ОРГАНІЗАЦІЯ ПСИХІАТРИЧНОЇ СЛУЖБИ

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COMMUNITY MENTAL HEALTH TEAMS FOR PEOPLE WITH MENTAL DISORDERS: A PILOT PROJECT IN UKRAINE

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Pilot project of mobile community mental health teams (mCMHT) for people with mental disorders was organized in four regions. The goal was to improve the quality of life and outcomes of people with mental disorders by providing comprehensive, specialized mental health care in community settings as an alternative to inpatient hospital care. Additionally project aimed to foster integration of mental health care into the primary health care system.

Objective: to compare the organization of the mCMHTs in four cites: their model of work, most common diagnoses of patients they work with, the methods of referral to the teams, their intervention types.

Materials and methods. Materials were collected from teams weekly data reports completed via online data collection system, patient **questionnaires,** site visits and interviews with specialists.

Results. Uneven coverage area, different available services and needs of the population formed the individual characteristics of each mCMHT. The possibility to adapt the general model of community-based care to the local context was an important condition for the effective operation of mobile teams as well as teams could concretize eligibility criteria, organize referral pathways and choose full or part time staff.

Conclusions. Community model had proven to be effective in the treatment of patients with severe mental disorders, patients who have no access to mental health services and internally displaced people with mental health problems. Furthermore, first experience of community based mental health service implementation showed not only the main gap which could be filled in, but also challenges which could appear. The limits are related to the large geographical territories which need to be addressed, to the incomplete knowledge of care and to the lack of support and cooperation with primary healthcare system, social services and local organizations taking care of people with mental disorders, stigmatization and community distrust to psychiatric services.

Keywords: mental health, community based, mobile community mental health teams, pilot project.

Background. Pilot project in Ukraine Mobile community mental health teams (mCMHT) for people with mental disorders started in January 2016 with support from WHO. Topicality of this project leads to current humanitarian crisis in Ukraine caused by military events, absent community-based services and limited mental health treatment provision at the primary care level.

The data acquired from monitoring of displaced and conflict – affected populations worldwide showed that this cohort is at risk of not only developing the specific stress – related disorders. The common mental disorders also have an increased incidence in this group [1-3]. Mental health care is provided mostly by state services which are still institutionalized and stigmatized. In the situation of military conflict strenuous activity of state psychiatric services still does not cover all the needs of the population, and in some regions its activity is further complicated by the destruction of the hospital buildings, presence of a large number of internally displaced people (IDP) and the lack of services availability due to destroyed roads and checkpoints.

General practitioners are commonly undertrained in mental diseases recognition and treatment [4]. Non-government organizations (NGOs) also take their part in providing some mental health care to affected population but they often focus on trauma-related mental health problems and immediate consequences of stressful events [5, 6]. The communication between state mental health services and NGOs is very poor and everyone prefers to work separately.

The current international practice is to develop comprehensive community-based mental health care and switch away

from institutionalized care [7-10]. The main differences are not only in the structure of services but also in the principles and objectives that govern the way in which service providers perform their work and position their clients in relation to themselves. Community-based mental health care is one part of a balanced, comprehensive mental health system which incorporates primary care services and inpatient services. Strong linkages and formal referral pathways between each element of the service system are vital to ensure continuity of care for patients. Also services aim to coordinate and collaborate with the various agencies and service providers relevant to the needs of those with mental illness in the local community, in order to improve access to services and increase social inclusion.

In January 2016 the pilot project Mobile community mental health teams (mCMHT) for people with mental disorders was initiated with the support of WHO in four regions of Ukraine: Odesa, Dnipro, Sumy, Slavyansk.

Subsequently a project was developed aiming to improve the quality of life and outcomes of people with mental disorders by providing comprehensive, specialized mental health care in community settings as an alternative to inpatient hospital care and to foster integration of mental health care into the primary health care system. Also project aimed to introduce and test a model of community-based mental health care which could be scaled up over time to form a part of the greater mental health reform process.

This paper aims to provide a brief description of the model of care and to highlight the main differences in organization of work of mCMHT in four pilot sites in Ukraine. Also we shall emphasize on the aspects paramount in providing mental health care and the obstacles that might arise during the process.

Objective: to compare the organization of the mobile community teams in four cites: their model of work, most common diagnoses of patients they work with, the methods of referral to the teams, their intervention types.

Materials and methods

Materials were collected from teams weekly data reports completed via online data collection system, patient **questionnaires,** site visits and interviews with specialists.

Results

The initial model of care was developed in consultation with local stakeholders to ensure sensitivity to the context. This initial model was then presented to the teams in each site and adapted as necessary depending on local factors including the structure of existing services, perceived gaps in service delivery and access, geography and workforce availability.

1. The general model of care

Aims and objectives of the mCMHT

MCMHTs perform the following distinct and important functions as required:

- provision of biological and psychosocial interventions for individuals experiencing severe mental disorders with the objective to prevent hospital admission, minimize disability and improve functioning;
- provision of focused support for FD and other primary medical service providers in order to improve their capacity in dealing with patients who have moderate and mild mental disorders.

Management

Direct management by Chief Doctors of the regional psychiatric services.

Service provision and office base

Services can be provided in the community (home visits, field visits to local medical facilities etc) and in the mCMHT office which can be based in regional psychiatric dispensaries or rehabilitation centers.

Staffing

Teams consist of psychiatrists, nurses, social workers and psychologists, who received short-term training in multidisciplinary team management, main principles of community based care and goals of the project. Additionally teams received regular supervision. Team coordinator role was given to one or two of the team members.

Referrals

Referrals can be accepted from family physicians and other primary health care staff, hospital psychiatrists, outpatient psychiatrists, social services, family, self-referral.

Eligibility

Individuals, requiring treatment and care for psychosis or other severe mental disorders either recently discharged from hospital or at risk of hospitalization, or people experiencing a significant decrease in functioning due to the impact of a severe mental disorder, or people unable to access outpatient services because of any reason are eligible for treatment at a mCMHT. Eligibility criteria were specified by each team with priority to IDPs, conflict-affected communities, people who cannot access mental health services or individuals with first episode of psychosis.

Case-finding and linkages

Chief Doctors and team coordinators decided how to organize cooperation with potential local referrers (FD, outpatient and inpatient psychiatrists, psychological and social services, NGOs, school counselors, student polyclinics etc). Methods used: letters, callings, meetings with coordinator / team members, conferences, flyers etc.

Interventions

Bio-psychosocial interventions were guided by treatment plan developed by team staff along with patient (including medications and psychosocial support to patients and their families).

2. Differences in work organization and functioning in mCMHTs

Different social and geographic background as well as range of local mental health services substantially influenced the choice of service model. The management staff and teams themselves contributed to the process of adaptation.

Table 1 provides an overview of the differences of team models in four pilot sites.

Discussion

The possibility to adapt the general model of community-based care to the local context was an important condition for the effective operation of mobile teams. Uneven coverage area, different available services and needs of the population formed the individual characteristics of each of the teams.

Table 1. Differences in work organization and functioning in mCMHTs

Components influencing work organization	Location			
	Odesa	**Slavyansk**	**Dnipro**	**Sumy**
Local context	- Relatively developed outpatient and rehabilitation services; - many camps with internally displaced people (IDP)	- Near the fighting area; - main psychiatric facility was destroyed by shelling; - many roadblocks complicate patient's access to services	- Developing outpatient and rehabilitation services, whole mental health system still old-fashioned ; - many international targeted projects aimed to improve rehabilitation services; - many IDPs	- Developing outpatient and rehabilitation services, whole mental health system still old-fashioned ; - lack of international targeted projects aimed to improve rehabilitation services
Office base	Rehabilitation service	Regional psychiatric dispensary	Regional psychiatric dispensary	Regional psychiatric dispensary
Service provision	Half of the team provides outreach services (home visits and field visits to IDP camps) and another half provides services at the team office	Predominantly outreach services	Predominantly at the team office (preferable by patients)	Predominantly at the team office (preferable by patients)
Catchment area	≈200 sq km+ distant field visits	≈1500 sq km	≈200 sq km	≈100 sq km
	corresponds to 100-150 000 population			
Staff	Full-time: 1 social worker Half-time: 2 psychiatrists 2 psychologists 3 nurses 1 driver	Full-time: 1 psychiatrist 1 psychologist 1 nurse 1 social worker 1 driver	Half-time: 3 psychiatrists 2 psychologists 2 nurses 1 social worker 1 driver	Full time: 1 social worker 1 psychologist Half-time: 2 psychiatrists 2 nNurses 1 driver
Coordinator	Medical deputy of the Chief Doctor and nurse from the team	Psychiatrist and nurse from the team	Psychiatrist from the team	Nurse from the team
Referrals	Patient 76 % Inpatient hospital 3 % Other 5 % Not reported 17 %	Patient 35 % Family member 21 % Family doctor 17 % Outpatient psychiatrist 19 % Inpatient hospital 3 % Other 6 %	Outpatient psychiatrist 83 % Family member 2 % Patient 1 % Family doctor 1 % Other services 13 %	Outpatient psychiatrist 23 % Patient 11 % Family member 17 % Family doctor 5 % Other 3 % Not reported 41 %
Case-finding	Flyers and proactive callings and meetings with potential local referrers (FD, social services, outpatient and inpatient psychiatrists) which were conducted by team coordinator	Flyers, local media and proactive meetings with potential local referrers (FD, social services, outpatient and inpatient psychiatrists) which were conducted by all specialists from the team (separately)	Team mostly used existing network of referral pathways	Flyers and calls by Chief Doctor to potential local referrers (FD, outpatient and inpatient psychiatrists), team mostly used existing links with outpatient services
Eligibility criteria	Individuals with serious mental disorders, particularly those at risk of hospitalization or recently discharged from hospital, with priority to IDPs and people who need more intensive support than standard outpatient services can provide	Individuals with serious mental disorders, particularly those at risk of hospitalization or recently discharged from hospital, with priority to IDPs, conflict-affected communities and people who cannot access mental health services	Individuals with first episode psychosis (psychotic disorder duration of up to 5 years)	Severe mental health disorders, priority is given to Individuals with first episode psychosis and people who need more intensive support than standard outpatient services can provide
Most common diagnoses according initial assessments	Schizophrenia 19 % Anxiety disorder 5 % Depressive disorder 1 % Acute psychotic episode 1 % Other psychosis 1 % Substance abuse 1 % Other 71 %	Schizophrenia 24 % Depressive disorder17 % Anxiety disorder 14 % PTSD 5 % Adjustment disorder 5 % Other psychosis 4 % Bipolar disorder 2 % Acute psychotic episode 1 % Personality disorder 2 % Substance abuse 1 % Other 21 %	Acute psychotic episode 55 % Schizophrenia 13 % Anxiety disorder 7 % Depressive disorder 6 % Other psychosis 6 % Bipolar disorder 3 % Personality disorder 2 % Acute stress 1 % Adjustment disorder 1 % Other 1 %	Schizophrenia 40 % Anxiety disorder 12 % Acute psychotic episode 10 % Other psychosis 9 % Depressive disorder 7 % Personality disorder 3 % Bipolar disorder 2 % PTSD 2 % Substance abuse 2 % Other 10 %
Consultations provided	≈ 204 per month	≈ 109 per month	≈ 51 per month	≈ 111 per month
	Estimated from number of client visits during 9 months (medical, psychological, psychosocial, family Interventions and secondary consultations)			

In general, a pilot project has shown the efficiency of mCMHTs working with patients with serious mental disorders. Mostly, team worked with patients with psychotic disorders or severe anxiety and depressive disorders. Evaluation of the results showed a significant increase of patients' social functioning, as well as patients' satisfaction of a new form of work (according to interviews and questionnaires). Patients willingly participated in the project and the main referral source was self-referral.

Team's staff also rated this project as effective mode of work with psychiatric patients. Noting, however, that it is resource – consuming due to the necessity of adjustment to the new work model, to a pilot project status (not legislated) and to a greater intensity of work with the patient.

Trainings and supervisions were another important strategy aimed to support teams and increase their efficacy.

Variations in the model adopted by the different cities provided valuable information about the elements that were successful. For example: full-time employment of at least part of the specialists in the team, proactive personal and team meetings with potential stakeholders, using flyers and leaflets to increase self-referrals and awareness in the community, communication with broad network of organizations which can deal with people with mental disorders, using unmarked vehicles, involving management staff to coordinator position. Adequate communication with FD created the conditions for better detection of primary psychiatric disorders. However, secondary consultations were rare, because FD have little desire to keep patients with mental disorders in their practice (according to interviews with team members).

Another decisions hindered implementation at the operational level. Among them were: too strict eligibility criteria, part-time employment of all specialists, field visits to regions where initial medical examination was not carried out and where the team had to perform a greater amount of work consulting many people without mental disorders.

The limits are related to the large geographical areas which need to be addressed, to the incomplete knowledge of care and to the lack of support and cooperation with primary healthcare system.

Other drawbacks included the fact that project was temporary and hence patients did not want to join it as well as specialists did not want to refer their patients because of not knowing what will be next; large geographical areas which need to be addressed; incomplete knowledge of principles and methodology of community based care and need for additional training; lack of awareness and ability to identify mental illness among family doctors; lack of support and cooperation with primary healthcare system and NGOs; stigma and deficiency of public awareness.

Lessons learned:

1. Strong and active support of medical directors and local authorities is crucial for effective implementation of mCMHTs.

2. New referral pathways must be organized. The current system of referrals cannot be relied on.

At least part of the mCMHT should be represented by the full-time employed staff. Staff should be properly trained.

3. Special attention should be paid to communication with GP and this algorithm should be regulated legislatively.

4. Cooperation with NGOs must be encouraged.

5. Proactive case-finding should also accept the possibility of patient self-referral.

6. The staff should be properly trained and supervisions are necessary.

7. Efforts should be made to decrease stigmatization and raise public awareness.

Conclusions

The pilot project showed the effectiveness of the mobile community mental health care for people with severe mental disorders and with impaired social functioning or difficulties in access to mental health services. Also, this first experience outlined the main difficulties that may arise in further implementation. Such difficulties can be overcome by creating competent legal framework, educating mental health specialists and general practitioners and by raising public awareness and decreasing stigmatization.

Perspectives for further research

In the future it is necessary to continue the assessment of effectiveness of the mCMHTs in long term perspective, as well as to evaluate the features of the implementation of community based mental health care in other regions.

References

1. Jong, J. T., Komproe, I. H., & van Ommeren, M. (2003). Common mental disorders in postconflict settings. *The Lancet,* vol. 361, no. 9375, pp. 2128–2130. DOI:10.1016/S0140-6736(03)13692-6.
2. Epping-Jordan, J. E., van Ommeren, M., Ashour, H. N., Maramis, A., Marini, A., Mohanraj, A., … Saxena, S. (2015). Beyond the crisis: building back better mental health care in 10 emergency-affected areas using a longer-term perspective. *International Journal of Mental Health Systems*, vol. 9 (15). DOI:10.1186/s13033-015-0007-9. Retrieved from: https://ijmhs.biomedcentral.com/articles/10.1186/s13033-015-0007-9. (Accessed 17.06.2016).
3. Priebe, S., Bogic, M., Ajdukovic, D., Franciskovic, T., Galeazzi, G. M., Kucukalic, A., … Schützwohl, M. (2010). Mental disorders following war in the Balkans: a study in 5 countries. Archives of General Psychiatry, vol. 67, issue 5, pp. 518–528. DOI:10.1001/archgenpsychiatry.2010.37.
4. Becker, T., & Vazquez-Barquero, J. L. (2001). The European perspective of psychiatric reform. *Acta Psychiatrica Scandinavica*, vol. 104, issue s410, pp. 8–14. DOI:10.1034/j.1600-0447.2001.1040s2008.x.
5. Tol, W.A., Barbui, C., Galappatti, A., Silove, D., Betancourt, T. S., Souza, R., … van Ommeren, M. (2011). Mental health and psychosocial support in humanitarian settings: linking practice and research. *The Lancet*, vol. 378, no. 9802, pp. 1581–1591. DOI:10.1016/S0140-6736(11)61094-5.
6. van Ommeren, M., Saxena, S., & Saraceno, B. (2005). Mental and social health during and after acute emergencies: emerging consensus? *Bulletin of the World Health Organization*, vol. 83, no. 1, pp. 71–75.
7. Thornicroft, G., & Tansella, M. (2013). The balanced care model: the case for both hospital- and community-based mental healthcare. *The British Journal of Psychiatry*, vol. 202, issue 4, pp. 246-248. DOI:10.1192/bjp.bp.112.111377.
8. *The European Mental Health Action Plan 2013-2020*. (2013). World Health Organization. Copenhagen, WHO Regional Office for Europe. Retrieved from: http://www.euro.who.int/__data/assets/pdf_file/0020/280604/WHO-Europe-Mental-Health-Acion-Plan-2013-2020.pdf. (Accessed 17.06.2016).
9. Thornicroft, G., & Tansella, M. (2003). *What are the arguments for community-based mental healthcare?* Copenhagen, WHO Regional Office for Europe (Health Evidence Network report). Retrieved from: http://www.euro.who.int/__data/assets/pdf_file/0019/74710/E82976.pdf. (Accessed 17.06.2016).
10. Killaspy, H. (2006). From the asylum to community care: learning from experience. *British Medical Bulletin*, no. 79-80 (1), pp. 245–258. DOI:10.1093/bmb/ldl017.

Список використаної літератури

1. Jong J. T. Common mental disorders in postconflict settings / J. T. Jong, I. H. Komproe, M. van Ommeren // The Lancet. – 2003. – vol. 361, no. 9375. – P. 2128-2130.
2. Epping-Jordan J. Beyond the crisis: building back better mental health care in 10 emergency-affected areas using a longer-term perspective / J. E. Epping-Jordan, M. van Ommeren, H. N. Ashour, A. Maramis et al. // International Journal of Mental Health Systems. – 2015. – Vol. 9 (15). Режим доступу: https://ijmhs.biomedcentral.com/articles/10.1186/s13033-015-0007-9 (дата звернення: 17.06.2016).

3. Priebe S. Mental disorders following war in the Balkans: a study in 5 countries / S. Priebe, M. Bogic, D. Ajdukovic [et al.] // Archives of General Psychiatry. – 2010. – Vol. 67, issue 5. – P. 518-528.
4. Becker T. The European perspective of psychiatric reform / T. Becker, J. L. Vazquez-Barquero // Acta Psychiatrica Scandinavica. – 2001. – vol. 104, Issue s410. – P. 8-14.
5. Tol W. A. Mental health and psychosocial support in humanitarian settings: linking practice and research / W. A. Tol, C. Barbui, A. Galappatti [et al.] // The Lancet. – 2011. – Vol. 378, no. 9802. –P. 1581-1591.
6. van Ommeren M. Mental and social health during and after acute emergencies: emerging consensus? / M. van Ommeren, S. Saxena, B. Saraceno // Bulletin of the World Health Organization. – 2005. – Vol. 83, no. 1. – P. 71-75.
7. Thornicroft G. The balanced care model: the case for both hospital- and community-based mental healthcare / G. Thornicroft, M. Tansella // The British Journal of Psychiatry. – 2013. – Vol. 202, issue 4. – P. 246-248.
8. World Health Organization. The European Mental Health Action Plan 2013-2020. Copenhagen, WHO Regional Office for Europe, 2013. Режим доступу: http://www.euro.who.int/__data/assets/pdf_file/0020/280604/WHO-Europe-Mental-Health-Acion-Plan-2013-2020.pdf (дата звернення: 17.06.2016).
9. Thornicroft G. What are the arguments for community-based mental healthcare? / G. Thornicroft, M. Tansella. – Copenhagen, WHO Regional Office for Europe (Health Evidence Network report), 2003. Режим доступу: http://www.euro.who.int/document/E82976.pdf (дата звернення: 17.06.2016).
10. Killaspy H. From the asylum to community care: learning from experience / H. Killaspy // British Medical Bulletin. – 2006. – No. 79-80 (1). – P. 245-258.

СПІЛЬНОТНІ БРИГАДИ З ОХОРОНИ ПСИХІЧНОГО ЗДОРОВ'Я ДЛЯ ОСІБ З ПСИХІЧНИМИ РОЗЛАДАМИ: ПІЛОТНИЙ ПРОЕКТ В УКРАЇНІ

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Мобільні спільнотні бригади з охорони психічного здоров'я (МСБОПЗ) для осіб з психічними розладами організовані в чотирьох регіонах України. Метою проекту є покращення якості життя та функціонування осіб, хворих на психічні розлади, шляхом забезпечення комплексної спеціалізованої допомоги за місцем проживання в якості альтернативи госпіталізації. Крім того, проект був спрямований на сприяння інтеграції охорони психічного здоров'я в систему первинної медико-санітарної допомоги.

Мета даної роботи – провести порівняння організаційних моделей роботи МОБПЗ у чотирьох пілотних регіонах: місцевий контекст, особливості роботи, найпоширеніші діагнози пацієнтів, з якими вони працюють, методи, напрямки, типи втручання.

Матеріали і методи дослідження: щотижневі он-лайн звіти МОБПЗ, опитувальники для пацієнтів, матеріали, отримані за результатами відвідування пілотних регіонів та інтерв'ю з фахівцями.

Результати. Різниця в обсязі зони покриття, доступних послугах та потребах населення сформувала індивідуальні особливості кожної МОБПЗ. Можливість адаптувати загальну модель спільнотної допомоги до місцевого контексту стала важливою умовою для ефективної роботи бригад з урахуванням можливості конкретизувати критерії включення, організувати шляхи направлення та обрати повну чи часткову зайнятість персоналу.

Висновки. МСБОПЗ довели свою ефективність при лікуванні хворих з тяжкими психічними розладами, що супроводжуються значним зниженням соціального функціонування, а також пацієнтів, які тимчасово не мають доступу до послуг з охорони психічного здоров'я і внутрішньо переміщених осіб з проблемами психічного здоров'я. Крім того, перший досвід показав бар'єри, які можуть виникнути на шляху подальшої імплементації спільнотної форми допомоги. Обмеження пов'язані з великою площею територій, які повинні бути охоплені, недостатнім знанням нової форми роботи, відсутністю підтримки і співпраці з первинною ланкою медичної допомоги, соціальними службами та організаціями, що можуть займатися особами, які мають психічні розлади, а також стигматизацією та недовірою з боку спільноти до психіатричної служби.

Ключові слова: психічне здоров'я, спільнотні бригади, мобільна спільнотна бригада з охорони психічного здоров'я, пілотний проект.

ОБЩИННЫЕ БРИГАДЫ ПО ОХРАНЕ ПСИХИЧЕСКОГО ЗДОРОВЬЯ ДЛЯ ЛИЦ С ПСИХИЧЕСКИМИ РАССТРОЙСТВАМИ: ПИЛОТНЫЙ ПРОЕКТ В УКРАИНЕ

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Мобильные общинные бригады по охране психического здоровья (МОБОПЗ) для лиц с психическими расстройствами организованы в четырех регионах Украины. Целью проекта является улучшение качества жизни и функционирования лиц, страдающих психическими расстройствами, путем обеспечения комплексной специализированной помощи по месту жительства в качестве альтернативы госпитализации. Кроме того, проект был направлен на содействие интеграции охраны психического здоровья в систему первичной медико-санитарной помощи.

Цель данной работы – провести сравнение организационных моделей работы МОБПЗ в четырех пилотных регионах: местный контекст, особенности работы, наиболее распространенные диагнозы пациентов, с которыми они работают, методы, направления, типы вмешательства.

Материалы и методы исследования: еженедельные он-лайн отчеты МОБПЗ, опросники для пациентов, материалы, полученные по результатам посещения пилотных регионов и интервью со специалистами.

Результаты. Разница в территориальном охвате, доступных услугах и потребностях населения сформировала индивидуальные особенности каждой МОБПЗ. Возможность адаптировать общую модель общинной помощи к местному контексту стала важным условием для эффективной работы бригад с учетом возможности конкретизировать критерии включения, организовать пути направления и выбрать полную или частичную занятость персонала.

Выводы. МОБОПЗ доказали свою эффективность при лечении больных с тяжелыми психическими расстройствами, сопровождающимися значительным снижением социального функционирования, а также пациентов, которые временно не имеют доступа к услугам по охране психического здоровья и внутренне перемещенных лиц с проблемами психического здоровья. Кроме того, первый опыт показал барьеры, которые могут возникнуть на пути дальнейшей имплементации общинной формы помощи. Ограничения связаны с большой площадью территорий, которые должны быть охвачены, недостаточным знанием новой формы работы, отсутствием поддержки и сотрудничества с первичным звеном медицинской помощи, социальными службами и организациями, которые могут заниматься лицами, имеющими психические расстройства, а также стигматизацией и недоверием со стороны сообщества к психиатрической службе.

Ключевые слова: психическое здоровье, общинные бригады, мобильная общинная бригада по охране психического здоровья, пилотный проект.

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