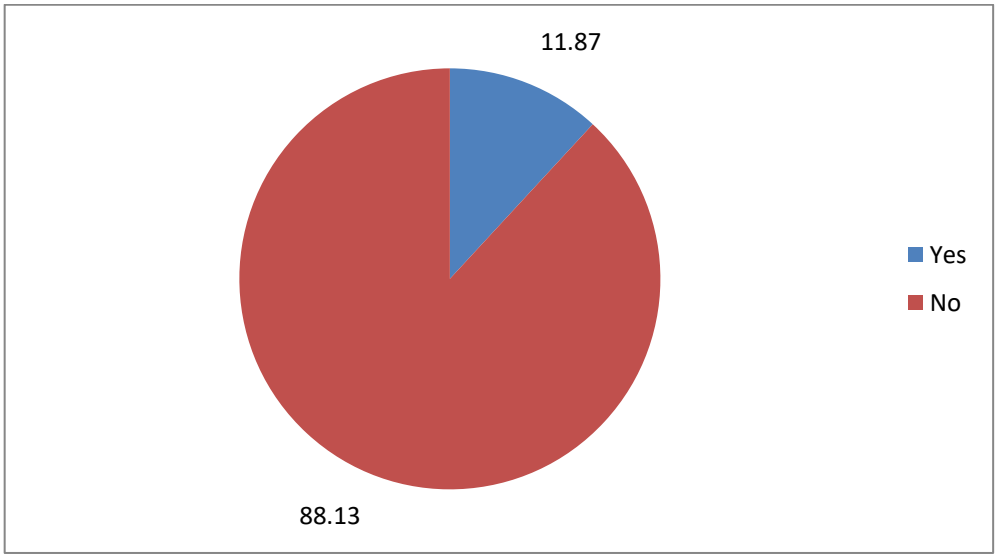

Figure 3.32. The distribution of people who are ready to seek psychological, psychotherapeutic and psychiatric help, based on "Whether you have complaints of pain or discomfort in internal organs and muscles that do not subside after taking medications. The doctor's treatment does not bring relief" %.

To the question "If necessary, would you seek counseling from a psychologist", 56.19% answered positively, and 43.81% - negatively (Figure 3.33).

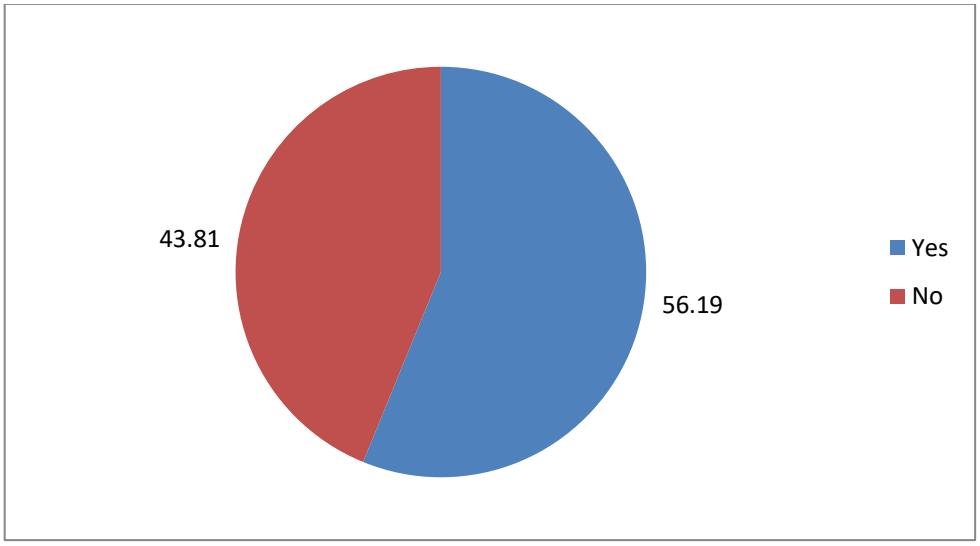

Figure 3.33. Distribution of persons who are ready to seek psychological, psychotherapeutic and psychiatric help on the basis of "If necessary, you would seek advice from a psychologist" %

To the question "Choose the reason for consulting a psychologist," 92.94% believed that such a need could not arise, 7.06% feared the consequences (Figure 3.34).

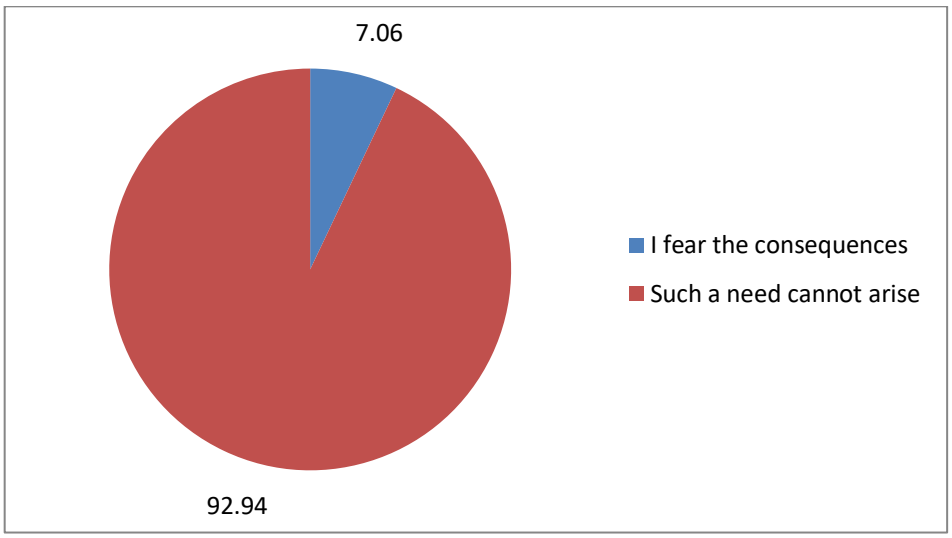

Figure 3.34. Distribution of persons who are ready to seek psychological, psychotherapeutic and psychiatric help on the basis of "Choose the reason for consulting a psychologist" %.

To the question "If necessary, would you consult a psychotherapist?" 65.13% answered positively, 34.87% - negatively (Figure 3.35).

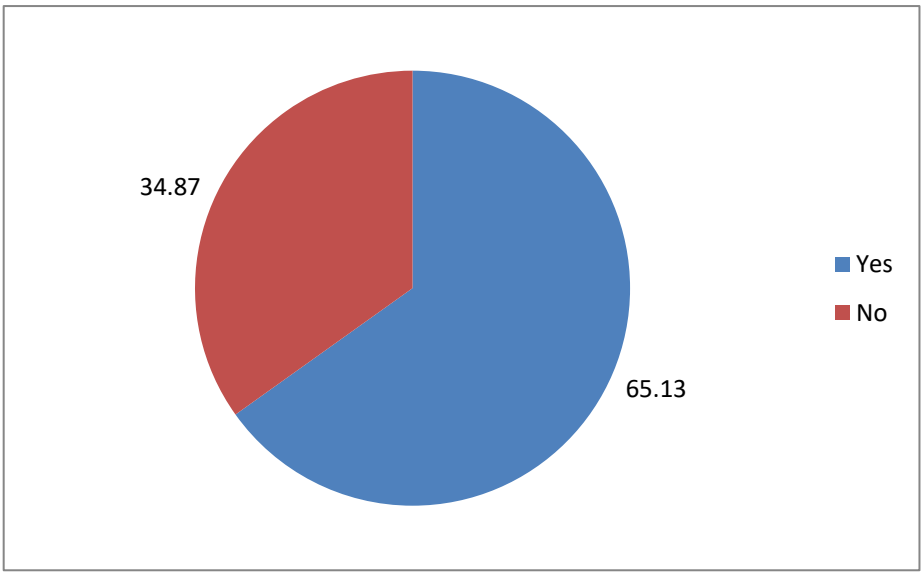

Figure 3.35. The distribution of persons who are ready to seek psychological, psychotherapeutic and psychiatric help, based on "If necessary, would you seek advice from a psychotherapist" %

To the question "Choose the reason for consultation with a psychotherapist" 87.53% answered "Such a need cannot arise", 12.47% were afraid of the consequences of such treatment (Figure 3.36).

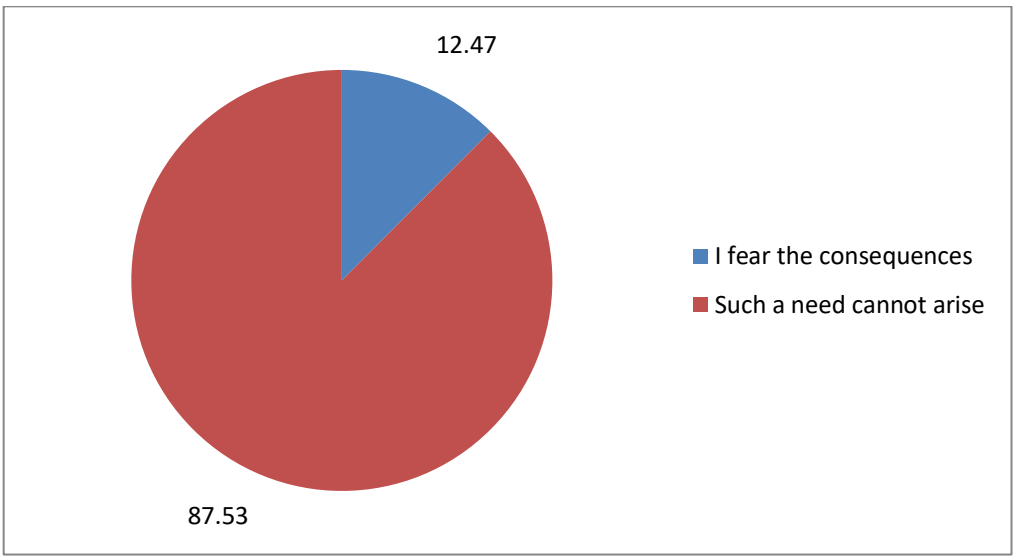

Figure 3.36. Distribution of persons who are ready to seek psychological, psychotherapeutic and psychiatric help on the basis of "Choose the reason for consultation with a psychotherapist" %

To the question "If necessary, would you consult a psychiatrist?" 86.79% were ready to consult a psychiatrist if necessary, 13.21% excluded such a possibility (Figure 3.37).

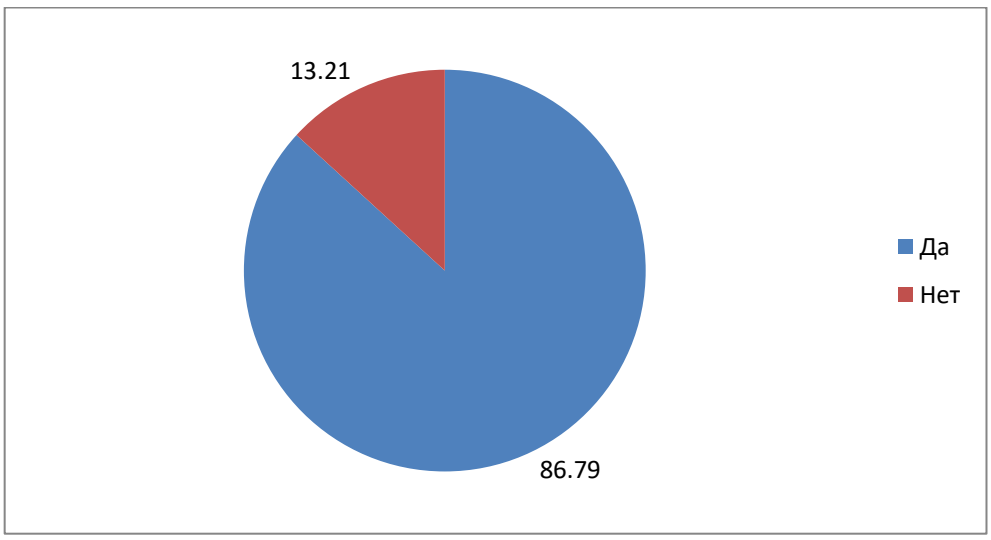

Figure 3.37. Distribution of persons who are ready to seek psychological, psychotherapeutic and psychiatric help, on the basis of "If necessary, would you seek advice from a psychiatrist" %.

To the question "Choose the reason for consulting a psychiatrist", 72.78% answered "Such a need cannot arise", 27.22% were afraid of the consequences of such treatment (Figure 3.38).

Figure 3.38. Distribution of persons who are ready to seek psychological, psychotherapeutic and psychiatric help on the basis of "Choose the reason for consulting a psychiatrist" %

Thus, the analysis showed a general increase in the need for psychological, psychotherapeutic and psychiatric care.

The definition of socio-medical determinants of the need for psychological, psychotherapeutic and psychiatric care of the population was carried out through a global assessment and analysis of blind network queries "Psychologist", "Psychotherapist", "Psychiatrist", the leader of which was the population of the metropolitan regions of Moscow and St. Petersburg.

There was an increase in demand in 2022 compared to 2021 by 44% for sedative drugs and by 48% for antidepressants. In proportion to the increase in the need for specialized drug therapy, there was an increase in the level of anxiety of the population, panic attacks, and a fourfold increase in the number of visits to a psychologist, mainly due to anxiety (44% of cases) and depression (20% of cases).

Women had the greatest medical activity in forming the need for psychological, psychotherapeutic and psychiatric care, amounting to 61.96%. The age range of the surveyed citizens who were ready to seek psychological,

psychotherapeutic and psychiatric help was from 25 to 44 years old - 63.38% - economically active population. The structure of the respondents was dominated by married people – 65.89%, 86.62% - working, 91.47% - those who had suffered a coronavirus infection in mild (58.78%) and moderate (35.56%) severity, in 50.17% of cases - those who felt unwell, lack of strength, increased fatigue.

Among the respondents who were ready to seek psychological, psychotherapeutic and psychiatric help, 56.19% were ready to turn to a psychologist, 65.13% to a psychotherapist, 86.79% to a psychiatrist.

The objective justification of the socio-medical determinants of the need for psychological, psychotherapeutic and psychiatric care was the close correlation between the signs (questions asked to the respondents). A close relationship (R=0.7) was recorded between the signs of "Memory loss, difficulties in learning new things" and "Decreased performance; difficulties in communicating with others", "Decreased performance; difficulties in communicating with others" and "Willingness to consult a psychotherapist" (R=0.64), "Depressive mood" and "Memory loss, difficulties in communicating with people" (R=0.76), "Depressive mood" and "Decreased performance" (R=0.76), "Depressive mood" and "Willingness to seek psychiatric advice (R=0.51), "Age" and "Chronic diseases" ((R= - 0.55).

The results obtained state a statistically significant increasing, but completely unconscious, inadequate need of the population for psychological, psychotherapeutic and psychiatric care, which is the basis for the need to form a population routing system in providing adequate targeted psychological, psychotherapeutic and psychiatric care.

CHAPTER 4. DISABILITY OF THE POPULATION IN MENTAL DISORDERS

The mental health of the population reflects the level of public health, being an indicator of social well-being. Currently, one in 10 inhabitants of the planet suffers from mental disorders, and one in four will meet with them at one time or another in their lives. Mental disorders and behavioral disorders occupy leading positions in the structure of morbidity and permanent disability.

The peculiarity of mental illnesses is that they often lead to deep social and psychological maladjustment, and, in the vast majority, are the cause of disability. For a number of years, this particular group of patients has been leading in primary disability, in which about 75% are people of working age. The total number of people with disabilities due to mental disorders in Russia is more than 8% of the total number of people with disabilities in all diseases [6, 14, 18, 23].

Disability in mental illness has traditionally been considered in four groups: 1, 2, 3 and children. According to the third group, patients have moderate deviations in mental health, patients are considered capable, have the right to work on an equal basis with the majority; according to the second group, the psyche of patients is destroyed to a pronounced extent, but they can take care of themselves and their loved ones, they can work in a specially equipped place for no more than three hours a day; according to the first group, the patient has a complete lack of legal capacity, he does not have the right to work, and needs a guardian.

4.1. Disability in schizophrenia, schizotypal and delusional disorders.

A long-term study of mental disorders of the population of the Russian Federation has shown the presence of stable trends in general disability of the population in schizophrenia, schizotypal and delusional disorders: the growth of the first disability group from 0.78 in 2004 to 1.39 per 100 thousand population in 2021 (r=0.85) and the third disability group from 1.78 in 2004 to 3.78 per 100 thousand population in 2021 ((r=0.86), a decrease from 25.32 in 2004 to 19.14 per 100

thousand population in 2021 – the second disability group (r=-0.9), an increase from 0.47 in 2004 to 0.57 per 100,000 population in 2021, is the disability of children (r=0.58) ($p<0.05$). (Figure 4.1).

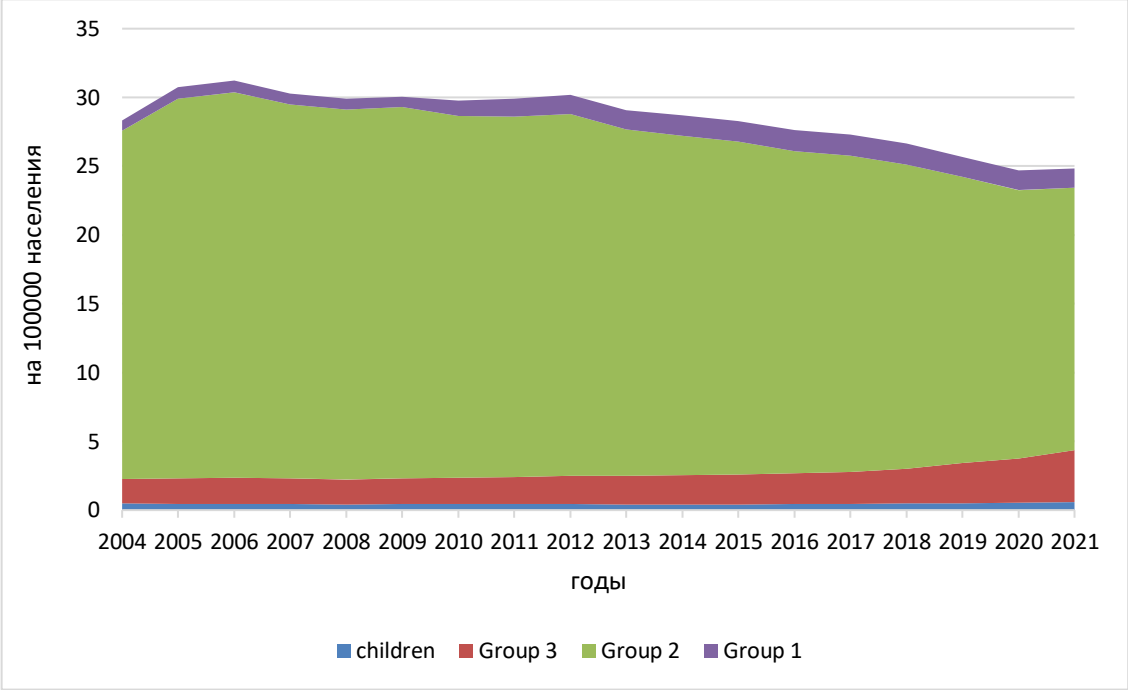

Figure 4.1. Dynamics of the general disability of the population in schizophrenia, schizotypal and delusional disorders, per 100,000 population

The dynamics of the newly identified disability maintained similar trends: unstable growth of the 1st group - from 0.006 to 0.01 per 100,000 population in the range from 2004 to 2021 (r=0.05), steady growth from 0.09 to 0.55 per 100,000 population in the range from 2004 to 2021 (r=0.81) of the third group, a steady increase from 0.47 to 0.57 per 100,000 population in the range from 2004 to 2021 (r=0.67) of the group of children, a steady decrease from 0.76 to 0.16 per 100,000 population in the range from 2004 to 2021 (r= - 0.79) of the second group (Figure 4.2).

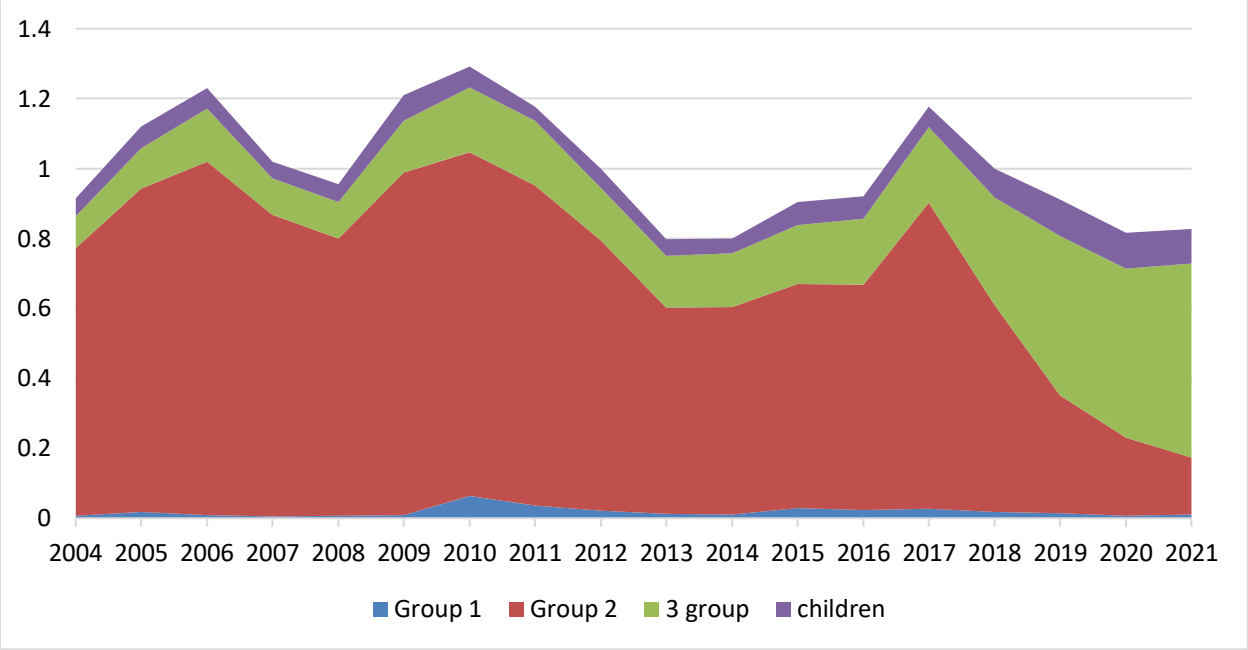

Figure 4.2. Dynamics of the first-time disability of the population in mental disorders: schizophrenia, schizotypal and delusional disorders, per 100,000 population

The demographic structure of the disability of the population with mental disorders: schizophrenia, schizotypal and delusional disorders is represented mainly by women (54.01%), in a slightly smaller proportion by men (44.37%) and minimally (1.61%) by children (Figure 4.3).

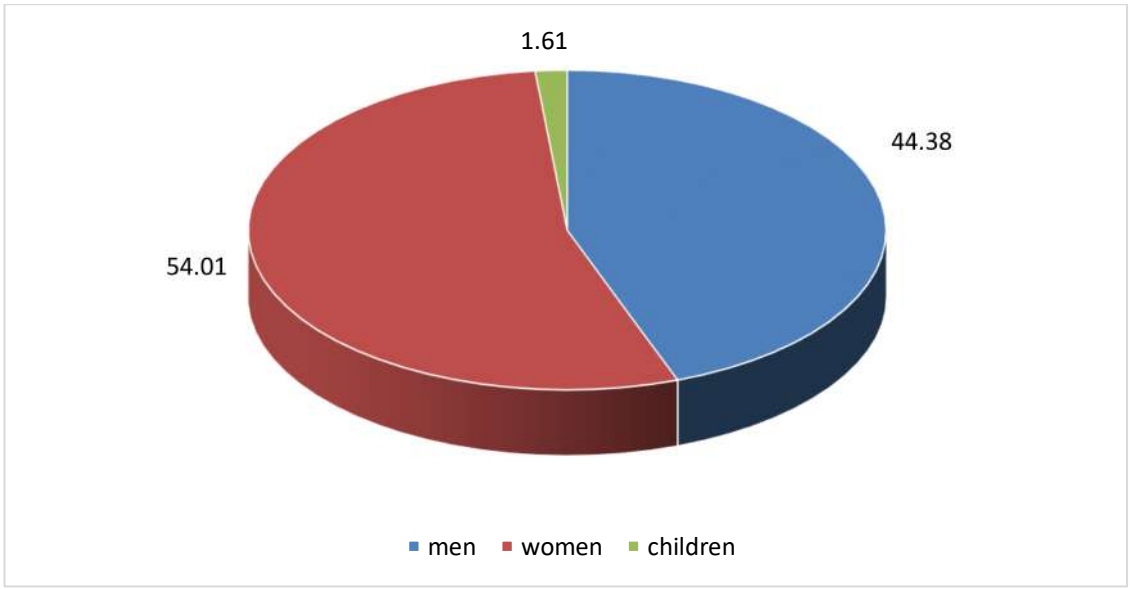

Figure 4.3. Demographic structure of disability in mental disorders: schizophrenia, schizotypal and delusional disorders, %

4.2. Population disability in mood disorders (affective disorders).

The dynamics of the general disability of the population with mood disorders (affective disorders) indicated the absence of changes in the indicator in patients of the first disability group: from 0.01 in 2004 to 0.01 per 100 thousand population in 2021, a steady downward trend in patients of the second disability group: from 1.04 per 100 thousand population in 2004 to 0.35 per 100 thousand population in 2021 (r= -0.53), an unstable growth trend in children: from 0.0009 per 100,000 population in 2004 to 0.01 per 100,000 population in 2021 (r= 0.24) (Figure 4.4).

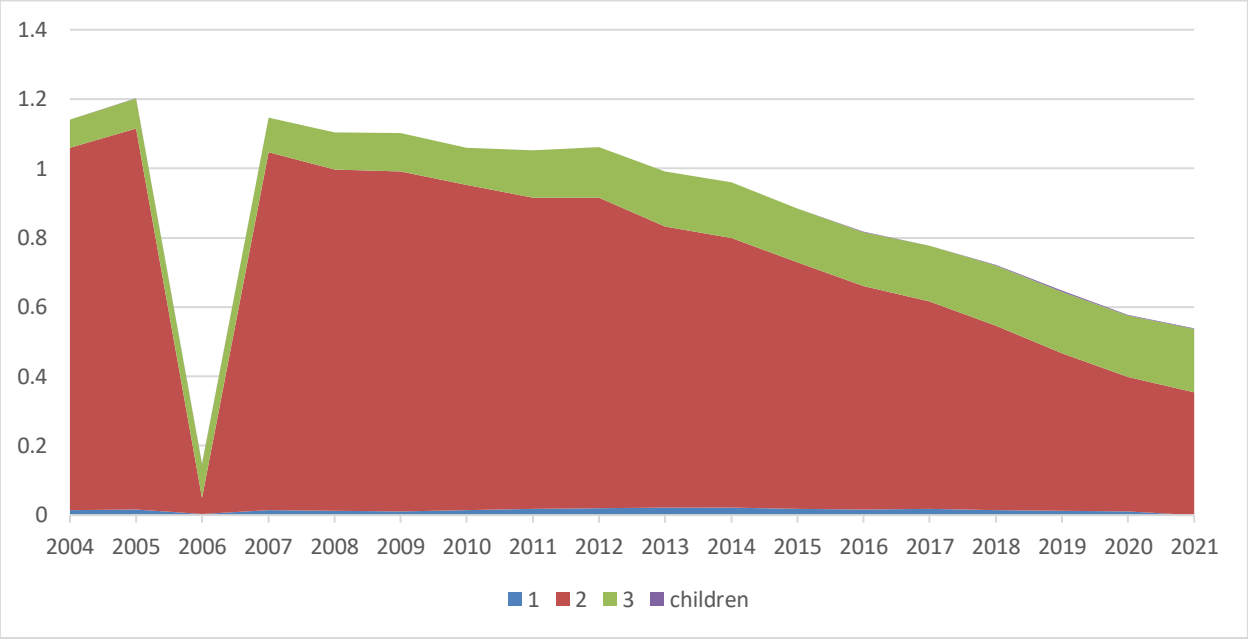

Figure 4.4. Dynamics of the general disability of the population in mood disorders (affective disorders), per 100,000 population.

For the first time, disability in mood disorders (affective disorders) decreased unsustainably in the first: from 0.003 per 100,000 population in 2004 to 0 in 2021 (r= - 0.06) and the second: from 0.05 in 2004 to 0.0009 per 100,000 population in 2021 (r= -0.32) disability groups, children: from 0.0009 per 100,000 population in 2004 to 0 in 2021 (r= 0.53) and steadily increased in the third group: from 0.01 per 100,000 population in 2004 to 0.02 per 100,000 population in 2021 (r = 0.97) (Figure 4.5).

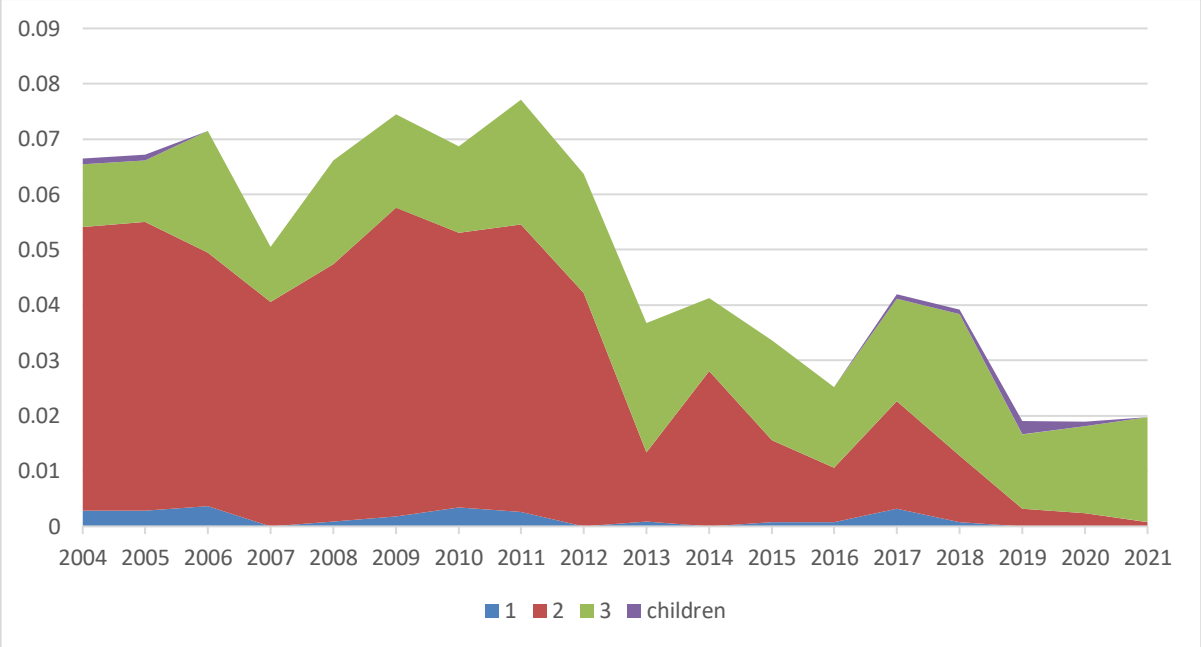

Figure 4.5. Dynamics of the first-time disability of the population with mood disorders (affective disorders), per 100,000 population

In the demographic structure of disability in mood disorders (affective disorders), women dominated, accounting for 70,03%, and men were noticeably inferior to them, accounting for 27,64%. Children occupied the minimum share - 2,33% (Figure 4.6).

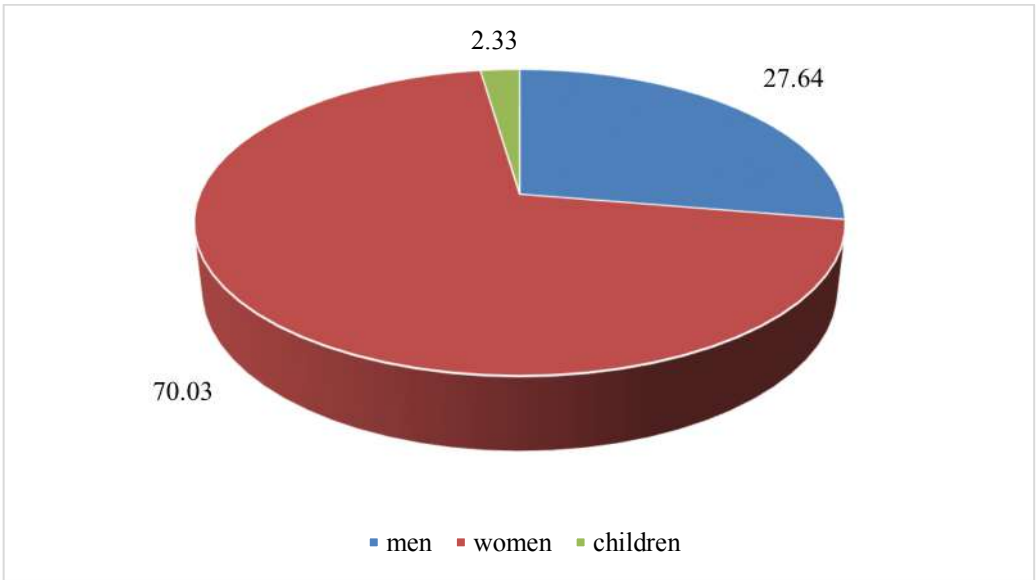

Figure 4.6. Demographic structure of general disability in mood disorders (affective disorders), %.

4.3. Disability in neurotic, stress-related, and somatoform disorders.

The dynamics of the general disability of the population with neurotic stress-related and somatoform disorders indicated an unstable increase in the indicator in patients of the first disability group: from 0.0009 in 2004 to 0.036 per 100,000 population in 2021 (r= 0.31), a steady downward trend in patients of the second disability group: from 0.089 per 100,000 population in 2021 (r= 0.31). 100,000 population in 2004 to 0.018 per 100,000 population in 2021 (r= -0.76), an unstable downward trend in patients of the third group from 0.017 per 100,000 population in 2004 to 0.0008 per 100,000 population in 2021 (r=-0.53), a steady downward trend in children: from 0.006 per 100,000 children in 2004 to 0.0 per 100,000 children in 2021 (r= -0.62) (Figure 4.7).

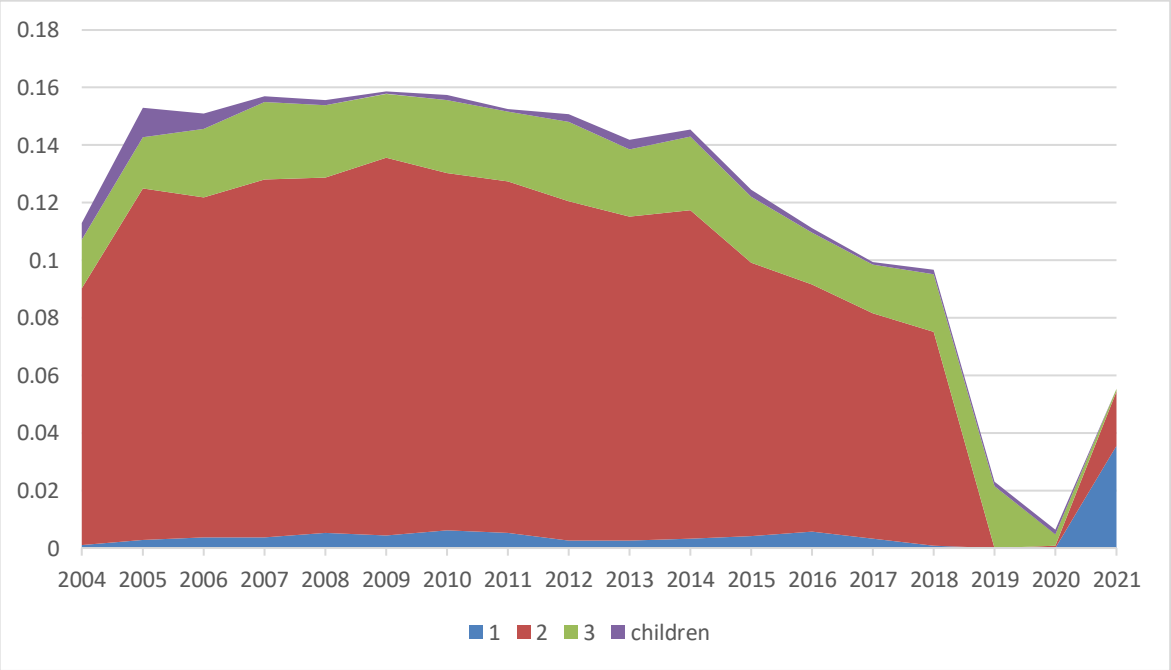

Figure 4.7. Dynamics of the general disability of the population in neurotic, stress-related, and somatoform disorders, per 100,000 population.

The dynamics of the newly identified disability of the population in neurotic, stress-related, and somatoform disorders indicated an almost zero indicator in patients of the first disability group, a steady downward trend in patients of the second disability group: from 0.007 per 100,000 population in 2004 to 0.0008 per 100,000 population in 2021 (r= 0.03), an unstable downward trend in patients of the third disability group from 0.004 per 100,000 population in 2004 to 0.0008 per

100,000 population in 2021 (r=-0.61), in children: from 0.004 per 100,000 children in 2004 to 0.0 per 100,000 children in 2021 (r= -0.49) (Figure 4.8).

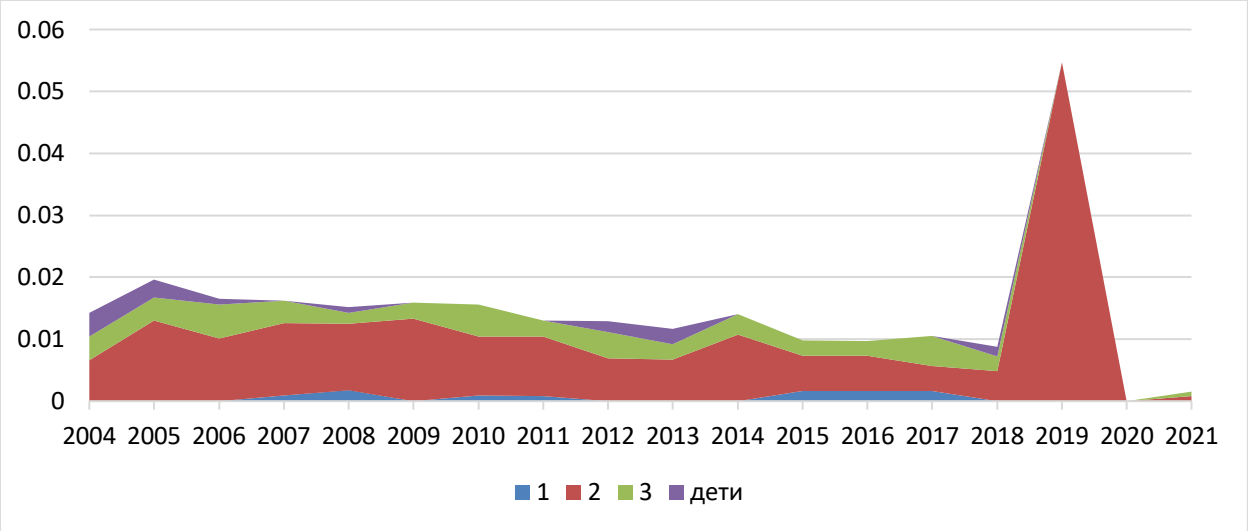

Figure 4.8. Dynamics of newly identified disability of the population in neurotic, stress-related, and somatoform disorders, per 100,000 population.

In the demographic structure of the disability of the population with neurotic, stress-related, and somatoform disorders, women dominated, accounting for 50.8%, and men were noticeably inferior to them, accounting for 34.6%. Children occupied the minimum share, occupying 14.5% (Figure 4.9).

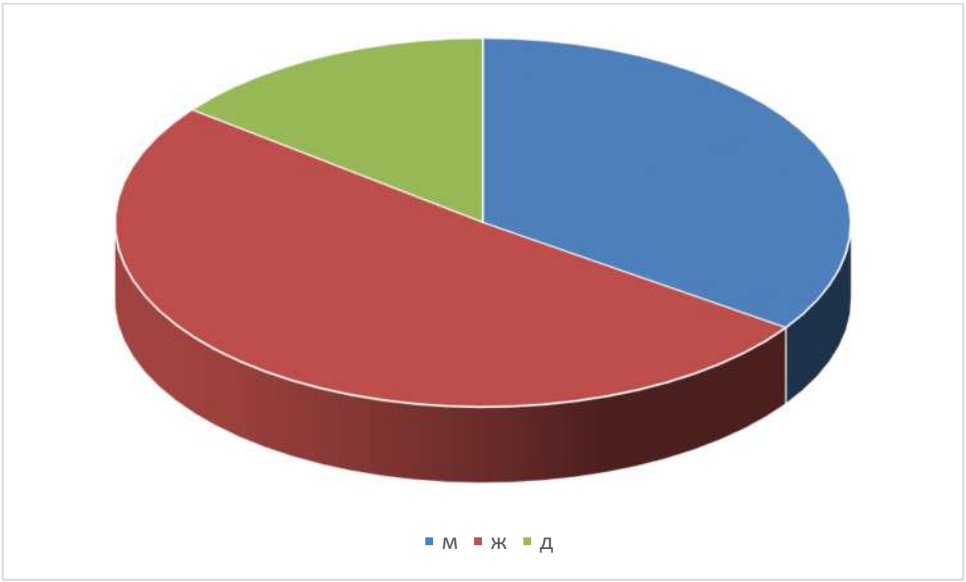

Figure 4.9. Demographic structure of disability in neurotic, stress-related, and somatoform disorders, %.

4.4. Disability in personality and behavior disorders in adulthood.

The dynamics of the general disability of the population with personality and behavior disorders in adulthood in the period 2004-2021 was decreasing: in the first group it varied from 0.004 to 0.003, in the second - from 0.18 to 0.041, in children – from 0.006 to 0.002, remained unchanged in the third group – from 0.03 to 0.03 (r= -0.61) (Figure 4.10).

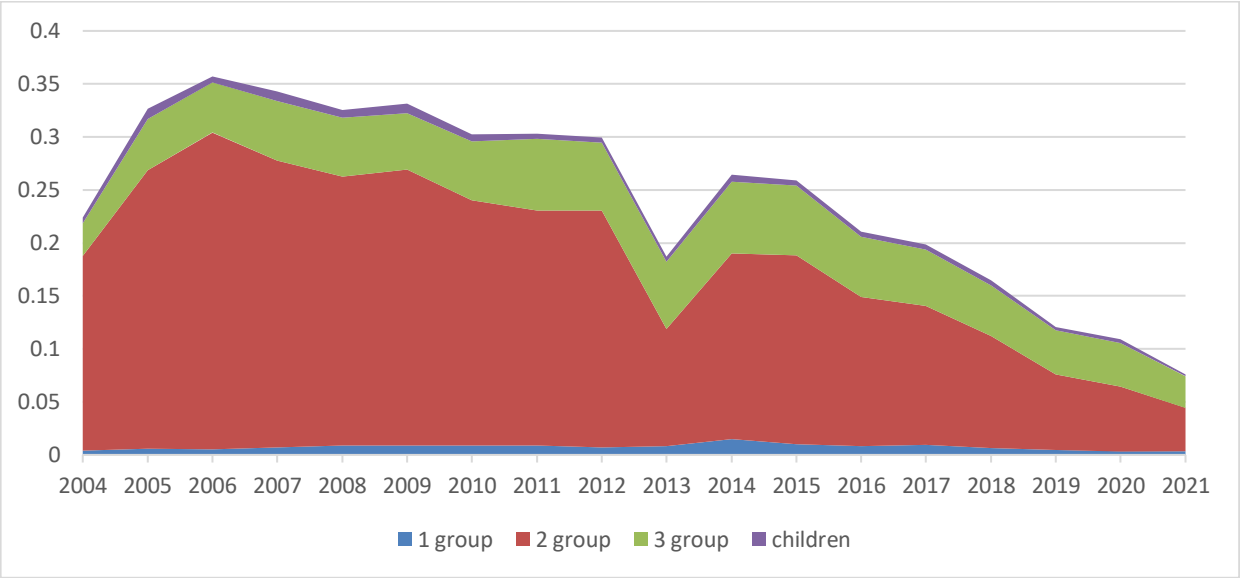

Figure 4.10. Dynamics of the general disability of the population with personality and behavior disorders in adulthood, per 100,000 population.

The dynamics of the first-time disability of the population with personality and behavior disorders in adulthood in the period 2004-2021 was decreasing: in the first disability group, varying from 0.002 to 0.0, the second – from 0.02 to 0.0, children – from 0.002 to 0.0 and steadily increased in the third – from 0.02 to 0.03 (r= -0.87) (Figure 4.11.).

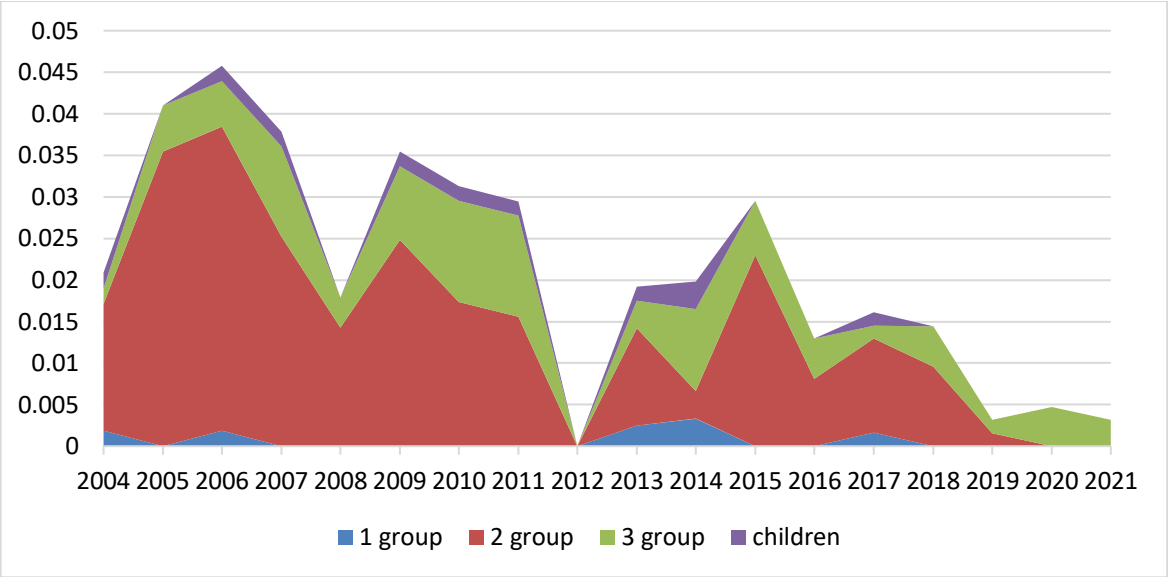

Figure 4.11. Dynamics of the first-time disability of the population with personality and behavior disorders in adulthood, per 100,000 population.

In the demographic structure of the disability of the population with personality and behavior disorders in adulthood, men predominated, accounting for 75.7%. Women took the second place – 16.2%, children – the third, amounting to 9.05% (Figure 4.12).

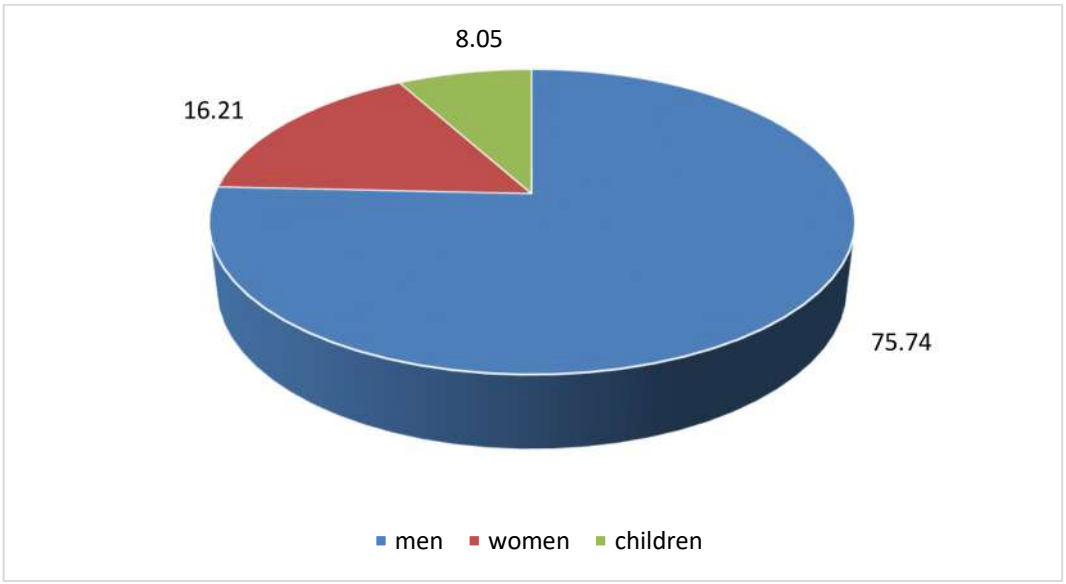

Figure 4.12. Demographic structure of general disability in personality and behavior disorders in adulthood, %.

4.5. Disability in behavioral syndromes associated with physiological disorders and physical factors.

The first group of disability in behavioral syndromes associated with physiological disorders and physical factors occurred only in 2012, amounting to 0.02 per 100,000 population, the second in 2013 and 2014 – 0.0017 each, in 2016 and 2017 – 0.0016, the third disability group and the group of children were absent in this nomination (Figure 4,13).

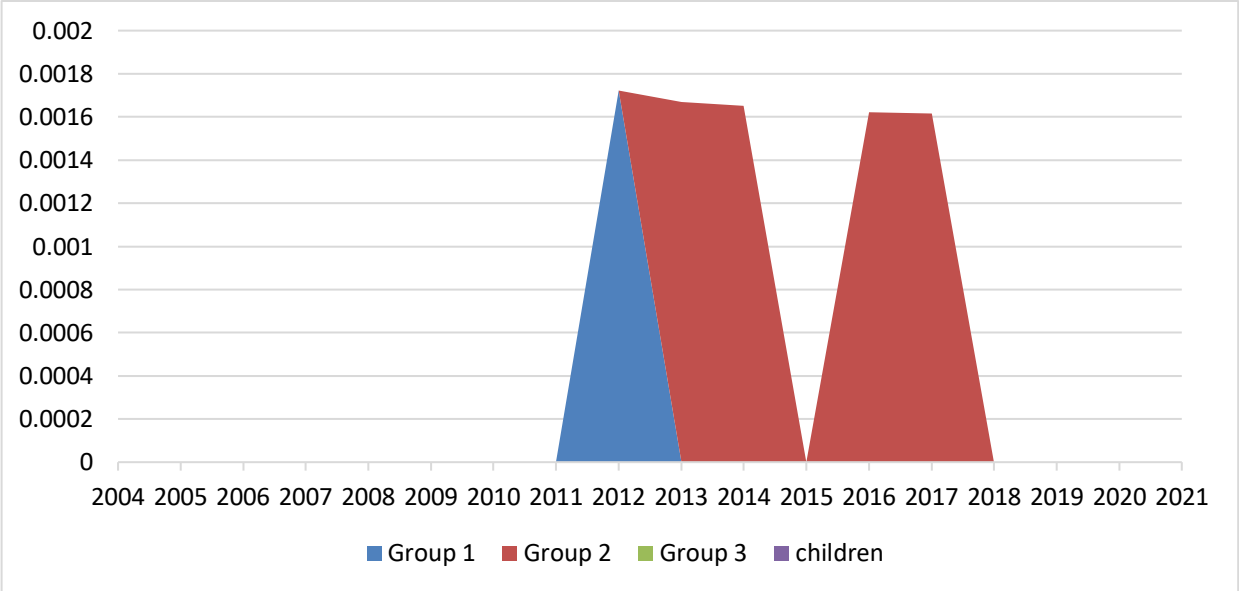

Figure 4.13. Dynamics of the general disability of the population in behavioral syndromes associated with physiological disorders and physical factors per 100,000 population.

The first identified disability of the population with behavioral syndromes associated with physiological disorders and physical factors did not occur in group 1, in the second group it occurred in 2011 (0.0017), in 2012 (0.0017), in 2014 (0.0016), in group 3 – in 2016 (0.0016), in 2021 (0.0032), for children in 2011 (0,005), 2016 (0,003), 2018 (0,005), 2019 (0,005), 2020 (0,005), in 2021 (0.005) (Figure 4.14).

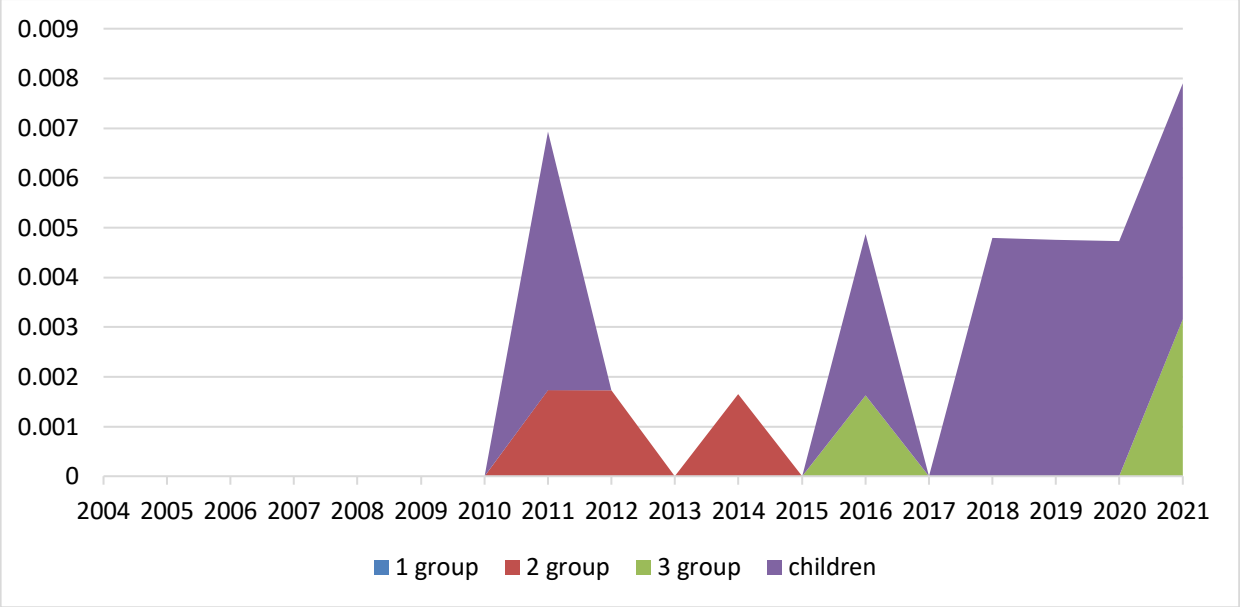

Figure 4.14. Dynamics of the newly identified disability of the population in behavioral syndromes associated with physiological disorders and physical factors per 100,000 population.

In the demographic structure of the disability of the population with behavioral syndromes associated with physiological disorders and physical factors, men dominated, accounting for 53.4%, and women were noticeably inferior to them, accounting for 29.5%. Children occupied the minimum share - 17.09% (Figure 4.15).

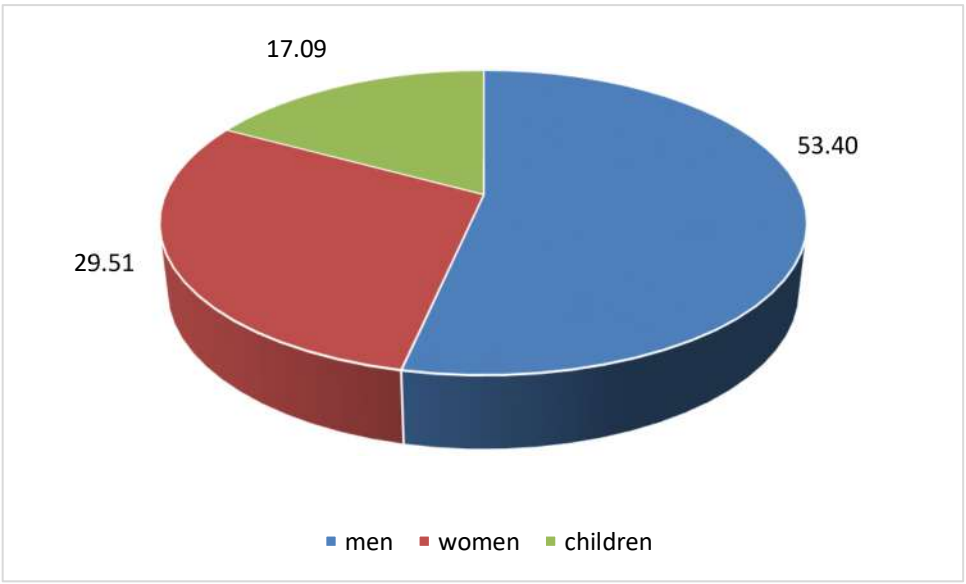

Figure 4.15. Demographic structure of disability in behavioral syndromes associated with physiological disorders and physical factors, %

4.6. Disability of the population in mental retardation.

The dynamics of the general disability of the population with mental retardation had stable trends: growth - in the range 2004-2021 in the disabled of the first group: from 1.65 to 2.1 (r=0.9), children: from 2.2 to 2.6 (r=0.88), decrease – in the disabled of the 2nd group: from 4.6 to 3.02 (r=-0.87), disabled people of 3 groups: from 0.77 to 0.73 (r=-0.82) (Figure 4.16).

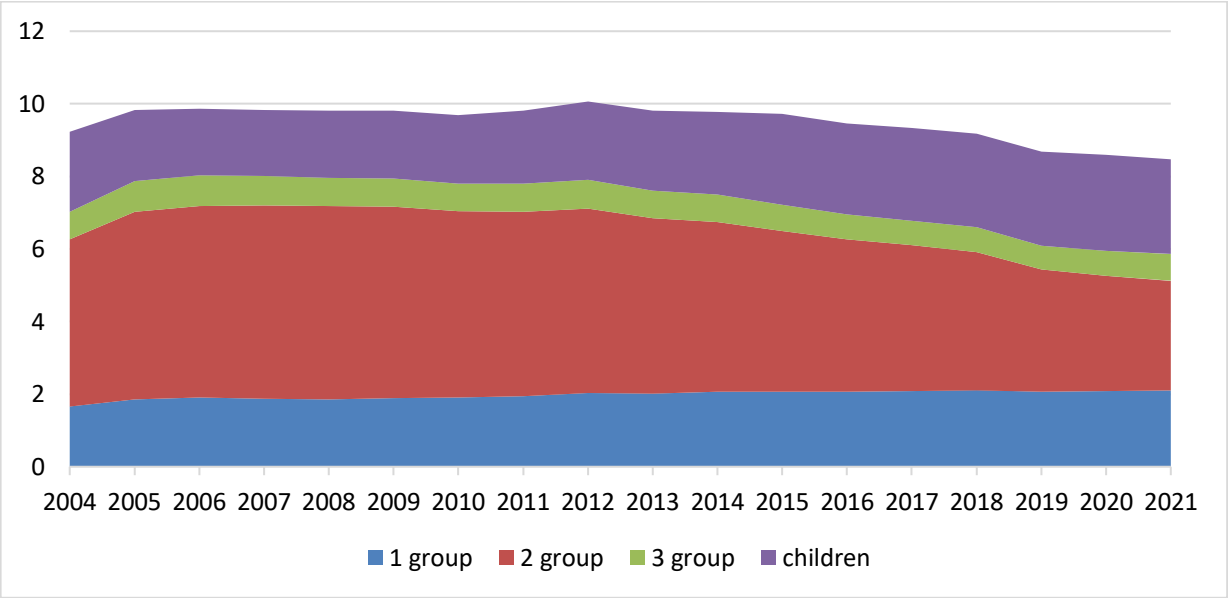

Figure 4.16. Dynamics of the general disability of the population with mental retardation, per 100,000 population.

The dynamics of the newly identified disability of the population with mental retardation had a steady growth trend in the period 2004-2021 in the disabled of the first group : from 0.01 to 0.02 (r=0.72), the disabled of the 3rd group: from 0.02 to 0.03(r=-0.7), children: from 0.23 to 0.27 (r=0.6), and a steady downward trend in the disabled of group 2: from 0.06 to 0.02 (r=-0.83), (Figure 4.17).

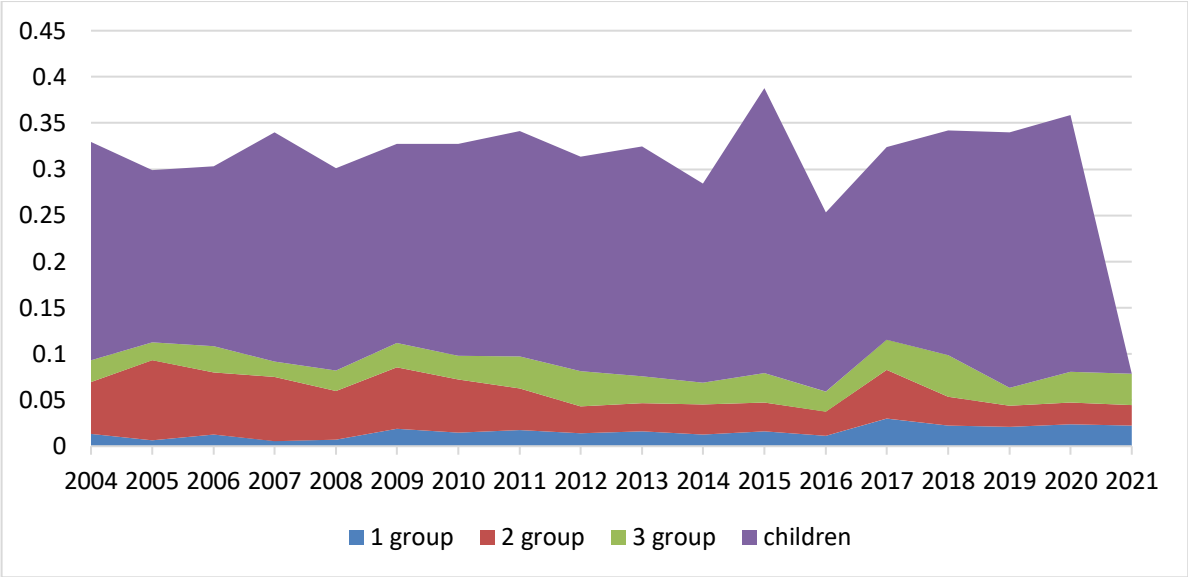

Figure 4.1. Dynamics of the first-time disability of the population with mental retardation, per 100,000 population.

In the demographic structure of the population with mental retardation, men prevailed, amounting to 32.15%, women took the second place – 23.1%, children – the third: 24.82% (Figure 4.18).

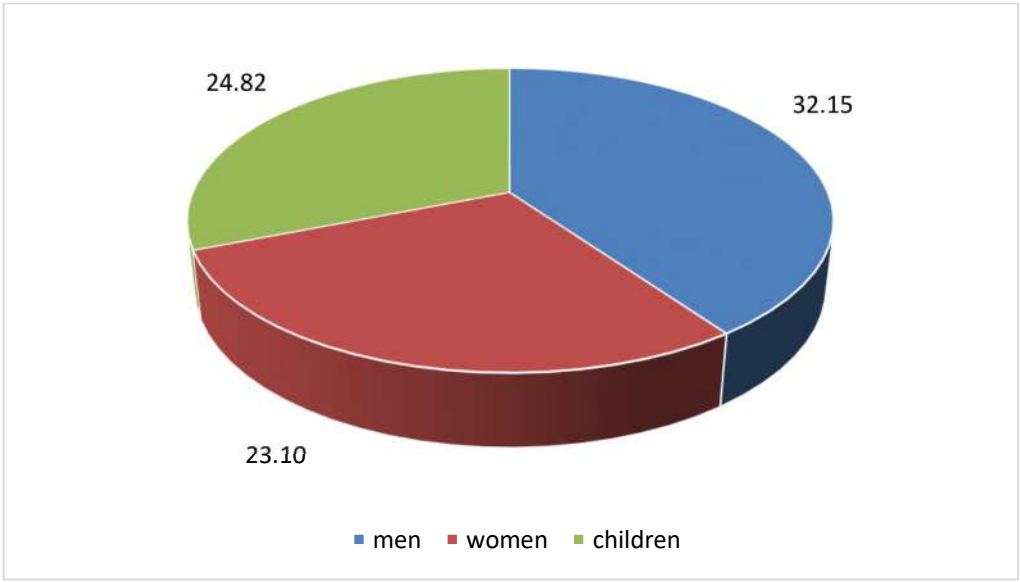

Figure 4.18. Demographic structure of general disability in mental retardation, %.

4.7. Population disability in emotional, behavioral disorders typically beginning in childhood and adolescence.

The dynamics of the general disability of the population with emotional disorders, behavioral disorders, usually beginning in childhood and adolescence, had a steady downward trend in the period 2004-2021 in the disabled of the first group : from 0.004 to 0.003 (r=-0.81), the second: from 0.009 to 0.003 (r=-0.6), an unstable trend in the disabled of the third group : from 0.004 to 0.003 (r= - 0.4) and children: from 0.03 to 0.02 (r= - 0.3) (Figure 4.19).

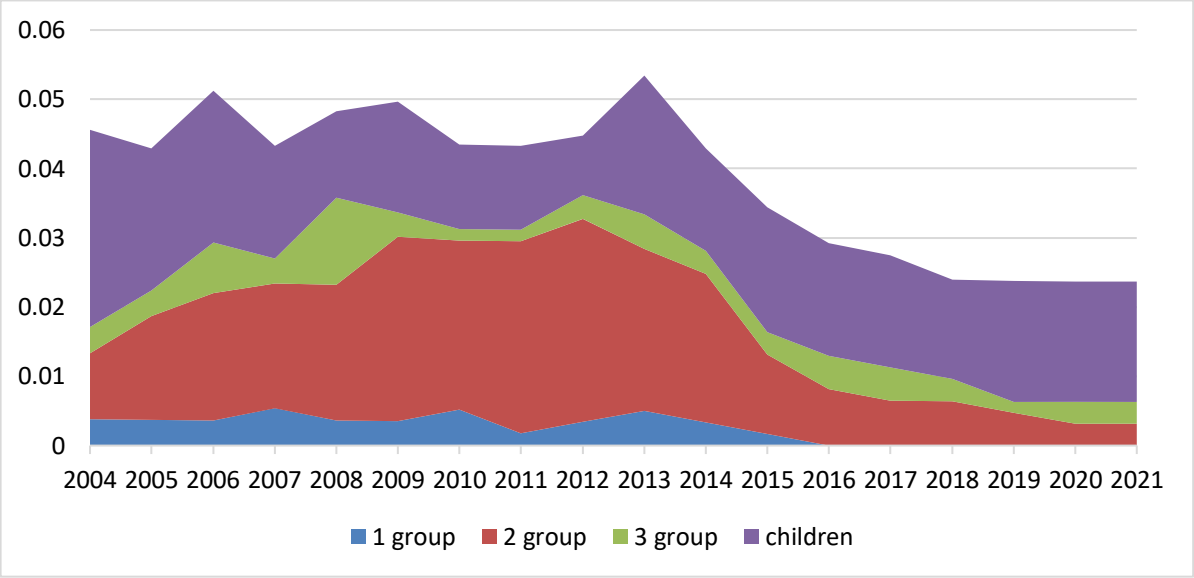

Figure 4.19. Dynamics of the general disability of the population in emotional disorders, behavioral disorders, usually beginning in childhood and adolescence, per 100,000 population.

The first identified disability of the population in emotional disorders, behavioral disorders, usually beginning in childhood and adolescence, occurred only in 2010 (0.002) in the first group, steadily decreased in the second group from 0.004 to 0.0 (r= - 0.6), increased unstable in the third group from 0 to 0.003 and children – from 0.004 to 0.005 (Figure 4.20).

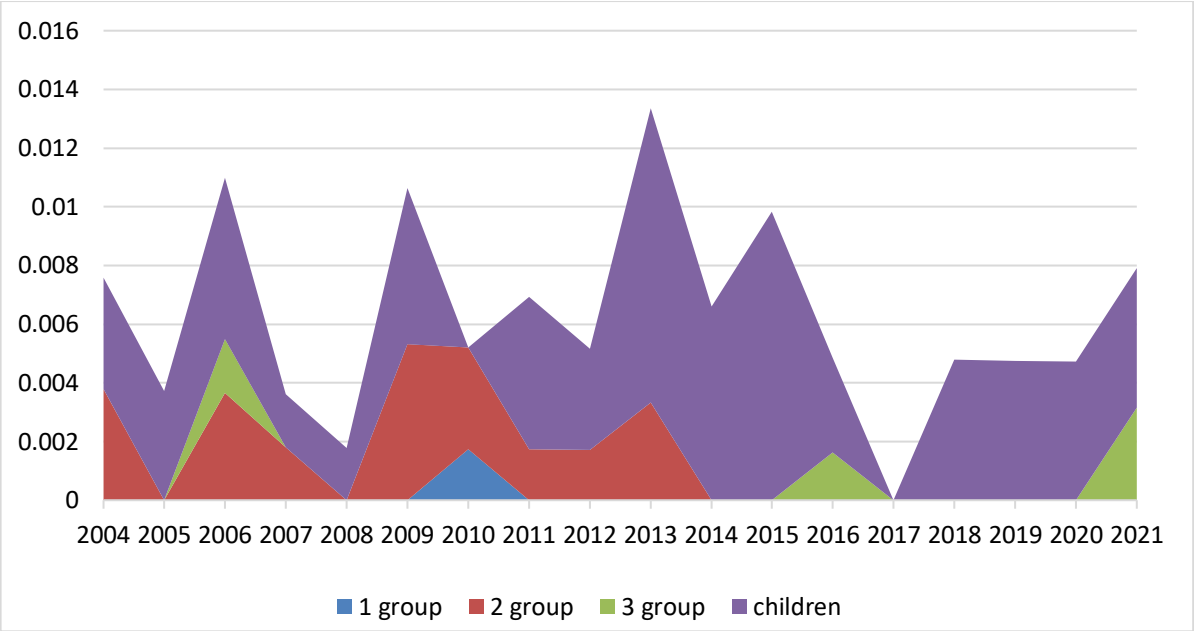

Figure 4.20. Dynamics of newly identified disability in the population with emotional disorders, behavioral disorders, usually beginning in childhood and adolescence, per 100,000 population.

In the demographic structure of the disability of the population with emotional disorders, behavioral disorders, usually beginning in childhood and adolescence, children prevailed, amounting to 49.0%, men took the second place – 37.9%, and women 13.05% took the third place (Figure 4.21).

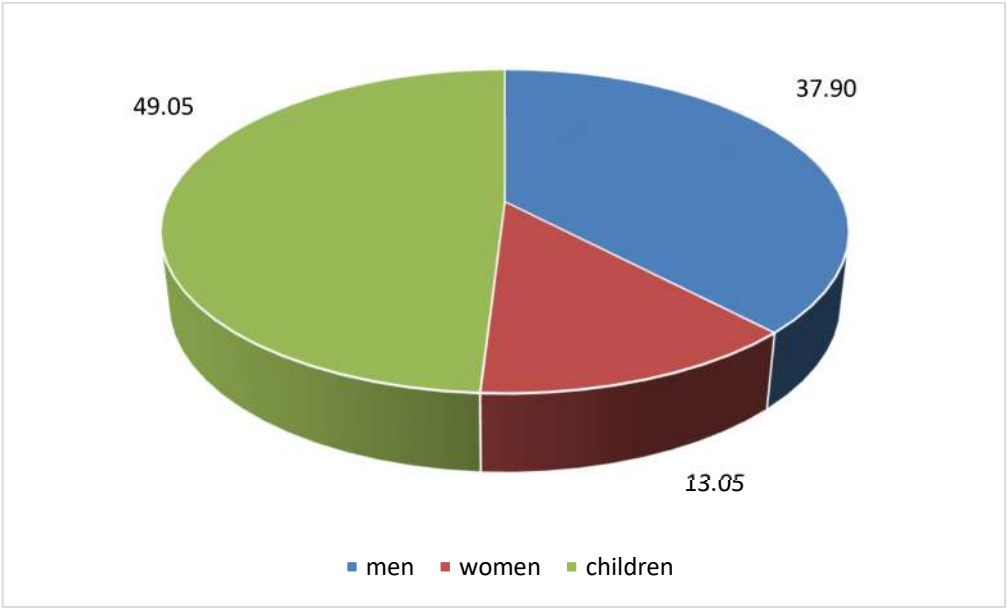

Figure 4.21. Demographic structure of disability in disorders of psychological (mental) development, %.

Thus, the greatest disability was provided by Mental retardation with a pronounced tendency to increase overall disability for the first group (1.6o/llc – 2.1 o/llc) and children (2.2 o/llc– 2.6 o/llc), newly identified disability – for the first (0.01 o/llc – 0.02o/llc), the third (0.02o/llc – 0.03 o/LLC) and children (0.23o/llc - 0.27o/llc). In the demographic structure of Mental retardation, men prevailed, accounting for 32.15%, children ranked second: 24.8%, women – third:23.1%.

Mental disorders took the second place in terms of general disability: schizophrenia, schizotypal and delusional disorders with a steady growth trend of the first group (0.006 o/llc – 0.01 o/llc), the third group (0.09 o/ llc -0.55 o/ llc), children (0.47 o/ llc -0.57 o/llc). The demographic structure of the disability of the population with mental disorders: schizophrenia, schizotypal and delusional disorders is represented mainly by women (54.01%), in a slightly smaller proportion by men (44.37%) and minimally (1.61%) by children.

Personality and behavioral disorders in adulthood took the third place in terms of general disability, with decreasing trends in the first (0.004 o/llc – 0.003 o/llc), the second (0.18 o/llc -0.041 o/llc), children (0.006 o/llc -0.002 o/llc) and stabilization in the third the group (0.03 o/llc – 0.03 o/LLC). In the demographic structure of the general disability of the population with personality and behavior disorders in adulthood, men predominated, accounting for 75.7%. Women took the second place – 16.2%, children – the third, amounting to 9.05%.

In fourth place was disability in neurotic, stress-related, and somatoform disorders with an unstable increase in the index in patients of the first group from 0.0009 to 0.036 per 100,000 population, a steady downward trend in patients of the second group: from 0.089 o/ llc to 0.018 o/llc, children: from 0.006 o/LLC to 0.0 o/llc, an unstable downward trend in patients of the third group from 0.017 o/llc to 0.0008 o/llc. In the demographic structure of the disability of the population with neurotic, stress-related, and somatoform disorders, women dominated, accounting for 50.8%, and men were noticeably inferior to them, accounting for 34.6%. Children occupied the minimum share, occupying 14.5%.

The fifth place was occupied by general disability in emotional disorders, behavioral disorders, usually beginning in childhood and adolescence, with a steady downward trend in the period 2004-2021 in the disabled of the first group : from 0.004 to 0.003, the second: from 0.009 to 0.003, unstable trends of the disabled of the third group : from 0.004 to 0.003, children: from 0.03 to 0.02. In the demographic structure of the disability of the population with emotional disorders, behavioral disorders, usually beginning in childhood and adolescence, children prevailed, amounting to 49.0%, men took the second place – 37.9%, women took the third place – 13.05%.

The sixth place was occupied by disability in mood disorders (affective disorders), in the demographic structure of which women dominated, accounting for 69.2%, and men were noticeably inferior to them, accounting for 28.8%. Children occupied the minimum share - 2.05%. There were no changes in the indicator in patients of the first disability group: from 0.01 to 0.01 in the range from 2004 to 2021, the tendency to decrease in the indicator in patients of the second disability group was stable: from 1.04 to 0.35, the growth trend in children was unstable: from 0.0009 to 0.01.

CHAPTER 5. SOCIO-MEDICAL DETERMINANTS OF THE PROCESS OF PROVIDING PSYCHOLOGICAL, PSYCHOTHERAPEUTIC AND PSYCHIATRIC CARE

5.1. Socio-medical determinants of psychological, psychotherapeutic and psychiatric care provided by medical specialists

The analysis of the process of providing psychological, psychotherapeutic and psychiatric care by medical specialists included the study of the conditions of its provision, the identification of key factors, the relationship with the effectiveness and effectiveness of the provision of psychological, psychotherapeutic and psychiatric care.

Thus, 53.97% of doctors, 31.88% of nurses, 9.88% of heads of departments of medical organizations, 2.52% of senior nurses, 0.97% of pharmacists, 0.78% of pharmacists participated in the survey (Figure 5.1).

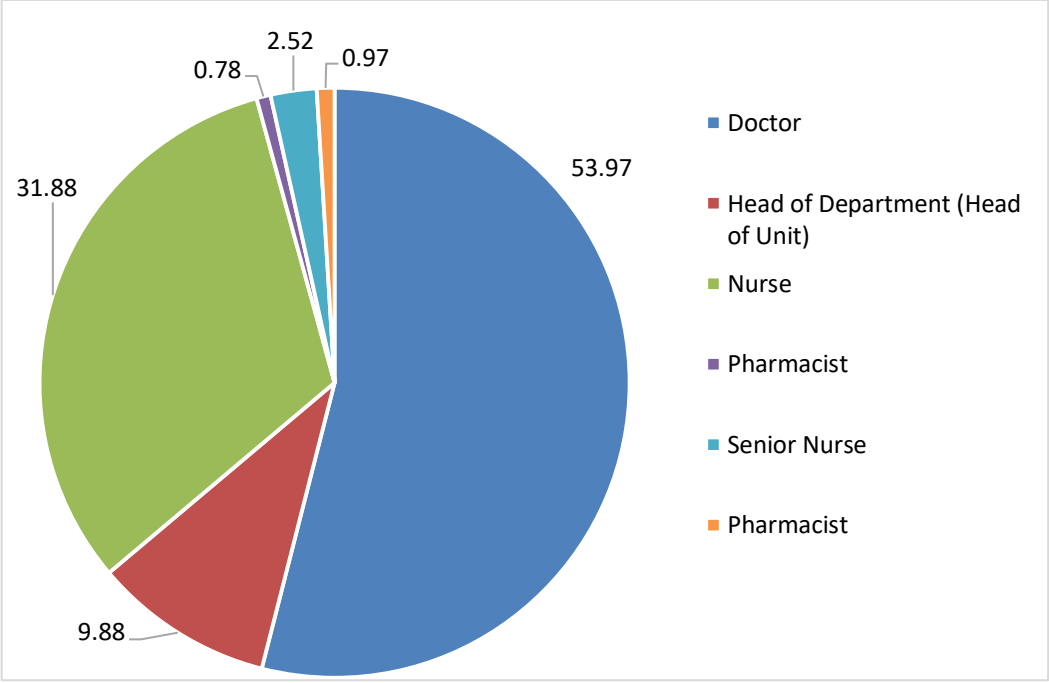

Figure 5.1. The official structure of medical and pharmaceutical workers involved in the provision of psychological, psychotherapeutic and psychiatric care

Female persons predominated among the respondents, amounting to 70.22% (Figure 5.2).

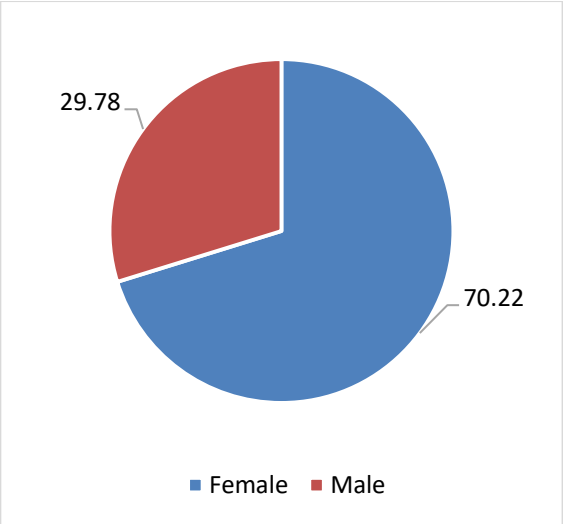

Figure 5.2. The structure of medical and pharmaceutical workers involved in the provision of psychological, psychotherapeutic and psychiatric care, by gender, %

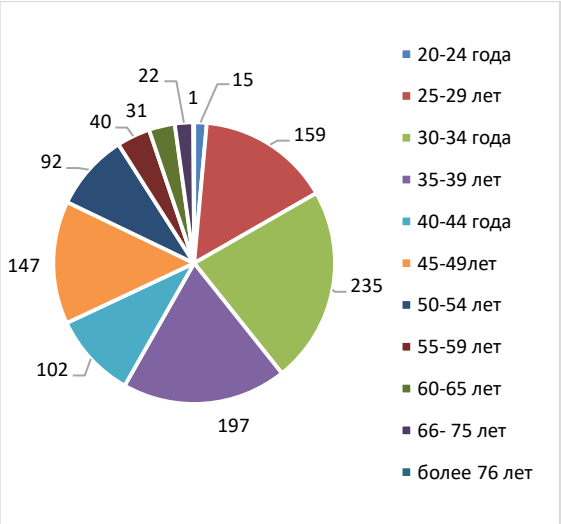

Figure 5.3. The structure of medical and pharmaceutical workers involved in the provision of psychological, psychotherapeutic and psychiatric care, by age, %

More than 90% of the respondents were people of economically active age: 22.57% - 30-34 years old, 18.92% - 35-39 years old, 15.27% - 25-29 years old, 14.12% - 45-49 years old, 8.84% - 50-54 years old, 3.84% - 55-59 years old, 2.98% - 60-65 years old (Figure 5.3).

There were 58.21% who were married. 26.99% of the surveyed medical workers had the status of "Single (unmarried)". 11.14% of the employees were divorced, 3.65% were widows (Figure 5.4).

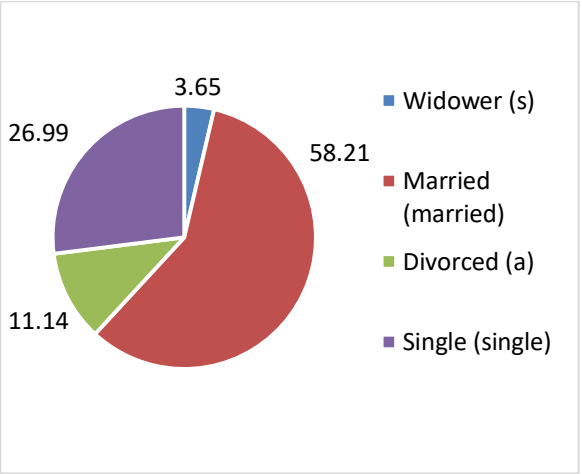

Figure 5.4. Structure of medical and pharmaceutical workers involved in the provision of psychological, psychotherapeutic and psychiatric care, by marital status, %

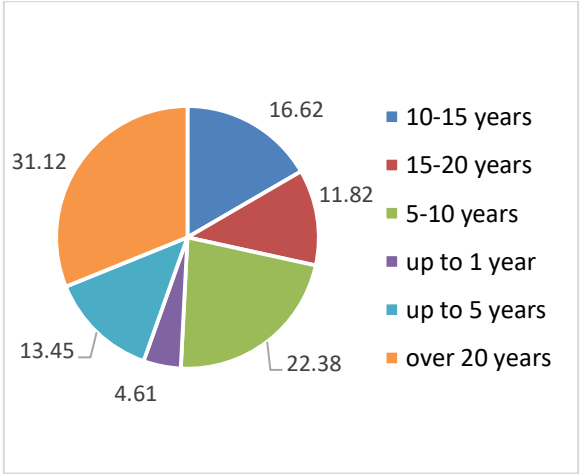

Figure 5.5. Structure of medical and pharmaceutical workers involved in the provision of psychological, psychotherapeutic and psychiatric care, by duration of work in the specialty, %

Worked in the specialty for over 20 years 31.12% of respondents, 15-20 years – 11.82%, 10-15 years – 16.62%, 5-10 years – 22.38%, under 5 years – 13.45% (Figure 5.5).

9.03% of employees have worked at this workplace for over 20 years, 15-20 years – 4.8% of employees, 10-15 years – 9.8% of employees, 5-10 years – 14.79% of employees, up to 5 years – 24.02% of employees, up to 1 year – 37.56% (Figure 5.6).

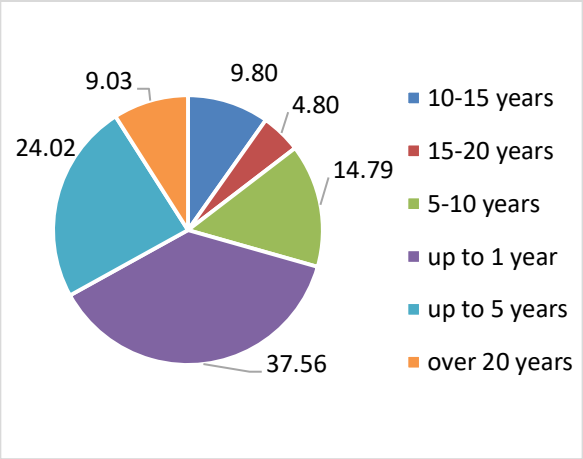

Figure 5.6. The structure of medical and pharmaceutical workers involved in the provision of psychological, psychotherapeutic and psychiatric care, according to the duration of work at the current place, %

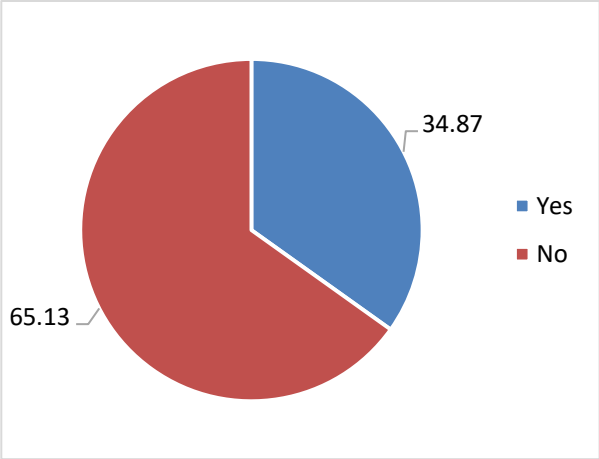

Figure 5.7. The structure of medical and pharmaceutical workers involved in the provision of psychological, psychotherapeutic and psychiatric care, according to the combination at the current location, %

Combined main work with additional workload only 34.87% of the respondents (Figure 5.7).

A small proportion of employees (12.3%) combined work in this medical organization and an outside one (Figure 5.8).

55.14% of the surveyed employees had a shift schedule, 44.86% worked daily (Figure 5.9).

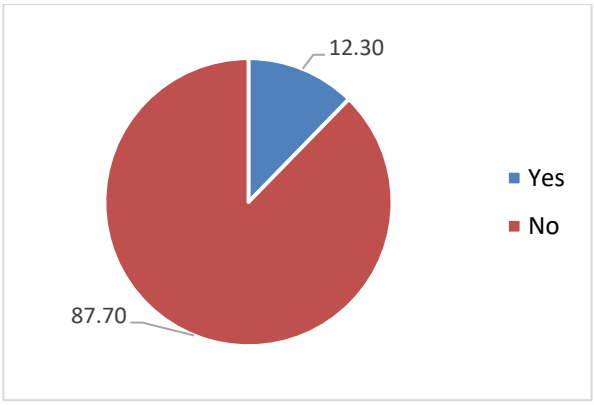

Figure 5.8. The structure of medical and pharmaceutical workers involved in the provision of psychological, psychotherapeutic and psychiatric care, according to external combination, %.

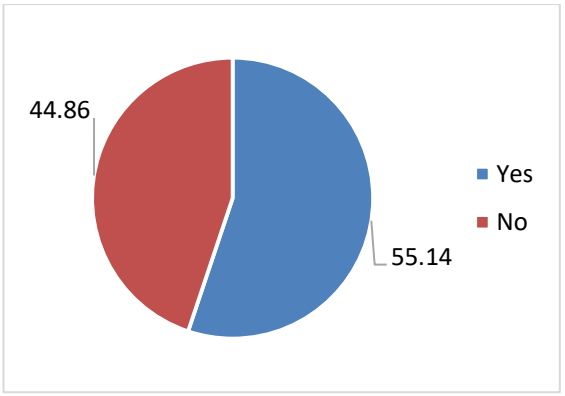

Figure 5.9. The structure of medical and pharmaceutical workers involved in the provision of psychological, psychotherapeutic and psychiatric care, according to a shift work schedule, %.

80.31% of the respondents were on duty according to the standard (Figure 5.10).

36.22% of the surveyed employees experienced emotional devastation (Figure 5.11).

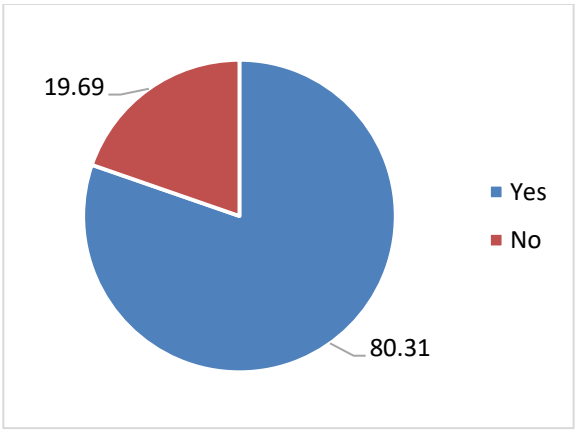

Figure 5.10. The structure of medical and pharmaceutical workers involved in the provision of psychological, psychotherapeutic and psychiatric care, on duty according to the standard, %

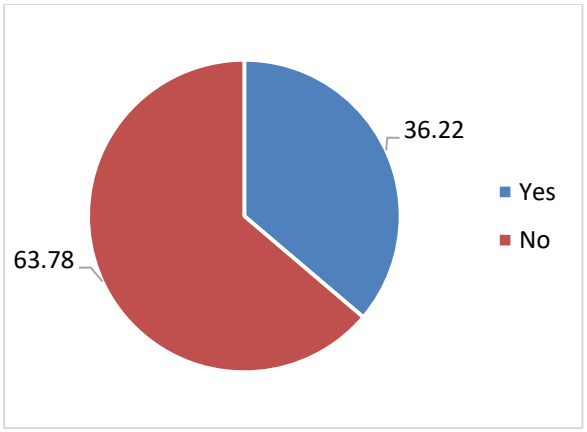

Figure 5.11. The structure of medical and pharmaceutical workers involved in the provision of psychological, psychotherapeutic and psychiatric care, on the basis of "Emotional devastation", %

41.59% of employees took additional duty (Figure 5.12).

More than half of the surveyed medical workers (56.58%) felt morning fatigue before work (Figure 5.13).

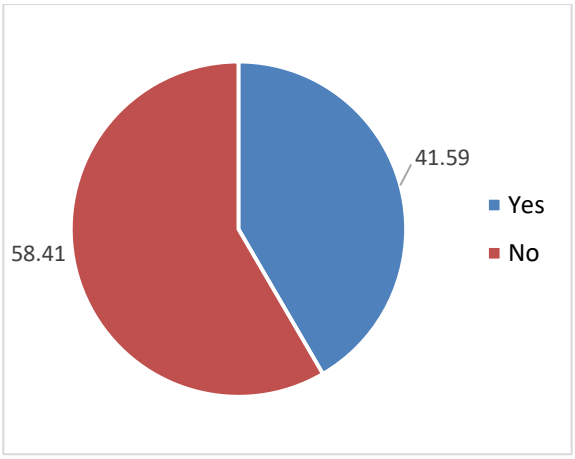

Figure 5.12. The structure of medical and pharmaceutical workers involved in the provision of psychological, psychotherapeutic and psychiatric care, on additional duty, %

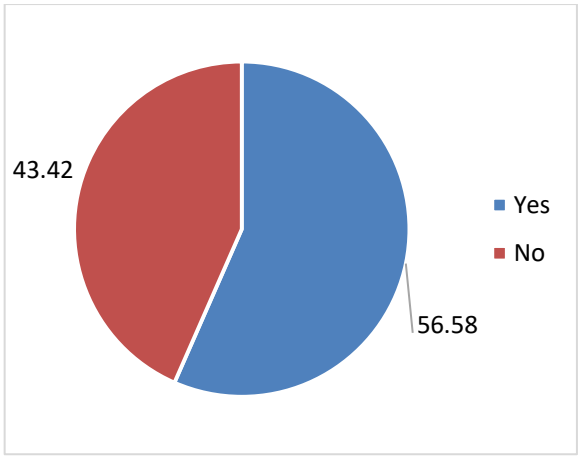

Figure 5.13. The structure of medical and pharmaceutical workers involved in the provision of psychological, psychotherapeutic and psychiatric care, on the basis of "Morning fatigue before work", %

Apathy and depression were experienced by 30.45% of respondents (Figure 5.14).

25.65% of respondents had a feeling of the limit of possibilities (Figure 5.15).

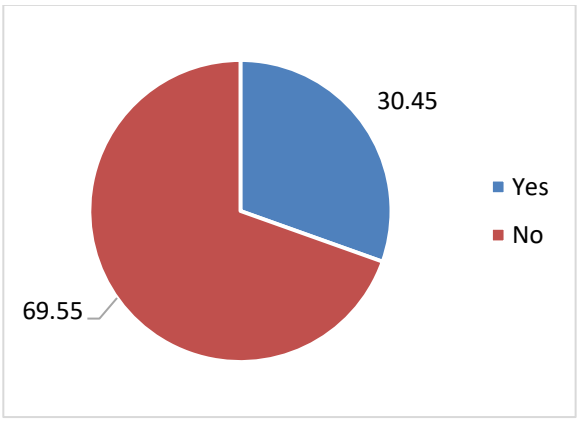

Figure 5.14. The structure of medical and pharmaceutical workers involved in the provision of psychological, psychotherapeutic and psychiatric care, on the basis of "Apathy, depression", %.

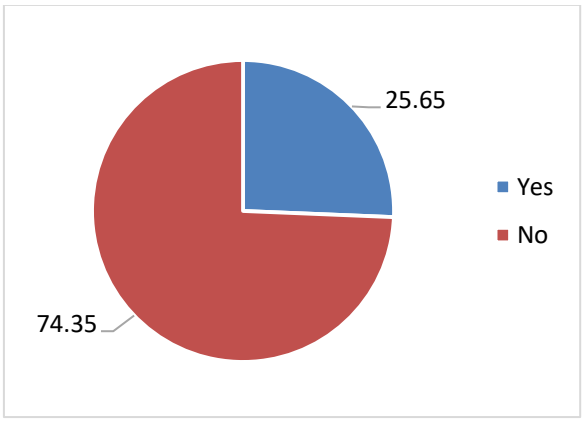

Figure 5.15. The structure of medical and pharmaceutical workers involved in the provision of psychological, psychotherapeutic and psychiatric care, based on the "Feeling of the limit of possibilities", %.

63.02% of respondents were energetic and inspired, 36.98% - this was unusual (Figure 5.16).

Managed to do a lot at work 94.24% of respondents (Figure 5.17).

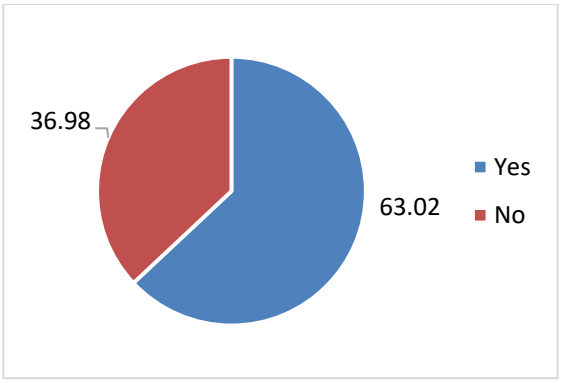

Figure 5.16. The structure of medical and pharmaceutical workers involved in the provision of psychological, psychotherapeutic and psychiatric care, on the basis of "Energetic, inspired", %.

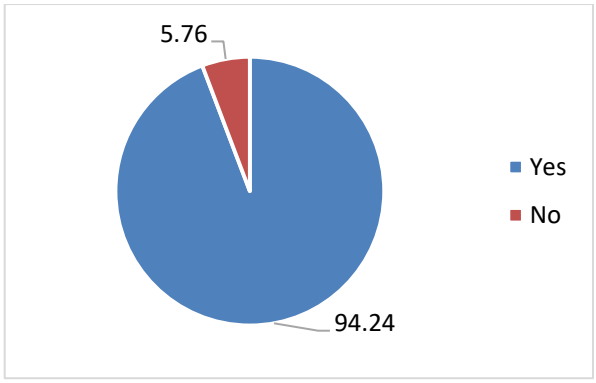

Figure 5.17. Structure of medical and pharmaceutical workers involved in the provision of psychological, psychotherapeutic and psychiatric care, on the basis of "I manage to do a lot at work", %.

Rated their work by 5 points 43.32% of respondents, by 4 points – 45.44%, by 3 points – 7.68%, by 2 points – 3.55% (Figure 5.18).

More than half of the respondents (65.03%) received incentive allowances (Figure 5.19).

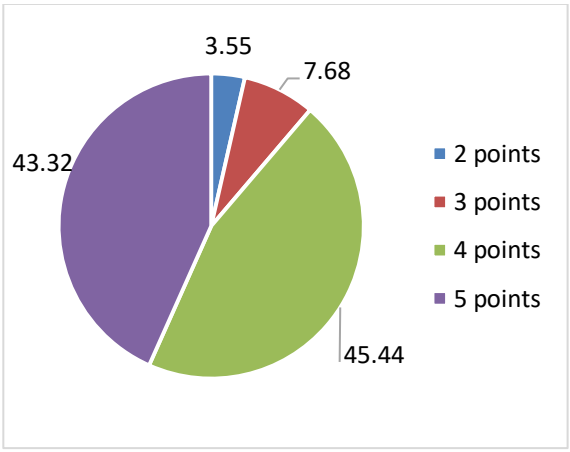

Figure 5.18. The structure of medical and pharmaceutical workers involved in the provision of psychological, psychotherapeutic and psychiatric care, based on the "Assessment of their work",%.

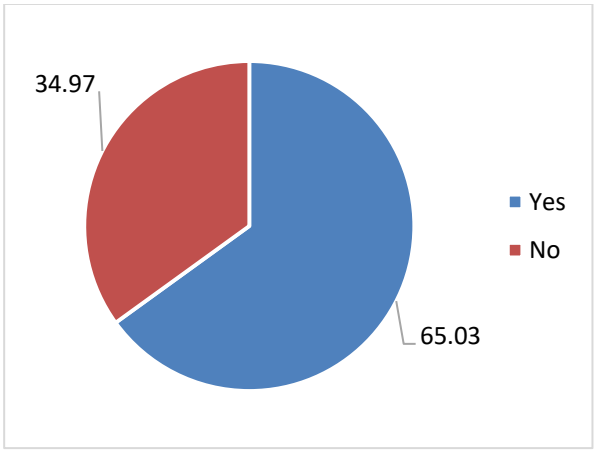

Figure 5.19. The structure of medical and pharmaceutical workers involved in the provision of psychological, psychotherapeutic and psychiatric care on the basis of "I receive incentive allowances", %.

However, only 29.01% of employees were satisfied with wages (Figure 5.20).

Raised their level of qualification 94.62% of employees, 5.38% did not work on this issue (Figure 5.21).

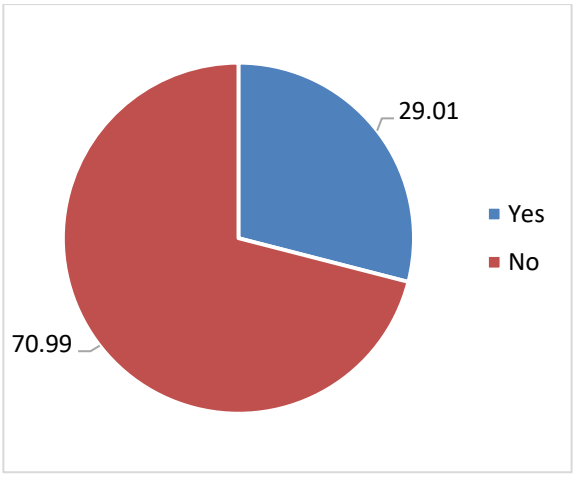

Figure 5.20. The structure of medical and pharmaceutical workers involved in the provision of psychological, psychotherapeutic and psychiatric care on the basis of "Satisfied with wages", %.

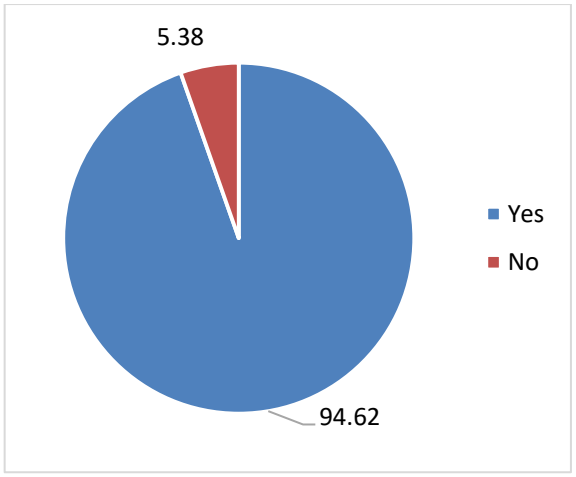

Figure 5.21. The structure of medical and pharmaceutical workers involved in the provision of psychological, psychotherapeutic and psychiatric care, on the basis of "Raising the level of qualification", %.

Participated in the program of continuing medical and pharmaceutical education 88.47% of the surveyed workers (Figure 5.22).

Were satisfied with the working conditions in the hospital 64.55% of workers (Figure 5.23).

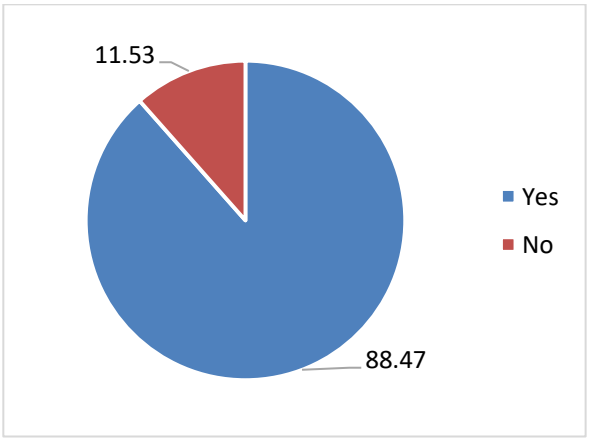

Figure 5.22. The structure of medical and pharmaceutical workers involved in the provision of psychological, psychotherapeutic and psychiatric care, on the basis of "Participating in the program of continuing medical and pharmaceutical education", %.

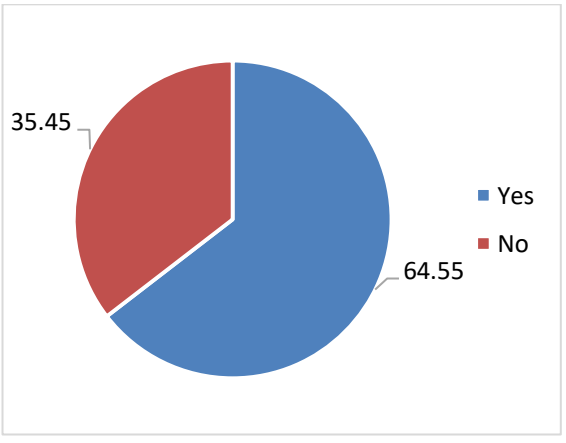

Figure 5.23. The structure of medical and pharmaceutical workers involved in the provision of psychological, psychotherapeutic and psychiatric care, based on "Working conditions in the hospital", %.

More than half (64.36%) of workers believed that they had enough rest (Figure 5.24).

98,08% of employees used annual leave (Figure 5.25).

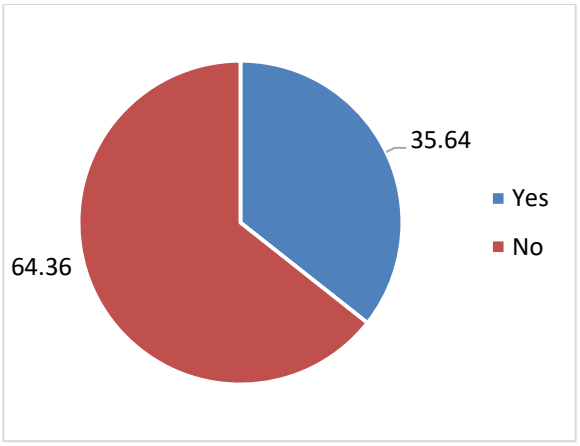

Figure 5.24. The structure of medical and pharmaceutical workers involved in the provision of psychological, psychotherapeutic and psychiatric care, on the basis of "Is there enough rest", %

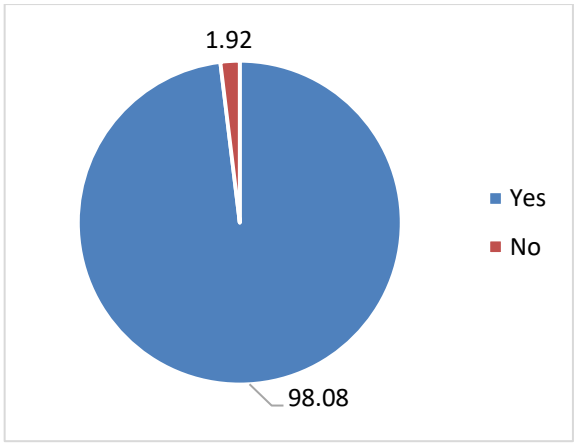

Figure 5.25. The structure of medical and pharmaceutical workers involved in the provision of psychological, psychotherapeutic and psychiatric care, on the basis of "Annual leave", %

Additional leave was used by 38.02% of the surveyed workers (Figure 5.26).

82,61% employees considered their health satisfactory, 17.39% had the opposite opinion (Figure 5.27).

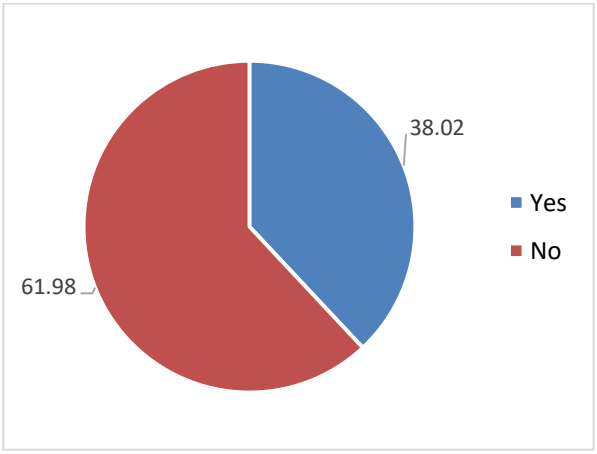

Figure 5.26. The structure of medical and pharmaceutical workers involved in the provision of psychological, psychotherapeutic and psychiatric care on the basis of "Additional leave", %.

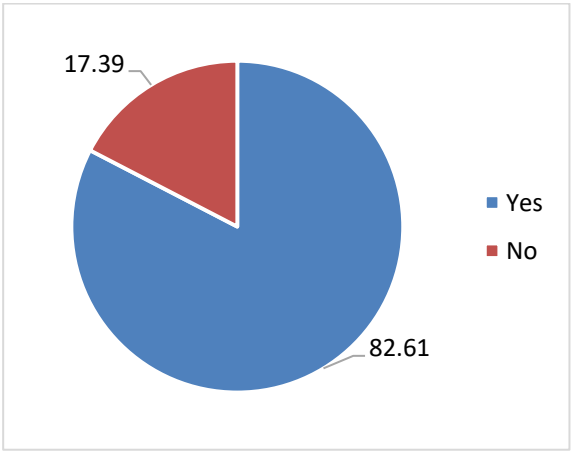

Figure 5.27. The structure of medical and pharmaceutical workers involved in the provision of psychological, psychotherapeutic and psychiatric care, on the basis of "Satisfactory health", %.

24.13% of workers had bad habits, 75.87% did not have them (Figure 5.28).

More than half of the employees (57.54%) have never been on sick leave, 35.45% - visited 1 time a year, 4.61% - 2 times a year, 2.4% - more than 2 times a year (Figure 5.29).

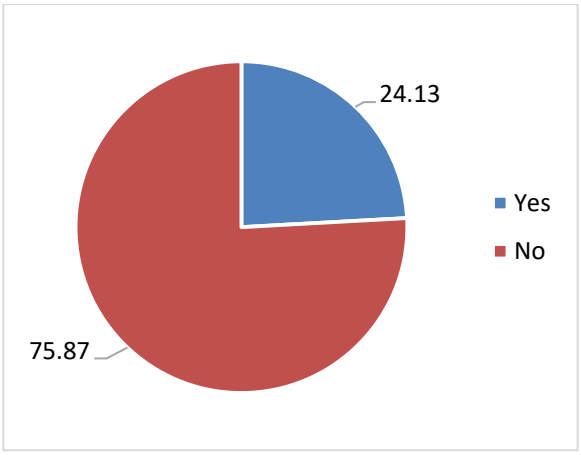

Figure 5.28. Structure of medical and pharmaceutical workers involved in the provision of psychological, psychotherapeutic and psychiatric care, on the basis of "bad habits", %.

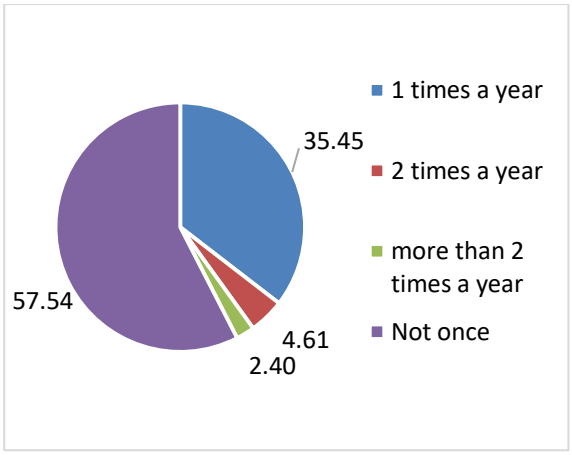

Figure 5.29.The structure of medical and pharmaceutical workers involved in the provision of psychological, psychotherapeutic and psychiatric care, based on "How often do you visit the disability list", %.

Of the respondents 43.8% suffered a mild coronavirus infection, 29.39% were not ill, 24.5% were of moderate severity, 2.02% were transferred to severe form (Figure 5.30).

More than half (53.22%) of respondents were not given a sick leave for 12 months, 20.17% were ill for up to 7 days, 18.73% - 7-14 days, 6.44% - more than 14 days (Figure 5.31).

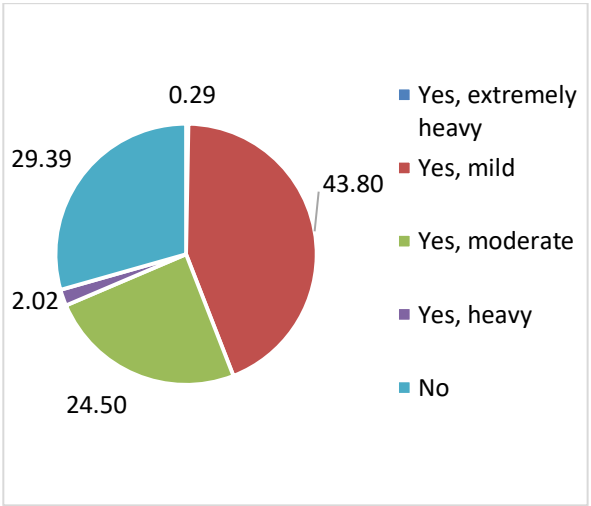

Figure 5.30. The structure of medical and pharmaceutical workers involved in the provision of psychological, psychotherapeutic and psychiatric care, based on "Have you had a coronavirus infection", %/

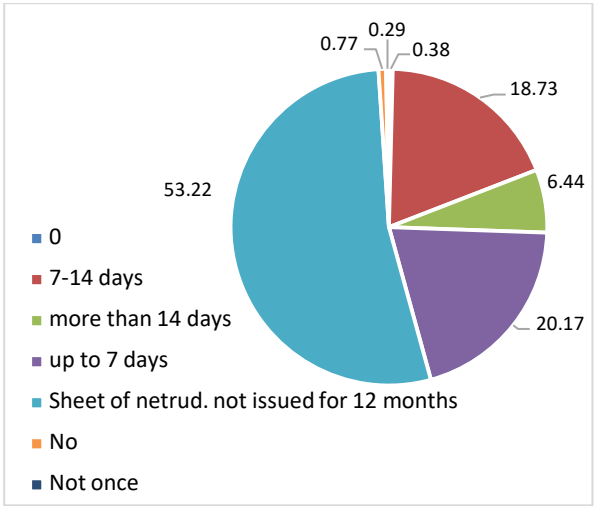

Figure 5.31. The structure of medical and pharmaceutical workers involved in the provision of psychological, psychotherapeutic and psychiatric care, based on the "Duration of stay on the disability list", %/

80,88% of respondents were engaged in disease prevention (Figure 5.32).

Associated with the workload of 52.83% of the surveyed medical workers (Figure 5.33).

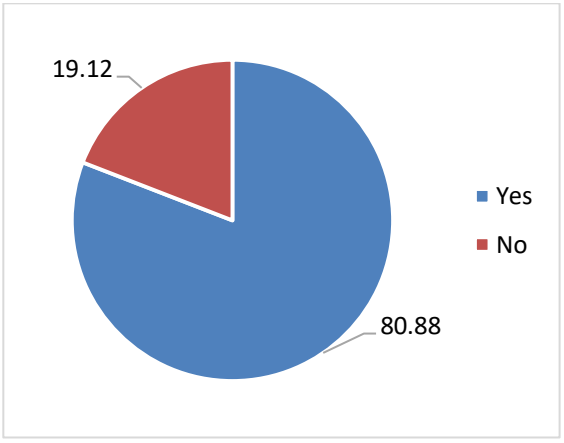

Figure 5.32. The structure of medical and pharmaceutical workers involved in the provision of psychological, psychotherapeutic and psychiatric care, on the basis of "I am engaged in disease prevention", %/

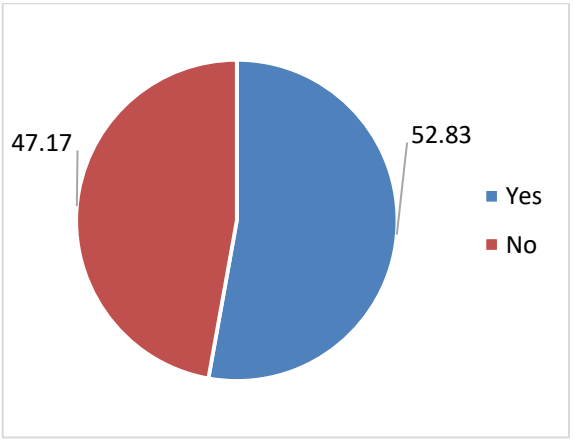

Figure 5.33. The structure of medical and pharmaceutical workers involved in the provision of psychological, psychotherapeutic and psychiatric care on the basis of "I associate exacerbation of diseases with stress", %/

Exacerbation of chronic diseases was associated with 22.38% of respondents (Figure 5.34).

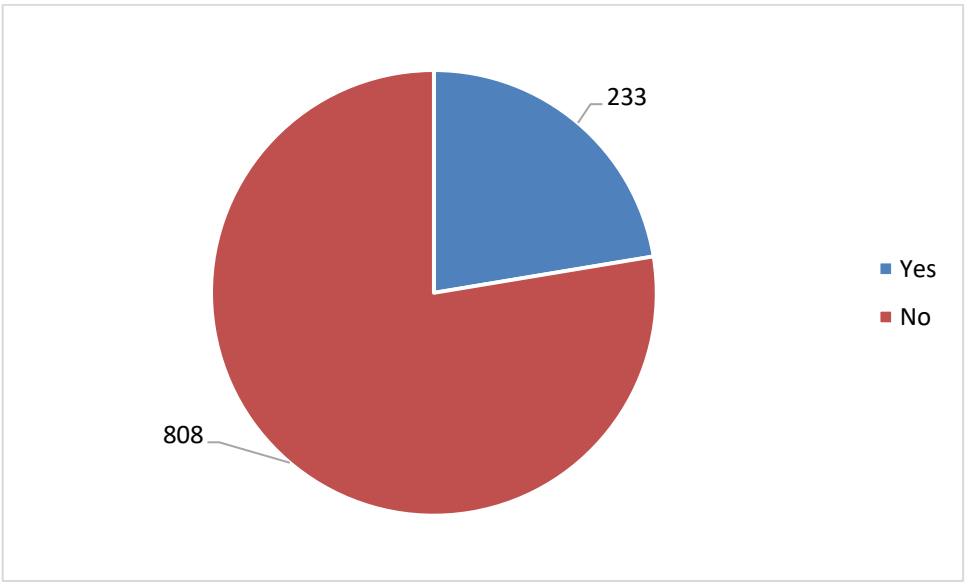

Figure 5.34. The structure of medical and pharmaceutical workers involved in the provision of psychological, psychotherapeutic and psychiatric care, on the basis of "I associate the exacerbation of diseases with the profession", %

Close correlations were found between the signs of "Emotional emptiness" and "Apathy, depression" (R= 0.72), "Emotional emptiness" and "Feeling of the limit of possibilities" (R= 0.53), "Apathy, depression" and "Feeling of the limit of possibilities" (R= 0.63), reflecting direct correlations, and "Emotional devastation" and "Energetic, inspired"((R= -0.53), "Apathy, depression" and "Energetic, inspired"((R= -0.51) with the inverse force of correlation dependence.

5.2. Medical and social determinants of morbidity of patients who applied for psychological, psychotherapeutic and psychiatric care

In the structure of the surveyed patients who sought psychological, psychotherapeutic and psychiatric help, 60.96% were women, 39.04% were men (Figure 5.35).

The leading were ages: 30-34 years -22.57%, 35-39 years -18,92% , 25-29 – 15,27%, 45-49 – 14,12%. The remaining ages were represented by small groups: 50-54 years – 8.84%, 55-59 years – 3.84%, 60-65 years – 2.11%, 20-24 years – 1.44%, 66-75 years – 2,11, over 76 – years 0.1% (Figure 5.36).

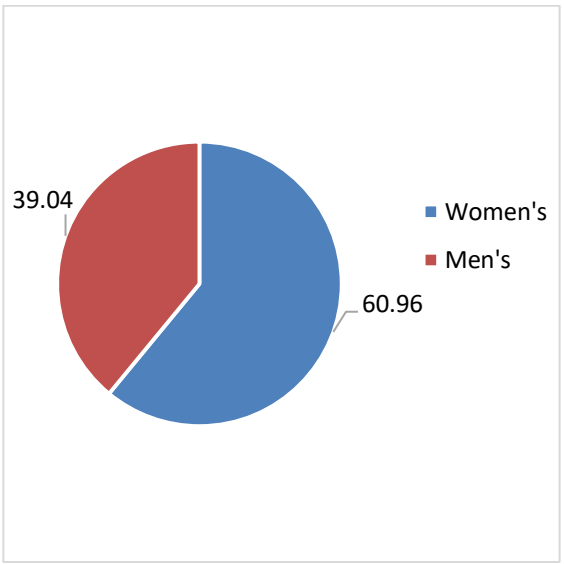

Figure 5.35. The structure of patients receiving psychological, psychotherapeutic and psychiatric care, by gender, %.

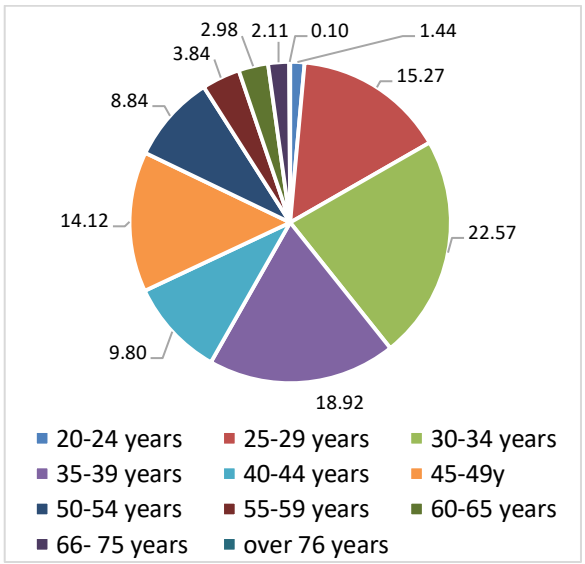

Figure 5.36. The structure of patients receiving psychological, psychotherapeutic and psychiatric care, by age, %.

The main place in the structure of the respondents was occupied by old–age pensioners – 33.19%, in second place were employees of private–owned institutions - 18.27%, did not work - 12.43% of respondents, worked in state-owned institutions 10.96%, students accounted for 7.82%, 6.36% were self-employed (Figure 5.37).

Among the respondents, the main share was the disabled of the second group – 52.67%, the second place was occupied by the share of the disabled of the third group – 36.7%, the third – of the first group – 10.67% (Figure 5.38).

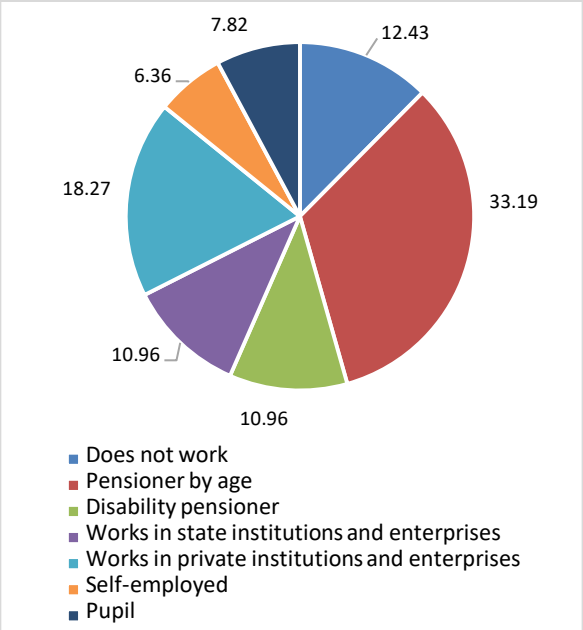

Figure 5.37. The structure of patients receiving psychological, psychotherapeutic and psychiatric care by social status, %.

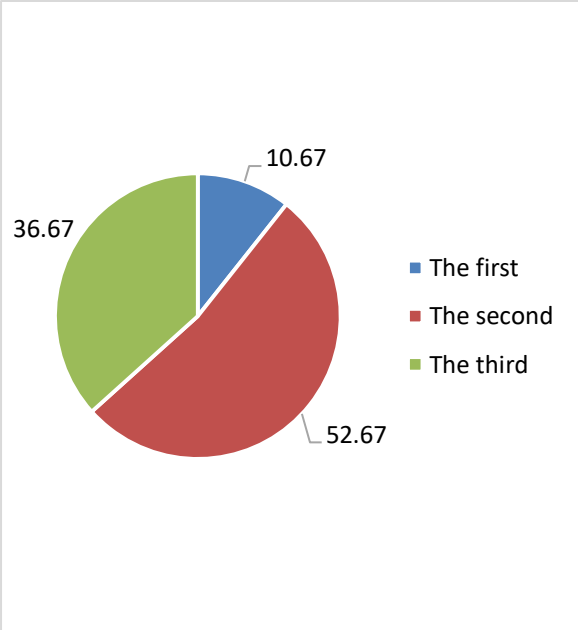

Figure 5.38. The structure of patients receiving psychological, psychotherapeutic and psychiatric care, by disability group, %.

Among the respondents, education workers were in the first place – 19.92%, construction – 14.99% in second place, industry and finance - 10.27%, 10.06% - healthcare, 9.86% - trade and services, 6.98% - science and higher education, 4.93% - culture and law enforcement agencies, 4.72% - transport,3.08% - agriculture (Figure 5.39).

A large proportion of patients (45.59%) were represented by secondary medical personnel. The second place (18.48%) was occupied by representatives of junior medical staff, the third (18.07%) – support staff, the fourth (4.93%) – was shared by senior, middle-level managers, homeworkers, 3.08% of patients worked in a specialized workshop (Figure 5.40).

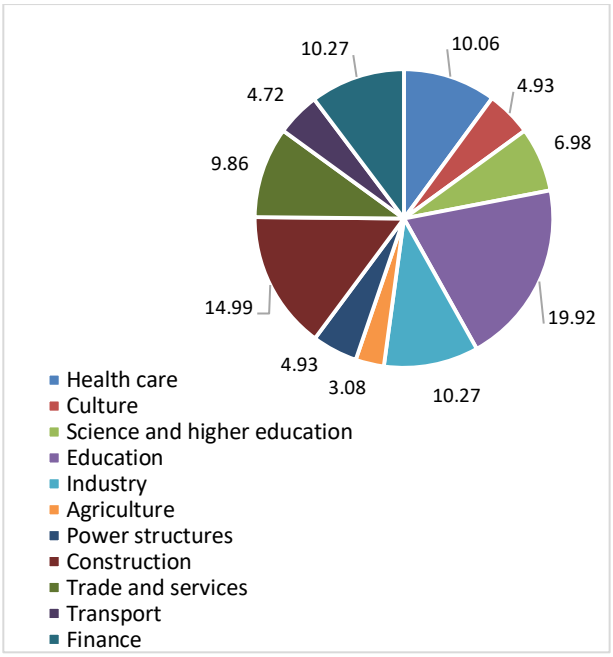

Figure 5.39. The structure of patients receiving psychological, psychotherapeutic and psychiatric care, by field of activity, %.

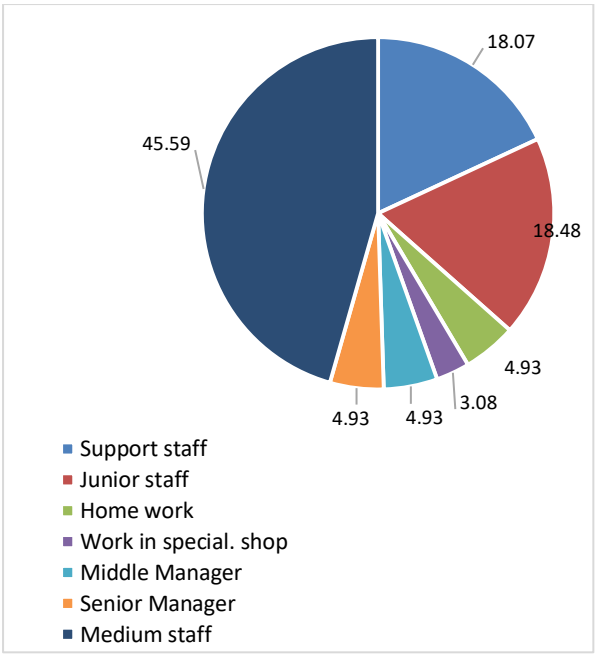

Figure 5.40. The structure of patients receiving psychological, psychotherapeutic and psychiatric care, by position, %.

Among patients, a large proportion (60.75%) were those who received higher education, 39.25% - specialized secondary and technical secondary (college, technical school, college) (Figure 5.41).

By family composition, patients were divided as follows: 40.28% lived with a spouse and children, 35.31% lived alone, 13.01% with parents, 11.4% with children (Figure 5.42).

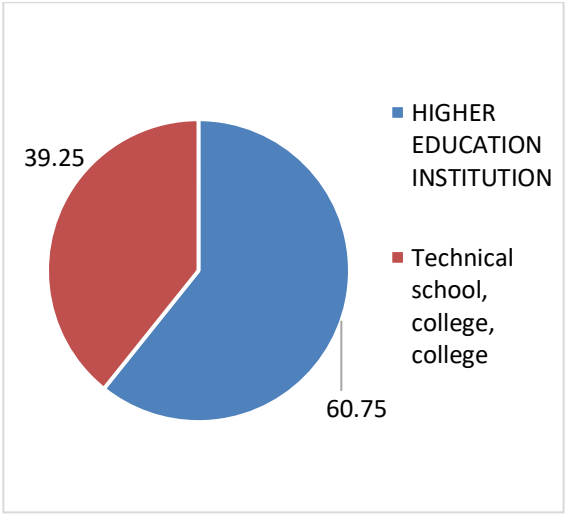

Figure 5.41. The structure of patients receiving psychological, psychotherapeutic and psychiatric care, by level of education, %.

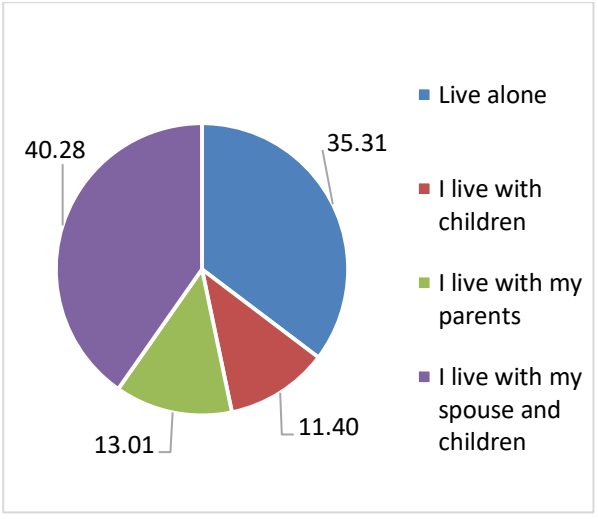

Figure 5.42. The structure of patients receiving psychological, psychotherapeutic and psychiatric care, by family composition, %.

In the first place were patients who are married (40.28%), in the second (29.24%) – single (unmarried), in the third (18.2%) – divorced, in the fourth (12.28%) – widows (Figure 5.43).

In 63.74% of cases, family relationships in patients receiving psychiatric and psychotherapeutic care were friendly, in 20.47% of cases – formal, in 11.99% - conflicting with individual family members, in 3.8% - conflicting with all family members (Figure 5.44).

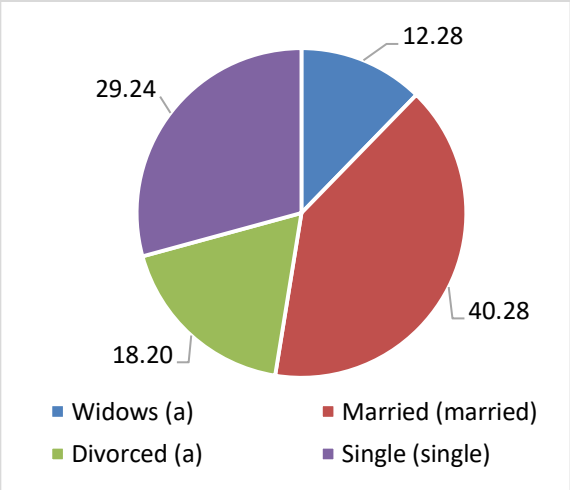

Figure 5.43. The structure of patients receiving psychological, psychotherapeutic and psychiatric care, by marital status, %.

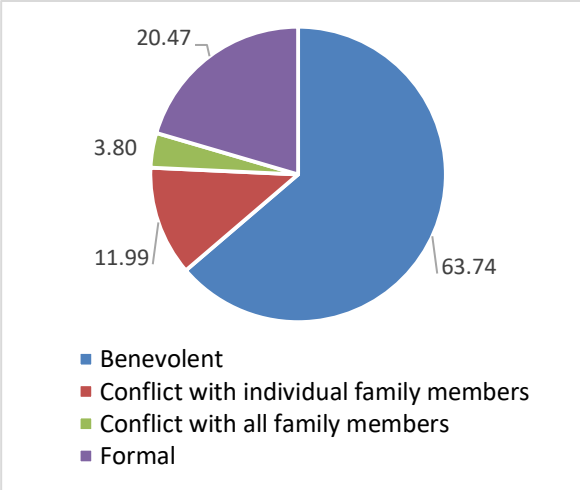

Figure 5.44. The structure of patients receiving psychological, psychotherapeutic and psychiatric care, according to family relationships, %.

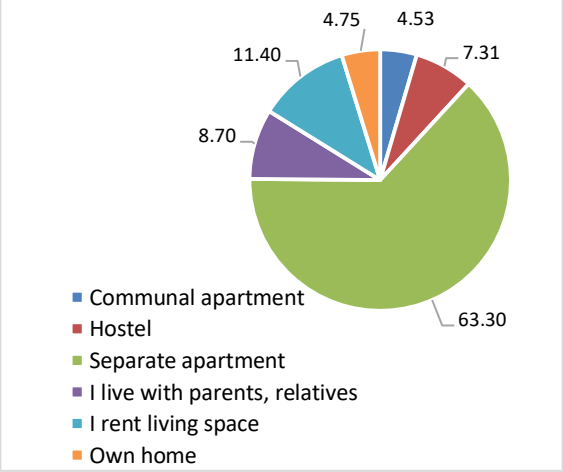

Figure 5.45. The structure of patients receiving psychological, psychotherapeutic and psychiatric care, based on "Housing conditions", %.

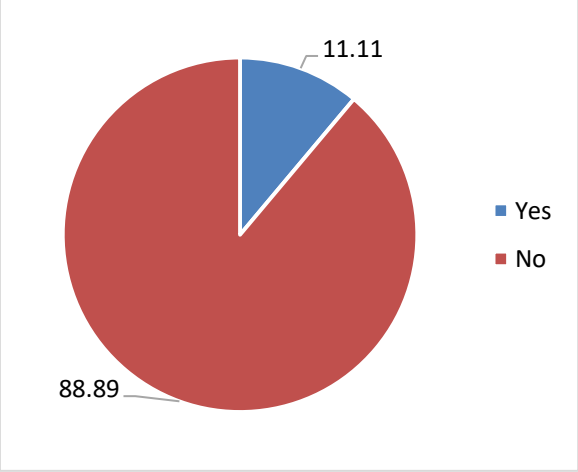

Figure 5.46. The structure of patients receiving psychological, psychotherapeutic and psychiatric care on the basis of "Hereditary burden of mental illness", %.

63.3% lived in a separate apartment, 11.4% rented a living space, 8.7% lived with parents, relatives, 7.31% lived in a dormitory, 4.75% lived in their own house, 4.53% - communal apartment (Figure 5.45).

Hereditary burden of mental illness was detected only in 11.11% of patients (Figure 5.46).

The early period of development in 72.22% of patients proceeded without features, pathological mental changes in early childhood were noted in 27.78% of patients (Figure 5.47).

Timely early development was recorded in 68.57% of patients, accelerated in 16.59% of patients, delayed in 14.86% of patients (Figure 5.48).

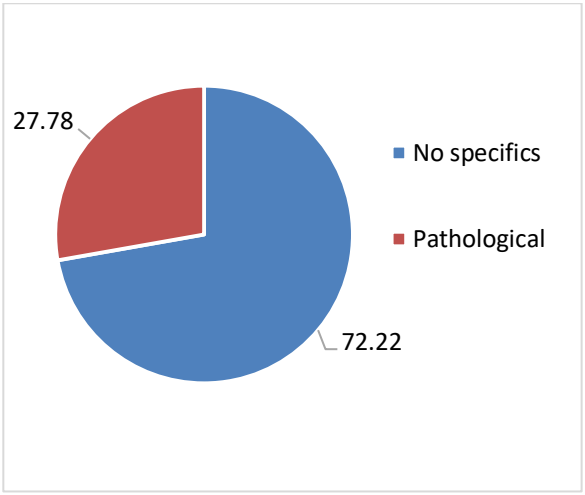

Figure 5.47. The structure of patients receiving psychological, psychotherapeutic and psychiatric care, based on "How early ontogenesis proceeded", %.

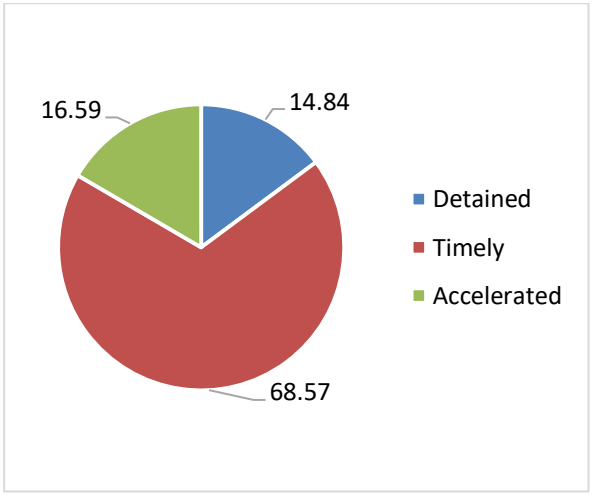

Figure 5.48. The structure of patients receiving psychological and psychotherapeutic and psychiatric care, based on the "Assessment of early development", %.

Features of the micro-social environment in childhood in patients who sought psychiatric and psychological and psychotherapeutic help, were as follows: 40.94% were raised in a full family, 27.56% - in a single-parent family, according to 5.56% - in an orphanage, with relatives, with a stepfather, 3.73% - with parents suffering from alcoholism (Figure 5.49).

One third of the patients were brought up harmoniously, 18.64% - according to the "Cinderella" model, 18.57% - as the idol of the family, 14.84% - in a state of neglect, 7.31% - in overprotection and inconsistent upbringing (Figure 5.50).

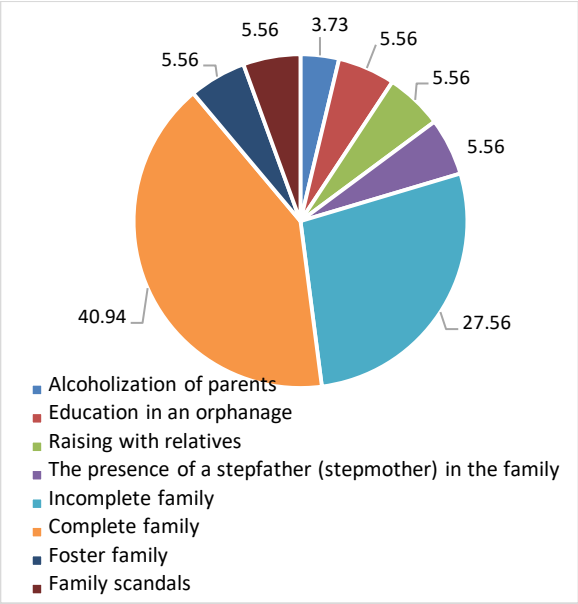

Figure 5.49. The structure of patients receiving psychological, psychotherapeutic and psychiatric care based on the "Peculiarities of the micro-social environment in childhood", %.

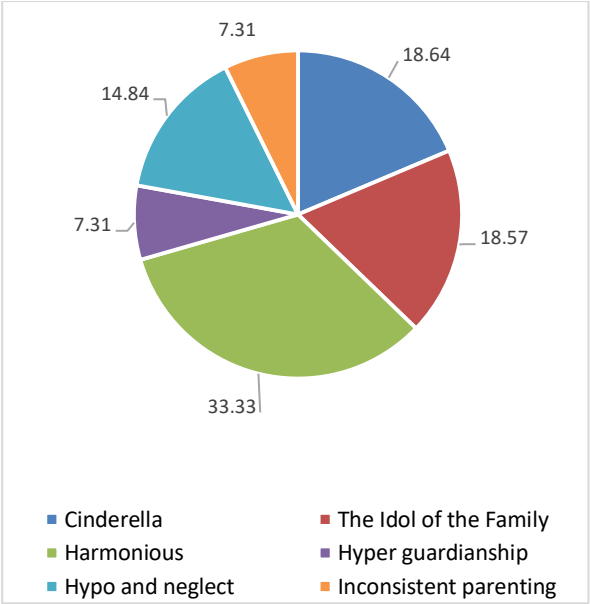

Figure 5.50. The structure of patients receiving psychological, psychotherapeutic and psychiatric care, based on the "Type of upbringing", %.

In 38.89% of patients, both parents were engaged in upbringing, 33.33% - mother, 20.47% - father, 5.48% - other family members, 1.83% - no one (Figure 5.51).

In early childhood, 44.44% of patients had unclassified disorders (Figure 5.52).

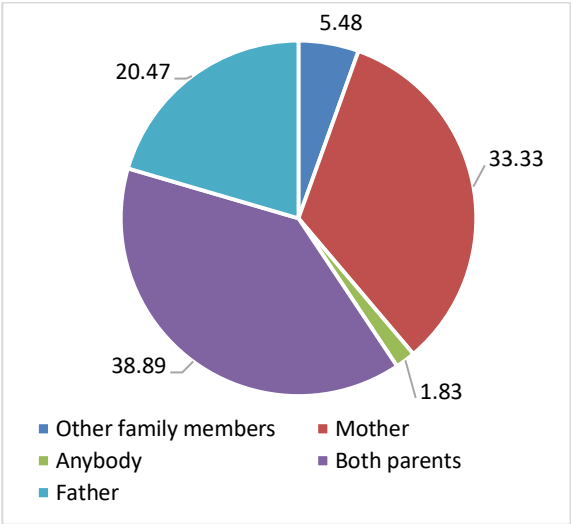

Figure 5.51. The structure of patients receiving psychological, psychotherapeutic and psychiatric care, based on "Who was primarily engaged in education", %.

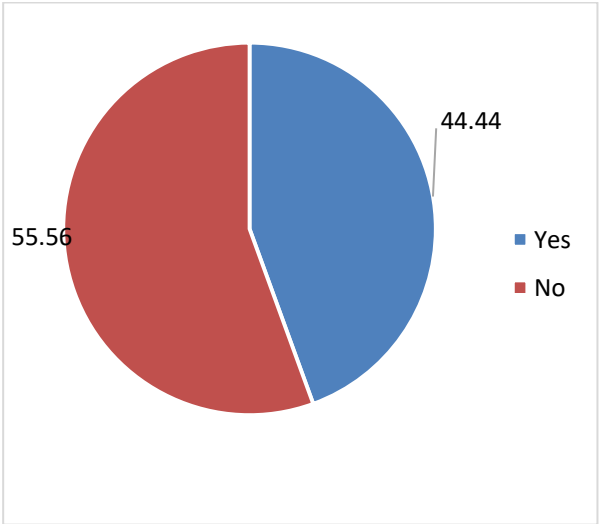

Figure 5.52. The structure of patients receiving psychological, psychotherapeutic and psychiatric care on the basis of "Unclassified disorders in early childhood", %.

38.89% of patients had no behavioral disorder in childhood, 14.91% were in a state of opposition and imitation, 13.01% had deviant behavior (alcoholism, escapes from home, smoking), 5,48% of the patients were hypercompensated and grouped with their peers (Figure 5.53).

More than 80% of patients were not under the supervision of a psychiatrist, 11,1% received medical advice, 1.83% were under dispensary supervision and were observed privately (Figure 5.54).

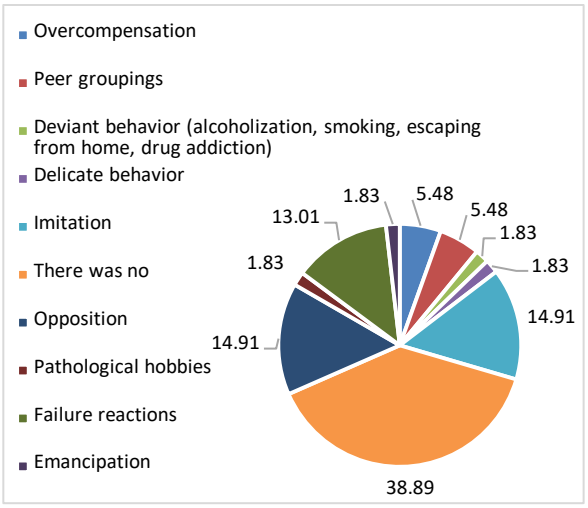

Figure 5.53. The structure of patients receiving psychological, psychotherapeutic and psychiatric care on the basis of "Behavioral disorders in childhood", %.

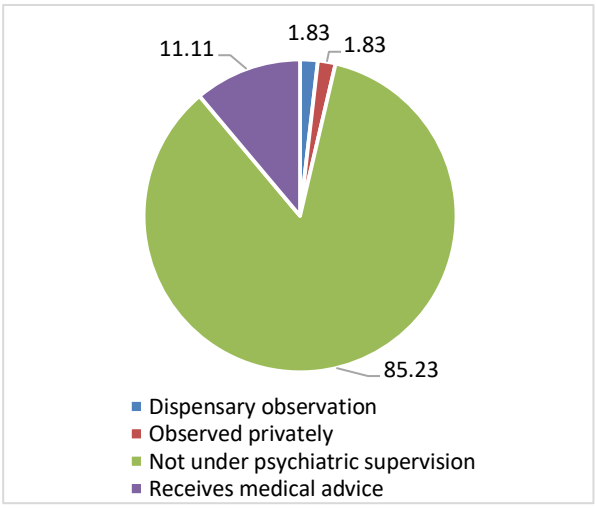

Figure 5.54. Structure of patients receiving psychological and psychotherapeutic and psychiatric care, on the basis of "Observation by a psychiatrist", %.

Among patients receiving psychological and psychotherapeutic and psychiatric care, on the basis of "Number of years of observation and treatment by a psychiatrist", 30.69% were observed for 1 year, 27.72% - 2 years, 28.22% - 3 years, 5.45% - 4 years, 4.95% - more than 5 years, 2.97% - 5 years (Figure 5.55).

Within the cultural norm, 75.88% of patients consumed alcohol, were alcohol dependent - 16.74%, abused -7.38% (Figure 5.56).

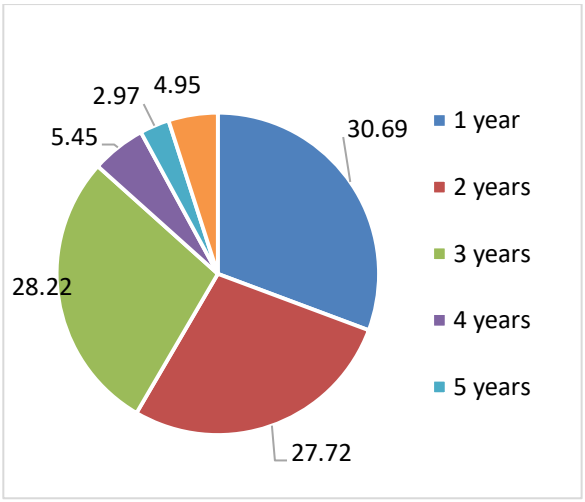

Figure 5.55. The structure of patients receiving psychological, psychotherapeutic and psychiatric care, based on the "Number of years of observation and treatment by a psychiatrist", %.

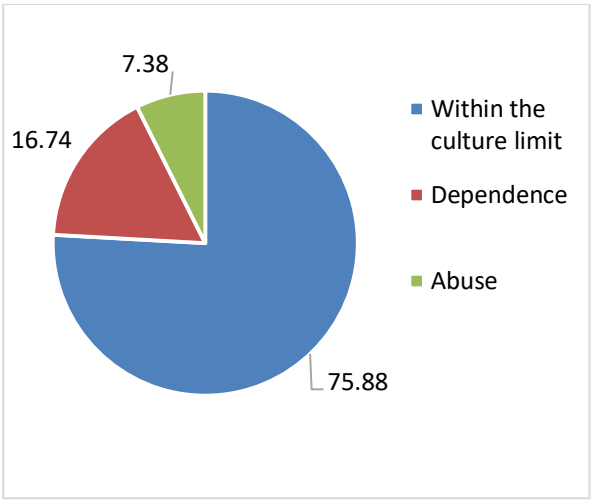

Figure 5.56. The structure of patients receiving psychological, psychotherapeutic and psychiatric care, based on the "Attitude to alcohol", %.

35.16% of patients had chronic somatic diseases (Figure 5.57).

Among patients receiving psychiatric and psychotherapeutic care, 50.0% of patients had not previously been ill with Covid – 19 coronavirus infection; 18.57% were slightly ill, 16.67% were of moderate severity, 7.38% each severe and extremely severe current (Figure 5.58).

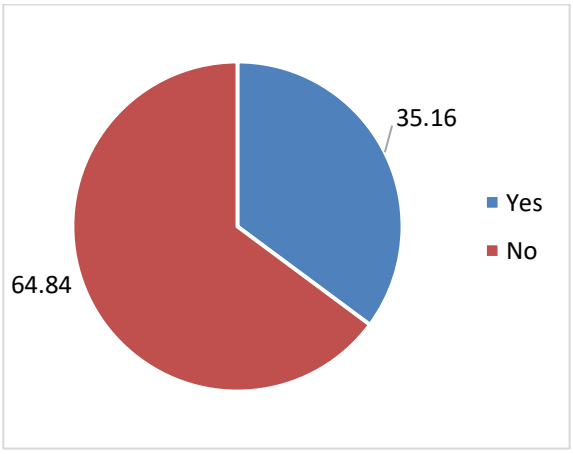

Figure 5.57. The structure of patients receiving psychological and psychotherapeutic and psychiatric care, based on the "Presence of chronic somatic diseases", %.

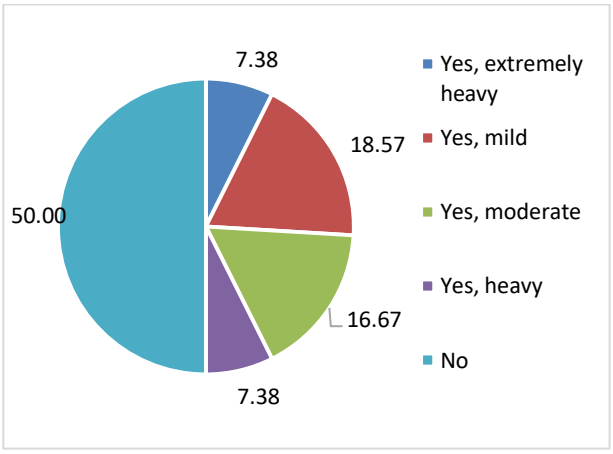

Figure 5.58. The structure of patients receiving psychological, psychotherapeutic and psychiatric care, based on the "Coronavirus infection in the anamnesis (Covid - 19)", %.

46.27% of patients had an exacerbation of diseases once a year, 33.33% twice a year, 20.39% were constantly ill (Figure 5.59).

The need for inpatient treatment 1 time per year accounted for 46.27% of patients, 2 times a year – for 33.33%, more than 2 times a year – for 20.39% of patients (Figure 5.60).

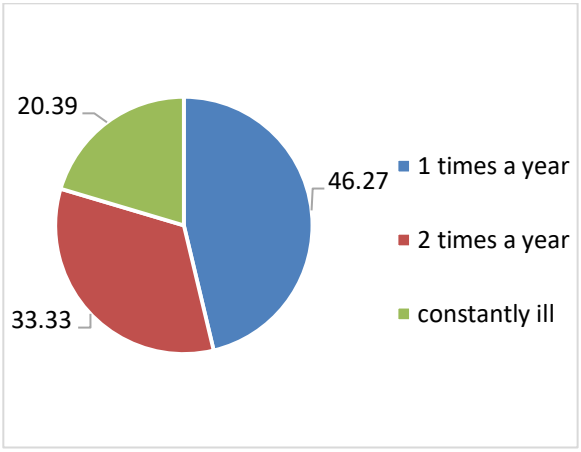

Figure 5.59. The structure of patients receiving psychological, psychotherapeutic and psychiatric care, based on the "Frequency of exacerbation of chronic somatic diseases", %/

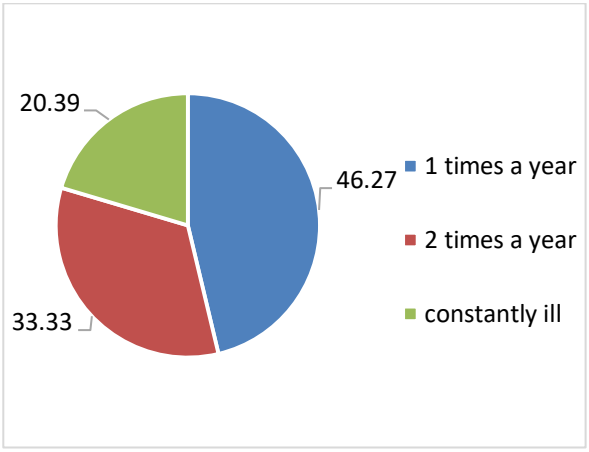

Figure 5.60. The structure of patients receiving psychological, psychotherapeutic and psychiatric care, based on the "Need for inpatient treatment for chronic somatic diseases", %/

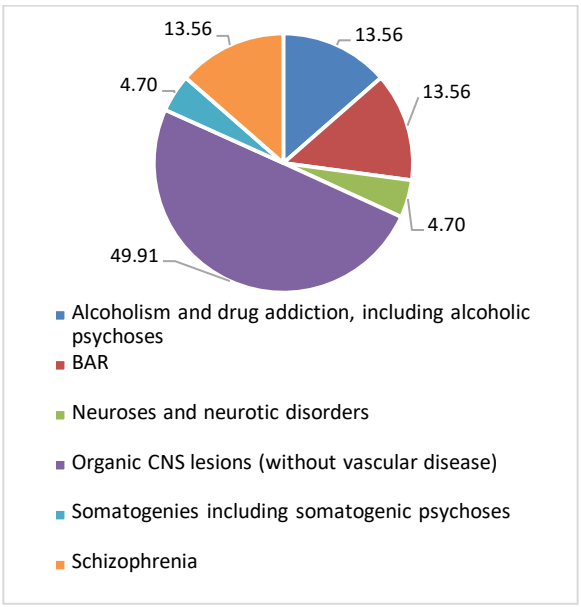

Figure 5.61. The structure of patients receiving psychological, psychotherapeutic and psychiatric care, on the basis of "Nosology", %.

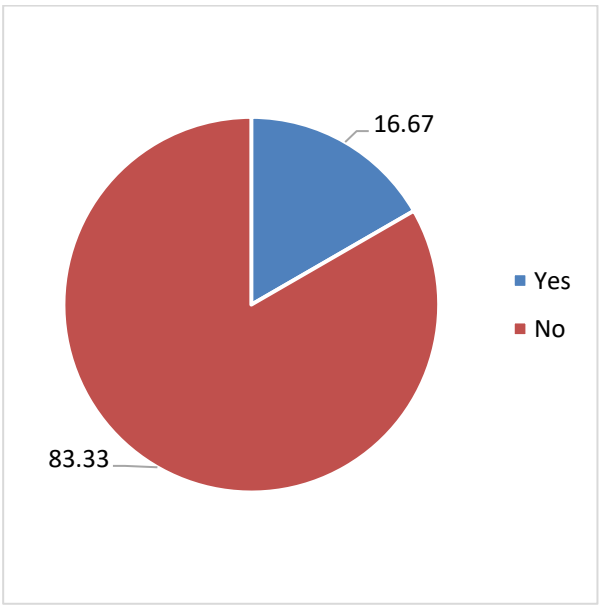

Figure 5.62. The structure of patients receiving psychological, psychotherapeutic and psychiatric care, based on the "Use of psychotropic drugs", %.

In the structure of nosological forms, organic lesions of the central nervous system took the first place (49.91%), schizophrenia, BAR and alcoholism competed with each other, amounting to 13.56% in each group. The minimum proportion was

4.7% each of somatogenies, including somatogenic psychoses, and neuroses and neurotic disorders (Figure 5.61).

Psychotropic drugs were used in relation to 16.67% of patients (Figure 5.62).

In the first place were patients receiving tranquilizers (34.21%), in the second - normotimics (32.89%), in the third – antidepressants (21.93%), and in the fourth – antipsychotics (10.96%) (Figure 5.63).

12.94% of patients received psychotherapeutic care (Figure 5.64).

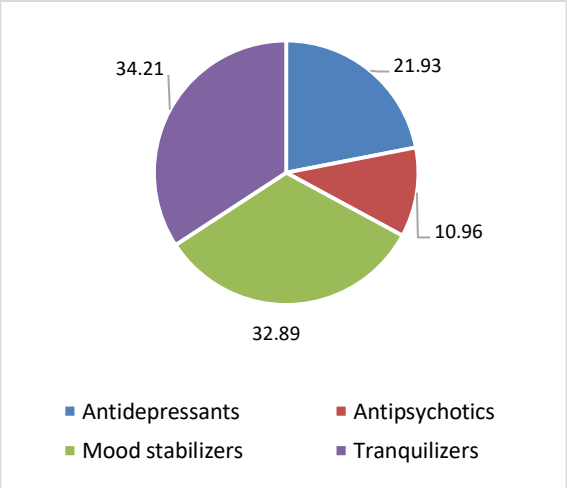

Figure 5.63. The structure of patients receiving psychological, psychotherapeutic and psychiatric care, based on the "Class of psychotropic drugs", %.

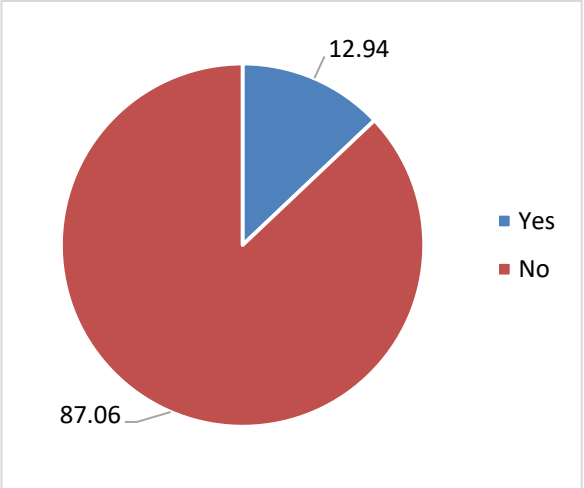

Figure 5.64. The structure of patients receiving psychological and psychotherapeutic and psychiatric care, based on the "Use of psychotherapeutic assistance", %.

According to the form of psychotherapy, patients were distributed as follows: 57.06% received therapy individually, 28.81% - in group form, 14.12% - in the family (Figure 5.65).

According to the "Duration of psychotherapeutic influence", the distribution was as follows: 42.94% of patients received ultrashort therapy, 28.81% - short (up to 30 days), 14.12% were distributed long-term (up to 12 months) and long-term (over a year) therapy (Figure 5.66).

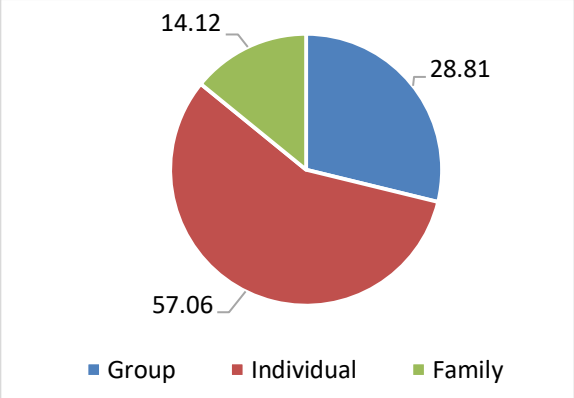

Figure 5.65. The structure of patients receiving psychological and psychotherapeutic and psychiatric care, according to the "Form of psychotherapy", %.

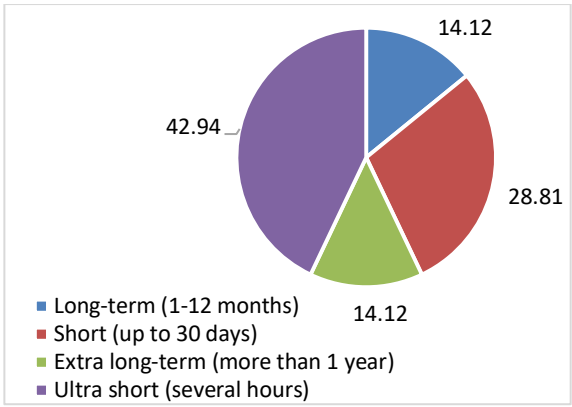

Figure 5.66. The structure of patients receiving psychological and psychotherapeutic and psychiatric care, based on the "Duration of psychotherapeutic exposure", %.

The measures taken in 60.24% of patients were effective, in 39.76% - not (Figure 5.67).

According to the criterion "Clinical effectiveness of treatment", practical recovery occurred in 29.53% of patients, and the proportion of patients with the condition remained unchanged, a slight improvement was noted in 20.47%, complete recovery and recovery occurred in 10.24% of patients (Figure 5.68).

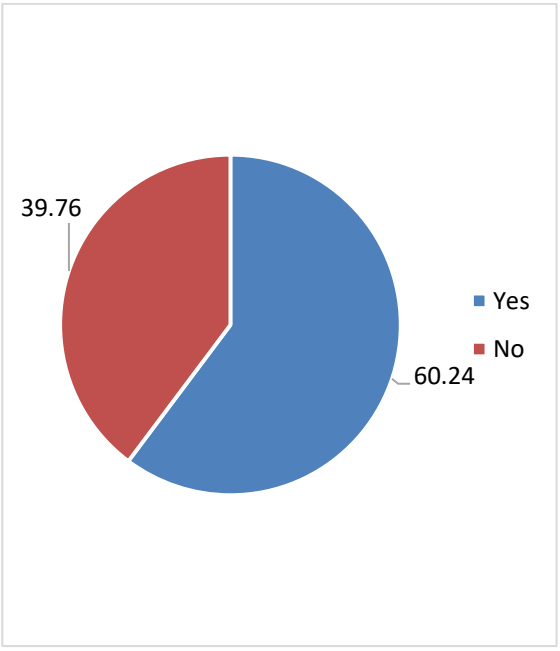

Figure 5.67. The structure of patients receiving psychological and psychotherapeutic and psychiatric care, based on the "Effectiveness of the measures taken", %.

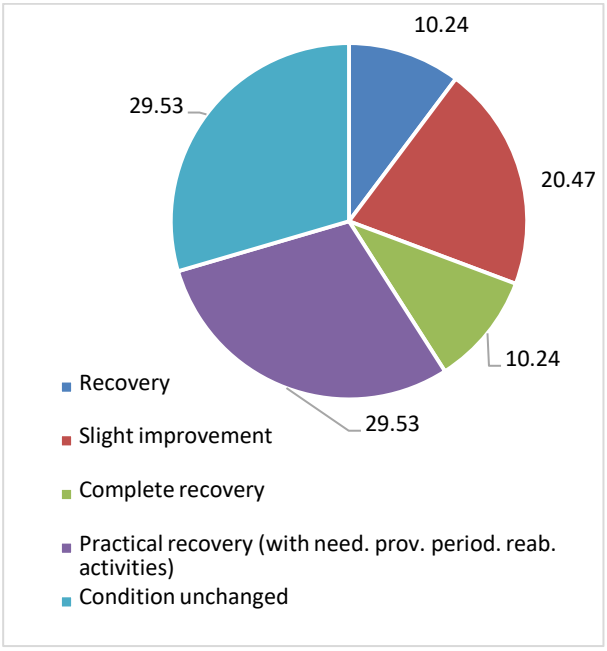

Figure 5.68. The structure of patients receiving psychological, psychotherapeutic and psychiatric care, based on the "Clinical effectiveness of treatment", %.

Of patients receiving treatment, 40.16% partially restored their social and labor status, 30.31% completely restored, and 29.53% had a pronounced decrease in social and labor adaptation (Figure.5.69).

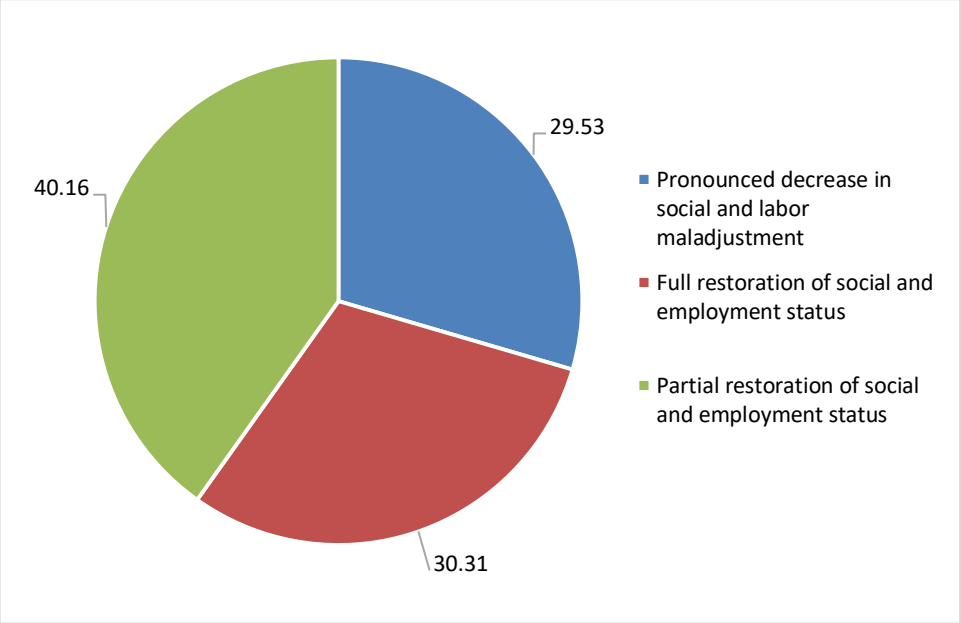

Figure 5.69. The structure of patients receiving psychological, psychotherapeutic and psychiatric care, based on the "Assessment of social effectiveness", %

5.3. Expert assessment of the modern system of organization of psychiatric care.

A sociological survey of psychiatric experts from health care organizers evaluating the effectiveness of psychiatric and psychological-psychotherapeutic care showed: 90% of experts believed that the examination of patients conducted by a psychiatrist in a general somatic network (polyclinic, multidisciplinary hospital) would increase the level of effectiveness of medical care to the population (Figure 5.70).

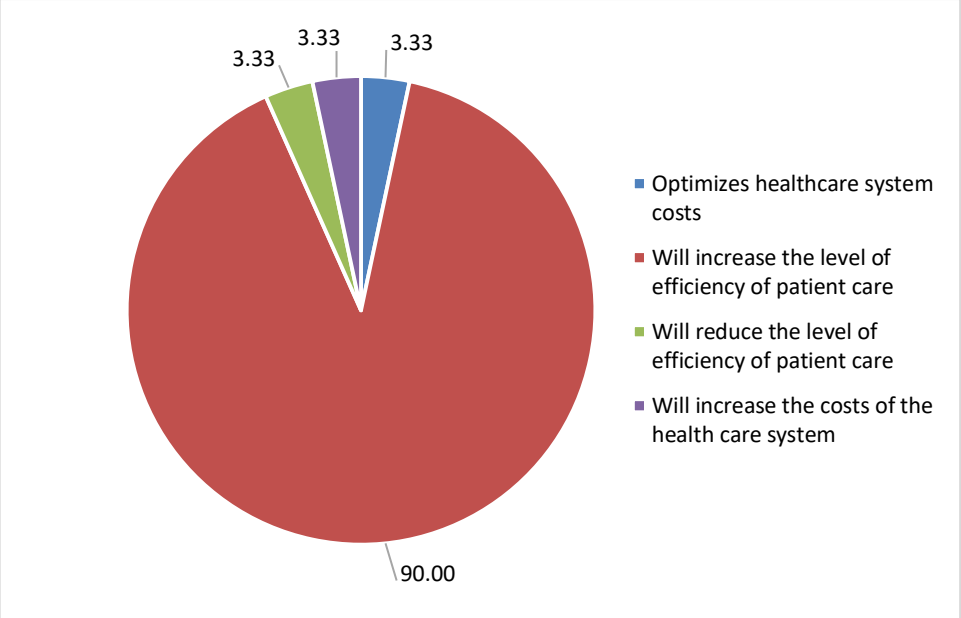

Figure 5.70. The structure of the responses of experts who expressed their opinion on the effects of screening of the patient's mental state conducted by a psychiatrist in a general somatic network (polyclinic, multidisciplinary hospital), %.

To the question "Do you think that the number of non-psychotic mental disorders has increased among various segments of the population?" 93.3% of experts answered the question positively (Figure 5.71).

To the question "Do you think that the system of providing psychiatric care to the population needs to be reformed?" 86.67% of experts answered the question positively (Figure 5.72).

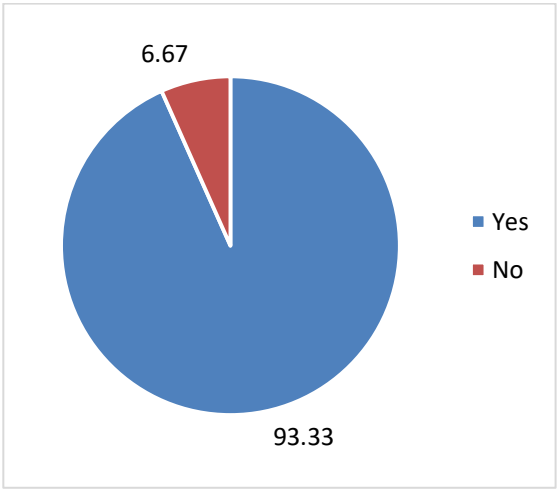

Figure 5.71. The structure of the responses of experts who expressed their opinion about the increase in the number of non-psychotic mental disorders among various populations, %.

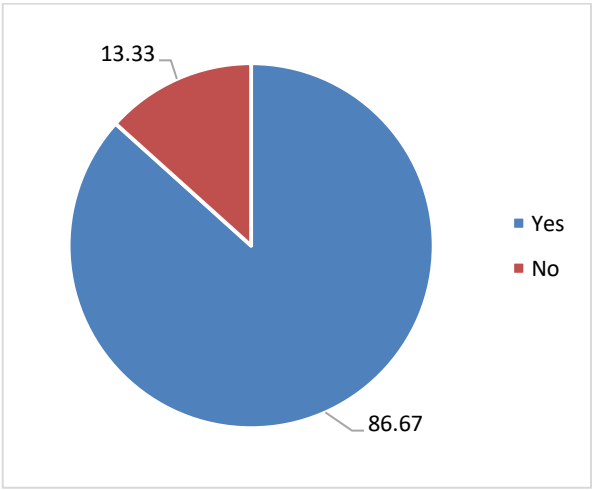

Figure 5.72. The structure of the responses of experts who expressed their opinion on the need to reform the system of psychiatric care (Do you think that the system of providing psychiatric care to the population needs to be reformed), %.

To the question "How, in your opinion, the use of the basic indicator "Provision of somatic profile medical organizations with psychiatrists" can affect the change in the values of the following targets?" 93.3% indicated that an increase in psychiatrists would increase the proportion of mental illnesses detected at early stages among the first-time psychiatric diagnoses (Figure 5.73).

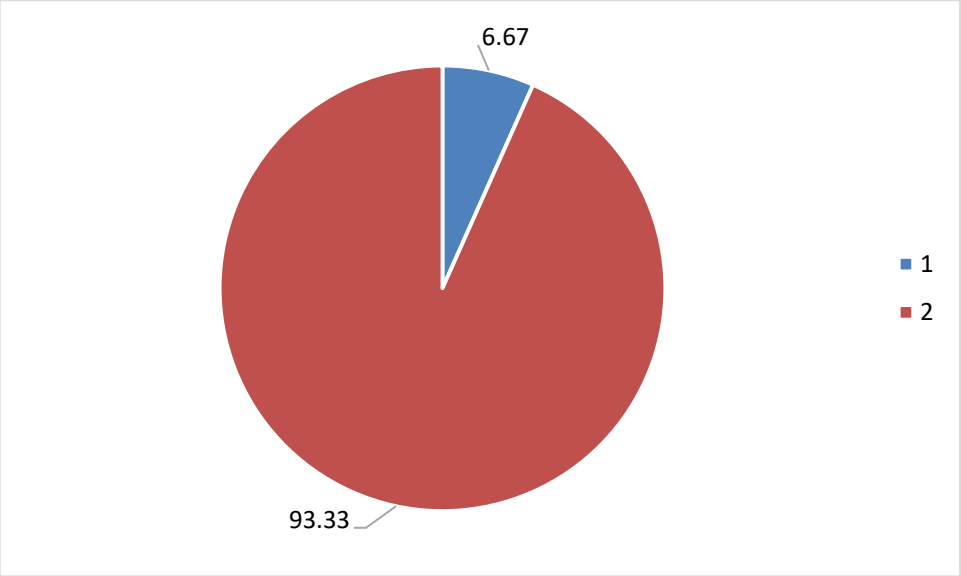

Figure 5.73. The structure of the responses of experts who expressed their opinion on the use of the basic indicator "Provision of somatic profile medical organizations with psychiatrists" may affect an increase in the proportion of mental illnesses detected at early stages among newly diagnosed psychiatric diagnoses, %.

To the question "How, in your opinion, the use of the baseline indicator "The proportion of mental illnesses identified at an early stage from among the newly established mental disorder" can affect the change in the values of the targets: " Provision of somatic medical organizations with psychiatrists", "Frequency of visits to a therapist, neurologist, doctors of other specialties", "Awareness of the population about the possibility of receiving psychiatric care, frequency of hospitalizations to somatic beds, timely provision of psychiatric care to patients" 76.67% of experts claimed that an increase in the value of the baseline indicator would negatively affect the change in the above targets, 20.0% - would have little effect, 3.33% - would not affect (Figure 5.74).

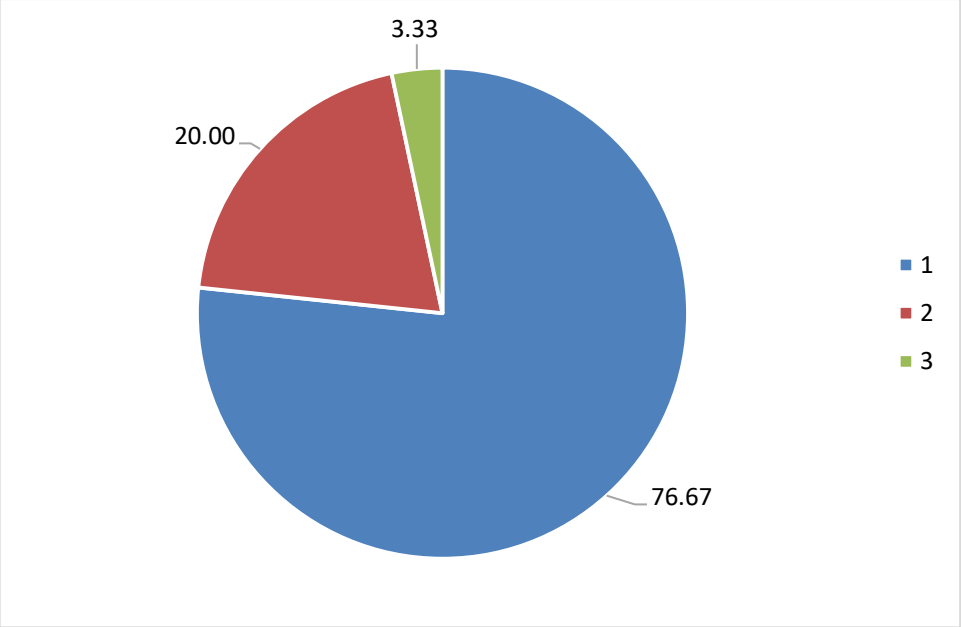

Figure 5.74. The structure of the responses of experts who expressed their opinion on how the use of the basic indicator "The proportion of mental illnesses detected at early stages from among the newly established mental disorders" can affect the change in the values of the following targets: "Provision of somatic profile medical organizations with psychiatrists", "Frequency of visits to a therapist, neurologist, doctors of other specialties", "Awareness of the population about the possibility of receiving psychiatric care, the frequency of hospitalizations to somatic beds, timely provision of psychiatric care to patients, %.

To the question "How, by- in your opinion, the use of the basic indicator "Frequency of visits to a therapist, neurologist, doctors of other specialties" may affect the change in the values of the following targets: "The proportion of mental illnesses detected at early stages among psychiatric diagnoses for the first time", "Provision of somatic medical organizations with psychiatrists", "Awareness of the population about the possibility of receiving psychiatric care", "Frequency of hospitalizations to somatic beds", "Timely provision of psychiatric care to patients" 86.67% considered, that the base indicator will increase the value of the targets, 10.0% - will have little effect, 3.33% - will not affect (Figure 5.75).

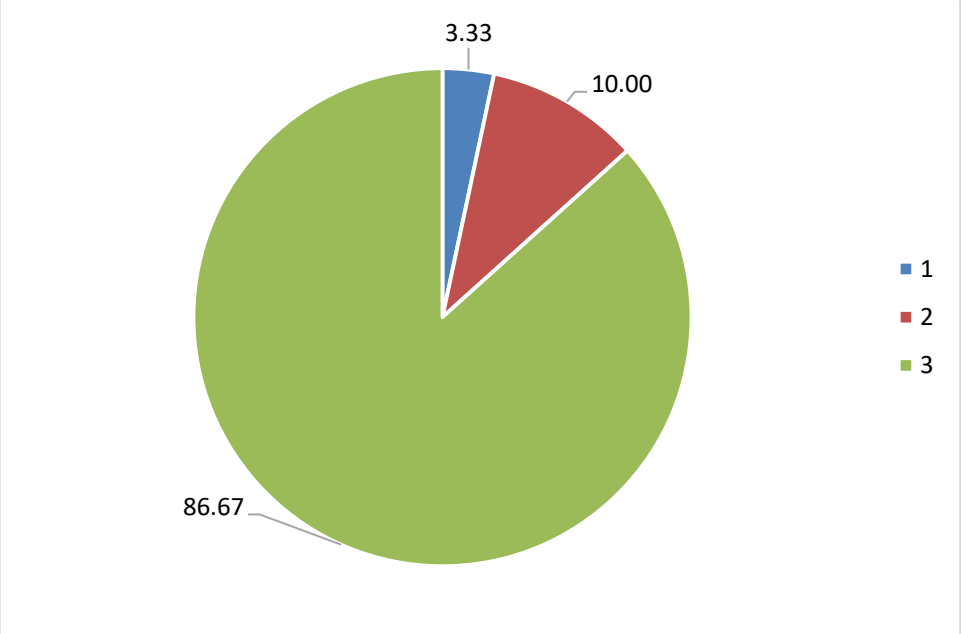

Figure 5.75. The structure of the responses of experts who expressed their opinion on how the use of the basic indicator "Frequency of visits to a therapist, neurologist, doctors of other specialties" can affect the change in the values of the following targets: "The proportion of mental illnesses detected at early stages among first-time psychiatric diagnoses", "Provision of somatic medical organizations with psychiatrists", "Awareness of the population about the possibility of receiving psychiatric care", "Frequency of hospitalizations to somatic beds", "Timely provision of psychiatric care to patients",%.

To the question "How, in your opinion, the use of the basic indicator "Awareness of the population about the possibility of receiving psychiatric care" can affect the change in the values of the following targets: "The proportion of mental illnesses detected at early stages among first-time psychiatric diagnoses", "Provision of somatic profile medical organizations with psychiatrists", "Frequency of hospitalizations to somatic profile beds", "Timely provision of psychiatric care to patients", "Frequency of visits to a therapist, neurologist, doctors of other specialties"? 73.33% of experts believed that the baseline indicator would negatively affect the change in targets (Figure 5.76).

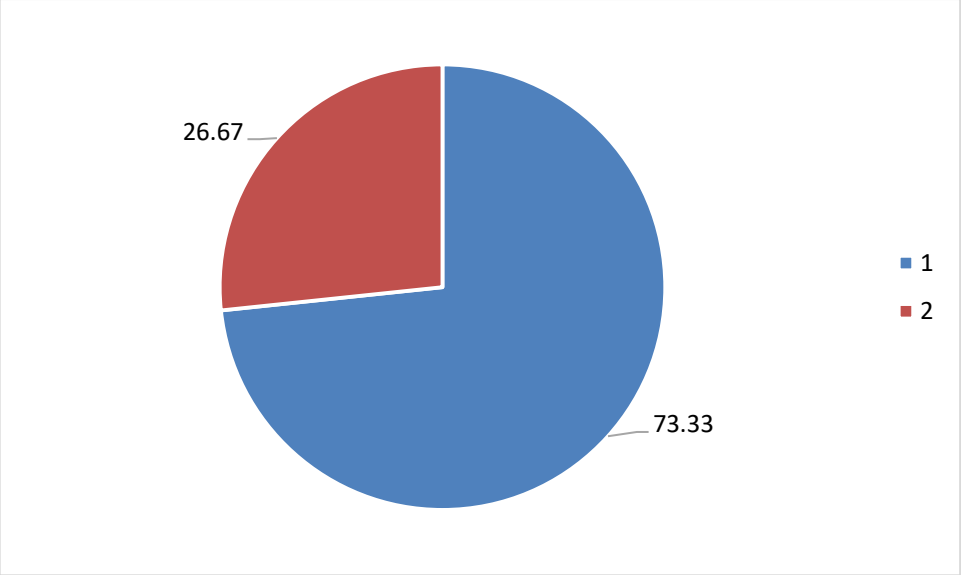

Figure 5.76. The structure of the responses of experts who expressed their opinion on how the use of the basic indicator "Awareness of the population about the possibility of receiving psychiatric care" will affect the change in targets: "The frequency of visits to a therapist, neurologist, and doctors of other specialties" may affect changes in the values of the following targets: "The proportion of mental illnesses detected at early stages among first-time psychiatric diagnoses", "Provision of somatic medical organizations with psychiatrists", "The frequency of hospitalizations to somatic beds", "Timely provision of psychiatric care to patients",%.

To the question "How, in your opinion, the use of the basic indicator "The frequency of hospitalizations to somatic beds" will affect the change in target indicators: "Awareness of the population about the possibility of receiving psychiatric care", "The proportion of mental illnesses detected at early stages among first-time psychiatric diagnoses", "Provision of somatic medical organizations with psychiatrists", "Timely provision of psychiatric care to patients", "Frequency of visits to a therapist, neurologist, doctors of other specialties"? 93.33% of experts believed that the baseline indicator would significantly affect the change in targets (Figure 5.77).

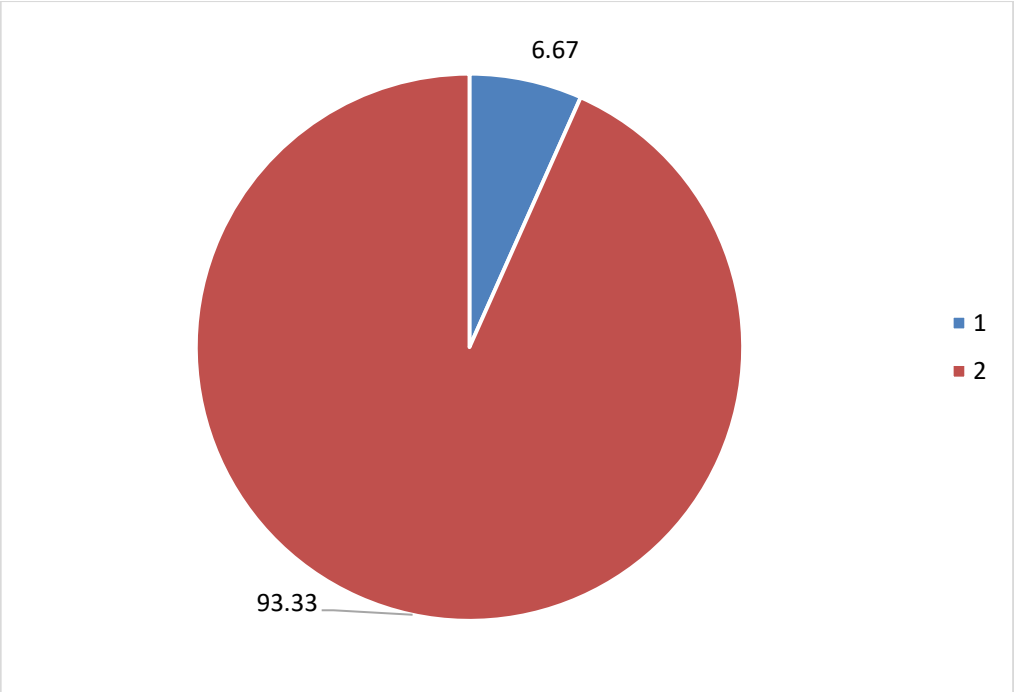

Figure 5.77. The structure of the responses of experts who expressed their opinion on how the use of the basic indicator "Frequency of hospitalizations to somatic beds" can affect the change in the values of the following target indicators: "Awareness of the population about the possibility of receiving psychiatric care", "Frequency of visits to a therapist, neurologist, doctors of other specialties", "The proportion of mental illnesses detected in early stages among the first psychiatric diagnoses", "Provision of somatic medical organizations with psychiatrists", "Timely provision of psychiatric care to patients" % .

To the question "How, in your opinion, the use of the basic indicator "Timely provision of psychiatric care to patients" can affect the change in the values of the following targets: "Awareness of the population about the possibility of receiving psychiatric care", "The proportion of mental illnesses detected at early stages among the first psychiatric diagnoses", "Provision of medical organizations with a somatic profile psychiatrists", "Frequency of visits to a therapist, neurologist, doctors of other specialties"? 76.67% of experts believed that the baseline indicator would significantly affect the change in targets, 16.67% would not affect, and 3.33% equally would not significantly affect (Figure.5.78).

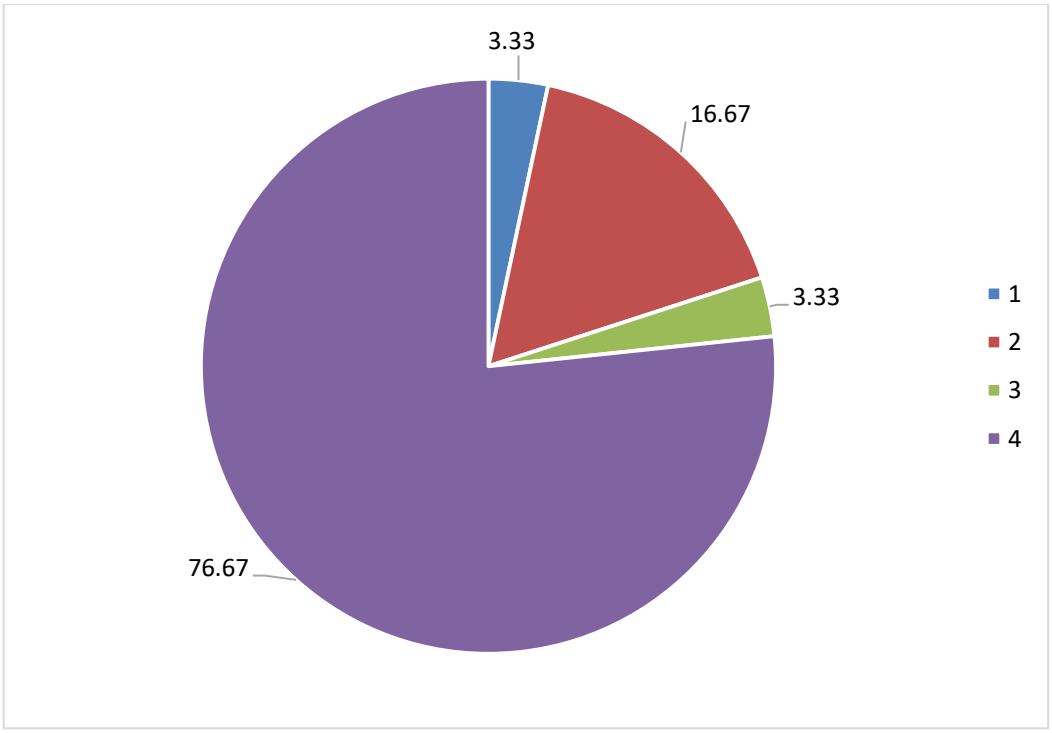

Figure 5.78. The structure of the responses of experts who expressed their opinion on how the use of the basic indicator "Timely provision of psychiatric care to patients" can affect the change in the values of the target indicators: "Awareness of the population about the possibility of receiving psychiatric care", "The proportion of mental illnesses detected at early stages among the first-time psychiatric diagnoses", "Ensuring medical organizations with a somatic profile by psychiatrists", "Frequency of visits to a therapist, neurologist, doctors of other specialties"? % .

To the question "How, in your opinion, the use of the basic indicator "The proportion of mental illnesses detected at early stages from among the newly established mental disorders" can affect the change in the values of the target indicators: "Awareness of the population about the possibility of receiving psychiatric care", "Provision of somatic medical organizations with psychiatrists", "Timely provision of psychiatric patients help", "Frequency of visits to a therapist, neurologist, doctors of other specialties"? 50.0% of experts believed that the baseline indicator would significantly affect the change in targets, 43.33% - would have little effect, 6.67% – would not affect (Figure 5.79).

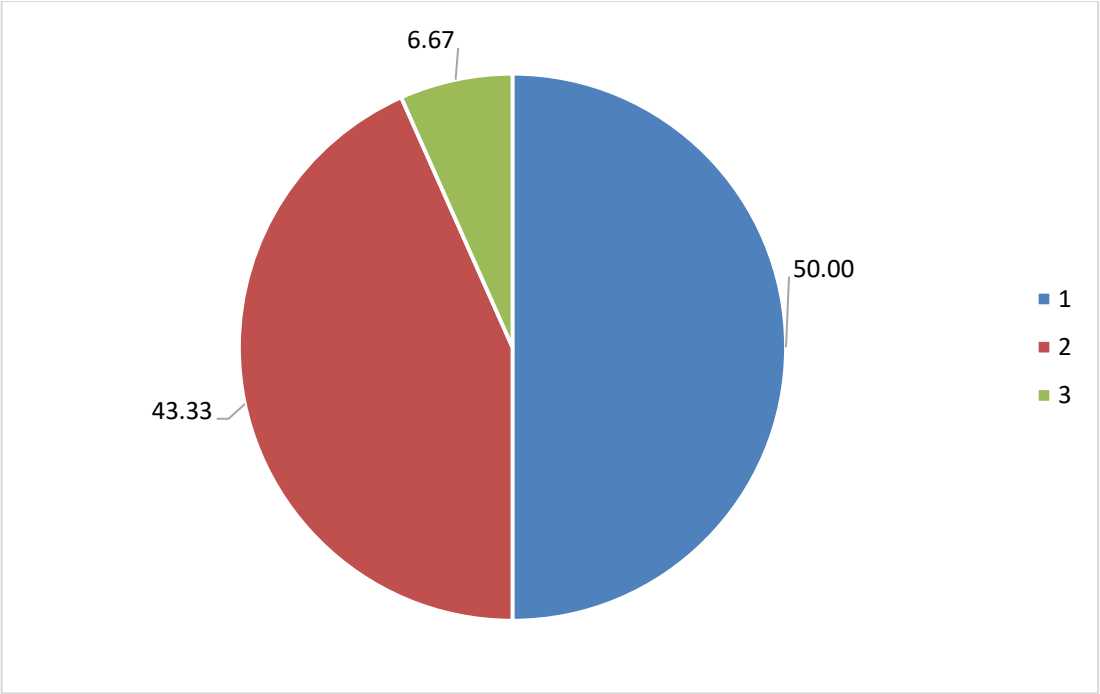

Figure 5.79. The structure of the responses of experts who expressed their opinion on how the use of the basic indicator "The proportion of mental illnesses detected at early stages from among the newly established mental disorders" can affect the change in the values of the target indicators: "Awareness of the population about the possibility of receiving psychiatric care", "Provision of somatic medical organizations with psychiatrists", "Timely provision of psychiatric care to patients", "Frequency of visits to a therapist, neurologist, doctors of other specialties, %.

To the question "How, in your opinion, the use of the baseline indicator "The proportion of mental illnesses detected at early stages from among the newly established mental disorders" can affect the change in the values of the target indicator: "Awareness of the population about the possibility of receiving psychiatric care", 63.33% of experts believed that the baseline indicator would significantly positively affect the change in the target, 23.33% - will not affect, 10.0% - will have an insignificant positive effect, 3.33% – will have an insignificant negative effect (Figure 5.80).

The basic indicator "The proportion of mental illnesses detected at an early stage from among the newly diagnosed mental disorders", according to 93.33% of experts, significantly influenced the target indicator "Timely provision of psychiatric care to patients" (Figure 5.81).

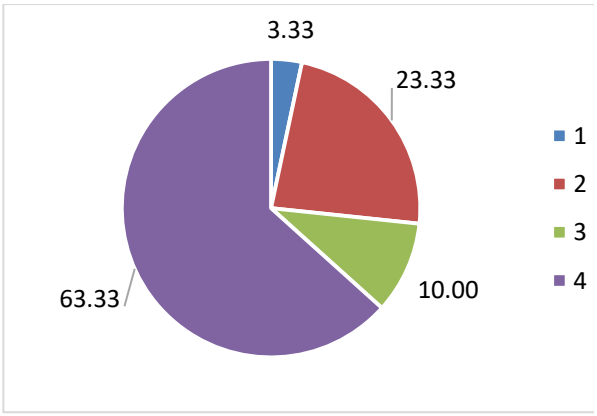

Figure 5.80. The structure of the responses of experts who expressed their opinion on how the use of the basic indicator "The proportion of mental illnesses identified at an early stage from among the newly established mental disorders" affects the change in the values of the indicator "Awareness of the population about the possibility of receiving psychiatric care", %.

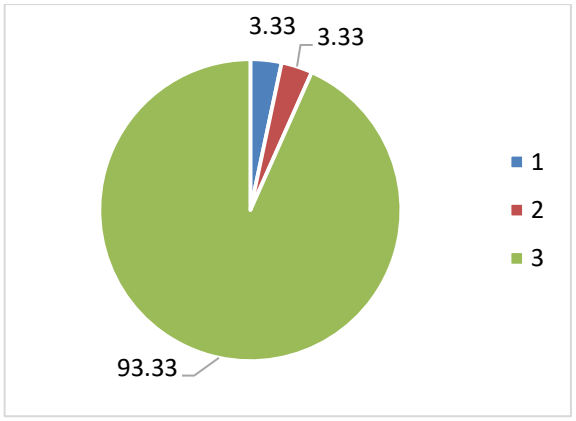

Figure 5.81. The structure of the responses of experts who expressed their opinion on how the use of the basic indicator "The proportion of mental illnesses detected at early stages from among the newly established mental disorders" affects the change in the values of the indicator "Timely provision of psychiatric care to patients", %.

The fact that the basic indicator "Frequency of visits to a therapist, neurologist, and doctors of other specialties" has no effect on the target indicator "The proportion of mental illnesses detected at early stages among first–time psychiatric diagnoses" was claimed by 46.67% of experts, has a significant negative impact - 36.67%, has an insignificant negative impact – 16.67% (Figure 5.82).

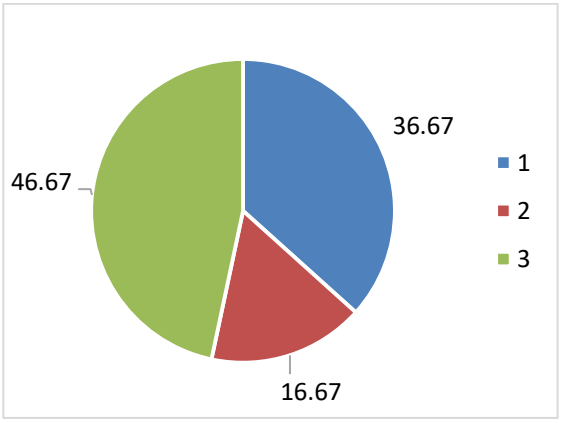

Figure 5.82. The structure of the responses of experts who expressed their opinion on how the use of the basic indicator "Frequency of visits to a therapist, neurologist, doctors of other specialties" affects the change in the values of the indicator "The proportion of mental illnesses detected at early stages among first-time psychiatric diagnoses",%

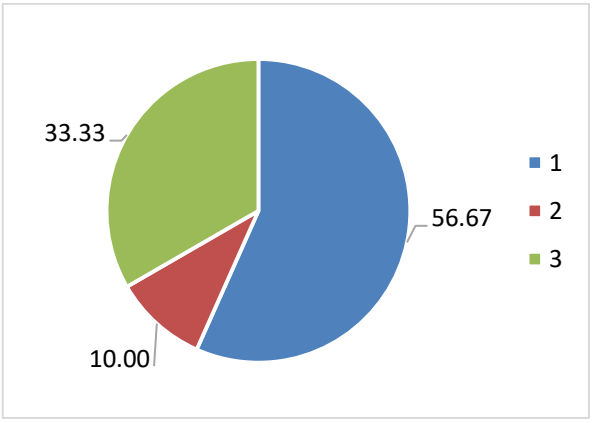

Figure 5.83. The structure of the responses of experts who expressed their opinion on how the use of the basic indicator "Frequency of visits to a therapist, neurologist, doctors of other specialties" can affect the change in the values of the target indicator "Provision of somatic profile medical organizations with psychiatrists",%.

The influence of the basic indicator "Frequency of visits to a therapist, neurologist, and doctors of other specialties" on the change in the values of the target indicator "Provision of somatic medical organizations with psychiatrists" 56.67% of experts called significantly negative, 33.33% - zero, 10.0% - insignificantly negative (Figure 5.83).

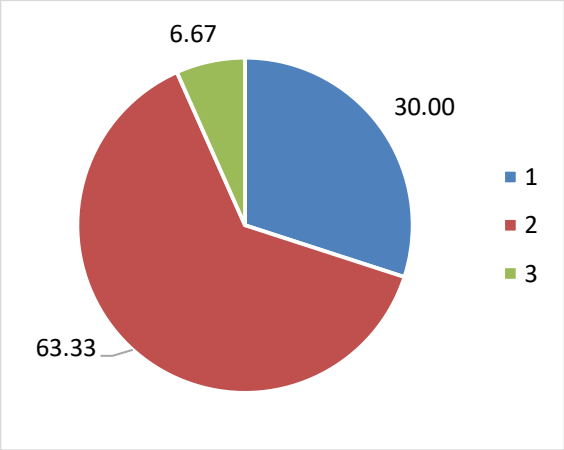

Figure 5.84. The structure of responses from experts who expressed their opinion on how the use of the baseline indicator "Frequency of visits to a therapist, neurologist, doctors of other specialties" affects the change in the values of the indicator "Frequency of hospitalizations per beds of a somatic profile,"%.

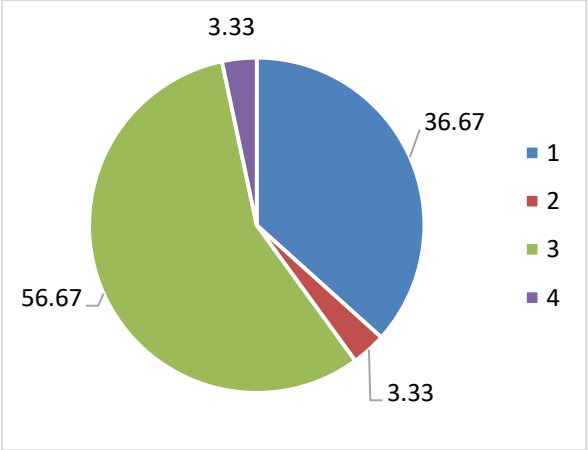

Figure 5.85. The structure of responses from experts who expressed their opinion on how the use of the baseline indicator "Frequency of visits to a therapist, neurologist, doctors of other specialties" affects the change in the values of the indicator "Timely provision of psychiatric care,"%.

"The frequency of visits to a therapist, neurologist, doctors of other specialties" has a negative insignificant effect on the change in the values of the indicator "The frequency of hospitalizations to somatic beds, according to 63.33% of experts, negatively significantly – 30.0%, does not affect – 6.67% (Figure 5.84).

"The frequency of visits to a therapist, neurologist, and doctors of other specialties" does not affect the change in the values of the indicator "Timely provision of psychiatric care to patients" according to 56.67% of experts, a significant negative – 36.67% (Fig.5.85).

The use of the basic indicator "Awareness of the population about the possibility of receiving psychiatric care" significantly positively affects the change in the values of the indicator "The proportion of mental illnesses detected at early stages among first-time psychiatric diagnoses" was considered by 86.67% of experts, and only 6.67% believed that it had little or no effect (Figure 5.86).

"Awareness of the population about the possibility of receiving psychiatric care" negatively significantly affects the change in the values of the indicator "Frequency of visits to a therapist, neurologist, doctors of other specialties" according to 40.0% of experts, negatively insignificant – 56.67%, does not affect – 3.33% (Figure 5.87).

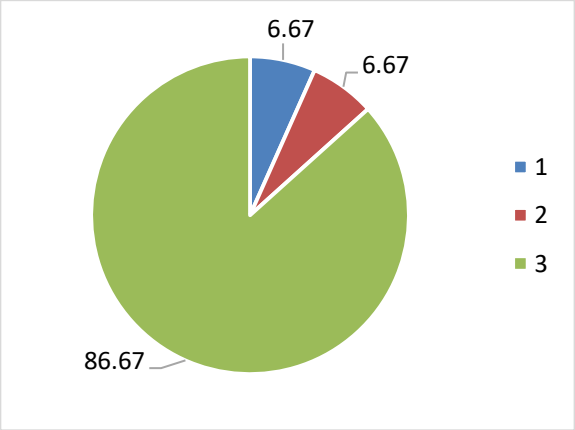

Figure 5.86. The structure of the responses of experts who expressed their opinion on how the use of the basic indicator "Awareness of the population about the possibility of receiving psychiatric care" affects the change in the values of the indicator "The proportion of mental illnesses detected at early stages among first-time psychiatric diagnoses", %.

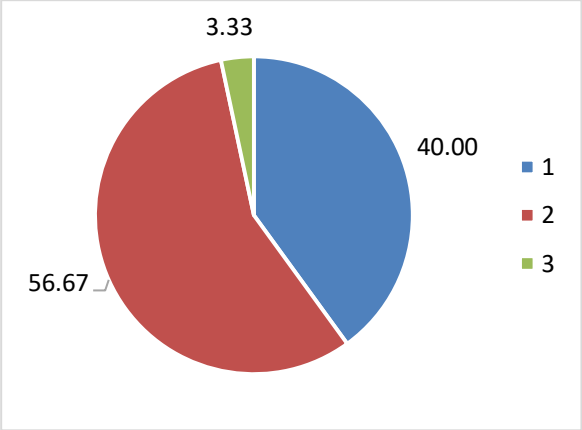

Figure 5.87. The structure of the responses of experts who expressed their opinion on how the use of the basic indicator "Awareness of the population about the possibility of receiving psychiatric care" affects the change in the values of the indicator "Frequency of visits to a therapist, neurologist, doctors of other specialties", %.

According to 50.0% of experts, the basic indicator "Awareness of the population about the possibility of receiving psychiatric care" significantly positively affects the change in the values of the indicator "Provision of somatic medical organizations with psychiatrists, 35.0% does not affect, 15.0% has an insignificant positive effect (Figure 5.88).

The basic indicator "The frequency of hospitalizations to somatic beds" does not affect the change in the values of the indicator "The proportion of mental illnesses detected at early stages among first–time psychiatric diagnoses", 50.0% of experts considered, significantly negatively influenced - 30.0%, insignificantly – 16.67% (Figure 5.89).

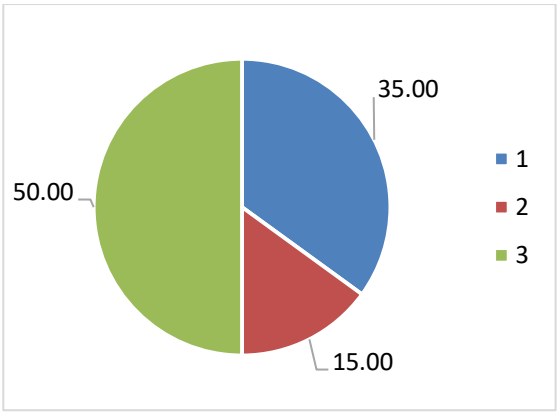

Figure 5.88. The structure of the responses of experts who expressed their opinion on how the use of the basic indicator "Awareness of the population about the possibility of receiving psychiatric care" affects the change in the values of the indicator "Provision of somatic medical organizations with psychiatrists" %.

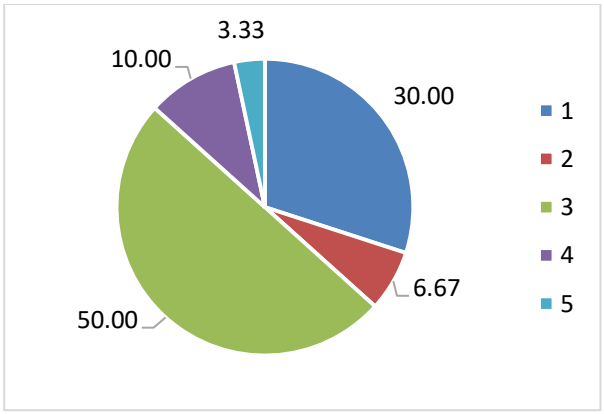

Figure 5.89. The structure of the responses of experts who expressed their opinion on how the use of the basic indicator "The frequency of hospitalizations to somatic beds" can affect the change in the values of the indicator "The proportion of mental illnesses detected at early stages among first-time psychiatric diagnoses" %.

The basic indicator "The frequency of hospitalizations to somatic beds", according to 66.67% of experts, had no effect on the target indicator "Awareness of the population about the possibility of receiving psychiatric care", and 26.67% believed that it could only have a negative effect (Figure 5.90).

Almost half of the experts believed that "Frequency of hospitalizations to somatic beds" can negatively significantly affect the change in the values of the indicator "Timely provision of psychiatric care to patients", 40.0% - did not affect at all (Figure 5.91).

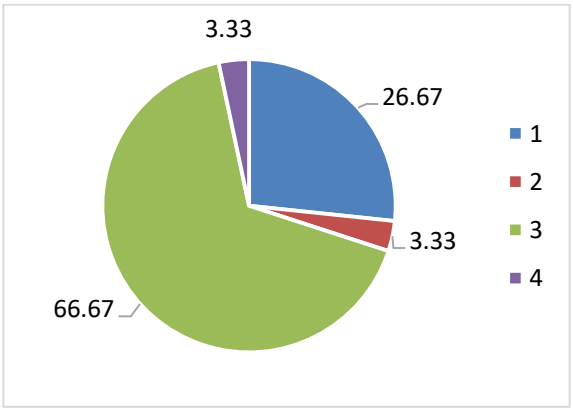

Figure 5.90. The structure of the responses of experts who expressed their opinion on how the use of the basic indicator "Frequency of hospitalizations to somatic beds" can affect the change in the values of the indicator "Awareness of the population about the possibility of receiving psychiatric care" %.

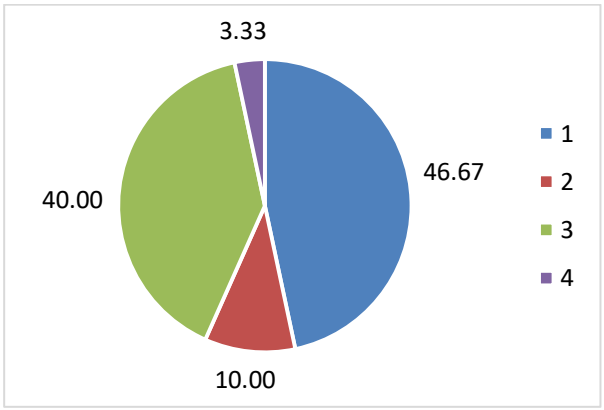

Figure 5.91. The structure of the responses of experts who expressed their opinion on how the use of the basic indicator "Frequency of hospitalizations to somatic beds" can affect the change in the values of the indicator "Timely provision of psychiatric care to patients" %.

And almost unequivocally, about 90% of experts argued that the basic indicator "Timely provision of psychiatric care to patients" can significantly positively affect the change in the values of the indicator "The proportion of mental illnesses detected at early stages among newly diagnosed psychiatric diagnoses" (Figure 5.92).

63,33% of experts denied the influence of the baseline indicator "Timely provision of psychiatric care to patients" on the change in the values of the target indicator "Frequency of visits to a therapist, neurologist, doctors of other specialties", they were supported by 30.0% who believed that the baseline indicator would have an insignificant negative impact on the target (Figure 5.93).

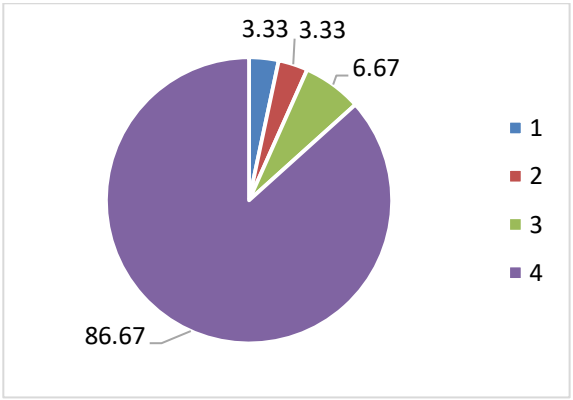

Figure 5.92. The structure of the responses of experts who expressed their opinion on how the use of the basic indicator "Timely provision of psychiatric care to patients" can affect the change in the values of the indicator "Proportion of mental illnesses detected at early stages among first-time psychiatric diagnoses" %.

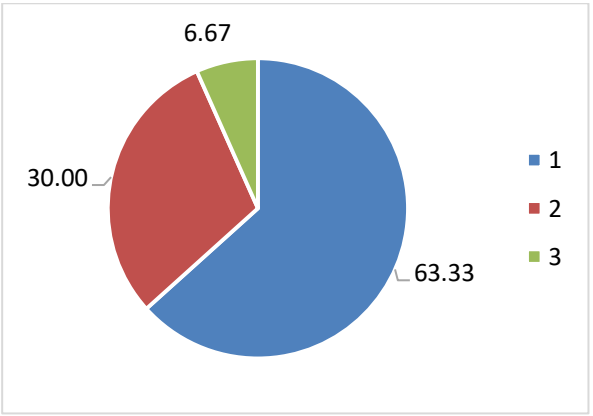

Figure 5.93. The structure of the responses of experts who expressed their opinion on how the use of the basic indicator "Timely provision of psychiatric care to patients" can affect the change in the values of the target indicator "Frequency of visits to a therapist, neurologist, doctors of other specialties" %.

90% of experts believed that "Timely provision of psychiatric care to patients" could affect the change in the values of the target indicator "Awareness of the population about the possibility of receiving psychiatric care" (Figure 5.94).

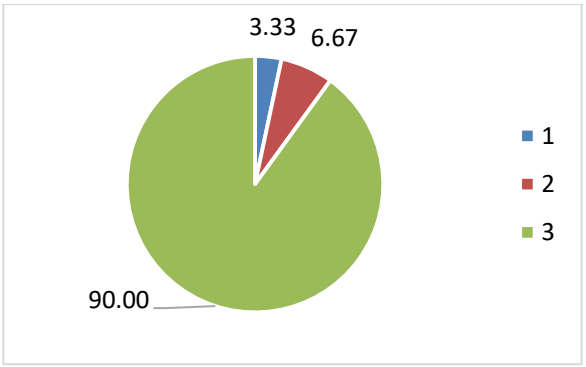

Figure 5.94. The structure of the responses of experts who expressed their opinion on how the use of the basic indicator "Timely provision of psychiatric care to patients" can affect the change in the values of the target indicator "Awareness of the population about the possibility of receiving psychiatric care" %.

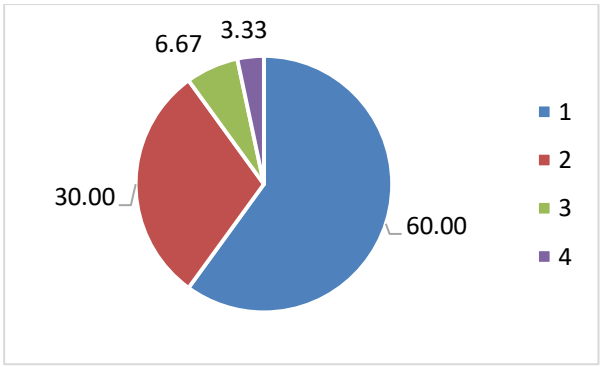

Figure 5.95. The structure of the responses of experts who expressed their opinion on how the use of the baseline indicator "Timely provision of psychiatric care to patients" can affect the change in the values of the target indicator "Frequency of hospitalizations to somatic beds" %.

More than half of the experts believed that the basic indicator "Timely provision of psychiatric care to patients" could not affect the change in the values of the target indicator "The frequency of hospitalizations to somatic beds, 30% of experts found a weak negative relationship between the basic and target indicators (Figure 5.95).

"Timely provision of psychiatric care to patients" can significantly affect the change in the values of the target indicator "Provision of somatic medical organizations with psychiatrists" - 73.33% of experts considered, insignificantly – 20.0% of experts (Figure 5.96).

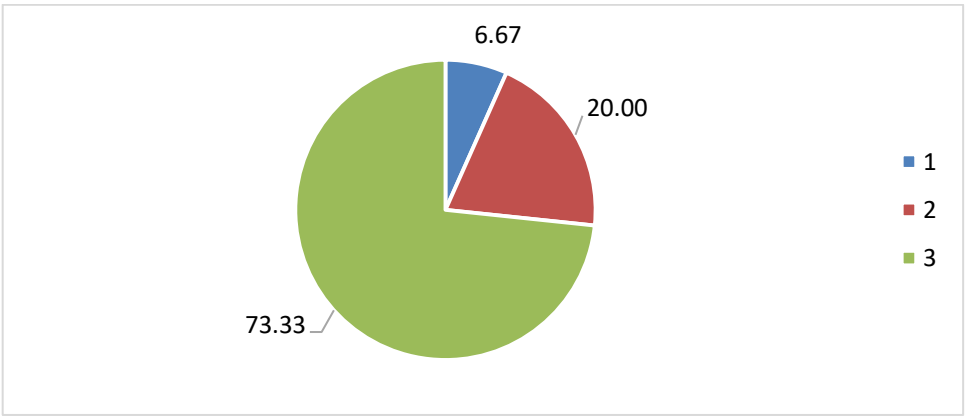

Figure 5.96. The structure of the responses of experts who expressed their opinion on how the use of the basic indicator "Timely provision of psychiatric care to patients" can affect the change in the values of the target indicator "Provision of somatic profile medical organizations with psychiatrists" %.

A close correlation was recorded between the signs:

• "Screening of the patient's mental state conducted by a psychiatrist in a general somatic network (polyclinic, multidisciplinary hospital)" and "Provision of medical organizations with a somatic profile to psychiatrists" - (R=-0.78);

• "Screening of the patient's mental state conducted by a psychiatrist in a general somatic network (polyclinic, multidisciplinary hospital" and "Awareness of the population about the possibility of receiving psychiatric care" - (R=-0.91);

• "Screening of the patient's mental state conducted by a psychiatrist in a general somatic network (polyclinic, multidisciplinary hospital" and "Frequency of hospitalizations to somatic beds (R=-0.78);

• "Screening of the patient's mental state conducted by a psychiatrist in a general somatic network (polyclinic, multidisciplinary hospital)" "Do you think that the system of providing psychiatric care to the population needs to be reformed?" (R=0.81);

• "Do you think that the system of providing psychiatric care to the population needs to be reformed?" and "Do you think that the number of non-psychotic mental disorders has increased among different populations?" (R=0.69);

• "Provision of somatic medical organizations with psychiatrists" and the use of the basic indicator "Timely provision of psychiatric care to patients" may affect the change in the values of the following targets?" (R=0.81);

• The use of the basic indicator "Timely provision of psychiatric care to patients" may affect the change in the values of the following targets "Provision of somatic medical organizations with psychiatrists" (R=0.91);

• "Provision of somatic profile medical organizations with psychiatrists" and ""Proportion of mental illnesses detected at early stages among first-time psychiatric diagnoses" (R=0.92);

• "The proportion of mental illnesses detected at early stages among newly diagnosed psychiatric diagnoses" and "Timely provision of psychiatric care" (R=0.74)

• "Frequency of visits to a therapist, neurologist, doctors of other specialties" and "Frequency of hospitalizations to therapeutic beds" (R=0.63).

Thus, the socio-medical assessment of the process of providing psychological, psychotherapeutic and psychiatric care reflected the real need for it of the population, the medical and social characteristics of the sick population, the factors that caused the occurrence of diseases, the effectiveness of treatment, the conditions for providing psychological, psychotherapeutic and psychiatric care by specialized specialists and reserves for improving the effectiveness of its provision.

Psychological, psychotherapeutic and psychiatric care was provided by women in 70.22%, in 90% of able–bodied, economically active age, mainly from 25 to 49 years old, in 58.21% of married people who worked in this specialty for 1/3 – over 20 years, 1/3 - from 5 to 20 years, combining main work with additional workload, in 55.14% who had a shift schedule, in 56.58% who felt tired before work, in 30.45% - apathy and oppression, in 88.7% who rate their work at 5 and 4, in 65.03% who received incentive payments, in 70.99% dissatisfied with their earnings, in 94.62% professionally trained in the NMO model, in 64.55% satisfied with working conditions, in 98.08% using their annual leave, in 82,61% who considered their health was satisfactory, in 75.87% who did not have bad habits, in 57.54% who were not on the sick list, in 43.8% who suffered from COVID coronavirus infection – 19 in mild form, 52.83% linking the exacerbation of diseases with occupational stress, negative occupational determinants of "Emotional devastation" and "Apathy, depression".

Among the patients receiving psychological and psychotherapeutic and psychiatric care, 60.96% were women from 25 to 49 years old, 52.67% were disabled in the second group, 36.7% - in the third, 10.67% - in the first, 1/5 were education workers, proportionally – of the remaining professional groups, 40.28% married, 63.74% in friendly relations, 63.3% living in a separate apartment, 88.89% who did not have a hereditary predisposition to mental illness, who had normal and accelerated development in early childhood, 70.0% who were raised in a family, 38.89% by both parents, 33.33% - mother, 20.47% - father. In 44% of the

respondents, unclassified disorders were detected in childhood, 80% were not under the supervision of a psychiatrist, were observed by a psychiatrist in adulthood for 1, 2 and 3 years proportionally, 35.16% had chronic diseases, 1 (46.27%) and 2 (33.33%) received inpatient treatment once a year.

In the structure of nosological forms, the first place was occupied by organic lesions of the central nervous system (49.91%), schizophrenia, BAR and alcoholism competed with each other, amounting to 13.56% in each group. The minimum proportion was 4.7% each of somatogenies, including somatogenic psychoses, and neuroses and neurotic disorders.

Drug therapy with tranquilizers, neuroleptics and antidepressants was distributed proportionally among patients – 1/3. More than 50% of patients received therapy individually, 28.81% - in a group, 14.12% - in a family. The duration of treatment was classified as ultrashort (40% of patients), short (up to 30 days) (28.81%), long (up to 12 months) (14.12%) and ultra-long (over a year) (14.12%). In 29.53% of patients, recovery occurred, in 29.53% - the condition remained unchanged, 20.47% - partial improvement. Among the patients receiving treatment, 40.16% partially restored their social and labor status, 30.31% completely restored it, and 29.53% had a pronounced decrease in social and labor adaptation.

The expert assessment carried out by specialized specialists organizing psychiatric and psychological-psychotherapeutic assistance to the population statistically reliably indicated that:

- the system of providing psychiatric care to the population needs to be reformed,

- the number of non-psychotic mental disorders has increased among various segments of the population,

-the examination of patients conducted by a psychiatrist in a general somatic network (polyclinic, multidisciplinary hospital) will increase the level of effectiveness of medical care to the population,

- the increase in psychiatrists will increase the proportion of mental illnesses detected at early stages among newly diagnosed psychiatric diagnoses,

-"Timely provision of psychiatric care to patients" may affect changes in the values of the target indicators: "Awareness of the population about the possibility of receiving psychiatric care", "The proportion of mental illnesses detected at early stages among newly diagnosed psychiatric diagnoses",

-"The proportion of mental illnesses detected at an early stage out of the number of newly diagnosed mental disorders" significantly affects the target indicator "Timely provision of psychiatric care to patients",

-"The frequency of visits to a therapist, neurologist, and doctors of other specialties" does not affect the change in the values of the indicator "Timely provision of psychiatric care to patients",

-"Awareness of the population about the possibility of receiving psychiatric care" significantly positively affects the change in the values of the indicator "The proportion of mental illnesses detected at early stages among first-time psychiatric diagnoses",

-"Timely provision of psychiatric care to patients" can significantly positively affect the change in the values of the indicator "The proportion of mental illnesses detected at early stages among newly diagnosed psychiatric diagnoses".

CHAPTER 6. ORGANIZATIONAL AND MANAGEMENT MODEL FOR IMPROVING MECHANISMS FOR PROVIDING PSYCHOLOGICAL AND PSYCHOTHERAPEUTIC AND PSYCHIATRIC CARE.

The basis for improving the mechanisms for providing psychological, psychotherapeutic and psychiatric care is the dynamic growth of the population's need for psychological, psychotherapeutic and psychiatric care, the increasing role of external factors-challenges that cause the growth of such a need (consequences of COVID-19, armed conflicts, natural disasters), the imperfection of the regulatory framework, the lack of flexible mechanisms in the organization of medical care, catastrophic personnel shortage, emotional burnout of medical personnel due to high professional loads. These circumstances leave open the question of population satisfaction in psychological, psychotherapeutic and psychiatric care, increase the risks of increased morbidity and disability with mental disorders, endanger a healthy population, necessitate a detailed study of the need for psychological, psychotherapeutic and psychiatric care, the dynamics of morbidity and disability, the demographic structure and structure of causes, the formation of adequate routing of the population seeking help medical care, in case of identification of specific symptoms of pathological or borderline conditions, contact a medical psychologist, psychotherapist, psychiatrist.

The study of the need for psychological, psychotherapeutic and psychiatric care of the population revealed its socio-medical determinants, as evidenced by the close correlation between the signs (questions asked to respondents). A close relationship (R=0.7) was recorded between the signs of "Memory loss, difficulties in learning new things" and "Decreased performance; difficulties in communicating with others", "Decreased performance; difficulties in communicating with others" and "Willingness to consult a psychotherapist" (R=0.64), "Depressive mood" and "Memory loss, difficulties in communicating with people" (R=0.76), "Depressive mood" and "Decreased performance" (R=0.76), "Depressive mood" and

"Willingness to seek psychiatric advice (R=0.51), "Age" and "Chronic diseases" ((R= - 0.55).

The obtained results stated the presence of a statistically significant increasing, but completely unconscious, inadequate need of the population for psychological, psychotherapeutic and psychiatric care, which served as the basis for the development of a population routing system to provide adequate targeted psychological, psychotherapeutic and psychiatric care.

The data of the sociological survey indicated that 60-70 percent of patients in the somatic hospital had not previously been seen by a psychiatrist and had not been treated in a psychiatric hospital. These patients did not come to the attention of a psychiatrist, psychotherapist and psychologist, they were treated in polyclinics and somatic hospitals. It is for this category of patients that an innovative technology for the organization of specialized psychiatric care is required for the effective use of resources of medical organizations, the quality of provision and patient satisfaction with medical care.

In order to identify the actual needs of the population for psychological, psychotherapeutic and psychiatric care, improve the efficiency of polyclinics, diagnostic centers, hospitals, improve the quality of medical care and patient satisfaction, patient routing of the general somatic network was developed, according to which a group of patients who were repeatedly hospitalized, examined by doctors of various profiles, who did not show gross somatic pathology and a group of actively complaining about pain, not being stopped by medications, depressed mood, sleep and memory disorders, intra-family problems. It is proposed to refer these categories of patients to somatic specialists and divide them into two streams:

-they complain of apathy, sleep and memory disorders, etc. on their own,

-complaints are made by relatives about conflict behavior, sleep and memory disorders, etc. of the patient and confirmed by examination and examination data, questionnaires for further referral for consultation and treatment to a psychiatrist (in the presence of psychotic conditions), a psychotherapist (in case of mental disorders

without acute conditions), a psychologist (in the presence of psychological difficulties for correction).

This algorithm allows you to significantly reduce the load on the general somatic network, select specialized patients who avoid contacting specialized institutions, provide them with targeted specialized timely psychiatric care, form a commitment to a healthy lifestyle, reduce the socio-economic burden on healthcare and professional burnout of medical specialists, ensure the safety of mentally healthy citizens, objectify morbidity and disability to justify adequate financing of the psychiatric service, eliminate the shadow market of medical services for the provision of psychiatric, psychological and psychotherapeutic care.

Algorithm

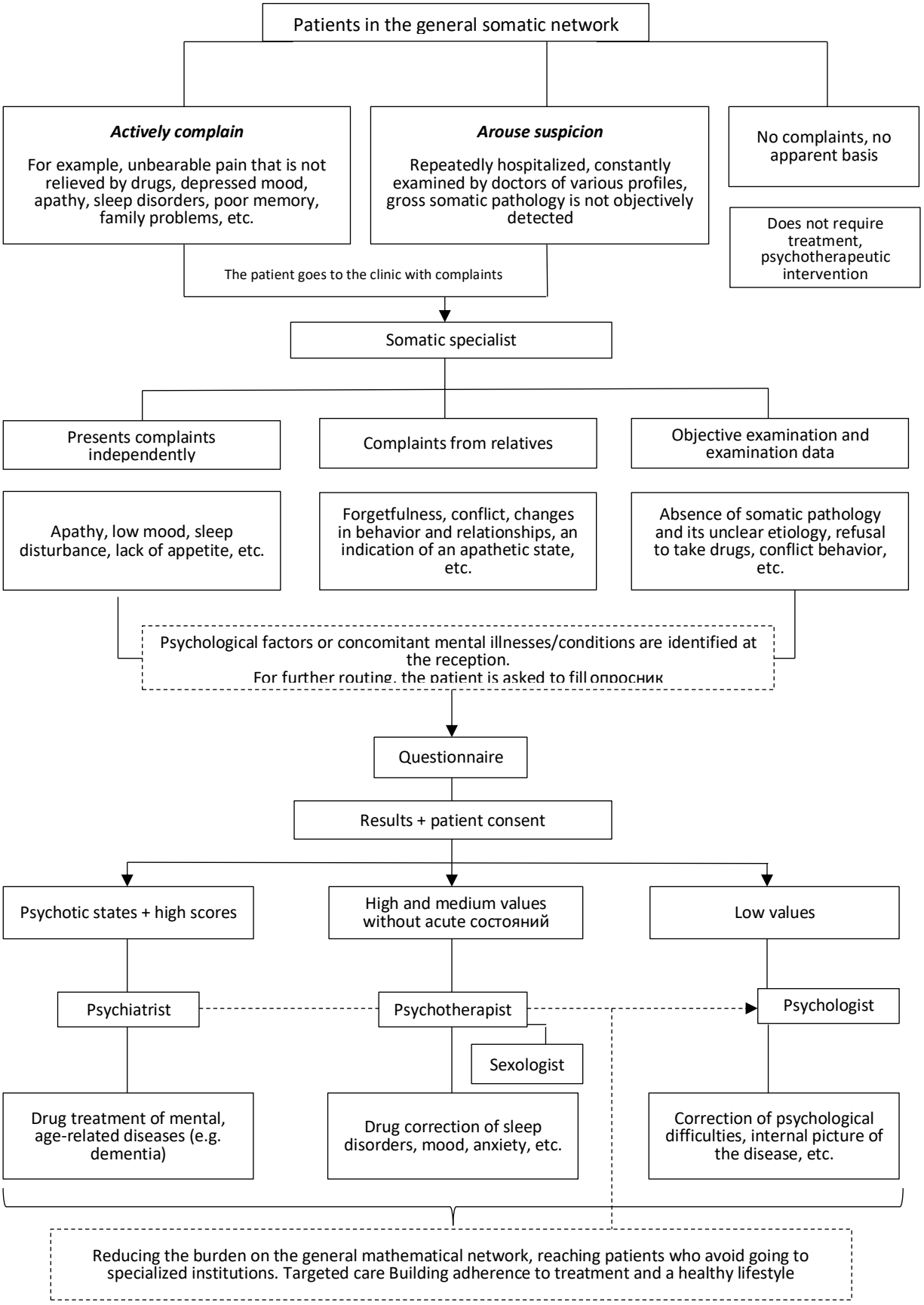

Figure 6.1. Organizational and managerial model of effective psychiatric care for the population.

CONCLUSION

A high rhythm of life, reduced stress tolerance, emotional burnout and the consequences of the COVID – 19 pandemic significantly affect a conditionally healthy group of the population, especially of working age, causing neurotic, anxiety - phobic, affective and other reactions, which causes an increased risk of addiction, especially from alcohol and tobacco and leads to irreversible consequences: disruption of social functioning, intra-family conflicts and much more. Any kind of psychological and psychiatric care may be ineffective due to a belated referral to a specialist when gross irreversible violations have already been formed. In the general somatic network, medical care for patients is provided by medical specialists without taking into account the actual mental state, since its degree does not reach the need for transfer to a psychiatric hospital, and there is often no consent to consult a psychiatrist.

The high relevance of the problem, the presence of a negative trend in the morbidity of the population due to mental disorders, aggressive socio-political determinants for mental health, the need to create a methodological framework for the management of psychiatric care and resource provision in it, necessitated the conduct of this study. The high scientific and managerial value of this problem for the theory and practice of healthcare organization served as the basis for this study.

The peculiarity of the study was that there are patients already receiving psychiatric care - these are patients of psychiatric hospitals and dispensaries. In neuropsychiatric dispensaries, 2.7 – 2.8 million medical examinations are carried out per year. Those who have been treated in a hospital and are under observation at a neuropsychiatric dispensary, or are already being observed at a neuropsychiatric dispensary, are subject to examination. To the somato-psychiatric department of the multidisciplinary hospital GBUZ City Clinical Hospital No. 67 named after L.A. Vorokhobov Department of Health of the city of Moscow receives patients, 60-70 percent of whom have not previously been seen by a psychiatrist and have not been treated in a psychiatric hospital. These patients did not come to the attention of a

psychiatrist, psychotherapist and psychologist, they were treated in polyclinics and somatic hospitals. It is for this category of patients that an innovative technology for the organization of specialized psychiatric care is required for the effective use of resources of medical organizations, the quality of provision and patient satisfaction with medical care.

Statistical reporting was generated using the program "Medkarta Pro". The study involved information from forms No. 30, 36, 10, registry data, doctor's appointments, and medical commissions.

The object of the study was patients receiving psychological, psychotherapeutic and psychiatric care, the population ready to seek psychological, psychotherapeutic and psychiatric help, and medical specialists involved in the provision of psychological, psychotherapeutic and psychiatric care.

The subject of the study was a set of theoretical, methodological and practical issues related to the medical and social assessment of the population's need for psychological, psychotherapeutic and psychiatric care, the processes of its receipt by patients and provision by medical specialists and the development of an innovative management model for psychological, psychotherapeutic and psychiatric care.

The hypothesis of the study stated that the functioning of an innovative model of the organization of psychological, psychotherapeutic and psychiatric care reduces the burden on the health care system, increases the efficiency, quality and accessibility of medical care to the population.

The purpose of the study was to develop mechanisms for improving the organization of psychiatric care for the population. The achievement of the goal was facilitated by the solution of the following tasks:

1. Substantiation of the need to improve the mechanisms of organization of psychological, psychotherapeutic and psychiatric care for the population based on an assessment of the regulatory framework and data from literary sources,

2. Analysis of the need for psychological, psychotherapeutic and psychiatric care according to online inquiries and a sociological survey of the population,

3. Analysis of the dynamics and structure of the causes and demographic structure of disability of mental disorders of the population for 2004-2021

4. Determination of the medical and social determinants of the provision of psychological, psychotherapeutic and psychiatric care,

5. Building an organizational and managerial model of effective psychiatric care for the population.

At the first stage, the study of literary sources on the problem of the organization of psychological, psychotherapeutic and psychiatric care to the population was carried out on the basis of an assessment of the regulatory framework and data from literary sources.

At the second stage, online data was collected on the need for psychological, psychotherapeutic and psychiatric care of the population, statistical data in the State Clinical Hospital 67 in Moscow based on the materials of market reports for 2004-2021, statistical data on general and newly identified disability of mental disorders, the demographic structure of disability.

At the third stage, a sociological survey of the population was conducted to identify the willingness to seek psychological, psychotherapeutic and psychiatric help, medical specialists providing psychological, psychotherapeutic and psychiatric care, patients receiving psychological, psychotherapeutic and psychiatric care.

At the fourth stage, the medical and social determinants of the provision of psychological, psychotherapeutic and psychiatric care were determined.

At the fifth stage, an organizational and managerial model of effective psychiatric care for the population was built. The following methods were used: analytical, sociological survey, demographic coefficients, dynamic series, correlation and regression analysis, forecasting, organizational experiment.

The organizational model of psychological, psychotherapeutic and psychiatric care is based on the key medical and social determinants of morbidity and disability with mental disorders, determined by the method of correlation and regression analysis, measures to control their changes and effective management, medical, socio-economic efficiency.

The analysis showed a general increase in the need for psychological, psychotherapeutic and psychiatric care.

The definition of socio-medical determinants of the need for psychological, psychotherapeutic and psychiatric care of the population was carried out through a global assessment and analysis of blind network queries "Psychologist", "Psychotherapist", "Psychiatrist", the leader of which was the population of the metropolitan regions of Moscow and St. Petersburg.

There was an increase in demand in 2022 compared to 2021 by 44% for sedative drugs and by 48% for antidepressants. In proportion to the increase in the need for specialized drug therapy, there was an increase in the level of anxiety of the population, panic attacks, and a fourfold increase in the number of visits to a psychologist, mainly due to anxiety (44% of cases) and depression (20% of cases).

Women had the greatest medical activity in forming the need for psychological, psychotherapeutic and psychiatric care, amounting to 61.96%. The age range of the surveyed citizens who were ready to seek psychological, psychotherapeutic and psychiatric help was from 25 to 44 years old - 63.38% - economically active population. The structure of the respondents was dominated by married people – 65.89%, 86.62% - working, 91.47% - those who had suffered a coronavirus infection in mild (58.78%) and moderate (35.56%) severity, in 50.17% of cases - those who felt unwell, lack of strength, increased fatigue.

Among the respondents who were ready to seek psychological, psychotherapeutic and psychiatric help, 56.19% were ready to turn to a psychologist, 65.13% to a psychotherapist, 86.79% to a psychiatrist.

The objective justification of the socio-medical determinants of the need for psychological, psychotherapeutic and psychiatric care was the close correlation between the signs (questions asked to the respondents). A close relationship (R=0.7) was recorded between the signs of "Memory loss, difficulties in learning new things" and "Decreased performance; difficulties in communicating with others", "Decreased performance; difficulties in communicating with others" and "Willingness to consult a psychotherapist" (R=0.64), "Depressive mood" and

"Memory loss, difficulties in communicating with people" (R=0.76), "Depressive mood" and "Decreased performance" (R=0.76), "Depressive mood" and "Willingness to seek psychiatric advice (R=0.51), "Age" and "Chronic diseases" ((R= - 0.55).

The results obtained state a statistically significant increasing, but completely unconscious, inadequate need of the population for psychological, psychotherapeutic and psychiatric care, which is the basis for the need to form a population routing system in providing adequate targeted psychological, psychotherapeutic and psychiatric care.

At the same time, the dynamic assessment of the general and newly identified disability characterized statistically stable trends of insignificant decrease in indicators, which in fact indicated the lack of reliable official statistical reporting due to the presence of private psychiatrists, medical psychologists, psychotherapists, patient care to conceal diagnoses, and the possibility of treatment at home. At the same time, even the indicators of official statistics of mental disorders were very alarming, as mental retardation provided the greatest disability with a pronounced tendency to increase overall disability for the first group (1.6o/llc – 2.1o/llc) and children (2.2o/llc– 2.6o/llc), newly identified disability – for the first (0.01o/llc – 0.02o/LLC), a third (0.02o/llc – 0.03o/llc) and children (0.23o/llc - 0.27o/llc). In the demographic structure of Mental retardation, men prevailed, accounting for 32.15%, children ranked second: 24.8%, women – third:23.1%.

Mental disorders took the second place in terms of general disability: schizophrenia, schizotypal and delusional disorders with a steady growth trend of the first group (0.006 o/ llc – 0.01 o/ llc), the third group (0.09 o/ llc -0.55 o/ llc), children (0.47 o/ llc -0.57 o/llc). The demographic structure of the disability of the population with mental disorders: schizophrenia, schizotypal and delusional disorders is represented mainly by women (54.01%), in a slightly smaller proportion by men (44.37%) and minimally (1.61%) by children.

Personality and behavioral disorders in adulthood took the third place in terms of general disability, with decreasing trends in the first (0.004 o/llc – 0.003 o/llc),

the second (0.18 o/llc -0.041 o/llc), children (0.006 o/llc -0.002 o/llc) and stabilization in the third the group (0.03 o/llc – 0.03 o/LLC). In the demographic structure of the general disability of the population with personality and behavior disorders in adulthood, men predominated, accounting for 75.7%. Women took the second place – 16.2%, children – the third, amounting to 9.05%.

In fourth place was disability in neurotic, stress-related, and somatoform disorders with an unstable increase in the index in patients of the first group from 0.0009 to 0.036 per 100,000 population, a steady downward trend in patients of the second group: from 0.089 o/ llc to 0.018 o/llc, children: from 0.006 o/LLC to 0.0 o/llc, an unstable downward trend in patients of the third group from 0.017 o/llc to 0.0008 o/llc. In the demographic structure of the disability of the population with neurotic, stress-related, and somatoform disorders, women dominated, accounting for 50.8%, and men were noticeably inferior to them, accounting for 34.6%. Children occupied the minimum share, occupying 14.5%.

The fifth place was occupied by general disability in emotional disorders, behavioral disorders, usually beginning in childhood and adolescence, with a steady downward trend in the period 2004-2021 in the disabled of the first group : from 0.004 to 0.003, the second: from 0.009 to 0.003, unstable trends of the disabled of the third group : from 0.004 to 0.003, children: from 0.03 to 0.02. In the demographic structure of the disability of the population with emotional disorders, behavioral disorders, usually beginning in childhood and adolescence, children prevailed, amounting to 49.0%, men took the second place – 37.9%, women took the third place – 13.05%.

The sixth place was occupied by disability in mood disorders (affective disorders), in the demographic structure of which women dominated, accounting for 69.2%, and men were noticeably inferior to them, accounting for 28.8%. Children occupied the minimum share - 2.05%. There were no changes in the indicator in patients of the first disability group: from 0.01 to 0.01 in the range from 2004 to 2021, the tendency to decrease in the indicator in patients of the second disability

group was stable: from 1.04 to 0.35, the growth trend in children was unstable: from 0.0009 to 0.01.

The analysis of the process of providing psychological, psychotherapeutic and psychiatric care by medical specialists included the study of the conditions of its provision, the identification of key factors and determinants, the relationship with the effectiveness and efficiency of providing psychological, psychotherapeutic and psychiatric care.

Psychological, psychotherapeutic and psychiatric care was provided by women in 70.22%, in 90% of able–bodied, economically active age, mainly from 25 to 49 years old, in 58.21% of married people who worked in this specialty for 1/3 – over 20 years, 1/3 - from 5 to 20 years, combining main work with additional workload, in 55.14% who had a shift schedule, in 56.58% who felt tired before work, in 30.45% - apathy and oppression, in 88.7% who rate their work at 5 and 4, in 65.03% who received incentive payments, in 70.99% dissatisfied with their earnings, in 94.62% professionally trained in the NMO model, in 64.55% satisfied with working conditions, in 98.08% using their annual leave, in 82,61% who considered their health was satisfactory, in 75.87% who did not have bad habits, in 57.54% who were not on the sick list, in 43.8% who suffered from COVID coronavirus infection – 19 in mild form, 52.83% linking the exacerbation of diseases with occupational stress, negative occupational determinants of "Emotional devastation" and "Apathy, depression".

Among the patients receiving psychological and psychotherapeutic and psychiatric care, 60.96% were women from 25 to 49 years old, 52.67% were disabled in the second group, 36.7% - in the third, 10.67% - in the first, 1/5 were education workers, proportionally – of the remaining professional groups, 40.28% married, 63.74% in friendly relations, 63.3% living in a separate apartment, 88.89% who did not have a hereditary predisposition to mental illness, who had normal and accelerated development in early childhood, 70.0% who were raised in a family, 38.89% by both parents, 33.33% - mother, 20.47% - father. In 44% of the respondents, unclassified disorders were detected in childhood, 80% were not under

the supervision of a psychiatrist, were observed by a psychiatrist in adulthood for 1, 2 and 3 years proportionally, 35.16% had chronic diseases, 1 (46.27%) and 2 (33.33%) received inpatient treatment once a year.

In the structure of nosological forms, the first place was occupied by organic lesions of the central nervous system (49.91%), schizophrenia, BAR and alcoholism competed with each other, amounting to 13.56% in each group. The minimum proportion was 4.7% each of somatogenies, including somatogenic psychoses, and neuroses and neurotic disorders.

Drug therapy with tranquilizers, neuroleptics and antidepressants was distributed proportionally among patients – 1/3. More than 50% of patients received therapy individually, 28.81% - in a group, 14.12% - in a family. The duration of treatment was classified as ultrashort (40% of patients), short (up to 30 days) (28.81%), long (up to 12 months) (14.12%) and ultra-long (over a year) (14.12%). In 29.53% of patients, recovery occurred, in 29.53% - the condition remained unchanged, 20.47% - partial improvement. Among the patients receiving treatment, 40.16% partially restored their social and labor status, 30.31% completely restored, and 29.53% had a pronounced decrease in social and labor adaptation.

The expert assessment carried out by specialized specialists organizing psychiatric and psychological-psychotherapeutic assistance to the population statistically reliably indicated that:

- the system of providing psychiatric care to the population needs to be reformed,

- the number of non-psychotic mental disorders has increased among various segments of the population,

-examination of patients conducted by a psychiatrist in a general somatic network (polyclinic, multidisciplinary hospital) will increase the level of effectiveness of medical care to the population,

The increase in psychiatrists will increase the proportion of mental illnesses detected at an early stage among newly diagnosed psychiatric diagnoses,

-"Timely provision of psychiatric care to patients" may affect changes in the values of the target indicators: "Awareness of the population about the possibility of receiving psychiatric care", "The proportion of mental illnesses detected at early stages among newly diagnosed psychiatric diagnoses",

-"The proportion of mental illnesses detected at an early stage from among the newly diagnosed mental disorders" significantly affects the target indicator "Timely provision of psychiatric care to patients",

-"The frequency of visits to a therapist, neurologist, doctors of other specialties" does not affect the change in the values of the indicator "Timely provision of psychiatric care to patients",

-"Awareness of the population about the possibility of receiving psychiatric care" significantly positively affects the change in the values of the indicator "The proportion of mental illnesses detected at early stages among first-time psychiatric diagnoses",

-"Timely provision of psychiatric care to patients" can significantly positively affect the change in the values of the indicator "The proportion of mental illnesses detected at early stages among first-time psychiatric diagnoses."

In order to identify the actual needs of the population for psychological, psychotherapeutic and psychiatric care, improve the efficiency of polyclinics, diagnostic centers, hospitals, improve the quality of medical care and patient satisfaction, patient routing of the general somatic network was developed, according to which a group of patients who were repeatedly hospitalized, examined by doctors of various profiles, who did not show gross somatic pathology and a group of actively complaining about pain, not being stopped by medications, depressed mood, sleep and memory disorders, intra-family problems. It is proposed to refer these categories of patients to somatic specialists and divide them into two streams:

-complain about apathy, sleep and memory disorders, etc. on their own,

-complaints are made by relatives about conflict behavior, sleep and memory disorders, etc. of the patient and confirmed by examination and examination data,

questionnaires for further referral for consultation and treatment to a psychiatrist (in the presence of psychotic conditions), a psychotherapist (in case of mental disorders without acute conditions), a psychologist (in the presence of psychological difficulties for correction).

This algorithm allows you to significantly reduce the load on the general somatic network, select specialized patients who avoid contacting specialized institutions, provide them with targeted specialized timely psychiatric care, form a commitment to a healthy lifestyle, reduce the socio-economic burden on healthcare and professional burnout of medical specialists, ensure the safety of mentally healthy citizens, objectify morbidity and disability to justify adequate financing of the psychiatric service, eliminate the shadow market of medical services for the provision of psychiatric, psychological and psychotherapeutic care.

CONCLUSIONS

1. A general increase in the need for psychological, psychotherapeutic and psychiatric care was recorded with the leadership of the population of the capital regions of Moscow and St. Petersburg. There was an increase in the level of anxiety of the population, panic attacks, a fourfold increase in the number of visits to a psychologist, mainly due to anxiety (44% of cases) and depression (20% of cases), an increase in demand in 2022 compared to 2021 by 44% for sedative drugs and 48% - for antidepressants. The greatest medical activity in the formation of the need for psychological, psychotherapeutic and psychiatric care was possessed by women, amounting to 61.96%. The age interval of the surveyed citizens who were ready to seek psychological, psychotherapeutic and psychiatric help was from 25 to 44 years old -63.38% - the economically active population. The structure of the respondents was dominated by married people - 65.89%, in 86.62% - working, in 91.47% - having undergone a coronavirus infection in a mild (58.78%) form and moderate (35.56%) severity, in 50.17% of cases - feeling unwell, lack of strength, increased fatigue. Among the respondents who were ready to seek psychological, psychotherapeutic and psychiatric help, 56.19% were ready to turn to a psychologist, 65.13% to a psychotherapist, 86.79% to a psychiatrist.

2. The objective justification for the formation of socio-medical determinants of the need for psychological, psychotherapeutic and psychiatric care was the close correlation between the signs (questions asked to the respondents). A close relationship (R = 0.7) was recorded between the signs "Memory decline, difficulties in mastering the new" and "Performance decline; difficulties in communicating with others, "" Reduced performance; difficulties in communicating with others "and" Willingness to see a psychotherapist "(R = 0.64)," Depressed mood "and" Decreased memory, difficulties in communicating with people "(R = 0.76)," Depressed mood "and" Decreased performance "(R = 0.76)," Depressed mood "and" Willingness to consult a psychiatrist (R = 0.51), "Age" and "Chronic diseases" ((R = - 0.55).

3. The greatest disability was provided by mental retardation with a pronounced upward trend in general disability for the first group (1.6 o/llc - 2.1o/llc) and children (2.2o/ooo- 2.6o/llc), newly diagnosed disability - for the first (0.01o/llc - 0.02o/llc), third (0.02o/llc - 0.03o/llc) and children (0.23o/llc - 0.27o/ooo). In the demographic structure of mental retardation, men prevailed, amounting to 32.15%, children ranked second: 24.8%, women - third: 23.1%.

4. The second place in terms of general disability was taken by Mental disorders: schizophrenia, schizotypal and delusional disorders with a stable growth trend of the first group (0.006 o/ooo - 0.01 o/ooo), the third group (0.09 o/ooo -0.55 o/ooo), children (0.47 o/ooo -0.57 o/ooo). The demographic structure of disability of the population in mental disorders: schizophrenia, schizotypal and delusional disorders is represented mainly by women (54.01%), in a slightly lower proportion by men (44.37%) and minimally (1.61%) by children.

5. The third place in terms of general disability was taken by personality and behavior disorders in adulthood, having downward trends in the first (0.004 o/ooo - 0.003 o/ooo), the second (0.18 o/ooo -0.041 o/ooo), children (0.006 o/ooo -0.002 o/ooo) and stabilization in the third group (0.03 o/ooo - 0.03 o/ooo). The demographic structure of the general disability of the population for personality and behavior disorders in adulthood was dominated by men, amounting to 75.7%. Women took second place - 16.2%, children - third, amounting to 9.05%.

6. In fourth place was disability in neurotic, stress-related, and somatoform disorders with an unstable increase in the indicator in patients of the first group from 0.0009 to 0.036 per 100 thousand of the population, a steady downward trend in the indicator in patients of the second group: 0, 089 v/ooo to 0.018 v/ooo, children: 0.006 v/ooo to 0.0 v/ooo, an unstable downward trend in patients of the third group from 0.017 v/ooo to 0.0008 v/ooo. The demographic structure of the disability population in neurotic, stress-related and somatoform disorders was dominated by women, at 50.8%, and men were noticeably inferior to them, at 34.6%. Children occupied the minimum share, occupying 14.5%.

7. The fifth place was occupied by general disability in emotional disorders, behavioral disorders, usually beginning in childhood and adolescence, having a steady downward trend in the interval 2004-2021 in disabled people of the first group: from 0.004 to 0.003, the second: from 0.009 to 0.003, unstable tendencies of disabled people of the third group: from 0.004 to 0.003, children: from 0.03 to 0.02. In the demographic structure of the disability of the population with emotional disorders, behavioral disorders, usually beginning in childhood and adolescence, children predominated, amounting to 49.0%, the second place was occupied by men - 37.9%, the third - women 13.05%.

8. The sixth place was occupied by disability in mood disorders (affective disorders), in the demographic structure of which women dominated, amounting to 69.2%, and men were noticeably inferior to them, amounting to 28.8%. Children occupied the minimum share - 2.05%. There were no changes in the indicator in patients of the first group of disability: from 0.01 to 0.01 in the range from 2004 to 2021, the tendency to reduce the indicator in patients of the second group of disability was stable: from 1.04 to 0.35, unstable - the growth trend in children: from 0.0009 to 0.01.

9. The socio-medical assessment of the process of providing psycho-psychotherapeutic and psychiatric care reflected the real need of the population for it, the medical and social characteristics of the population, the factors that caused the occurrence of diseases, the effectiveness of treatment, the conditions for the provision of psycho-psychotherapeutic and psychiatric care by specialized specialists and reserves for increasing the efficiency of its provision.

10. Psychological, psychotherapeutic and psychiatric care was provided by women in 70.22%, in 90% of working age, economically active age, mainly from 25 to 49 years old, at 58,21% married, worked in this specialty for 1/3 - over 20 years, 1/3 - from 5 to 20 years, combining the main work with an additional load, 55.14% had a shift schedule, 56.58% felt tired before work, in 30.45% - apathy and oppression, in 88.7% evaluating their work at 5 and 4, in 65,03% of those who received incentive payments, 70.99% dissatisfied with their earnings, in 94,62% are

professionally trained in NMO models, 64.55% are satisfied with working conditions, in 98.08% using their annual leave, in 82,, 61% who considered their health satisfactory, in 75.87% who did not have bad habits, in 57.54% who were not on sick leave, in 43.8% of those who underwent coronavirus infection COVID - 19 in a mild form, in 52.83% linking exacerbation of diseases with occupational burden, negative occupational determinants "Emotional devastation" and "Apathy, oppression."

11. Among patients who received psychological, psychotherapeutic and psychiatric care, 60.96% were women from 25 to 49 years old, at 52,67% of people with disabilities of the second group, 36.7% - the third, 10.67% - the first, for 1/5 of education workers, in proportion to the rest of the professional groups, in 40.28% of married, 63.74% in friendly relations, 63.3% living in a separate apartment, 88.89% had no hereditary predisposition to mental diseases that had normal and accelerated development in early childhood, 70.0% were raised in a family, 38.89% by both parents, 33.33% by the mother, 20.47% by the father. In 44% of respondents in childhood, unclassified disorders were detected, 80% were not under the supervision of a psychiatrist, observed by a psychiatrist in adulthood for 1, 2 and 3 years proportionally, in 35.16% had chronic diseases, 1 (46.27%) and 2 (33.33%) received inpatient treatment once a year.

In the structure of nosological forms, the first place was occupied by organic CNS lesions (49.91%), schizophrenia, BAR and alcoholism competed with each other, amounting to 13.56% in each group. The minimum proportion was 4.7% each of somatogenies, including somatogenic psychoses, and neuroses and neurotic disorders.

Drug therapy with tranquilizers, antipsychotics and antidepressants was distributed among patients proportionally - 1/3. More than 50% of patients received therapy individually, 28.81% - in the group, 14.12% - in the family. Treatment duration was classified as ultra-short (40% of patients), short (up to 30 days) (28.81%), long (up to 12 months) (14.12%) and ultra-long (over a year) (14.12%). 29.53% of patients recovered, 29.53% - condition unchanged, 20.47% - partial

improvement. Among patients receiving treatment, 40.16% partially restored social and labor status, 30.31% - fully restored, and 29.53% - had a pronounced decrease in social and labor adaptation.

12. Expert assessment carried out by specialized specialists organizing psychiatric and psychological and psychotherapeutic assistance to the population, statistically reliably testified that

the system of providing psychiatric care to the population needs reform, the number of non-psychotic mental disorders has increased among various contingents of the population, an examination of patients conducted by a psychiatrist in a general mathematical network (polyclinic, multidisciplinary hospital) will increase the level of efficiency of medical care for the population, an increase in psychiatrists will increase the proportion of mental illnesses detected at early stages among newly diagnosed psychiatric diagnoses, "Timely provision of patients with psychiatric care" may affect the change in the values of the targets: "Public awareness of the possibility of receiving psychiatric care," "The proportion of mental illness, identified in the early stages among newly diagnosed psychiatric diagnoses, "" The proportion of mental illness, identified at early stages from the number of newly diagnosed mental disorders "significantly affects the targets" Timely provision of patients with mental health care, " "The frequency of visits to the therapist, neurologist, doctors of other specialties" does not affect the change in the values of the indicator "Timely provision of patients with psychiatric care," "Awareness of the population about the possibility of receiving psychiatric care" significantly positively affects the change in the values of the indicator "The proportion of mental diseases detected in the early stages among newly diagnosed psychiatric diagnoses,"

"Timely provision of patients with psychiatric care" can significantly positively affect the change in the values of the indicator "The proportion of mental illness detected in the early stages among new psychiatric diagnoses."

PRACTICAL RECOMMENDATIONS

1. Health authorities should ensure adequate planning of the costs of organizing psychiatric care in the primary health care system with the aim of primary prevention of mental disorders in the population, effective use of resources in the network of medical organizations providing medical care for somatic diseases.

2. Taking into account a significant proportion of patients (60-70%) who seek medical help in multidisciplinary hospitals and need advice from a medical psychologist, psychotherapist and psychiatrist, health authorities should select those sent for treatment in a multidisciplinary hospital to identify mental disorders, taking into account their intensity, to redistribute them to a medical psychologist, psychotherapist, psychiatrist for adequate diagnosis and therapy.

3. Given the significant role of preventive measures in preserving the mental health of the population, medical workers need to promote a healthy lifestyle and clearly demonstrate the importance of prevention in reducing the risk of mental illness and maintaining health.

4. The primary prevention of the occurrence of mental disorders should include the routing of all patients seeking medical care to the primary and inpatient level of the health care system for specific sorting (through a questionnaire) of patients and organizing adequate medical care for them.

5. The research materials can be used in the training of specialists in higher education programs of residency in the specialty "Public Health and Health," additional professional training of heads of medical organizations.

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APPENDIX

Patient Questionnaire

Paul		Men's
		Women's
Socio-professional characteristics		
Education		Missing or auxiliary school
		Primary or lower secondary
		Secondary education
		Advanced education
		Secondary vocational education
		Higher education
Social status		Works in government agencies and enterprises
		Works in private institutions and enterprises
		Self-employed
		Does not work
		Pensioner by age
		Disability pensioner
		Pupil
Disability group (disabled)		The first
		The second
		The third
Field of professional activity (for employees)		Industry
		Agriculture
		Construction
		Finance
		Education
		Science and higher education
		Culture
		Health care
		Trade and services
		Transport
		Power structures
Other:		
Position (for employees)		Senior Manager
		Middle Manager
		Medium staff
		Junior staff
		Support staff
		Work in special. shop

		Home work
Other:		
Education (for learners)		School
		Technical school, college, college
		HIGHER EDUCATION INSTITUTION
Socio-cultural characteristics		
Marital status		Married (married)
		Single (single)
		Divorced (a)
		Widows (a)
Family composition (for persons with it)		I live with my spouse and children
		I live with children
		I live with my parents
		Live alone
Family relationships		Benevolent
		Formal
		Conflict with all family members
		Conflict with individual family members
Living conditions		No fixed abode
		Hostel
		Neuropsychiatric boarding school
		Nursing home
		Communal apartment
		Separate apartment
		Own home
		I live with parents, relatives
		I rent living space
Clinical characteristics		
Hereditary burden of mental illness		Yes (if possible, specify the diagnosis)
		No
Early ontogeny (obstetric history, antenatal period, perinatal period)		No specifics
		Pathological
Early development assessment		Timely
		Accelerated
		Detained
		Complete family

Features of the microsocial environment in childhood		Incomplete family
		Foster family
		Raising with relatives
		The presence of a stepfather (stepmother) in the family
		Education in an orphanage
		Family scandals
		Alcoholization of parents
Parenting type		Harmonious
		"The Idol of the Family"
		"Cinderella"
		Hypo and neglect
		Hyper guardianship
		Inconsistent parenting
Who was mainly engaged in upbringing		Both parents
		Father
		Mother
		Other family members
		Anybody
Unclassified disorders in early childhood (stuttering, enuresis, descent, anorexia, neurotic tics, pathological habitual activities, etc.)		No
		Yes
Violations of behavior in childhood		There was no
		Failure reactions
		Opposition
		Imitation
		Overcompensation
		Emancipation
		Peer groupings
		Pathological hobbies
		Deviant behavior (alcoholization, smoking, escaping from home, drug addiction)
		Delicate behavior
Follow-up with a psychiatrist at the time of the examination (indicate the number of years)		Not under psychiatric supervision
		Receives medical advice for _____ years
		Follow-up _____ years

		Observed privately for _____ years
Attitude to alcohol		Within the culture limit
		Abuse
		Dependence
Nosological characteristics		
Residence profile of the subject		Neurology
		Endocrinology
		Surgery
		Neurosurgery
		Cardiology
		Therapy
		Traumatology
		Psychiatry
		Coloproctology
		Purulent surgery
		Urology
		Gynecology
		Otorhinolaryngology
		Ophthalmology
		Obstetric Department of Pregnancy Pathology
		Anesthesiology and resuscitation (perinatal center)
		Pathologies of newborns and premature babies
		Obstetric physiology department
		Orphan Center
		Cardioresuscitation
		Neuroresuscitation
		General resuscitation
		Surgical resuscitation
Presence of chronic somatic diseases		Yes
		No
Frequency of exacerbation of chronic somatic diseases		1 times a year
		2 times a year
		constantly ill
Need for hospital treatment for chronic somatic disease		1 times a year
		2 times a year
		more than 2 times a year
History of coronavirus infection (Covid - 19)		Yes, mild
		Yes, moderate

		Yes, heavy
		Yes, extremely heavy
		No
Leading psychopathological syndrome at the time of examination		No pathology detected
		Reduced energy potential
		Emotional smoothness
		Motor inhibition
		Asthenic s-m
		Obsessive-phobic c-m
		Hysteroneurotic s-m
		Hypochondriac s-m
		Dysphoria
		Mania (hypomanic state)
		Mixed affect
		Anxiety depression
		Depression apato-abulic
		Depression dreary
		Depression within delusional disorder
		Dysmorphophobia
		Delusional s-m
		Paranoic
		Paraphrenic
		Paranoid
		Hallucinatory
		Catatonic
		Hebephrenic
		Delirium
		Depression/confusion
		Oneuric syndrome
		Cognitive disorganization
		Psychopathic syndromes
		Psychopathic syndromes
		Sleep disorders
		Confabulations
		Epileptiform syndrome
Diagnosis (MKB-10 code)		
Treatment measures taken by the patient prior to the examination		
Use of psychotropic agents		Yes, antipsychotics
		Yes, antidepressants
		Yes, normotimics
		Yes, tranquilizers

		No
Application of psychotherapeutic care		Yes
		No
Form of psychotherapy		Individual
		Group
		Family
Duration of psychotherapeutic impact		Ultra short (several hours)
		Short (up to 30 days)
		Long-term (1-12 months)
		Extra long-term (more than 1 year)
Effectiveness of previous treatment and rehabilitation measures		Yes
		No
Clinical efficacy		Complete recovery
		Practical recovery (with the need for periodic rehabilitation measures)
		Recovery
		Slight improvement
		Condition unchanged
Social performance assessment		Full restoration of social and employment status
		Partial restoration of social and employment status
		Pronounced decrease in social and labor maladjustment
Post-examination treatment		
Use of psychotropic agents		Yes, antipsychotics
		Yes, antidepressants
		Yes, normotimics
		Yes, tranquilizers
		No
Application of psychotherapeutic care		Yes
		No
Form of psychotherapy		Individual
		Group
		Family
Duration of psychotherapeutic impact		Ultra short (several hours)
		Short (up to 30 days)
		Long-term (1-12 months)
		Extra long-term (more than 1 year)

Effectiveness of previous treatment and rehabilitation measures		Yes
		No
Clinical efficacy		Complete recovery
		Practical recovery (with the need for periodic rehabilitation measures)
		Recovery
		Slight improvement
		Condition unchanged
Social performance assessment		Full restoration of social and employment status
		Partial restoration of social and employment status
		Pronounced decrease in social and labor maladjustment

Questionnaire for population

Paul		Men's
		Women's
Age		15-19 years
		20-24 years
		25-29 years
		30 - 34 years
		35 - 39 years
		40 - 44 years
		45 - 49 years
		50 - 54 years
		55 - 59 years
		60-64 years
		65 - 69 years
		70 - 74 years
		75 - 79 years
		80 and over
Marital status		Married (married)
		Single (single)
		Divorced (a)
		Widower (s)
Social status		Work in government agencies and enterprises

		Work in private institutions and enterprises
		Do not work
		Pensioner by age
		Disability pension
Family composition		I live with my spouse and children
		I live with children
		I live with my parents
		Live alone
Do you have chronic diseases		Yes
		No
Have you had a coronavirus infection (Covid - 19)?		Yes, mild
		Yes, moderate
		Yes, heavy
		Yes, extremely heavy
		No
Do you feel depressed?		Yes
		No
Do you notice anxiety, anxiety, fear?		Yes
		No
Do you have a periodic feeling of panic?		Yes
		No
Do you have insomnia, nightmares?		Yes
		No
Do you notice increased irritability, the inability to restrain your emotions?		Yes
		No
Do you notice a decrease in memory, difficulties in assimilating new information?		Yes
		No
Do you notice any difficulties in communicating with others?		Yes
		No
Do you notice malaise, lack of strength, increased fatigue?		Yes
		No
Do you notice a decrease in performance?		Yes
		No
Do you have any complaints about pain that does not subside after taking medications or discomfort in internal organs and muscles? Treatment with a doctor does not bring relief		Yes
		No
		Yes

If necessary, you would seek advice from a psychologist		No, such a need cannot arise
		No, I fear the consequences
If necessary, you would seek advice from a psychotherapist		Yes
		No, such a need cannot arise
		No, I fear the consequences
If necessary, you would consult a psychiatrist		Yes
		No, such a need cannot arise
		No, I fear the consequences

Questionnaire for medical personnel

Paul		Men's
		Women's
Your age		20-24 years
		25-29 years
		30-34 years
		35-39 years
		40-44 years
		45-49y
		50-54 years
		55-59 years
Please indicate your marital status		Married (married)
		Single (single)
		Divorced (a)
		Widower (s)
Duration of work in the specialty		up to 1 year
		up to 5 years
		5-10 years
		10-15 years
		15-20 years
		over 20 years
Duration of work at the current location		up to 1 year
		up to 5 years
		5-10 years
		10-15 years
		15-20 years

		over 20 years
Do you have a part-time job or a combination in a hospital?		Yes
		No
Do you have external part-time employment?		Yes
		No
Do you work on a shift schedule?		Yes
		No
Does the number of shifts per month correspond to the standard? (in case of shift schedule)		Yes
		No
Do you take additional duty?		Yes
		No
Do you feel emotionally devastated?		Yes
		No
Do you feel tired in the morning when you need to get up and go to work?		Yes
		No
Do you feel apathy, oppression?		Yes
		No
You feel at the limit of your capabilities		Yes
		No
You feel energized and encouraged at work		Yes
		No
During the day you manage to do a lot at work		Yes
		No
How can you rate your work?		5 points
		4 points
		3 points
		2 points
Do you receive incentive bonuses for improving the quality of work?		Yes
		No
Are you satisfied with your salary?		Yes
		No
Are you upgrading your skills?		Yes
		No
Do you participate in continuing medical education?		Yes
		No
Are you satisfied with the working conditions in the hospital?		Yes
		No
Are you resting enough?		Yes
		No
Do you have annual paid leave?		Yes
		No

Do you have additional paid leave?		Yes
		No
Do you consider your state of health satisfactory?		Yes
		No
Do you have bad habits?		Yes
		No
How often are you on a certificate of incapacity for work?		Not once
		1 times a year
		2 times a year
		more than 2 times a year
What diseases do you suffer from?		Cardiovascular system
		Respiratory system
		Gastrointestinal tract
		Musculoskeletal system
		Nervous system
		Skin and subcutaneous fat
		Kidneys and bladder
		Ear, throat, nose
		Gynecologic
History of coronavirus infection (Covid - 19)		Yes, mild
		Yes, moderate
		Yes, heavy
		Yes, extremely heavy
		No
Length of stay on the certificate of incapacity for work during the year		up to 7 days
		7-14 days
		more than 14 days
Do you pay attention to disease prevention?		Yes
		No
Do you think that exacerbations of diseases are associated with workload?		Yes
		No
Are your diseases related to the profession?		Yes
		No

EXPERT QUESTIONNAIRE

1. What are the quantitative indicators of the evaluation of the health care system in terms of the organization of psychiatric care My answer

_____

_____

2. Highlight from them secondary indicators of the evaluation of the health care system in terms of the organization of psychiatric care

My answer _____

_____

3. Name the key quantitative indicators of the evaluation of the health care system in terms of the organization of psychiatric care

My answer _____

_____

5. In your opinion, the screening of the patient's mental state conducted by a psychiatrist in the general mathematical network (polyclinic, multidisciplinary hospital)

- Will increase the level of efficiency of medical care to the patient;

-It will reduce the level of effectiveness of medical care to the patient;

-Will increase the costs of the health care system;

-Optimizes healthcare system costs.

6. Do you think that the number of non-psychotic mental disorders has increased among different populations?

-Yes

-No

7. Do you think that there is an increase in the number of patients with mental disorders in general medical institutions of the health care system?

-Yes

-No

8. Do you think that the system of providing mental health care to the population needs to be reformed?

-Yes

-No

9. How do you think the use of the baseline indicator "Provision of medical organizations with a somatic profile by psychiatrists" can affect the change in the values of the following targets.

Indicator	-2	-1	0	1	2
Proportion of mental illness detected early among new psychiatric diagnoses					
Frequency of visits to GP, neurologist, doctors of other specialties					
Public awareness of the possibility of receiving mental health care					
Hospitalization rate per somatic bed					
Timely provision of mental health care to patients					

10. How, in your opinion, the use of the baseline indicator "The proportion of mental illnesses detected at the early stages from the number of newly diagnosed mental disorders" can affect the change in the values of the following targets.

Indicator	-2	-1	0	1	2
Provision of medical organizations with a somatic profile by psychiatrists					
Frequency of visits to GP, neurologist, doctors of other specialties					
Public awareness of the possibility of receiving mental health care					
Hospitalization rate per somatic bed					
Timely provision of mental health care to patients					

11. How, in your opinion, the use of the baseline indicator "Frequency of visits to a therapist, neurologist, doctors of other specialties" can affect the change in the values of the following targets.

Indicator	-2	-1	0	1	2
Proportion of mental illness detected early among new psychiatric diagnoses					
Provision of medical organizations with a somatic profile by psychiatrists					
Public awareness of the possibility of receiving mental health care					
Hospitalization rate per somatic bed					
Timely provision of mental health care to patients					

12. How, in your opinion, the use of the basic indicator "Awareness of the population about the possibility of obtaining mental health care" can affect the change in the values of the following targets.

Indicator	-2	-1	0	1	2
Proportion of mental illness detected early among new psychiatric diagnoses					
Frequency of visits to GP, neurologist, doctors of other specialties					
Provision of medical organizations with a somatic profile by psychiatrists					
Hospitalization rate per somatic bed					

Timely provision of mental health care to patients					

13. How, in your opinion, the use of the baseline indicator "Hospitalization rate per beds of somatic profile" can affect the change in the values of the following targets.

Indicator	-2	-1	0	1	2
Proportion of mental illness detected early among new psychiatric diagnoses					
Frequency of visits to GP, neurologist, doctors of other specialties					
Public awareness of the possibility of receiving mental health care					
Provision of medical organizations with a somatic profile by psychiatrists					
Timely provision of mental health care to patients					

14. How, in your opinion, the use of the baseline indicator "Timely provision of patients with psychiatric care" can affect the change in the values of the following targets.

Indicator	-2	-1	0	1	2
Proportion of mental illness detected early among new psychiatric diagnoses					
Frequency of visits to GP, neurologist, doctors of other specialties					
Public awareness of the possibility of receiving mental health care					

Hospitalization rate per somatic bed					
Provision of medical organizations with a somatic profile by psychiatrists					

Dear experts!

We ask you to help us assess the impact of indicators on each other.

To do this, we will use the following scale:

'0 '- Changing the baseline value has no noticeable effect on the target.

'+ 1 '/' -1' - A change in the baseline value may result in a slight or moderate change in the target.

'+ 2 '/' -2' - a change in the value of the basic indicator directly entails a change in the target indicator.

The sign determines the direction of influence:

'+' - the values of both the base and target indicators change unidirectionally (both increase or both decrease).

'- '- the values of the base and target indicators change in different directions (if the first grows, then the second falls, and vice versa).