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SPECIFICITY OF PSYCHOLOGICAL SERVICES IN THE HEALTHCARE SYSTEM OF CIS COUNTRIES. SPECIFICITY OF PSYCHOLOGICAL SERVICES IN THE HEALTHCARE SYSTEM OF EUROPEAN COUNTRIES.

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Abstract

This article provides a comparative analysis of the organizational, legal, and practical aspects of psychological service delivery in the healthcare systems of the CIS (Commonwealth of Independent States) and European countries. In CIS countries, psychological services are primarily integrated into state medical institutions, with no clear distinction between psychotherapeutic and psychiatric care. In the European model, community-based psychological services, the private sector, and universal health insurance systems have made psychological counseling independent and widespread. The article analyzes the specific features, advantages, and disadvantages of both regional models, as well as the various models of psychological service delivery.

Keywords

psychological service, CIS countries, European countries, healthcare system, psychotherapy, public health, psychological counseling, health insurance.

RELEVANCE OF THE TOPIC

Globally, mental health issues have become increasingly pressing, especially after the COVID-19 pandemic. According to WHO data, more than 25% of the world's population will need psychological help at some point in their lives. Nevertheless, the organization of psychological services differs significantly across regions. CIS countries — the post-Soviet space — are in a transitional phase from traditional psychiatric approaches to psychological counseling, while European Union countries have advanced experience in community-based psychological

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services and deinstitutionalization. This comparative analysis is important for identifying opportunities to effectively use European experience to improve the healthcare systems of Uzbekistan and other CIS countries.

INTRODUCTION

The concept of psychological services can be understood in a narrow and a broad sense. In the narrow sense, it refers to activities that include psychological counseling, psychocorrection, and psychotherapy. In the broad sense, it includes the preservation of mental health, prevention, rehabilitation, and improving psychological culture in society.

In CIS countries (Russia, Ukraine, Belarus, Kazakhstan, Uzbekistan, and others), psychological services were historically formed on the basis of the Soviet psychoneurological school, where psychologists worked mainly under the supervision of psychiatrists in clinical settings. In European countries (Germany, France, Great Britain, Sweden, the Netherlands, and others), psychological services developed as an independent professional field, integrated into the public health system, with widespread private practice.

MAIN PART

1. Specificity of psychological services in CIS countries

1.1. **Governance structure:** Psychological services are mainly part of the state medical system (polyclinics, dispensaries, hospitals). In some CIS countries, there are school psychologists within the Ministry of Education system, but the connection with the medical system is weak.

1.2. **Personnel training:** There is a specialization in clinical psychology, and these specialists primarily work in psychiatric institutions. Psychotherapy is taught in courses at medical institutes, mainly for psychiatrists. Psychologists either do not have the right to practice psychotherapy or have limited rights.

1.3. **Standardization and legal framework:** There are few specific laws regulating the activities of psychological services in the CIS. In most cases, psychologists operate within the framework of laws on psychiatric care.

1.4. **Financing:** Psychological services are funded mainly from the state budget, and health insurance is underdeveloped (voluntary insurance exists in some countries). Private psychological centers exist but are expensive for socially vulnerable groups.

1.5. **Specificity in the CIS:** Psychological services still play a secondary role, subordinate to psychiatric care. For example, in Uzbekistan, although psychological counseling services have been expanding in recent years, there are still insufficient personnel and a lack of a systematic approach.

2. Specificity of psychological services in European countries

2.1. **Integrated system:** In the European Union, psychological services operate at all levels, from primary care to specialized centers. For example, the IAPT (Improved Access to Psychological Therapies) program in the UK provides free psychological services to the general public.

2.2. **Independent professional status:** Psychologists (clinical, school, organizational) are licensed separately. Psychotherapy is not exclusively a medical domain but is also within the rights of psychologists (specifically in Germany, Austria, Switzerland).

2.3. **Compulsory insurance system:** In Germany and France, universal health insurance covers the costs of psychological counseling and psychotherapy. Patients can contact a psychologist directly or through a psychiatrist.

2.4. **Deinstitutionalization:** In Europe, the number of psychiatric hospitals has been reduced, and outpatient and community-based psychological centers have been developed. This is an effective strategy against stigma.

2.5. **Digital psychological services:** Telepsychology and online therapy platforms (e.g., KRY, MindDoc) are widespread in Europe and are covered by insurance.

DISCUSSION AND RESULTS

Discussion: Comparing the CIS and European models of psychological services reveals a number of fundamental differences. These differences cover several important aspects: the organizational structure of psychological care, financing mechanisms, the status of personnel, patient access routes, prevention systems, and the level of stigma in society.

First, there is a sharp contrast regarding the legal status and professional independence of psychologists. In CIS countries, the psychologist plays a subordinate, auxiliary role to the psychiatrist. That is, psychological services are considered part of psychiatric care, and a psychologist does not have the right to make independent diagnoses or provide psychotherapy. In contrast, in European countries, the psychologist acts as an independent provider, holds a separate license, and has the right to work directly with patients without a psychiatrist's referral.

Second, the differences regarding the right to provide psychotherapy deserve special attention. In the CIS, psychotherapy is traditionally considered the exclusive competence of psychiatrists. Psychologists are limited to psychocorrection and counseling; applying psychotherapeutic methods requires a medical degree. In the European model, clinical psychologists have the right to provide psychotherapy, which significantly increases the number of specialists offering psychological care and expands access to help.

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Third, there are fundamental differences in financing systems. In CIS countries, psychological care is mainly funded from the state budget, but these funds are insufficient. In those CIS countries that have compulsory health insurance systems (e.g., Russia, Kazakhstan), psychological services are either not fully covered by insurance or the coverage is limited. In Europe, universal health insurance systems (e.g., in Germany, France, the Netherlands) cover the costs of psychological counseling and psychotherapy. This makes psychological care accessible and affordable to broad segments of the population, including socially vulnerable groups.

Fourth, the patient's route to accessing psychological help also differs. In the CIS, a patient can generally only see a psychologist with a referral from a psychiatrist. This creates an additional barrier that often discourages patients from seeking psychological help. In Europe, patients can contact a psychologist directly. For example, under the IAPT program in the UK, patients can self-refer or be referred by their primary care physician to psychological therapy centers.

Fifth, the issues of community prevention and the level of stigma are of particular importance. European countries conduct widespread public campaigns on mental health issues and have implemented programs to increase psychological literacy in schools and workplaces. This has significantly reduced the stigma associated with seeking psychological help. In CIS countries, the stereotype left over from the Soviet era — "going to a psychiatrist is shameful" — remains strong. This leads people to hide their psychological problems and seek help late.

The advantages of the CIS model include centralized prevention and control capabilities, as well as the orderly functioning of the system when psychiatric and psychological care are clearly separated. However, the disadvantages are greater: low funding for psychological services, staff shortages, delays in implementing modern psychotherapeutic methods, inability for patients to voluntarily access psychological care, and high levels of stigma.

The advantages of the European model are rapid and widespread access to psychological care, diverse therapeutic approaches, a strong community system, and effective anti-stigma strategies. Disadvantages include the high cost of some services in the private sector, certain bureaucratic barriers related to insurance (e.g., limits on the number of therapy sessions), and uneven distribution of psychological services in some countries (especially in rural areas).

Results: The analysis shows that in most CIS countries, psychological services are still undergoing an institutional transition. In the post-Soviet space, many reforms are still needed in legislation and practice to develop psychological services. Kazakhstan has taken important steps towards implementing border and

insurance models, while Uzbekistan has recently been developing a system of republican psychological service centers and school psychologists. However, none of these countries yet has a comprehensive, universal psychological service system like the European model.

The European model offers advanced methods of continuing education, licensing, monitoring, and standardization. For CIS countries, it is recommended to draw on European experience in the following areas: integrating psychological services into the insurance system, strengthening community prevention, expanding psychologists' rights to provide psychotherapy, and conducting regular awareness campaigns to combat the stigma associated with seeking psychological help.

Furthermore, the results indicate that the CIS and European models cannot be completely replicated in one another. Each region's specific cultural, historical, and economic conditions have shaped its psychological service systems. Therefore, rather than directly copying European experience, it is advisable to adapt it to local conditions in CIS countries.

Future research should focus on harmonizing national psychological service standards in CIS countries with European and WHO recommendations, as well as developing mechanisms for mutual experience exchange among CIS countries.

CONCLUSION

1. The specificity of psychological services in CIS countries lies in their historical integration into the psychiatric system and the fact that they have not yet become a fully independent professional field. Psychologists mainly play an auxiliary role, and the right to provide psychotherapy belongs primarily to psychiatrists.

2. The European model of psychological services is an advanced system based on universal health insurance, deinstitutionalization, and the independent practice of psychologists. Patients can contact a psychologist directly, and psychotherapy is within the competence of psychologists as well.

3. For CIS countries, it is recommended to adopt European experience in integrating psychological services into the insurance system, strengthening community prevention, expanding psychologists' rights to provide psychotherapy, and implementing measures to reduce the stigma associated with psychological help.

4. Future research should focus on harmonizing national psychological service standards in CIS countries with European and WHO recommendations, as well as developing adapted models that take into account regional specificities.

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