INTEGRATION OF PSYCHIATRIC CARE INTO PRIMARY CARE

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Abstract. *The implementation of the program consists of a step-by-step process of diagnosing mental disorders in general somatic practice within the framework of the polyp-professional medical care model. This method shows that in the process of early diagnosis of mental disorders, specialists with one group are actively involved: a primary care doctor (PMSP), a nurse, a psychiatrist, a psychologist, a social worker. The main role in this process belongs to the general practitioner.*

Keywords: *psychiatric care, mental disorders, medical care.*

Introduction. The problem of providing psychiatric care for patients with non-psychotic mental disorders in primary care has not been solved for a long time. In recent decades, the relevance of his decision has increased. This is primarily determined by the needs of the primary medical network, since a large percentage of patients with somatic diseases (24-64%) suffer from joint mental disorders, and for their successful management it is necessary to use psychiatric and medico-psychological approaches [1]. Non-psychotic anxiety-depressive and mild cognitive disorders, as well as pathological dependence problems, are especially acute in this regard. The wide prevalence and low frequency of detection, as well as an insufficient number of combinations of somatic and anxiety-depressive disorders, significantly reduce the effectiveness of medical care, make it difficult to organize and increase the dissatisfaction of the population with the quality of Health [2].

The following information allows you to imagine to what extent the possibilities of providing psychiatric care for patients with mental disorders in the conditions of the main branch of health care are limited. The number of Psychiatrists in the country, most of them work in psychiatric institutions [3].

According to the most optimistic estimates, patients with mental disorders, including those associated with somatic diseases, make up at least 10% of the population. Thus, more than 10 million people with non-psychotic mental disorders are outside the mental health service and do not receive adequate support [4].

Health leaders recognize the importance of the problem at best, but this does not lead to any organizational and legal changes, modern forms of care for patients with non-psychotic mental disorders are not introduced in the primary medical network. Unfortunately, psychiatrists working in" large " psychiatry, like the heads of primary and general medical services, do not pay enough attention to the detection and treatment of mental disorders in this category of patients [5].

In the 90s of the 20th century, priorities changed in the organization of psychiatric care in most developed countries of the world. The burden of mental illness and primarily depression turned out to be so significant in terms of economic costs and overall social scope that it became the subject of a separate review of governments and various interstate institutions, including the World Bank. These trends not only persist, but are also increasing in the early 21st Century [6-9].

The above-mentioned trends coincided with reforms that began earlier in the field of helping people with mental disorders and continue to the present day. They were motivated by changes in ethical-legal approaches to both clinical data and mental health assessment, and the conditions under which mental patients were assisted. A consistent change in the system of providing psychiatric care should be based on the principles of strict legal regulation, maximum compliance with the civil rights of the patient, taking into account his active role in the therapeutic and diagnostic process, as well as relying on the communities of relatives and representatives of the patient. Measures to stigmatize mental disorders and people suffering from them include increasingly transferring the functions of providing mental health services to non-psychiatric institutions [10-16]. The organization of specialized offices, departments in primary medical network institutions is the most promising method of early detection and, if necessary, treatment of non – psychotic mental disorders in modern conditions, primarily anxiety-depressive disorders and cognitive disorders. In most cases, early adequate treatment, including forms of psychotherapeutic, psychological assistance, can be considered as a prevention of chronic, negative formation of mental disorders. Given the correlation of Affective Disorders and somatic pathology, this should correspond to the tasks of a preventive strategy in medicine [17-20].

The spread of the practice of diagnosing and treating non-psychotic mental disorders in primary medical network institutions is a general trend in the development of medical care in different countries of the world. There are preliminary data in favor of the positive impact of such practice on suicidal behavior indicators (Hungary, Sweden, Germany). However, care should be taken against the excessive use of antidepressants by General Practitioners in the United States [21].

In addition to depression, more attention is now paid to anxiety disorders, mild cognitive disorders. Epidemiological indicators of their prevalence began to be considered taking into account the socio-economic burden, including direct and indirect costs for diagnosis and treatment, early disability, loss of professional skills or a decrease in social activity due to other social restrictions [22].

Reforming psychiatric care, that is, ensuring its availability and proximity to the population, is not possible only within the framework of existing psychiatric services. Interaction with the general medical care system is necessary, in particular, in the form of the organization of individual forms of psychiatric care in primary medical network institutions [23]. Care for patients with non-psychotic, moderately defined mental disorders can be improved by engaging primary medical network resources (population proximity, availability, preventive and rehabilitation potential, stigma reduction) [24].

It should be borne in mind that modern health care is aimed at improving the quality of life of patients. It is impossible to solve the complex of relevant issues without appropriately improving the socio-psychological conditions of patients and using psychological factors in the therapeutic and rehabilitation process [25]. Compliance with the treatment regimen is very important, as well as psychological adaptation to lifestyle changes due to chronic diseases. In this

regard, the tasks of doctors to improve communication skills, increase their psychological competence and master the principles of professional ethics are of great importance [26].

In the recent past, several attempts have been made to change the current situation in local medicine in order to increase the role of Psychiatrists in the main branch of Health Care [27]. In the early 80s of the last century, the World Health Organization recommended that psychiatrists send their activities to the primary health department, expand the network of psychiatric departments on the basis of somatic treatment institutions, and train specialists in the field of Psychosomatic Medicine. At the same time, special attention was paid to depression, which is often accompanied by somatic diseases. Antidepressant treatment and short-term structured forms of psychotherapy are effective in 60-80% of patients with relatively mild forms of mental illness in primary medical network settings [28].

The purpose of the study: to develop a program for the early diagnosis of mental disorders in patients who have consulted primary care physicians.

Materials and methods. The implementation of the program consists of a step-by-step process of diagnosing mental disorders in general somatic practice within the framework of the polyp-professional medical care model. This method shows that in the process of early diagnosis of mental disorders, specialists with one group are actively involved: a primary care doctor (PMSP), a nurse, a psychiatrist, a psychologist, a social worker. The main role in this process belongs to the general practitioner. In the context of limited personnel resources, an abbreviated version of this model is possible, including the participation of only 2 specialists: a general practitioner and a psychiatrist. As psychometric tests that allow you to identify mental disorders in the early stages of their formation, it is recommended to use short tests for a quick assessment of mental state (for example, the "Neuropsychic adaptation" test). With a positive result-consultation with a psychiatrist (psychotherapist) is prescribed.

Research results and discussion. If the patient agrees to meet with a psychiatrist, the primary care doctor will arrange this consultation. In Stage 2, the interaction of the therapist and psychiatrist on patient management issues is carried out. The therapist receives feedback from the psychiatrist, which includes established diagnoses and recommendations for the management and treatment of a patient with mental disorders in the conditions of the primary medical network. In the future, specialists continue to interact with each other within the framework of the" escort "or" labor training" model. The process of improving the qualifications of Internist doctors in the field of psychiatry is also carried out in stages and is based on preparing specialists in the field of psychiatry to work with general doctors and teaching the latter the features of diagnosing mental disorders, deontology and communicating with patients. At Stage 1, a special training course for specialists (doctors, medical psychologists, nurses, social workers) is held in the Department of psychiatry (post-graduate education) of a medical institution: "foundations of polyp-professional cooperation in the primary care service for the diagnosis and treatment of mental disorders". The content of the work at Stage 2 is the training of general specialists. The course of study is based on programs aimed at diagnosing mental disorders and teaching communication skills, for each of which 72 hours are allocated. After the course of study, it is constantly advised to provide additional distance learning and early identification of patients with mental disorders and their management in the conditions of the primary medical network. Direct participation in the process of professional development of doctors of a general profile is carried out by the Regional

Psychiatric Service, which helps the Internist Doctor in difficult cases of diagnosis, monitors and takes into account the mental patients identified in general somatic institutions.

An assessment of the effectiveness of the early detection program for mental disorders proposed by General Practitioners is based on a comparative analysis of the detection of mental disorders before and after its use and a comparison of official statistics on the prevalence of mental disorders. "Early identification programs for patients with mental disorders in the primary care service", as well as on the establishment of a continuous postgraduate course for general practitioners on these issues. Itinerant cycles of day-to-day training of general practitioners have been carried out several times, a number of educational-methodological manuals and educational videos have been prepared, constant consultation contacts with General Practitioners of the Nanay district for the diagnosis and treatment of mental disorders are carried out. The methods developed were used in the development of the regional Target Program "years to prevent and combat socially significant diseases", the sub-program" mental disorders". Thanks to these comprehensive measures, the rate of primary diagnosis of B mental disorders increased by 25.6%, the proportion of primary morbidity of severe forms of mental pathology in the Nanay region is much lower than the edge in general (5.9% versus 23.9 %).

Literary data, as well as analysis of the practice available in our country, indicate that in the conditions of the primary medical network there are several basic models of the organization of psychiatric care for patients with shallow mental disorders: counseling, interaction models and correlation (support) models.

The consultation model is associated with the activities of psychiatrist-consultants in the cabinets of regional polyclinics and stationary departments of multidisciplinary clinics. The implementation of this model of psychiatric care improves the early diagnosis of mental disorders in patients who contact these institutions, which helps prevent the most severe consequences of these diseases.

This is characterized by the fact that, according to the Attending Physician-internist, patients suffering from mental disorders are sent to consult a psychiatrist. With this form of interaction, the psychiatrist receives very limited information about the patient, his somatic condition and the reasons for applying for advice. At the same time, the diagnosis made by the consultant, his appointment and recommendations are not sufficiently understood and justified for the doctor. In addition, the fact of a psychiatric diagnosis in medical documents often raises many questions and protests in patients. Therefore, in practice, many appointments of a psychiatrist are not performed, dynamic observation is not carried out. Disadvantages of this model include the episodic nature of counseling work, lack of continuity in patient management, inadequate communication between the doctor and the patient, and low patient compliance rates.

In this regard, the ideas of creating an integrated approach – "integrated medicine" - to the organization of psychiatric care for the population in different countries were put forward. The principles of" Integrated Medicine "include the" counter-movement " of psychiatry and General Medical Services, the development of unified organizational methods and the joint solution of the problems that arise. Historically, this approach evolved in a direction known as the liaison (liaison) model or interaction model.

This model is characterized by the presence of constant work communication of Psychiatrists and clinicians, which is manifested in the joint examination of patients, the

development of unified therapeutic approaches, dynamic psychiatric observation and consistent correction of therapy.

The advantage of this model is the possibility of carrying out highly qualified and comprehensive medical care. However, this model requires considerable labor and material resources and, first of all, additional professional training for doctors on psychological health programs.

Within the framework of this model, additional options for providing comprehensive medical care to patients of the primary medical network have been developed. They include, for example, a model called Unified Support [34]. The main component of this model is the improvement of the quality of communication between primary care physicians and psychiatrists, including current information on patient extracts, appeals and directions.

This includes a regular assessment of mental health surveys by primary care physicians. This system aims to increase the proportion of planned and systemic psychiatric activities, which can increase their quality. Important components of unified assistance are the development of patient management standards, training of doctors, monitoring the implementation of assistance standards. The formation of this model requires the transfer of the entire system of medical care to a fundamentally high level, which is characterized by the integration of the activities of various medical services and a clear separation of their functions. All this is possible only on the basis of appropriate personnel and material and technical support, including the development of appropriate Computer Information Systems.

Another variant of Liaison's psychosomatic approach is" collaborative " therapy, which aims to integrate specialized care into primary medical network activities. The collaborative model is particularly effective in treating somatic patients with the most common chronic somatic diseases (e.g., treating patients with damage to the musculoskeletal system, diabetes, certain forms of cardiovascular disease). Its main elements are regular visits to patients at home, carried out mainly by specially trained nurses, as well as an occasional objective assessment of the patient's condition, for example, with the help of short psychometric questionnaires, the formation of step-by-step epicrizes, holding many professional conferences, active dynamic observation.

Another form of the Liaison model is a relational model called "offset", where the consultant assistance and advice of a psychiatrist is employed by primary medical practitioners on a scheme to help improve the quality of care for patients with psychological and psychiatric problems. The effectiveness of this model, in fact, is due to the fact that the psychiatrist provides assistance to more patients than is limited only to direct consultations.

Practical work experience in providing psychiatric assistance to patients of primary health care and educational activities shows that the most promising model for integrating psychiatric service into the work of primary health care in the Russian context is an approach based on the escort principle.

Conclusions. Testing of the proposed program showed its high efficiency. After special training, general practitioners can use psychometric methods, determine the presence or absence of mental abnormalities, including at the pre-clinical level. Working in this direction will help increase the identification of individuals with mental disorders in the general somatic network.

Solving the problems listed above is not entirely sufficient to work on the medico-psychological and psychiatric support model. It is necessary to develop special training programs, other methodological documents, select a sufficient number of specialists, as well as create an

appropriate training base. In addition, the development of typical algorithms for providing assistance to patients with non-psychotic mental disorders in primary health conditions, as well as the preparation and publication of relevant regulatory documents at the federal and municipal level, is of great importance. A number of projects of these materials and their sample samples have already been prepared and widespread. However, the main issue that remains here to this day is the recognition by federal and municipal health authorities of the humanitarian, organizational and economic importance of the development of a model of medical-psychological and psychiatric support of the primary health care unit.

Solving this problem will help reform the primary care network, one of the main tasks of local health care. The development of assistance to individuals with non-psychotic and unspecified mental disorders has a significant preventive potential, since it does not allow the development of more complex, long-lasting and disabled forms of mental disorders.

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