What Is The Difference Between Outpatient And Inpatient Treatment?

Posted on October 2, 2018

Ambulatory and inpatient treatment are equally demanded in the territory of Moscow and the Moscow region, but not everyone knows what the differences are. Our narcological clinic, “Ugodie,” specializes in the return to the normal life of people with alcohol dependence.

The staff of the clinic is staffed with high-level doctors with extensive experience, and skills in the psychology of communicating with dependent patients. We have both inpatient and outpatient care. The pros and cons of each species are discussed below. On the recommendation of the doctor, the patient can choose the way of interacting with doctors, the price of services depends on this.

Outpatient And Inpatient Care: Difference

Outpatient treatment is applicable when the patient has willpower, is disciplined, and, for whatever reason, can not spend all the time in the clinic. He will have to attend procedures and regular consultations with the attending physician without being placed in a hospital ward. The patient is treated anonymously, without registration and no data is transferred to third parties. This method has many advantages:

The patient can live in the usual rhythm, not limited to the daily routine. The only condition is to be on time to see a doctor and undergo all the necessary procedures prescribed by the doctor.

The patient remains in his usual environment, where close people will help him to adapt to life without alcohol faster. The support of friends and relatives often plays a decisive role in the treatment.

A former alcoholic has the opportunity to get a job and do things that have long been delayed because of their addiction to alcohol. It helps to feel the importance of your place in society and opens the eyes of a person to a new life.

Inpatient treatment will be the best option for those patients who are not able to go to the clinic on their own and also abstain from alcohol consumption on their own. Unwillingness to fight alcoholism in outpatient treatment leads to the fact that a person quickly breaks down, in every possible way, evades repeated visits to a doctor, tests, and procedures. The hospital implies isolation of the dependent (but only with his consent) on the territory of the clinic with the possibility of walking, leisure, and visiting relatives and friends.

Significant advantages include:

Constant monitoring of the doctor for the patient's condition.

Finding the environment of the same patients helps to transfer the period of adaptation.

Complete absence of alcohol and alcohol-containing formulations in the clinic.

Inpatient and outpatient care equally help the dependent. The main thing is to awaken in a person the desire to stop drinking. Doctors of the Ugodie Clinic provide first aid at home and, in extreme cases, immediate hospitalization. Appeal to doctors is inexpensive, much less than the money that an alcoholic will take out of the house if in time not to help him get rid of addiction.

Social Pediatrics And Health Organization

M.D. Bakradze

Scientific Center of Children's Health, Russian Academy of Medical Sciences, Moscow

Hospitalization and outpatient treatment of children: benefits and risks

Contact Information:

Bakradze Maya Dzhemalovna, Candidate of Medical Science, Head of the Diagnostic and Rehabilitation Department of the Scientific Center for Children's Health of RAMS

Address: 119991, Moscow, Lomonosov Avenue, 2/62, phone: (495) 967-14-21 Received: 21.05.2009. Admitted for printing: 10.08.2009.

Over the past 20 years, the need for inpatient pediatric care has declined due to the introduction of innovative methods of treatment, which necessitated the decision to address issues related to outpatient treatment. The article presents an analysis of the advantages and disadvantages of the established practice of managing children with acute diseases at outpatient and inpatient stages. It is shown that the number of beds (per 10 thousand children aged 0-14 years) varies from 4-5 in the USA to 90 in the Russian Federation, with a tendency to the concentration of beds in large hospitals. The main reason for hospitalizations is nosocomial respiratory (up to 40% of cases) and rotavirus (up to 25% hospitalized in the epidemic season) infection. It was noted that the reduction in hospital stays of children with acute diseases and the introduction of stationary substitution technologies (day hospital) for children with chronic pathology could reduce the incidence of nosocomial infections. To reduce the need for inpatient stay is able to optimize outpatient care for children, in particular, to reduce visits to the patient at home and use the diagnostic capabilities of polyclinics for the needs of acute patients.

Keywords: children, hospitalization, outpatient treatment.

The system of motherhood and childhood protection in the USSR was formed after the October Revolution. It was an entire state system; it was based on the basic principles of Soviet public health: the state character, the unity of medicine, socioprofilaktivnoy orientation, planned development, active participation of the population, and the introduction of scientific achievements in practice. The merit of this system was the universal coverage of medical care for children and the precinct principle of the work of children's polyclinics in the single pediatrician system.

This system was fully formed by the beginning of the Great Patriotic War. In the war years, the number of hospital beds for children increased significantly – by 1942 by 28% (in the eastern regions of the RSFSR). It is characteristic that the increase was primarily due to children's infectious beds, which allowed for complete hospitalization of patients with diphtheria and scarlet fever, as well as patients with complicated cases of pertussis and measles. An important stage in the development of public health was the attempt to unite hospitals with polyclinics in the 1960s. It reflected the urgent need for

MD Bakradze

Scientific Center of Children's Health, Russian Academy of Medical Sciences, Moscow

Hospitalization and ambulatory treatment of children: advantages and risks

The need for hospitalization of pediatric patients has significantly reduced in the last 20 years. This fact led to issues or questions related to ambulatory treatment. The article presents an analysis of the advantages and shortcomings of the present management of children with acute diseases. It was shown that the number of beds (calculated to 10,000 children under the age of 0-14 years old) differs from 4 to 5 in the USA to 90 in the Russian Federation. The main reasons for hospitalization are nosocomial respiratory (up to 40% of cases) and rotaviral (up to 25% of cases in epidemic season) infections. It was a marker in the shortening of stays in the hospital and the implementation of hospital-replacing technologies (day hospitals) for the treatment of children with chronic pathology. Lessening the need for a hospital stay in the hospital.

Keywords: children, hospitalization, ambulatory treatment.

The creation of a continuous process of monitoring the child and correcting the deviations of his health, as well as the improvement of the skills of district pediatricians through their continuous training in the course of work in the hospital. This project, however, was not successful, and in the following years, the polyclinics began to work separately from the hospitals.

From the very beginning of the organization of polyclinics in Russia, acute care of children was carried out at home. This was justifiable in the case of uncontrolled, acute infectious childhood infections in the absence of conditions in the clinics for the isolation of those who applied. In the first quarter of the 20th century, home-based care was common in most economically developed countries, but already in the 1930s, it was curtailed because of the need for additional research on the patient.

Given the prevalence of the rural population, the large distances between settlements, and the high density of the urban population, all this led to an increase in the number of pediatric beds in the last quarter of the twentieth century to a level that reached 309.6 thousand in 1990, or about 100 beds for 10 thousand children (this is much more than in developed countries, which reflects the differences in both the demographic situation and the health organization).

At the end of the twentieth century, the tendency to reduce beds was observed in all countries, reflecting the increased opportunities for examination and treatment in outpatient settings. As can be seen from the data presented in Fig. 1, a significant reduction in bed capacity occurred in the countries of the former USSR, but in most other countries, this process was very intensive. In Russia, during the last 20 years, against a background of a decrease in the birth rate, there was a reduction in the bed capacity for children (Figure 2). By 2007, the number of beds decreased by 38.5% (to 190.2 thousand), but the standardized indicator (for 10 thousand children aged 0-14 years) remained at the level of the 1990s – 91.3. Thus, the provision of beds practically did not decrease.

A decrease in pediatric hospital beds occurred along with a change in its structure, mainly due to children's departments of multi-profile hospitals, as evidenced, for example, by data on the Republic of Tatarstan (Table 1). These data illustrate the process of concentration of bed capacity in larger hospitals, especially specialized ones.

Kazakhstan, Republic of Moldova, Ukraine, Russian Federation, Kyrgyzstan, Tajikistan, Estonia, Georgia, Armenia, Czech Republic, Slovakia, Hungary, Austria, Luxembourg, Switzerland, Italy, France, Slovenia, Croatia, Belgium, Cyprus, Finland, Iceland, Denmark, Sweden, Greece, Netherlands, Macedonia Norway, Portugal, Albania Spain Ireland, Great Britain Israel Turkey

□ 1990

2002 g

During the same period, the number of beds for children decreased in most of the economically developed countries, where, as a result, their security was an order of magnitude lower than in the Russian Federation. Thus, in the state of California (USA), between 1998 and 2007, The number of children's beds in more than 60 hospitals decreased by 800 (by 19%). As a result, pediatric inpatient care was concentrated in 8 regional children's hospitals and the availability of licensed pediatric

27th

Indicator Number of children's beds Hospitalized children (X1000) Hospitalization rate,%

Years 1991 2002 1991 2002 1991 2002

CRH, other general hospitals 4514 2601 (-42%) 71.9 52.7 (-28%) 60 37

Children's hospitals 2616 2866 (+ 10%) 48.9 88.9 (+ 82%) 40 53

Total 7130 5467 (-23%) 117.2 141.6 (+ 17%) – –

Number of beds per 10 thousand children 81.3 78.1 (-4%) – – – –

General pediatric beds 4991 2902 (-49%) – – 70 53

Specialized pediatric beds 2139 2565 (+ 20%) – – 30 47

QUESTIONS OF MODERN PEDIATRICS / 2009 / VOLUME 8 / № 4

Social Pediatrics and Health Organization

(without beds for newborns) fell to 4-5 per 10 thousand children [1].

Although the number of children's beds reflects many factors, including historical traditions, the tendency to reduce beds is based both on improving outpatient care and on rationalizing the work of the hospital.

Among the factors that stimulate the reduction in the number of beds for children, the most significant are:

• increasing the availability of outpatient diagnostics;

• simplification of therapeutic methods, in particular, the introduction of oral forms of antibiotics and oral rehydration;

• Improvement of the conditions for treatment at home.

In parallel, the methods of treatment in the hospital were improved, and the average length of stay of the patient on the bed was reduced. So, in the USA, during the last 10 years, it has been kept at the level of 4-5 days, whereas in the Russian Federation, it exceeds 14, which significantly increases the hospital load [2].

Reducing the number of beds in a number of countries has been an important part of health care reform, a way of overcoming economic difficulties, and an attempt to reduce the cost of expensive bunks. Obviously, the excess of beds in Russia aggravates the problems of financing health care.

Both outpatient and inpatient treatment have their pros and cons (Table 2). Naturally, more complex and severe patients should be treated in a hospital, but this is associated with certain risks. On the other hand, without creating the conditions for a full-fledged examination in the outpatient clinic, outpatient treatment of even a very difficult patient can be difficult.

In countries with a system of child care at the primary level, general practitioners (family doctors) the latter undergo thorough pediatric training at the postgraduate level; Pediatricians in these conditions act as specialists at the second level. In Russia, attempts to eliminate primary pediatric care in the

1990s were successfully suppressed.

Union of pediatricians in Russia, since the level of training of family doctors in pediatrics is not comparable to that of pediatricians. Throughout the world, there is also a clear tendency to increase the role of pediatricians in providing primary care to children – even in countries where the family doctor tradition is strong. Thus, in the USA, according to the National Statistical Office (2008), from 1990 to 2006, the number of general practitioners increased from 214 to 301 thousand (by 40%), and primary care pediatricians – from 36 to 57 thousand (by 60%) [3].

In Russia, the reduction in the number of beds is slow for a number of reasons, primarily because of difficulties in determining the need for beds. The lack of research on health services, in particular, the assessment of the effectiveness of hospitals and the difficulty in determining the optimal duration of treatment, led to the creation of unrealistic treatment standards. Essential were also fears that a decrease in bed capacity could lead to a reduction in the health budget and the violation of the interests of different categories of workers. Moreover, a reduction in the number of beds leads to a significant narrowing of the hospital's capabilities, which depend on the size of the hospital bed capacity.

There are, however, grounds for believing that the reduction in hospital bed capacity is hampered by the features of police services. In Russia, a sharply ill child is visited at home by a district doctor, in the evening and at night – by an emergency or ambulance doctor. In the majority of polyclinics, the acutely ill child is not served. This practice was introduced in the 1930s. Due to the risk of cross-infection, it has now become a brake on expanding outpatient care for children. Today, this system, hindering outpatient examination of an acutely ill child, has become the main reason for excessive hospitalization, unjustified use of antibiotics, and slow growth of the qualification of the district doctor, who does not observe the more severe patients in an acute condition. Undoubtedly, excessive hospitalization is associated with difficulties in diagnosis when visiting a child with a fever at home. At an examination in a polyclinic (survey, radiography, blood and urine tests

28

Out-patient treatment Inpatient treatment

Benefits Risk Benefits Risks

• Maintaining the child's habitual environment • Lack of additional contact with sources of infection • Observation of the child by the same doctor throughout the illness • Absence of abnormalities in the functioning of the family • Complexity in the organization of laboratory and arthroscopic examination • Difficulty in monitoring the patient's condition • Difficulty in upgrading the pediatrician • Difficulties care for some categories of patients • The need for parents to take care of a sick child • The discrepancy of housing conditions the patient needs • Large diagnostic and treatment options • Specialization • High qualification of doctors • The ability to monitor and intensive therapy • Violation of familiar surroundings • Psychological deprivation • Nosocomial infection • The high cost of bed

At the beginning of the disease, a significant proportion of children could be treated at home. The ban on visiting a polyclinic by an acutely ill child is an anachronism; the creation of appropriate conditions for this would allow a sharp reduction in the number of unreasonable hospitalization cases. The assessment of the practice of hospitalization of children with acute pathology, conducted within the framework of agreement No. 6-DK between the Scientific Center for Children's Health of the RAMS and the Moscow City Administration, showed that among children hospitalized in the thoracic and boxed ward of one of the large Moscow multidisciplinary pediatric hospitals, the majority did not need inpatient treatment: 80% of children with uncomplicated forms of acute respiratory viral infection (ARVI), 74% with obstructive bronchitis, up to 30% with pneumonia and urinary tract infection. Their hospitalization could be avoided provided that the clinic conducts urine and blood tests, otoscopy, X-ray examination, and consultations with specialists (otorhinolaryngologist, urologist, etc.).

Excess hospitalization of children with a moderate, not requiring special treatment of diseases in a large city with a developed network of outpatient care is wasteful. It can be no exaggeration to consider that with changing approaches to hospitalization, the hospital bed capacity, knowledge, and experience of specialists working in hospitals can be used 2-3 times more rationally.

Reducing the need for beds can be and through the introduction in the work of clinics of modern recommendations for diagnosis and treatment, which will reduce the need for hospitalization of patients. Thus, the introduction of the standards (algorithms) for diagnostics of pneumonia proposed by WHO in the outpatient practice of physicians in 2 polyclinics, as well as the possibility of roentgenography in the acute period, reduced the number of hospitalized children with ARI several times (Figure 3).

Excessive hospitalization is largely carried out with a diagnostic purpose, which is justified in the conditions of serving children with acute illness at home. In this situation, it would be deontological and economically feasible to create emergency (prehospital) care units that are widely distributed abroad but are absent in most Russian children's hospitals. In such departments, patients are examined before hospitalization and emergency treatment (relief of the temperature response, obstructive phenomena, the introduction of antispasmodics, rehydration, etc.). Patients who can continue treatment on an outpatient basis are not hospitalized. Additional states or the budget is not required if you carry out load recalculation, change standards, etc.

The difficulty in conducting a paraclinical examination of a sick child at home is one of the important reasons for the excessive use of antibiotics, which can reach up to 60-80% in patients with respiratory infections and, at best, does not happen below 25-30% [4]. At the same time, using simple methods, it is possible to significantly reduce the need for antibiotics for viral infections (Table 3).

Unlike pediatricians working in hospitals, ambulatory doctors have worse conditions for professional growth. They are less likely to use recommendations for diagnosis and treatment; New methods are introduced more slowly. Being deprived of the possibility of discussion, pediatricians of an outpatient department are often influenced by such factors as "group beliefs" and decision-making on the basis

of their ideas. So, the use of antibiotics is largely determined by the severity of clinical symptoms, in particular, the level of fever and cough force [5].

We found significant differences in the practice of the use of antibiotics by district doctors in the same type of patients, even in the same polyclinic [6].

Along with the excessive referral of patients to the hospital, the irrational use of hospital beds is associated with the illegally long duration of patients' stay in the hospital. In addition to unjustified consumption of resources, this is fraught with the development and spread of nosocomial infection. A vivid example is a nosocomial superinfection with respiratory viruses. Our data show that the frequency of respiratory viral superinfection exponentially increases with the increase in the period of hospitalization of children, and after the 10th day of hospitalization, it reaches 40% or more [7]. In addition, the frequency of superinfection increases with the increase in the period from the onset of the disease. An important problem is nosocomial rota-viral infection [8]. According to foreign authors, 91-94% of all cases of nosocomial diarrhea are caused by viruses, and the main etiologic factor is rotavirus [9, 10]. In this case, the nosocomial form of infection is, according to different data, from 50 to 70% of all cases of rotavirus infection [11]. Intra-hospital infection with rotavirus, in addition to the medical aspect itself, entails an increase in hospitalization for 3-5 days [12], the need for additional sanitary and epidemiological measures in the ward, and, as a result, additional costs. The main generally recognized method of combating the spread of nosocomial rotavirus infection is rigid adherence to hygiene measures in pediatric departments. At the same time, reducing the length of the stay of the child in the hospital is also an effective method of preventing this pathology.

When comparing the duration of treatment of children with the most common acute illnesses in a multidisciplinary pediatric hospital and the clinic of the NCPD of the Russian Academy of Medical Sciences, we found that using only necessary and sufficient diagnostic and therapeutic measures, the duration of hospitalization can be reduced by 2.5-5 times, 100% of patients can be discharged already on the 2nd-5th day (Figure 4).

To remedy the situation, it is necessary to revise the standards of treatment, especially those stimulating unnecessarily long hospitalization.

The second aspect is the care of early discharged patients from the hospital under the supervision of a hospital doctor, which allows for maintaining the same medical tactics throughout the treatment period of the patient. This experience (a home-based hospital for the treatment of children with appropriate facilities) has been accumulated in the Scientific Research Institute of Pediatrics of the NCPM of the Russian Academy of Medical Sciences for non-severe patients with an acute respiratory viral infection, bronchitis, and moderate pneumonia who were admitted to the hospital without proper indications [12]. Among these patients, 2/3 were in the hospital for 3 days or less, followed by 1-2 weeks (1-3 visits) by the same doctor on an outpatient basis. This scheme is especially important in children with more severe conditions, in which the dynamics of the process can best be assessed only by the doctor who observed the patient from the very beginning of treatment. Reduction of

hospitalization should aim not so much to save budgetary expenditures but rather to rationalize their redistribution. Thus, in the UK, less than 20% of the expected savings were received from the reduction in bed capacity [13]. It is also shown that a reduction in the length of stay in a hospital leads to a rise in the cost of treating a patient since the main expenses fall on the first days. In California, a reduction in beds by 11% led to a rise in the cost of treatment of 1 patient by 22% [17]. Therefore, the main goal of reducing the duration of hospitalization is not to save money but to reduce the negative factors of the hospital environment.

Thus, there is a large number of organizational, methodological, and scientific issues, the solution of which would allow for the redistribution of existing resources and raise a qualitatively new level of medical care for children with acute diseases. Conditions for the examination of severely ill children are in most children's polyclinics measures, such as expanding the diagnostic capabilities of outpatient care in pediatric care, introducing modern methods of examining and treating children, including inpatient substitution technologies, and reducing the duration of hospitalization, must certainly find their place in modern national pediatric practice, which will help improve and optimize medical care children.

The prevalence of risky use of psychoactive substances during pregnancy is difficult to estimate precisely for several reasons: because of the shame, denial, and stigma experienced by consumers of these substances, lack of necessary knowledge among antenatal care professionals, the presence of concomitant mental disorders and socio-cultural barriers, which may impede the conduct of such an assessment. Nevertheless, it is known that about one-third of the consumers of psychoactive substances who have applied for help in the United Kingdom are women, and more than 90% of them are of childbearing age (15-39 years). The results of large-scale studies performed on different populations in the United States make it possible to obtain a more complete picture of this phenomenon. For example, in the National Pregnancy and Health Survey, data were collected in the form of self-reports in a sample of 2,613 women who gave birth in 52 urban and rural hospitals. More than 5% of those who gave birth during the study used banned psychoactive substances during pregnancy, 2.9% of them took cannabinoids, and 2.9% cocaine at some points in the gestation period (for comparison: 20% smoked tobacco, and 18, 5% used alcohol). The following publication, which combined data from the National Household Survey in the United States for two years (1994 and 1995), indicates that 9.3% of women and girls aged 15-44 reported active use of illicit drugs, and 2.3% did this during pregnancy. Consequently, the problem is very important, especially because the health of both the mother and the child suffers.

The Impact Of The Use Of Psychoactive Substances On The Health Of The Mother

Dependence on heroin or other psychoactive substances can lead to ignoring many spheres of life of the individual who consumes them. The need to constantly extract the right amount of drugs takes a

lot of time and money, so people often stop caring about their health, nutrition, and social well-being. Injecting drug use increases the risk of contracting blood-borne viruses, such as HIV and hepatitis viruses, and leads to the development of abscesses and endocarditis. Infectious disease of the mother, abandonment, and malnutrition are partly responsible for the observed cases of underweight children at birth, high rates of preterm labor, and poor nutrition of newborns whose mothers used psychoactive substances (Fischer, 2000). Women may be involved in criminal activities (for example, prostitution, robbery, burglary), trying to raise funds in order to “finance” their drug addiction.

The treatment of substance abuse and dependence should depend on the nature of the substance and the individual characteristics of each individual patient; for each category of psychoactive substances, available medical treatment is provided. Treatment is impossible without knowing the pharmacological features of the substances used by the patient or a combination thereof. This is especially important in the treatment of overdose or detoxification in a patient with abstinence syndrome. It is important to understand that treatment of dependence requires many months and years of rehabilitation. Behavioral stereotypes developed during the thousand-fold injections of the drug will not disappear after detoxification and even after a typical 28-day in-patient rehabilitation program. Long-term outpatient treatment is needed. Although it is preferable to strive for complete abstinence, in practice, many patients are tempted to re-start using the drug, which may require repeated courses of treatment. In this case, maintenance therapy may be effective, such as long-term methadone treatment for opioid dependence. This process can be compared with the treatment of other chronic diseases, for example, diabetes mellitus, bronchial asthma, or arterial hypertension, which require long-term use of medications, and complete recovery is unlikely. If we consider dependence in the context of chronic disease, then the existing treatment of dependence can be considered quite effective (McLean et al., 1992; O’Brath, 1994). Long-term treatment is accompanied by an improvement in physical and mental status, as well as social and professional activities. Unfortunately, due to the general pessimism in the medical community regarding the effectiveness of the treatment, the therapeutic efforts are mainly aimed at correcting the complications of pulmonary, cardiovascular, and hepatic, and not correcting behavioral changes associated with dependence. Meanwhile, by directing efforts to treat the dependence itself, it is possible to prevent somatic complications, and this requires a long rehabilitation program.

Treatment and its cost

When treating mental illness and solving sensitive issues related to the patient’s psychological state, very many prefer to go to a paid psychiatric center. Unfortunately, state medicine does not always offer modern methods of treatment, a soft and sensitive approach to the patient, confidentiality, and an individual approach. Therefore, more and more people who face psychiatric diagnoses or who feel some discomfort are looking for information on paid psychiatric centers on the Internet and other sources of information. In Israel, psychiatry, like other branches of medicine, is at a very high level. Dozens of calls are sent to the IsraClinic clinic every day from patients and their relatives who would like to undergo treatment in a paid psychiatric center. We always conduct with our patients the most

honest dialogue; we tell them in detail about all the opportunities and perspectives that they have, about our methods and advantages.

Pros and cons of paid clinics

Among the advantages of paid psychiatric centers, it is worth noting the following:

Individual approach to the development of therapy

The best specialists in their field

The most modern methods of treatment

The use of effective drugs of the latest generation with a minimum number of side effects

Continuous monitoring of the therapy process and its effectiveness

Anonymity

Attention and delicacy of the approach from the administrative staff

Possibility of remote consultation of close patient

Support after the end of treatment

We listed the most basic pluses of paid psychiatric centers. Among the minuses of paid psychiatric centers, we note the following:

The cost of treatment is higher than in public clinics and hospitals

Due to a small staff of specialists, treatment and counseling in the center should be planned in advance, there is not always an opportunity to provide emergency psychiatric care.

As we see, in comparison with the pluses, the disadvantages of paid psychiatric centers are much smaller.

Israeli-paid psychiatric centers mainly practice outpatient treatment since recommendations for inpatient treatment are given only in case of danger from the patient for themselves or others. Therefore, in the planning of therapy, all aspects of the patient's condition are taken into account. The treatment plan is developed by specialists individually, based on the study of each case. In the clinic "IsraClinic" after a conversation with the patient or his relatives, the clinic physicians are going to a consultation, where they discuss the case and decide which therapy plan will be most effective. After that, the administration of the clinic sends an examination program or treatment program to the patient's e-mail or his proxies, which includes an exact list of medical procedures and their price. It is

important to note that the cost of treatment in paid psychiatric centers is based only on the necessity for this particular patient's medical or diagnostic measures. Thus, it is important to understand that the cost of treatment in paid psychiatric centers depends on several factors:

Diagnosis of the patient

Duration of the course of the disease

Presence of remissions in the history of the disease

Presence or absence of aggression, psychotic state

The history of treatment (medicament, psychotherapeutic, alternative)

The patient's condition to date

Presence of concomitant mental or physiological diseases

The more detailed information the specialists of the center receive, the more precise the program they can develop.

Note that if it is a question of treatment in a paid psychiatric center abroad, the cost of treatment will be added to the cost of living and food – these costs will help calculate the specialists of the center. Thus, the patient or his relatives will be able to get the most accurate information about all the expenses that are forthcoming to him in the treatment at a paid center abroad.