DEINSTITUTIONALIZATION OF THE MENTAL HEALTH CARE SYSTEM AND ANALYSIS OF THE INCIDENCE AND PREVALENCE OF MENTAL ILLNESS IN THE POPULATION OF DIFFERENT COUNTRIES OF THE WORLD AND UKRAINE

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Abstract. The purpose of this paper is to study the problems of mental health of the population of Ukraine in the organization of psychiatric care and the comparative experience of the European Union. The methods used in the work are: bibliosemantic, historical, content analysis. The article is devoted to the problem of mental health in Ukraine and in the EU countries. Statistics in Ukraine show an increase in mental disorders due to many problems: war, displacement of people, which is a great burden for the country. The WHO pays great attention in this direction: it analyzes each country and provides recommendations, an action plan, examples of other countries that have experience in improving mental health and quickly resolving issues. According to our observations, it was found that men in the period 2018–2020 were more likely to be treated and treated in psychiatric hospitals from 67,2% to 65,3%, respectively, as well as treated in day psychiatric hospitals from 57,3% to 59,4% respectively. At the same time, women underwent outpatient treatment for the same period from 78,9% to 81,0%, respectively, while less treatment was provided in psychiatric hospitals from 32,8% to 34,7%, respectively. People living in rural areas, as well as abroad, seek treatment less often than urban population and prefer inpatient psychiatric care due to poor transport links and lack of specialists

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in their place of residence. The European Union legislation is focused on decentralization of the mental health care system, development of community-based mental health services with social integration of patients (education, accommodation) at the level of the territorial community, capacity building and competent personnel with the introduction of a system of accreditation and certification of mental health professionals, as well as restructuring of state funding for specialized mental health care services, which is defined by the measure. Compliance with regulatory and legal issues in the treatment of persons with mental disorders. Implementation of deinstitutionalization in Ukraine in accordance with the experience of EU countries: reducing the number of places in psychoneurological hospitals, creating conditions for alternative treatment of mental patients in primary health care, in psychiatric departments in general hospitals, in day hospitals, in crisis centers, mental health centers. Adequate, decent, fair funding of the mental health care system. Improving the quality, volume, and timeliness of medical services in both urban and rural areas is one of the priority tasks of health care in every country in the world. In order for doctors to work in rural communities, it is necessary to create appropriate conditions for them: provide housing, transportation, decent salaries, satisfaction with work, life in this community, etc.

1. Introduction

Regulatory and legal support in the countries of the world in the field of medical services is provided by international and domestic acts that guarantee a person high-quality, qualified, timely medical care in case of illness, and especially for patients with mental disorders. In 1948, the governments of the Council of Europe member states signed the Convention for the Protection of Human Rights and Fundamental Freedoms, which aims to ensure and promote human rights and fundamental freedoms (entered into force for Ukraine in 1997). Article 1 of the Convention: "The obligation to respect human rights"; Article 2: "The right to life"; Article 3: "Prohibition of torture: no one shall be subjected to torture or to inhuman or degrading treatment or punishment"; Article 4: "Prohibition of slavery and forced labor: no one shall be held in slavery or servitude, or subjected to forced or compulsory labor"; Article 5: "The right to liberty and security of person". This is relevant today for mentally ill persons undergoing treatment in

psychoneurological hospitals and dispensaries. The Declaration stipulates that "all human beings are born free and equal in dignity and rights," setting a human rights standard, including for persons with mental disorders [1; 2].

The Declaration enshrines the right of everyone to a standard of living adequate for the health and well-being of himself or herself and of his or her family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his or her control [3; 4].

The resolution of the WHO, the Council of the EU, the Council of Europe since 1975, attaches great importance to the promotion of mental health in the humanitarian sphere (Helsinki Declaration 994_055) signed by the heads of 35 states in the capital of Finland – Helsinki, including the USSR. The Declaration addresses human experimentation, is directly related to clinical research, and has undergone eight revisions, the last in 2000. WHO invites all governments to strengthen cooperation to improve the effectiveness of the implementation of the provisions of the Helsinki Declaration (1975). The Meran Declaration reflects the successful experience of European countries and recommends that the governments of newly independent states take into account the following key areas when reforming the mental health care system: the main priorities of the national policy of each state are: ensuring mental well-being in the field of mental health care; adequate and fair funding for the development of mental health services at different stages of human life (children, adults, the elderly, people with disabilities); support and development of innovative projects and systems [5–9].

The main declaration for EU countries is the Hawaii Declaration of the World Psychiatric Association (1983). It was adopted by the World Psychiatric Association on 10.07.1983.

2. Reforming the Mental Health System

According to the Hawaii Declaration, the purpose of psychiatry is to treat mental illness and improve mental health. It is noted that psychiatrists should serve the interests of the patient, in accordance with the scientific knowledge gained and accepted ethical principles. According to Art. 6 of the Hawaii Declaration, the patient should be released from involuntary treatment as soon as the indications for such treatment disappear, and the

doctor must obtain the patient's voluntary consent for further therapy. Specific duties of a psychiatrist are defined, namely: in the treatment of patients with mental disorders there should be trust, confidentiality, contact with relatives, constant informing of the patient about his/her illness and treatment methods, not to violate the patient's rights, not to conduct experiments on the patient (effective for Ukraine on 06.03.2010). The annex to Resolution 37/194 sets out 6 principles of medical ethics that relate to the role of health professionals, and especially physicians, in protecting prisoners and detainees from torture and other cruel, inhuman or degrading treatment or punishment. It is emphasized that health care professionals are obliged to protect the physical and mental health of prisoners or detainees and to provide treatment of diseases of the same quality and level as provided to persons who are not imprisoned or detained [10].

The VIII World Congress of Psychiatrists in Athens, held in 1989, adopted the position and views of the World Psychiatric Association on the rights and legal protection of the mentally ill. This Charter continues and supplements the Hawaii Declaration (995_872), which reflects the main part of the main guiding principles on the rights of the mentally ill, namely: persons with mental disorders have the right to freedom, to treatment like other patients with other diseases, they should not be discriminated against because of their illness. They should receive professional, humane, decent care without coercion against the patient's will in accordance with the requirements of medical deontology. Such patients should not be used as labor, mistreated and humiliated in accordance with the Declaration (995_872) on the Rights of People with Mental Illness (1983) [11–13].

The General Assembly of the World Psychiatric Association at the VIII World Congress of Psychiatry in Athens (Greece) on October 17, 1989, adopted a provision prohibiting compulsory intervention, which is a gross violation of human rights and freedom of the patient. Therefore, special criteria and carefully defined guarantees are required for such intervention. Hospitalization or treatment should not be carried out against the will of the patient, unless the patient suffers from serious mental illness. Compulsory intervention should be carried out in accordance with the rule of least restriction [14].

Regarding the protection of mentally ill persons, the UN General Assembly adopted Resolution 46/119 "Protection of Persons with Mental

Illness and Improvement of Mental Health Care" in 1992 to eliminate any discrimination in these institutions. This document sets out 25 principles regarding persons with mental disorders: they have the right to exercise all civil, political, economic, social and cultural activities, patients have the right to a lawyer, have the right to live and work in society, have the right to undergo medical examination to detect mental disorders upon request or with the consent of a relative/guardian. A doctor must observe confidentiality and medical ethics. Patients have the right to medical and social assistance to maintain health and social reintegration through rehabilitation and occupational therapy. For any work, the patient should receive a monetary reward from the psychiatric institution, the treatment of each patient should be individualized and discussed with the patient or relative/guardian and changed during treatment if necessary, treatment should be aimed at preserving and strengthening the autonomy of the person, medications should be prescribed for therapeutic or diagnostic purposes, not for experiments. Resolution 46/119 adopted the Principles for the Protection of Persons with Mental Illness and Improvement of Mental Health Care. In the context of our study, special attention should be paid to the content of Principle 16 "Involuntary hospitalization": "a person may be involuntarily admitted to a mental institution as a patient on an involuntary basis, or a person already hospitalized as a patient on a voluntary basis may be detained as a patient in a mental institution on an involuntary basis if and only if a qualified professional working in the field of psychiatry authorized for this purpose by law establishes that the person suffers from mental illness and determines that: (a) as a result of that mental illness, there is a serious threat of immediate or imminent harm to that person or to others, or in the case of a person whose mental illness is severe and whose mental capacity is impaired refusal to hospitalize or keep the person in a psychiatric institution may lead to a serious deterioration of his or her health or make it impossible to apply appropriate treatment, which can only be carried out if he or she is hospitalized in a psychiatric institution in accordance with the principle of the least restrictive alternative. Compulsory hospitalization or detention for examination or preliminary treatment, for consideration of hospitalization or detention by a supervisory authority" [15–17].

PACE Recommendation 1235 "Psychiatry and Human Rights" (1994) states that treatment should be based on a distinction between patients with

incapacity and mentally ill patients, and the patient should have free access to a "defender" independent of the institution. Particular attention is paid to problems and abuses in psychiatry, including the prohibition of sexual harassment of patients by therapists, restrictions on the use of isolation rooms, and the prohibition of scientific research in the field of mental health without the patient's knowledge or against his or her will [18].

PACE recommendation 818 on the situation with mental illness (1977) suggests that the Committee of Ministers call on the governments of member states to take the following measures:

– review legislation relating to mental illness;

– establish independent special courts or commissions for mental health care to ensure the right to defense of persons with mental illness;

– to ensure the right of persons with mental illness to be heard in court proceedings in which a decision is made to recognize them as incapacitated [19].

The Salamanca Declaration on Principles, Policies and Practices for the Education of Persons with Special Educational Needs and the Framework for Action on the Education of Persons with Special Educational Needs (1994).

Member State governments call for the adoption of the principle of inclusive education in the form of a law or political declaration; the establishment of decentralized and participatory mechanisms for planning, monitoring and evaluating educational services for children and adults with special educational needs; and the promotion of the participation of parents, communities and organizations of persons with disabilities in planning and decision-making processes related to meeting special needs [20].

The Madrid Declaration on Ethical Standards of Psychiatric Practice (1996), which was adopted by the General Assembly of the World Psychiatric Association on August 25, 1996. The preamble to the Declaration emphasizes that psychiatrists should always be mindful of the boundaries of the relationship between psychiatrist and patient and be guided primarily by respect for patients and concern for their welfare and integrity. In addition, the Declaration insists on treatment based on partnership with persons with mental and behavioral disorders and on involuntary treatment only in exceptional circumstances [21].

The European Social Charter (1996, revised) sets out the rights of persons with disabilities to independence, social integration and participation in society. To this end, the Parties undertake to:

1) take the necessary measures to provide persons with disabilities with guidance, education and vocational training;

2) facilitate their access to jobs freely chosen by them and encourage employers to hire and retain persons with disabilities in the normal working environment and to adapt working conditions to the needs of persons with disabilities;

3) promote their full social integration and participation in society, have the right to fair remuneration, etc. [22; 23].

During any procedures, the patient has the right to demand the presence of persons who protect his or her rights, and any measures (medication, procedures, isolation, fixation methods, electroshock therapy) that were taken with the patient should be recorded in the medical record. The patient has the right to use the telephone, read newspapers, listen to the radio, watch television, and any comments made by the patient should be attached to the medical record at the patient's request. The psychiatric institution should have conditions to ensure the patient's safety and privacy and should be inspected/inspected with sufficient regularity by the competent authorities [24; 25].

There is a concept of "AAAQ" (defined in General Comment No. 14 (2000) of the Committee on Economic, Social and Cultural Rights), which aims to assist countries in realizing the "Right to the enjoyment of the highest attainable standard of physical and mental health (Article 12 of the International Covenant on Economic, Social and Cultural Rights)" provides for the following The right to health encompasses a range of both socio-economic factors that create the conditions that enable people to lead a healthy life and the basic components of health, such as food and diet, housing, access to potable water and adequate sanitation, safe and harmless working conditions and a health-promoting environment. According to the Committee's explanation, the right to health care includes interrelated principles: availability – the existence of sufficient medical facilities; accessibility as physical, economic, informational and non-discrimination to any patient; acceptability – medical facilities must adhere to medical ethics; quality – medical services provided by medical facilities must

be of high quality and scientifically sound. Access to quality healthcare services for people in rural areas is limited or unavailable in many countries around the world. Patients have to spend resources on travel, travel time, and accommodation in institutions that provide quality medical services. Due to the lack of specialists in institutions that should be in communities, departments, services (psychosocial centers, day care centers, dormitories for patients with chronic mental disorders), they do not receive timely and quality medical care. Governments spend large resources on the maintenance of large specialized institutions that provide care to a small number of patients with mental disorders, but if primary care facilities were created that were as close to the place of residence as possible and could provide greater benefit to a larger number of patients with mental disorders, they would not disrupt the possibility of communication and care by relatives of patients [26; 27].

Mental Health Promotion: Concepts, New Evidence, provides an explanation of the definition – mental health is "a state of well-being in which a person can realize his or her own potential, cope with the normal stresses of life, work productively and fruitfully, and be able to contribute to the life of his or her community" from the report of the World Health Organization, Department of Mental Health and Substance Abuse in collaboration with the Victorian Health Promotion Foundation and the University of Melbourne. WHO, Geneva (2005) [28].

At the WHO European Ministerial Conference (2006), the European Action Plan for Mental Health was developed. It defined the priorities of WHO and its Member States:

1) to promote mental health, prevention of mental disorders, treatment and rehabilitation of persons with mental disorders and care for them to promote greater awareness of the importance of mental well-being;

2) to carry out joint actions aimed at combating stigma, discrimination and inequality, as well as empowering and supporting people with mental disorders and their families to actively participate in this process;

3) to develop and implement comprehensive, integrated and effective mental health care systems, covering such elements as health promotion, prevention, treatment and rehabilitation, care and recovery;

4) ensure that the needs for qualified personnel capable of working effectively in all these areas are met [29; 30].

In the last decade, WHO has noted an increase in the global burden of mental illness among all diseases and is one of the leading causes of disability in the world, which is a great burden on the financial, economic and social policies of any state. It has been established that many countries at any level face the problem of preserving and strengthening the mental well-being of the population, especially among marginalized and vulnerable groups, given the scale of both material and human damage to society, the suffering of relatives of patients and disability. According to epidemiological studies, 5 to 7% of the world's population suffers from mental illness [31; 32].

At the X Conference of the European National Coordinators of the WHO Mental Health Program (2007), a working group was established to develop a "Joint Action Plan to improve the effectiveness of national programs to reform mental health systems in newly independent states," including Ukraine. And in 2008, at the conference of European National Coordinators (Merano, Italy), the working group adopted the WHO Merano Declaration on Mental Health in the Countries Formed after the Collapse of the USSR. This declaration contains WHO's expert assessment and recommendations for further strategy and tactics to improve the mental health system in the newly independent states: Azerbaijan, Kyrgyzstan, Tajikistan, Turkmenistan, Uzbekistan, Georgia, Moldova, Belarus, Ukraine and the Russian Federation [33].

The document "Improving health systems and services for mental health. WHO" (2009) contains the main tools for strengthening the mental health system in the context of overall health system development. This is a relevant summary of recent WHO initiatives to improve access to and quality of treatment and care for people with mental disorders [34].

The WHO Comprehensive Plan of Action for Mental Health 2013–2020 was adopted by the 66th World Health Assembly (2013, Geneva) for global and national action to promote mental well-being. The Action Plan focuses international attention on the neglected issues that have led to an increase in mental illness and that have become a burden for every nation. The most common mental illness in any country, and especially in low-income countries, is depression, which by 2030 will be the third leading cause of mental disorders, and the increase in stigma and discrimination in society against the mentally ill. Stigmatization of

people with mental disorders has been going on since ancient times and causes social undesirability and discrimination against these people all over the world [35–39].

People living in rural areas, and especially in low-income countries, face problems with both timely treatment and receiving qualified care. Programs and projects that are being developed in low- and middle-income countries to improve mental health are aimed at developing, equipping, and improving primary health care at the national level for more accessible universal health care coverage, intersectoral coordination, and responsiveness to patient requests. For this purpose, primary health care centers should be equipped with modern equipment, the Internet, electronic software, telemedicine consultations on any pathology, etc. [40–43].

The WHO Comprehensive Mental Health Action Plan describes the main, specific areas for Member States to achieve global goals, namely: strengthening the effectiveness of mental health leadership and management; providing comprehensive, integrated and social mental health services in communities; implementing mental health promotion and prevention strategies; and using information systems, evidence and research on mental health. Every year, WHO provides an analysis of the main indicators that countries have achieved and the measures that still need to be taken in the Mental Health Atlas. Changes to improve mental health in the world are not happening quickly due to the inability to adequately and equitably invest in the mental health system, which affects the health of the world's population (data from 177 WHO Member States – 97% of the world's population), and especially in low-income countries. According to the WHO Mental Health Atlas 2011 survey, 1% of the health care budget is spent on mental health services in low-income countries, and 5% in high-income countries [44].

According to the WHO (2003) recommendations on the organization of mental health services, modules for implementation by countries in the field of mental health promotion and care are proposed: plans and strategies for improving the mental health of the population, financing, lawmaking, restructuring and improving the quality of mental health care, training, information and education, and research in the field of mental health. All modules were proposed and adapted by the WHO (2003) by public authorities at all levels: Ministry of Health, National Health Service, health care providers, communities or organizations, human

rights activists, representatives or associations of families and individuals, representatives of different faiths who protect the interests of people with mental disorders [45–47].

The WHO classified the organization of mental health services in different countries into the following categories:

1. Primary health care mental health service, which includes medical services provided by family doctors, nurses, psychologists, psychiatrists, neurologists, social workers at the place of residence and remain in their environment. Also, centers for psychological assistance to the population can operate on the basis of the primary health care system, which will provide medical and psychological assistance with the initial signs of anxiety and depression, predictors of emotional burnout.

2. Mental health care service in general hospitals (for prevention of stigmatization) includes services provided in district or central general hospitals, hospitals at educational institutions in general wards and emergency psychiatric care units by psychiatrists, nurses, social psychologists, specialists who have completed a special training course in psychiatry.

3. Specialized institutional psychiatric clinics that provide services for patients with acute mental disorders in high-security wards, forensic psychiatry units, and for patients with hard-to-treat mental illnesses, with constant monitoring by human rights organizations [48–50].

High-quality and successful medical and psychological care at various levels requires: legislative approval of the Law on Mental Health Care (2000); decent, adequate, fair funding; provision of quality medical services by highly qualified, experienced mental health professionals of any level; treatment of patients with quality medications; use of modern methods of psychosocial intervention; accessibility of treatment for all segments of the population and constant monitoring of the quality of medical and psychological care [51].

Mental health services can be both public and private. Public mental health services in the community may include mobile multidisciplinary crisis teams that work closely with primary health care facilities, specialists from district or central general hospitals, hospitals at educational institutions in general wards and emergency psychiatric units, and rehabilitation services. Private community-based mental health services may include community

members, communities, traditional healers and medicine men, and private homes for people with mental illness [52–54].

Many countries have undergone decentralization reforms since 1980, which have had a positive impact not only on the economic reforms of the countries, but also on the health care system. Each country has gone through this process in different forms, plans, and projects, mainly for the same purpose: to stimulate economic growth, strengthen civil society, deepen democracy or delegate powers to lower-level governments, reduce rural poverty, and remove the limitations of centrally managed health systems to reach underserved rural communities in low- and middle-income countries. For this reason, the health sector has had to strategize (to maximize the positive and minimize the negative impact of decentralization reforms on a range of interventions in different settings [55–58].

The following countries have become important benchmarks in the field of mental health care: Spain, Italy, Poland, Hungary, Sweden, France, Great Britain and other countries. All of these countries have succeeded by adopting General Legislative Laws on Mental Health Care that created favorable conditions for successful reform in this area: reforming psychiatric hospitals, deinstitutionalizing specialized care, improving the level of primary health care at the place of residence, and switching to a multidisciplinary model of providing medical care to mentally ill persons. The main goals of this reform were aimed at strengthening and restoring patients' health, ensuring proper care, respecting patients' rights, maintaining confidentiality, informing patients about their treatment, involving patients in planning and implementing their care, building trust between staff and patients, consenting to treatment, notifying relatives and guardians of the diagnosis, etc. For example, in Spain, over 10 years (since 1986), the number of beds in psychiatric hospitals has decreased from 100 to 25 per 100 thousand patients, 500 mental health centers have been built with an average coverage of 87 thousand people, and conditions for treatment have been created in 95 psychiatric departments in general hospitals and 108 day hospitals [59–62].

In Italy, since 1978, the number of mentally ill people in psychiatric hospitals has been decreasing from 78538 in 1978 to 7704 in 1998, and in 2000 all psychiatric hospitals were closed. This was due to the adoption of Law 180 (the Basalia Law), which allowed patients to participate

in community life and receive treatment in psychiatric wards in general hospitals and day hospitals. The reform of psychiatric care is associated with improved legislation and the introduction of modern management and economic concepts, including a continuous model of treatment, advantages and disadvantages in the provision of psychiatric care in primary and secondary hospitals, and a model of integration of mental health care in the care of primary care providers in the community [63–66].

According to the Italian psychiatrist Lorenzo Toresini: "Deinstitutionalization in Italy is cheaper for society than financing and maintaining psychiatric hospitals." This law was taken as a model in 2001 by Brazil, No. 10216 "Law on Mental Health Care", which gave this country a quick solution to the issue of mental health of the Brazilian population. The health care reform was focused on the following areas of action: administrative, organizational and medical care delivery models. A new monthly assessment of implanted electronic medical records of referrals, treatment, quality of care, timeliness, and satisfaction with health care was introduced [67; 68].

The legislation of European countries (on the example of the Republic of Poland), unlike the Ukrainian one, is focused on decentralization of the mental health care system, development of community-based mental health services with social integration of patients (education, accommodation) at the level of the territorial community, capacity building and competent personnel with the introduction of a system of accreditation and certification of mental health professionals, as well as restructuring of state funding for specialized medical institutions. The experience of European countries shows that the treatment of mentally ill patients is carried out in psychological comfort, in a therapeutic environment – in "mental health centers" with the aim of "restoring human life", spiritual recovery, and integration of patients into society [69; 70].

In 1994, the Republic of Poland adopted the Law on Mental Health Protection ("Ustawa o ochronie zdrowia psychicznego"), which defines the term "mental health is a basic personal good of a person, and the protection of the rights of persons with mental disorders is the duty of the state". Currently, the National Mental Health Protection Program for 2017–2022 is in effect. Currently, there are 54 psychiatric hospitals in the Republic of Poland, which have reconstructed all inpatient facilities built more than

100 years ago, more than 100 general hospitals, 200 day care units for patients with mental disorders and 27 mental health centers for patients treated in community-based settings [71; 72].

In European countries, deinstitutionalization efforts focused on the design/reconstruction of old psychiatric hospital buildings and paid special attention to the architecture, physical conditions of the facilities, the environment, and the equipment installed for both patients and healthcare workers.

In its 2008 report, "Primary Health Care Now More Than Ever," the WHO drew the attention of all governments to the main groups of reform: universal coverage reforms; service delivery reforms; public policy reforms that would ensure healthier communities; and leadership reforms. Portugal and Brazil's reforms to improve mental health took into account the following key factors: teamwork with professional motivation, internal and external communication, strengthening of continuous learning activities, investment in facilities and equipment, commitment to information systems and computerization, proper payment for work performed, health care contracts between funders and providers, technical and political leadership, quality, and accreditation of facilities by a government agency [73–75].

In 2015, at the initiative of the Ukrainian Helsinki Human Rights Union, civil society organizations and with the support of the Ministry of Health of Ukraine, the legal, sanitary and hygienic conditions of three regional psychoneurological hospitals in Mykolaiv, Poltava and Kherson regions were monitored [76].

The findings of the inspections were virtually identical for all three institutions, namely: the implementation of the Principles for the Protection of Mentally Ill Persons and the Improvement of Mental Health Care, adopted by the UN General Assembly in resolution 46/119 (1991), was violated. There are violations of the Law of Ukraine "On Psychiatric Care" in the issue of involuntary hospitalization, there are no standard Regulations on inpatient psychiatric institutions, which makes the observance of human rights directly dependent on internal documents and hospital staff, and this does not meet international standards. Hospital staff are not familiar with international standards of human rights; communication between medical staff and patients is characterized by dominance and humiliation; patients do not have information about the adverse effects of prescribed medications;

alternative treatment is not offered; poor quality and insufficient nutrition for patients; meals are not scheduled; patients' privacy is not respected in these institutions; conditions of stay in inpatient facilities do not meet the space per patient (the norm is 6 m^2); there is insufficient furniture for personal belongings; there is no space for work. Inpatients do not have access to pastoral care, there are no conditions for occupational therapy, patients perform work for which they do not receive monetary compensation from the psychoneurological institution, there is no rehabilitation component and inadequate support for outpatient treatment [77].

To date, Ukraine, as one of the independent states, has not been able to create a modern system of psychiatric care based on a combination of inpatient and outpatient care. In 2000, Ukraine adopted the Law "On Psychiatric Care" (as amended) on the provision of psychiatric care and legal and social protection of persons suffering from mental disorders. Article 1 of this law defines "psychiatric care" as only the medical aspect of this problem, namely "psychiatric care is the provision of a set of special measures aimed at examining the state of mental health of persons on the grounds and in the manner prescribed by this law and other laws of Ukraine, prevention, diagnosis of mental disorders, treatment, supervision, care, medical and psychological rehabilitation of persons suffering from mental disorders." But today there is no money for rehabilitation. However, the preamble of this law states "On the legal and organizational principles of providing citizens with psychiatric care based on the priority of human and civil rights and freedoms, the responsibilities of executive authorities and local self-government bodies to organize the provision of psychiatric care and legal and social protection, training of persons suffering from mental disorders, social protection and training of patients suffering from mental disorders", which are not currently implemented in bylaws and at the local level.

The Law of Ukraine "On Amendments to Certain Legislative Acts of Ukraine on the Provision of Psychiatric Care" came into force and was enacted in 2018, bringing the norms of the current legislation in line with international standards and European practice [78].

Regarding the provision of psychiatric care, these amendments to the legislative acts of Ukraine concerned the creation of conditions for the development of rehabilitation (a system of measures and social services

aimed at mastering the knowledge and skills necessary for an individual to live independently in the social environment: awareness of their capabilities and limitations, social roles, understanding of rights and responsibilities, ability to provide self-care) and rehabilitation programs for persons with mental disorders.

Due to the large number of lawsuits filed by people with mental illnesses with the European Court of Human Rights, Ukraine adopted laws to ensure the rights of people with mental disorders. The provisions of the laws provide for ensuring the rights of incapacitated persons and patients to access justice; protection against arbitrariness of psychiatrists in the application of compulsory medical measures, which will reduce the number of lawsuits to the European Court of Human Rights.

The policy on mental health care in Ukraine was formulated in 1988. In Ukraine, mental health care is envisaged by the following Concepts: The Concept of the State Targeted Comprehensive Program for the Development of Mental Health Care in Ukraine for 2006–2010, which outlines the issues and problems related to mental health, the reasons for the ineffectiveness of mental health care and the need to address both medical and social problems of society. The reform of mental health services for children and adolescents, as part of the overall mental health reforms in Ukraine, was formulated in 2013 by the Ministry of Health, the Association of Psychiatrists and groups of mental health service users and endorsed by UNICEF. The concept of the State Program for Mental Health Care in Ukraine for the period up to 2020 provided an analysis of the origin of problems related to ineffective mental health care and ways to solve them [79; 80].

The concept of the National Program of Mental Health Care in Ukraine for the period up to 2025 identified problems and difficulties, analyzed the causes of these problems, and described the goal of the program to create a holistic, effective mental health care system that operates in a unified interagency space and guarantees the protection of human rights and freedoms [81].

The draft action plan for the implementation of the Concept of the State Targeted Program for Mental Health Care of Ukraine for the period up to 2030 provides for ways to overcome numerous problems in the field of mental health: overcoming stigmatization, discrimination, violations of the rights of mentally ill people, implementing preventive measures

for children, the elderly and veterans of military operations with mental health problems and deinstitutionalization – reducing beds in specialized psychiatric hospitals by 25% and increasing the number of beds in psychiatric hospitals.

The concept has the following main objectives:

1. Strengthening the management of the mental health system.

2. Provision of comprehensive, integrated mental health and social care services in the community where the person lives.

3. Promotion and prevention of mental health of the population.

4. Optimizing information systems, evidence-based medicine and improving mental health research.

In Ukraine, the Concept of the State Target Program for the period up to 2030 and the Law of Ukraine "On Amendments to Certain Legislative Acts of Ukraine on the Provision of Psychiatric Care" provide for only declarative programs for socialization of patients with psychoneurological pathology (employment accommodation), transition to a multidisciplinary form in the provision of rehabilitation services (family doctor, psychiatrist, psychologist (psychotherapist), nurse, social worker) and others, which are not implemented in any bylaws and are not provided with state funding.

Unfortunately, this concept does not include measures on architectural and planning solutions for the construction and reconstruction of psychiatric hospitals, psychiatric departments in general hospitals and day hospitals for the treatment of patients with mental disorders [82–84].

The most important step in the HCS reform should be considered the Concept of the Reform of Local Self-Government and Territorial Organization of Power in Ukraine, which is reflected in the Laws "On Cooperation of Territorial Communities" of 2014 № 34, "On Voluntary Amalgamation of Territorial Communities" of 2015 № 13. During the six years of the reform, 1070 UTCs were created in Ukraine [85; 86].

In 2020, the Law of Ukraine "On Amendments to Certain Laws of Ukraine on Determining the Territories and Administrative Centers of Territorial Communities" № 562-IX was adopted, which finally approved 1470 territorial communities to form an optimal network of primary healthcare facilities, ensure accessibility and quality of medical care at all levels, and ensure proper equipment. Also, provision of qualified and motivated medical personnel, reliable funding from various sources

according to the Resolution of the Cabinet of Ministers of Ukraine "Some issues of implementation of the program of state guarantees of medical care for the population in 2022", 2021, № 1440 [87; 88].

In Vinnytsia Oblast, 6 out of 29 rayons remained, which made up 63 territorial communities with a population of 1545416, served by 57 primary health care centers (PHC), 39 secondary level, and 32 tertiary level (highly specialized institutions). The reform should start with a specific city, district, or region.

To improve medical care, the Government of Ukraine prepared the Resolution "Some Issues of Establishment of Hospital Districts" of 2019 No. 1074, which provides for the establishment of hospital districts to provide high-quality, comprehensive, continuous medical care to the population of the relevant territory with modern material and technical facilities. The events of the pandemic brought not only negative consequences but also contributed to the improvement of the material and technical, medical, and diagnostic base in many healthcare facilities of the HCS. When hospital districts are created, doctors will receive the following: autonomy of the medical institution, financial motivation for the intensity and quality of work, motivation for professional development, improved staffing, development of the latest technologies, and improvement of the material and technical base of the institution. What patients will get: accessibility and convenience of integrated medical care, clear definition of responsibility, the ability to choose a doctor, better conditions of stay in the hospital, access to rehabilitation and recovery treatment, receiving state packages – "more health for the same money", "patient route", etc. [89–91].

According to the report of the International Medical Corps with the support of the World Bank Group "Assessment and Recommendations for Integrating Mental Health Care into the Primary Health Care System", it is stated that in Ukraine 90% (2015 report) of the funding for the mental health system is provided mainly to psychiatric hospitals [92; 93].

The use of medical care by mentally ill people in Ukraine is low due to the stigmatized mental health system, as well as the harsh treatment of people with mental and behavioral disorders during their stay in health care facilities and violation of all patient rights. In psycho-neurological institutions, stigmatization of mentally ill people by medical workers, who, on the contrary, should provide them with medical care, is very common.

British scientists have identified unprecedented cases of stigmatization of mentally ill people by doctors, the degree of which was many times greater in terms of ill-treatment than in the patient's normal society. On the one hand, the phenomenon of stigmatization can be seen as a defensive reaction of medical personnel to the sharp increase in the number of patients with mental disorders and the lack of proper conditions for their stay, as well as a protest against the lack of social protection from the state, mainly material support in the context of the economic and political crisis in the country. On the other hand, in the society of people with mental disorders, the process of stigmatization is already entrenched by relatives and friends [94].

The problem of modern medical deontology in Ukraine is the stigmatization of healthcare workers towards patients with HIV, tuberculosis, and nowadays COVID-19, and especially towards patients with mental disorders and any mental health problems, which leads to self-stigmatization of both patients and their families, who are left alone in solving this problem.

European countries constantly pay attention to the stigma against patients with mental disorders, so such patients find support not only from government agencies (medical, social), but also from non-governmental organizations (NGO), various faiths, community volunteers, etc. The main approaches to mental health patients abroad use the following principles: balanced care, treatment and rehabilitation, which are the basis for a measured approach to wellness [95; 96].

In the EU countries, various measures have been implemented to prevent stigmatization of healthcare workers towards patients, and measures are constantly being taken to prevent and prevent such phenomena in society. The main principles of treatment in EU countries are "restoration of human life", spiritual recovery of patients, reintegration into society and full life. The forms of overcoming stigma among healthcare professionals in European countries are different, for example: education, training, psychological counseling with healthcare professionals and with relatives who care for their relatives; caregivers (for money or free of charge), etc.

Hospitalization of mentally ill people in Ukraine for inpatient treatment is often not the right/optimal decision for the patient. This is why there is no statistical data on non-specialized care for people who do not want to be "labeled" for life.

The lack of social and psychological support/rehabilitation centers for people with alcohol and drug use problems, etc. remains an unresolved problem. Many private centers that provide such services have different levels of quality and are not licensed, and there are no legislative and regulatory norms to control the activities of such centers. Such centers are often of a "closed type" and provide only medication-based treatment.

At present, the mental health care reform has not been fully implemented, has many problems, and lacks clear actions. Despite the fact that in Lithuania in 2016, inpatient treatment of mental patients accounted for 5% of the national health fund compared to the cost of outpatient treatment. In Georgia, there is a "National Strategy and Action Plan for 2015–2020" adopted in 2014, which provides for increased funding for outpatient services, mobile teams/teams in the community and crisis services. In 2017, the ratio between community-based services and institutional services in Georgia was 42/58%, and funding for outpatient services increased by 2.5 times or more, and funding for mobile services/teams in the community and crisis interventions by 10 times or more [97].

The process of deinstitutionalization in Ukraine began in April 2020 after the implementation of the second stage of healthcare reform in the secondary and tertiary healthcare system: a 25% reduction in beds in psychoneurological hospitals and underfunding of specialized psychiatric hospitals ranged from minus 50-80% compared to last year. According to the Ministry of Health of Ukraine (as of the beginning of 2019), there were 58 psychiatric hospitals and 24 narcological inpatient facilities (22 inpatient drug treatment centers and 2 narcological hospitals) with a total bed capacity of 26915 psychiatric and 3371 narcological beds; the average length of stay in a psychoneurological hospital is 48.7-53.5 days in Ukraine, while in Poland it is 20.3 days and in Lithuania it is 20.8 days (treatment of patients in crisis). At the beginning of the russian aggression in 2022, an online questionnaire conducted by Goto R. (2022) received a response from 32 (52.5%) inpatient psychiatric facilities throughout Ukraine [98].

In June 2020, two Ukrainian associations applied to the WHO World Psychiatric Association (WPA): The Ukrainian Psychiatric Association (UPA) and the Association of Neurologists, Psychiatrists and Narcologists of Ukraine to help overcome the crisis that has arisen due to the disharmonious use of funding for the mental health system. The fact that the Ukrainian

mental health system inherited the Semashko model of health care from the Soviet era, the incomplete health care reform, and the lack of mental health services at the primary health care level have a strong impact on new changes in this area.

In recent years, the reform of the institutional mental health care system in Ukraine has been carried out at a slow pace and ineffectively, leading to the reduction of a large number of medical psychiatric staff and the discharge of patients. Implementation of mental health reform in Ukraine in accordance with the experience of EU countries: with the reduction of places in psychoneurological hospitals (deinstitutionalization), Ukraine needs to create new conditions for alternative treatment of mentally ill people and the population with negative mental health consequences after long-term actions in the East, the COVID-19 pandemic. It is necessary to provide accessible, timely, free psychological/psychiatric care in primary health care, in psychiatric departments in general hospitals, in day hospitals, in crisis centers, mental health centers, and to improve the work, it is necessary to create a single electronic register of appeals from the population of Ukraine to improve the provision of medical care [99–101].

The WPA Expert Commission identified many reasons for this crisis, but one of them is the result of a complete breakdown of trust between the Ministry of Health and psychiatrists, representatives of both psychiatric associations. In order to overcome this crisis in deinstitutionalization, the WPA indicated the following steps: the readiness of the Ministry of Health, the UPA and the Association of Neurologists, Psychiatrists and Narcologists of Ukraine to work together for the benefit of the mental health sector, for the benefit of people with mental illness. The concept note also contains tools and suggestions and examples of the experience of two countries, Georgia and Lithuania, to address the current crisis, and on the example of the UK, the WPA explains the great role of professional psychiatric societies (the British Royal College of Psychiatrists), which is constantly actively involved in the development and discussion of public policy in the field of mental health and in changes in this area. The UK government cannot develop mental health policy without first consulting the College of Psychiatrists [102].

With adequate, equitable financing of health care in Ukraine, using WHO indicators, per capita spending could be $1,000 (10% of GDP) on

health care and $100 (1% of GDP) on mental health care. Unfortunately, according to the World Bank, total health care expenditures in Ukraine in 2017 amounted to 7% of GDP, of which more than 50% of the population of Ukraine pay "out of pocket" [103].

Ukraine took the biggest step in improving the health of the population by adopting the Law of Ukraine "On State Financial Guarantees of Medical Care for the Population" № 2168-VIII of 2017, the Resolution of the Cabinet of Ministers of Ukraine "On the Establishment of the National Health Service of Ukraine" № 1101-2017-p of 2017, which gives impetus to concluding contracts with health care providers, implementing the development of an organizational structure with interregional departments, and so on [104–107].

Healthcare financing is an important component in the implementation of preventive measures for the mental health of the country's population. In Ukraine, 2.5% of the total budget is spent on mental health, of which 89% is allocated for inpatient treatment. At the same time, 30% of Ukrainians have suffered from mental disorders at least once in their lives, but after the pandemic and full-scale war, this figure has increased significantly, 75% of Ukrainians who need medical care for their mental health do not receive it, and 90% of deaths are caused by non-communicable diseases.

According to the International Renaissance Foundation (2016), the state and population expenditures per person (in US dollars) on the health care system in many countries have been established:

Public spending on health care in the United States per capita (PPP) is $8,877.9; in France, it is $3,964.3; in the United Kingdom, $3,351.7; in Georgia, $291.4; and in Ukraine, $226.6 per capita (PPP).

Private expenditures on health insurance per person (in PPP terms) in the United States are $697.6; in France – $351.4; in the United Kingdom – $194.1; in Georgia – $44.6; and in Ukraine – $12.9.

As for out-of-pocket expenditures per person (in PPP terms), the US is $1,094.2; France – $466.6; the UK – $631.6; Georgia – $443.2; and Ukraine – $290.3. Out-of-pocket costs, % of total healthcare expenditures: USA – 11.1%; France – 9.8%; UK – 15.1%; Georgia – 55.6%; Ukraine – 54.3%. According to a household survey conducted by the International Medical Corps with the support of the World Bank Group, 90.7% of inpatients paid for pharmaceuticals out of pocket [108–111].

According to the WHO "Atlas of Mental Health 2020", the average annual per capita public spending on mental health in the United States in 2019 was 7.49 (in US dollars). In 2019, the average global per capita spending on mental health hospitals was 2.77 (in US dollars). The Atlas provides up-to-date information on mental health policies, legislation and funding, availability and utilization of mental health services, human resources, and information/data collection systems [112; 113].

To provide neuropsychiatric care, a sufficient number of highly qualified specialists are needed: psychologists, psychiatrists, social workers, psychiatric nurses, and primary health care workers, who must have special training in the provision of mental health services. In many countries, there is a catastrophic shortage of highly qualified mental health care personnel. For example, based on data from the Association of American Medical Colleges, the American Board of Psychiatry and Neurology, and the US Census Bureau, the number of psychiatrists will decline to a projected minimum of 38821 per 100,000 population by 2024, which equates to a shortage of between 14280 and 31091 psychiatrists, depending on the psychiatrist-to-population ratio used. By 2050, the number of psychiatrists will range from a shortage of 17705 psychiatrists to a surplus of 3428 if measures are taken to develop a strategy to overcome this quantitative deficit with a stable population growth in the United States [114–116].

According to the results of the work carried out by the International Medical Corps with the support of the World Bank Group "on the assessment and recommendations for the integration of mental health care into the primary health care system", the number of psychiatrists in Ukraine in 2015 was 11.6 per 100,000 people, and in the EU countries – 7,75, while the number of psychologists per 100,000 people in Ukraine was 1.3, and in the EU countries was 2.7 per 100,000 people. The number of psychiatric nurses in Ukraine was 752 per 100,000 population, and in European countries – 824 per 100,000 population (data for 2009). Unfortunately, a major problem in Ukraine is that in psychoneurological health care facilities there is no interconnection between psychiatrists who diagnose patients and prescribe medication and psychologists and psychotherapists who may be in the same room as them, and there is no multidisciplinary approach to the treatment of patients with mental disorders.

The lack of doctors in rural areas is a problem in many countries, including Ukraine. Improving the quality, scope, and timeliness of medical services in both urban and rural areas is one of the healthcare priorities of every country in the world. In order for doctors to work in a rural community, it is necessary to create appropriate conditions for them: provide housing, transportation, decent wages, satisfaction with work, life in this community, etc. [117–120].

According to the WHO assessment of the mental health of the population of Ukraine, there is an insufficient qualification of medical psychiatric personnel to provide psychosocial assistance. This is confirmed by the 2019 report of the Ministry of Health of Ukraine on certified doctors who passed the exam: 85,1% of psychiatrists, 82,7% of neurologists, and 70,0% of mental health psychotherapists. However, 87,2% of general practitioners are inexperienced in managing patients experiencing mental health crises, 80,9% of staff are not trained to understand mental disorders, and staff focuses on physical injuries rather than mental health disorders, which can affect the correct management of patients. For example, 50% of patients with depression complained of back and abdominal pain. At the same time, in the EU countries, mental health institutions regularly conduct surveys of patients and relatives of patients regarding satisfaction, conditions of stay, and the attitude of medical staff to patients in these institutions.

The state should allocate considerable money for the training and retraining of such specialists. Particular attention should be paid to training of primary health care professionals (doctors, nurses, community service workers) in the community, as these professionals are more experienced in prescribing treatment for patients with physical illnesses, while they are not confident in their knowledge when providing care to mental health patients. In many countries, training consists of several seminars, but the analysis shows that the consolidation of the acquired skills requires a continuous course, not several seminars. And as a result, at the primary level, treatment of acute mental disorders may be better than in specialized psychiatric hospitals, which are institutions with a significant level of stigmatization of health workers and where patients receive a symptom of "hospitalization". There are positive aspects of primary care treatment: a patient can seek treatment at any time of illness, especially in the early stages, and not be afraid of being labeled; care is accessible and cheap and close to the place

of residence; there is no stigmatization by health care workers. At the same time, in a psychoneurological hospital, health care workers are very stigmatized towards mentally ill people, and primary care workers are better aware of the cultural and interpersonal relationships of their patients than staff of specialized psychoneurological hospitals, and they do not violate the rights of people with any disorders [121–122].

The main problems in the field of mental health care are: imperfection of national legislation in the field of mental health, lack of systematic implementation of sectoral and inter-sectoral standards, violation of the rights of persons with mental disorders, imperfection of regulation of activities in the field of mental health care, excessive concentration of mental health care in specialized, residential institutions, low level of awareness of medical staff about patients' rights and stigmatization of patients, lack of awareness of mental health in the judiciary.

Undoubtedly, high-quality treatment of patients requires good training, knowledge, skills in treating people with mental disorders and the use of modern methods of psychosocial influence. An important role is also played by state community mental health services, the so-called community-based rehabilitation services: club houses, day care centers, medical and social assistance centers, support groups, medical and labor workshops and other forms [123–125].

3. Analysis of the incidence and prevalence of mental illnesses in different countries of the world and Ukraine

In the context of mobility, intensification, globalization, pandemics, and military operations, the most important task in the field of health care in the world is to provide quality medical services to prevent diseases and prevent the spread of mental illnesses, which depend on many factors. According to the WHO, the main factor of human health depends on 60% of lifestyle, 30% on the environment, and 10% on the level of development of the health care system [126].

Hong S. (2023), Ai A.L. (2022), Patel S.Y. (2020) noted in their works that one in five Americans (5.6% of adults) suffers from mental disorders every year, but low-income people do not receive adequate services and this figure is even higher. The prevalence of mental disorders related to substance use in 2020 in the United States was 40 million people aged 12 and older. In

the United States, suicide is the tenth leading cause of death among people aged 10 to 34, with African Americans under 13 having a 2 times higher suicide rate than Americans. In 2017, 1.5 million people sought help in emergency departments for suicidal thoughts/attempts [127–129].

According to Zheng (2021), depression and anxiety disorders among Chinese nurses ranged from 28.4-47.1% [130].

According to a study by Ren X. (2020), Bai W. (2021) and other researchers, the incidence of anxiety in people during the COVID-19 pandemic was 25%, and the incidence of depression was 28% [131; 132].

According to Moitra M (2022), who conducted a systematic review of 84 countries in the period 2000-2019 on the provision of medical care for patients with depressive disorders, found that in high-income countries, mental health service coverage was 51% (33% received treatment) and in low-income countries up to 20% (8% received treatment). The level of minimum adequate treatment in high-income countries was 23%, and in low-income countries – 3%. Of the total number of people with mental disorders worldwide, 75% do not receive adequate, timely treatment, which in turn leads to much more complex mental disorders and suicide [133].

According to Jones E.A. (2021), Seban F. (2022), Premraj L. (2022), Patel U.K. (2022), Alkodaymi M.S. (2022), mental health during and after the COVID-19 pandemic has deteriorated for many people, and long-term neurological and psychiatric consequences are noted in most people around the world. Prior to the pandemic, 11% of people in the United States needed mental health care; after COVID-19, depression and anxiety increased to 40% among adults and emergency room visits for suicide attempts increased by 36%. The highest rate of patients who did not receive mental health care in the United States was among racial and ethnic minorities: 80% of Asian and Pacific Islander adults, 65% of Latinos, and 63% of African Americans [134–138].

According to statistical reports for the period of 2018–2020, the number of newly diagnosed cases of mental and behavioral disorders in Ukraine is registered from 183 thousand to 170 thousand, respectively, each year. In Ukraine, according to statistics for the period 2018–2020, we observe that patients with mental disorders seek medical care in the following psychiatric institutions built according to old requirements that did not take into account the "therapeutic, healing environment": from 63.8% to 70.6%

of patients sought care in outpatient clinics; from 32.2% to 27.0% – in psychiatric hospitals and from 4.0% to 2.4% – in day hospitals, respectively (Figure 1).

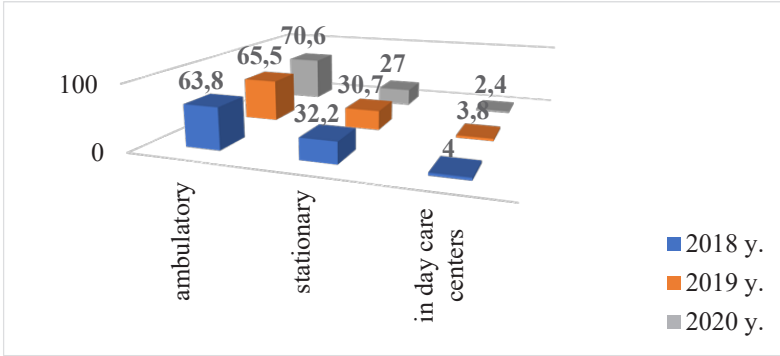

Figure 1. The share of different types of mental health care in Ukraine in 2018–2020, %

According to our observations, it was found that men in the period 2018–2020 were more likely to seek and receive treatment in inpatient facilities (67.2% to 65.3%, respectively), and were treated in day care centers (57.3% to 59.4%, respectively) Table 1.

Table 1

The proportion of referrals for psychiatric care in 2018–2020 in Ukraine, %

	Outpatient psychiatric care			Inpatient psychiatric care			Mental health care in day care centers		
	2018	2019	2020	2018	2019	2020	2018	2019	2020
Men	21,1%	20,8%	19,0%	67,2%	66,6%	65,3%	57,3%	56,6%	59,4%
Women	78,9%	79,2%	81,0%	32,8%	33,4%	34,7%	42,7%	43,4%	40,6%
Rural population	8,6%	8,7%	7,9%	32,1%	32,6%	31,9%	10,0%	8,0%	8,2%

At the same time, women received treatment on an outpatient basis from 78.9% to 81.0%, respectively, while fewer were treated in psychiatric hospitals from 32.8% to 34.7%, respectively. People living in rural areas, as

well as abroad, seek treatment less often than urban population and prefer inpatient psychiatric care due to poor transport links and lack of specialists in their place of residence.

According to O'Sullivan B.G. (2020), Ostini R. (2021), the problems of providing timely medical care are exacerbated by the fact that it is more difficult for people living in rural areas to receive timely specialized care due to problems with the construction of infrastructure between cities and villages, and a lack of doctors [139; 140].

According to the WHO assessment of the mental health of the population of Ukraine, there is an insufficient qualification of medical psychiatric personnel to provide psychosocial assistance. This is confirmed in the 2019 report of the Ministry of Health of Ukraine on certified doctors who passed the exam: 85.1% of psychiatrists, 82.7% of neurologists, and 70.0% of – of psychotherapists in the field of mental health. According to the researchers, 87.2% of general practitioners are not experienced in managing patients experiencing mental health crises, 80.9% of staff are not trained to understand mental disorders, and staff focuses on physical injuries rather than mental health disorders, which can affect the proper management of patients. For example, 50% of patients with depression complained of back and abdominal pain. At the same time, in the EU countries, mental health institutions regularly conduct surveys of patients and relatives of patients regarding satisfaction with the conditions of stay, the attitude of medical staff to patients, treatment, and rehabilitation in these institutions [141].

4. Conclusions

1. The European Union legislation is focused on decentralization of the mental health care system, development of community-based mental health services with social integration of patients (education, accommodation) at the level of the territorial community, capacity building and competent personnel with the introduction of a system of accreditation and certification of mental health professionals, as well as restructuring of state funding for specialized mental health care services, which is defined by the measure

2. In accordance with the Convention for the Protection of Human Rights and Fundamental Freedoms, Declarations: "Ethical Principles for Medical Research Involving Human Subjects", "On Principles, Policies

and Practices in the Education of Persons with Special Educational Needs and the Framework for Action on the Education of Persons with Special Educational Needs", "On Ethical Standards of Psychiatric Practice", "European Declaration on Mental Health", "On Mental Health in the Countries that were Created after the Collapse of the USSR", Resolution "Protection of Persons with Mental Illness and Improvement of Mental Health Care", Recommendation "Psychiatry and Human Rights", WHO documents, in particular the Green Paper "Improving Mental Health: Towards a Mental Health Strategy for the European Union", the treatment of patients with mental disorders is carried out in psychological comfort, in a therapeutic environment with the aim of "restoring a person's life", spiritual recovery, and integration of patients into society.

3. Compliance with regulatory and legal issues in the treatment of persons with mental disorders.

4. Implementation of deinstitutionalization in Ukraine in accordance with the experience of EU countries: reducing the number of places in psychoneurological hospitals, creating conditions for alternative treatment of mental patients in primary health care, in psychiatric departments in general hospitals, in day hospitals, in crisis centers, mental health centers.

5. Adequate, decent, fair funding of the mental health care system.

6. Improving the quality, volume, and timeliness of medical services in both urban and rural areas is one of the priority tasks of health care in every country in the world. In order for doctors to work in rural communities, it is necessary to create appropriate conditions for them: provide housing, transportation, decent salaries, satisfaction with work, life in this community, etc.

7. To provide highly qualified medical care to the population of Ukraine, medical workers of all levels should be able to work with the consequences of mental trauma, depression, as well as patients with chronic mental disorders in remission not only through medication, but also by mastering psychological methods that will help doctors themselves to overcome their "pre-illnesses".

8.Training and retraining of specialists providing mental health care – doctors, nurses, community service workers, psychiatrists, psychiatric nurses, psychologists – on a continuous basis, as well as training on teamwork for mutual assistance.

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