Applying the national mental health policy in conflict-affected regions: towards better social inclusion (Ukrainian case)

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Abstract

Purpose – *The ongoing armed conflict in Ukraine has had wide-ranging health, social and economic consequences for the civilian population. It has emphasised the need for comprehensive and sustainable reform of the Ukrainian mental health system. The Ukrainian Government has approved a vision for national mental health reform. This study aims to draw on the lessons of mental health reform in other conflict-affected settings to identify areas of priority for applying the national mental health policy in conflict-affected regions in the direction of better social inclusion of people with mental health conditions (Donetsk and Luhansk regions, directly affected by the conflict).*

Design/methodology/approach – *A literature review was conducted to identify lessons from implementing mental health reform in other conflict-affected settings. Findings were summarized, and best practices were applied to the national and regional policy context.*

Findings – *The literature described emergencies as an opportunity to build sustainable mental health systems. A systematic and long-term view for reform is required to capitalise on this opportunity. For better social inclusion, implementation of the concept for mental health and mental health action plans in Donetsk and Luhansk regions should prioritise raising mental health awareness and reducing stigma; developing the capacity of local authorities in the development and coordination of services; tailoring mental health service provision according to the availability of services and population need; targeting the needs of particularly vulnerable groups and embedding the activities of humanitarian actors in local care pathways.*

Research limitations/implications – *This study summarises the literature on mental health reform in conflict-affected settings and applies key findings to Eastern Ukraine. This study has drawn on various sources, including peer-reviewed journals and grey literature and made several practical recommendations. Nevertheless, potentially relevant information could have been contained in sources that were excluded based on their publication in another language (i.e. not in English). Indeed, while the included studies provided rich examples of mental health reform implemented in conflict-affected settings, further research is required to better understand the mechanisms for effecting sustainable mental health reform in conflict-affected settings*

Originality/value – *The paper describes opportunities for developing a local community-based mental health-care system in Ukraine, despite the devastating effects of the ongoing war.*

Keywords *Mental health reform, Conflict, Ukraine, Mental health policy, Conflict-affected regions*

Paper type *Conceptual paper*

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Introduction and background

There has been an ongoing armed conflict in Donetsk and Luhansk oblasts of Ukraine since April 2014, precipitated by the Revolution of Dignity (November 2013–February 2014) and the annexation of the Autonomous Republic of Crimea by Russia (February–March 2014). This aggression by Russia against Ukraine has resulted in significant human losses, civilian displacement and large-scale suffering. It has been estimated by many humanitarian organisations (including the World Health Organisation (WHO) and International Committee

for the Red Cross) that 5.5–6 million people live in violence-affected areas in Ukraine. According to the United Nations Human Rights Monitoring Mission data (from January 2019), 12,800–13,000 people were killed because of the armed conflict in Eastern Ukraine between April 2014 and December 2018. In total, 1.5 million Ukrainians have been estimated to have been internally displaced by the conflict (Ministry of Social Policy, 2020; Ukraine Recovery and Peacebuilding Assessment. Analysis of Crisis Impacts and Needs in Eastern Ukraine, 2015).

Conflicts have wide-ranging health, social and economic consequences for the civilian population. Research into the mental health implications of the ongoing conflict found that residents of Donetsk and Luhansk oblasts 38.9% of respondents had experienced a traumatic event (Kyiv International Institute of Sociology, 2018). More than a quarter (27.0%) of respondents had either been in the immediate conflict zone or have performed duties that imply having seen people killed or wounded in the conflict. The same study reported that 5.4% of respondents struggle with symptoms of depression, 8.2% of Post-Traumatic Stress Disorder (PTSD), 12.7% of the respondents showed excessive alcohol abuse.

Before the war, the Ukrainian health system had been characterised as inefficient and unresponsive to population needs (Lekhan *et al.*, 2015b; Weissbecker *et al.*, 2017). The Ukrainian health system retains many features of the Semashko model health system (inherited from the Soviet era following Ukrainian independence in 1991), including a bias towards inpatient service provision and centralised planning structures (Lekhan *et al.*, 2015b). These features lead to the social isolation of people with mental health conditions, and its consequences are still visible in Ukraine. The war has placed significant additional strain on the system. Damage to and destruction of many health facilities, including secondary and tertiary mental health facilities, in Donetsk and Luhansk regions (77 out of 350 and 26 out of 250 health care, respectively), a lack of necessities (including power, heating and clean water) and medical supplies in conflict-affected territories and migration of health workers (30%–70% of health workers have been estimated to have fled conflict-affected areas or been killed) have presented significant additional challenges, whereas humanitarian agencies and the WHO have filled some gaps in provision (Lekhan *et al.*, 2015a). However, seven years into the war, the availability of general health services remains limited.

The reality of mental health services within these regions is no different. The mental health system in Ukraine comprises psychiatric, psychoneurological and narcological hospitals, psychiatric, psychosomatic and narcological departments in general hospitals and outpatient facilities and outpatient cabinets of psychiatrists, child psychiatrists, doctors-psychotherapists and narcologists (see for example a map of Ukrainian mental health services via https://datawrapper.dwcdn.net/NdNzR/5/). The system emphasises inpatient service delivery (i.e. it has been estimated that 89% of mental health expenditure is spent on inpatient services). Very few mental health services are delivered in primary or community settings (Weissbecker *et al.*, 2017). Two years after the war, it was reported that access to specialised mental health services in Donetsk and Luhansk regions was limited because of travel and other restrictions (Nitzan Kaluski, 2015). Furthermore, a 2017 report on the mental health needs and service utilisation of internally displaced persons (IDPs) reported a treatment gap of 74% (Roberts *et al.*, 2019).

Experiences of other conflict-affected settings and countries strongly indicate that emergencies can provide an opportunity to make comprehensive and sustainable changes to mental health systems and respond to the population's mental health needs (Epping-Jordan *et al.*, 2015; World Health Organization, 2013). The primary task for the Ukrainian Government is transitioning from the current crisis response to a comprehensive and sustainable long-term strategy for improved mental health outcomes (Ryngach and Korolchuk, 2018). This task finds itself within the context of the ongoing reform of the Ukrainian health system and planned reform to the mental health system. Namely, since 2018, Ukraine has seen the

successful implementation of a range of structural changes to the health system, including the establishment of a single purchaser of health services (the National Health Service of Ukraine) and reform of the primary care sector. A concept note for mental health, a declaration of the key tenets of planned mental health reform, has also been approved by the Cabinet of Ministers (Ministry of Health of Ukraine, 2017). A National Mental Health Action Plan, 2021–2023, was released in October 2021, building on the concept note and aiming to support the development of integrated and accessible mental health care.

Planned reform seeks to introduce delivery of mental health care in the community in line with international models of mental health services. The concept note outlines the main directions for mental health care development in Ukraine over the next 13 years (Ministry of Health of Ukraine, 2017). The directions include (among others):

- improving MH awareness in society and reducing mental health stigmatisation;
- development of mental health promotion and mental disorders prevention;
- development of a community-based system of psychological and social support;
- implementation of procedures of mental health assessment into primary health care; and
- improvement in management effectiveness, interagency coordination and intersectoral cooperation in mental health service provision.

This article seeks to distil current evidence on mental health needs in Eastern Ukraine and how those mentioned above planned national mental health reforms are best implemented to address these needs and provide better social inclusion. The research aims are two-fold; firstly, to summarise lessons learned from the reform of mental health services in conflict-affected settings. Secondly, drawing on this evidence, identify priority areas for implementing national reforms in Donetsk and Luhansk regions.

Methodology

Using PubMed and MEDLINE, a comprehensive literature review was conducted to identify key lessons derived from implementing mental health reform in other conflict-affected settings. The identified articles were screened to determine whether they met the following inclusion criteria:

- describe or evaluate formal national or regional initiatives that have resulted in the rebuild or reform of mental health services during or following occupation, conflict or war; and
- pertain to low- and middle-income countries.

Articles that described emergency responses to conflict or the effects of conflict on the health system were also excluded. Studies not published in the English language were excluded. Reports and other non-peer-reviewed articles were included, provided they met the inclusion criteria for the search. The reference lists of included articles were reviewed to identify any relevant studies not identified in the original search. The literature search was conducted on 31 December, 2020.

Results

A total of 2,060 articles were identified for review. Following the review of these articles, eight articles were included. The reference lists of these articles were reviewed, and nine articles were included for analysis. A summary of this process can be found in Appendix 1. A table of included articles can be found in Appendix 2.

Included studies and reports identified a range of countries that have undertaken mental health reform during or following the conflict. A number of studies also described key themes and lessons related to the rebuilding and reform of mental health systems during or after a conflict (Baignana *et al.*, 2005; Epping-Jordan *et al.*, *(*2015); Patel *et al.*, 2011; Ventevogel *et al.*, 2022; World Health Organization, 2013). All articles described emergencies, including those that result from conflict, as an opportunity to build sustainable mental health systems. The negative impact of conflict on a population's mental health and well-being draws attention and resources (De Vries and Klazinga, 2006; Epping-Jordan *et al.*, 2015; Kienzler, 2019; Patel *et al.*, 2011; World Health Organization, 2013). This, coupled with the degradation of existing mental health services, provides the opportunity to build mental health systems that are person-centred and in line with evidence-based global guidelines (Epping-Jordan *et al.*, 2015; Patel *et al.*, 2011; Ventevogel *et al.*, 2022; World Health Organization, 2013). Indeed, all studies described efforts to reduce the delivery of institutionalised mental health services and enhance community-based mental health service delivery as part of its response to mental health needs in conflict-affected settings (Abuazza, 2013; Baignana *et al.*, 2005; De Val D'Espaux *et al.*, 2011; De Vries and Klazinga, 2006; Epping-Jordan *et al.*, 2015; Hasanović *et al.*, 2006; Karam *et al.*, 2016; Kienzler, 2019; Kucukalic *et al.*, 2005; Maukera and Blignault, 2015; Patel *et al.*, 2011; Sharma and Piachaud, 2011; Ventevogel *et al.*, 2011, 2012, 2022; World Health Organization, 2013).

Literature on the reform of mental health systems in other conflict-affected settings underscores that a long-term view of and systems-based approach to mental health reform is key to capitalising on this opportunity (Epping-Jordan *et al.*, 2015; Patel *et al.*, 2011; Ventevogel *et al.*, 2022). Many studies identified the central role of government, as well as the development of national mental health policy and action plans, as crucial components of this long-term view (De Val D'Espaux *et al.*, 2011; Epping-Jordan *et al.*, 2015; Kucukalic *et al.*, 2005; Patel *et al.*, 2011; Sharma and Piachaud, 2011; Ventevogel *et al.*, 2012, 2022; Zwi *et al.*, 2011). For example, in their review of efforts undertaken to rebuild and reform mental health services in ten emergency-affected settings, Epping-Jordan *et al.* found that while national policy and strategies were not necessarily required to enhance the delivery of mental health services (as was the case of Jordan), many countries undertook an integrated approach to the reform of mental health systems and that these efforts were accelerated by the impact of the emergency (Epping-Jordan *et al.*, 2015). Patel *et al.* similarly highlight the importance of a systems-based approach to intervention and emphasise the continuous collaboration of government, local stakeholders and professionals to ensure the sustainability and acceptability of any change (Patel *et al.*, 2011). The pivotal role of local stakeholders, particularly mental health professionals, in championing change was emphasised across all included studies. The role of external agencies in supporting sustainable change in many case studies was providing expertise, supporting the upskilling and capacity building of local stakeholders or functioning as a coordination body (Epping-Jordan *et al.*, 2015).

When tied to a longer-term view of the mental health system, reform in conflict-affected settings sought to address both new-onset and pre-existing mental health needs within the population. In line with this, a focus on trauma-based interventions (i.e. PTSD interventions) at the expense of the public mental health approach was discouraged and the importance of reforms including interventions for social healing was emphasised. For example, a study summarising lessons learned from mental health reform in post-conflict Burundi argues that health system strengthening should take place alongside social activities "to heal the social wounds of war" [p. 315 (Ventevogel *et al.*, 2011)]. Several studies also emphasise the importance of interventions that seek to tackle the stigma around mental health disorders alongside broader reform efforts (De Val D'Espaux *et al.*, 2011; Hasanović *et al.*, 2006; Kucukalic *et al.*, 2005; Patel *et al.*, 2011; Sharma and Piachaud, 2011; Ventevogel *et al.*, 2022; World Health Organization, 2013). The WHO similarly encourages that a range of

social and basic psychological interventions be made available to the whole population (World Health Organization, 2013). Such interventions may address distress within the population without a mental health disorder and support mental health services in line with the WHO's optimal mix of mental health services (World Health Organization, 2007), where self-care is emphasised.

Some identified articles also described in detail the capacity building programs that comprise a significant component of mental health reform undertaken in conflict-affected settings (Abuazza, 2013, 2013; Epping-Jordan *et al.*, 2015; Sharma and Piachaud, 2011; Ventevogel *et al.*, 2011, 2012; Zwi *et al.*, 2011). In many settings, a significant resource was invested into capacity building in primary care settings to afford conflict-affected populations access to essential mental health services at the community level (Abuazza, 2013; Epping-Jordan *et al.*, 2015; Karam *et al.*, 2016). The delivery of mental health first aid and basic counselling services across a range of community settings, including social workers and teachers, was also facilitated by capacity building programs (Epping-Jordan *et al.*, 2015; Karam *et al.*, 2016; Ventevogel *et al.*, 2011). The importance of leveraging local human resources to support sustainable reform was emphasised (Epping-Jordan *et al.*, 2015; Patel *et al.*, 2011; Ventevogel *et al.*, 2011). In line with this, many articles describe the training of staff working in the public sector (Epping-Jordan *et al.*, 2015; Maukera and Blignault, 2015; Patel *et al.*, 2011; Zwi *et al.*, 2011), where there is a greater likelihood that knowledge is often retained within the system (Patel *et al.*, 2011). Beyond training, a number of studies emphasised the importance of instituting supervision structures and apprenticeship models over more extended periods (Epping-Jordan *et al.*, 2015; Patel *et al.*, 2011; Ventevogel *et al.*, 2012), mainly where "helpers" (i.e. volunteers or individuals who may not have mental health or clinical background) provide intermediary mental health support to the population or link the community with mental health services (Patel *et al.*, 2011).

Of course, the success of mental health reform in conflict-affected settings has been mixed. In line with this, beyond describing key elements of interventions that supported sustained reform of mental health systems, the included articles identified several challenges associated with rebuilding mental health systems in conflict-affected settings. Funding constraints were identified as the key challenge across many studies (Epping-Jordan *et al.*, 2015; Karam *et al.*, 2016; Ventevogel *et al.*, 2022). Many conflict-affect settings receive support from donors over the shorter term (i.e. during the conflict to respond directly to the emergency) instead of funding for the implementation of longer-term interventions (Ventevogel *et al.*, 2022). The ability to maintain appropriate staffing (an in particular specialist mental health professionals) within health services, as well as sufficient human resources to effect change, was also cited as a key challenge (De Val D'Espaux *et al.*, 2011; Epping-Jordan *et al.*, 2015; Maukera and Blignault, 2015; Patel *et al.*, 2011; Sharma and Piachaud, 2011; Ventevogel *et al.*, 2011, 2012, 2022; World Health Organization, 2013). Additional challenges that threaten the long-term sustainability of mental health reform in conflict-affected settings include a lack of coordination between actors (Kucukalic *et al.*, 2005), the absence of adequate information technology systems (Kucukalic *et al.*, 2005), as well as the ineffective dissemination of health information to inform decision-making (Maukera and Blignault, 2015).

Discussion

The literature review results validate the premise underpinning the current study that the planned national reform of the Ukrainian mental health system can be applied to the conflict-affected regions of Donetsk and Luhansk. Indeed, the literature review findings highlight the conflict as an opportunity for Ukraine to effect sustainable and comprehensive reform to meet the mental health needs of the population residing in Eastern Ukraine. Evidence from the literature underscores that it is to Ukraine's advantage that there is broad

agreement on the long-term vision of mental health reform across Ukraine. The Concept Note directions for mental health reform are in line with evidence-based practice and clear links between the mental health needs of the Donetsk and Luhansk populations and concept note directions can be identified (Table 1). Furthermore, steady progress has been made in effecting broad health system reforms in Ukraine since 2018 (Lekhan *et al.*, 2007), providing a solid foundation for further health system strengthening and development (Quirke *et al.*, 2020).

Table 1 Mental health needs as defined by 2018 KIIS report (Kyiv International Institute of Sociology, 2018) and concept note directions (Ministry of Health of Ukraine, 2017)

Identified need	*Examples (taken from 2018 KIIS report) (Kyiv International Institute of Sociology, 2018)*	*Concept note on MH directions*
Low awareness and high stigmatisation of mental health disorders	About 37.1% consider attending a specialist as a sign that the person is not strong enough to cope with his/her own difficulties About 33.5% of respondents believe it is better to avoid people with emotional disorders to avoid having such a problem themselves More than half of respondents viewed a family member marrying an individual with mental disabilities or emotional disorders negatively (57.9% and 52.3%, respectively)	Improving MH awareness in society and reducing mental health stigmatisation
High level of common MH disorders and alcohol use disorders	About 8.2% of respondents indicated symptoms of PTSD, 5.4% of respondents indicated symptoms of depression and 1.5% of respondents indicated symptoms of anxiety About 12.7% of respondents were indicated to have problems with alcohol. Of these, 92.8% believe that they have do not have any problems with alcohol, whilst 7.2% believe they have a problem with alcohol	Development of mental health promotion and mental and alcohol use disorders prevention
Low level of accessibility of the services	Geographical location is an obstacle to accessing mental health services, especially in rural areas where there is a shortage of mental health professionals. In rural areas, people tend to talk about their problems with family and friends more often The absolute majority (83.0%) of the respondents do not know of psychosocial help centres in their area	Development of a community-based system of psychological and social support, including mobile teams
	When respondents seek help, they primarily attend non-mental health facilities, namely, a pharmacy (9.4%), a family doctor or a district doctor, a therapist (3.4%), a church (1.7%) or a neurologist at a polyclinic or a hospital (1.4% PHC providers reported that they are not equipped with knowledge on mental health disorders and therefore refuse to treat such disorders	Implementation of procedures of mental health assessment into primary health care
Mental health services not adapted to the needs of vulnerable groups	Three particularly vulnerable groups were identified; internally displaced persons in government-controlled territories; persons living within 20 km on both sides of the contact line; and people living in non-government-controlled areas. The most vulnerable among them are elderly, mother with small children and people with disabilities Only few of the above-mentioned populations seek for professional support. They seek psychosocial support from a family doctor (63.0%), pharmacy (36.0%), neurologist (27.2%), psychologist (25.0%) and psychotherapist (15.2%). Local psychosocial assistance is considered accessible by 34.0% and inaccessible by 10.2% of respondents. The main reasons for the inaccessibility of help were the lack of specialists (78.6%) and the high cost (6.0%)	Strengthening of the differentiation in mental health-care provision and sensitivity according to the needs of specific social groups
Low level of interagency coordination and intersectoral cooperation	A number of humanitarian actors providing mental health services are not embedded in the general healthcare and social system of services	Improvement in the effectiveness of management, interagency coordination and intersectoral cooperation in mental health service provision

The concept note for mental health presents an ambitious vision for mental health system service delivery for Ukraine across the longer term. But for the future roadmap for the concept note's implementation across Ukraine (Quirke *et al.*, 2020), priorities and first steps for service delivery and strengthening must be identified. Drawing on mental health reform evidence in conflict-affected settings and response to existing service provision and actions underway in Donetsk and Luhansk, we have determined five key priorities for applying the concept note to local mental health needs. These priorities include:

- mental health promotion and prevention;
- strengthening of stakeholder coordination collaboration;
- utilisation of existing infrastructure to tailor care to population needs;
- the targeting of particularly vulnerable groups and disadvantaged populations; and
- the embedding MHPSS humanitarian actors' activities into the local care pathways.

These priorities are discussed in more detail in turn below.

Mental health promotion and prevention

In line with the literature summarised, we recommend a public mental health approach to service provision within Donetsk and Luhansk. Specifically, we recommend that actions are undertaken to reduce the burden of PTSD and alcohol use disorders, given the high prevalence of these disorders in Donetsk and Luhansk (Kyiv International Institute of Sociology, 2018). We recommend that first-line responders (police, emergency services), as well as social workers, primary care providers, psychologists and psychiatrists, are trained in PTSD intervention (for example, psychological first aid (Psychological First Aid, 2014), mhGAP-HIG (World Health Organization and Office of the United Nations High Commissioner for Refugees, 2015), problem management plus (PM+) (World Health Organization, 2018) and skills for psychological recovery (Berkowitz *et al.*, 2010)). These educational tools have been translated and adapted for implementation in Ukraine. International humanitarian organisations have also piloted them in Donetsk and Luhansk oblasts. However, these guidelines and standards should be included in official local and national guidelines and pathways and further support from local and national authorities is required to ensure the sustained training of professionals in these tools.

Concerning alcohol misuse, we strongly recommend that a specific intervention strategy be developed at the oblast level and embedded in health services, workplaces and schools. It could include strategies to de-normalise excessive alcohol use [for example, counter-marketing (Palmedo *et al.*, 2017)], the restriction of the sale of alcohol and the enhanced availability of treatment services, including at the primary care level.

Finally, given the low levels of awareness of and high levels of stigma towards mental health disorders, we suggest the implementation of an anti-stigma and mental health awareness intervention. An awareness-raising campaign that seeks to reduce stigma towards people with mental health disorders, encourage self-care and access to professional mental health services is currently being implemented at a national level by the Mental Health for Ukraine (MH4U) project. Alongside this campaign, we recommend improving the awareness and understanding of mental health among local leaders in Donetsk and Luhansk. The MH4U project has delivered workshops for public servants in local health-care departments on mental health, including the role of psychologists, social workers and other professionals in mental health. Additional workshops that address human rights-based approaches to delivering mental health services could be provided to other local leaders.

Strengthen stakeholder coordination and collaboration

Extant literature on rebuilding mental health systems in conflict-affected settings emphasises the central role of local stakeholders and professionals in leading sustainable reform (Baignana *et al.*, 2005; De Val D'Espaux *et al.*, 2011; Epping-Jordan *et al.*, 2015; Patel *et al.*, 2011; Sharma and Piachaud, 2011; Ventevogel *et al.*, 2012; World Health Organization, 2013; Zwi *et al.*, 2011). In line with this, an organised and sustainable collaboration between local authorities and community leaders is essential to ensure the sustainable implementation of the concept note in Donetsk and Luhansk. To facilitate this, we recommend establishing coordination councils (CC) at the oblast level and establishing the local implementation teams (LITs) at the community level. LITs are well developed in the UK and ensure "organisational fitness" in delivering community mental health services through a whole system approach (National Health Service, 1999). In Ukraine, LITs and CC could be led by local authorities as budget holders for mental health service provision and comprise multisectoral representatives, NGOs and people with lived experience of mental disorders. Such bodies have already been established in Luhansk and Donetsk oblasts (for example, a LIT has been found in Mariupol city, near the contact line), with the support of the MH4U Project. Key tasks that fall under the remit of these bodies include the mapping of the mental health, social and other services available in the area for people with mental health conditions, conducting local needs assessments and developing local mental health action plans. The LIT in Mariupol, for example, has developed a local mental health action plan and is working with city authorities to embed this in the city development strategy.

Use existing infrastructure to tailor care to population needs

In principle, the optimal mix of mental health services should ensure services in communities close to an individual's place of work and living (Thornicroft and Tansella, 2013; World Health Organization, 2007, 2008). Conflict and its consequences have led many settings and countries to move from institution-based mental health service delivery to enhanced community-based provision and a focus on prevention (Abuazza, 2013; Baignana *et al.*, 2005; Epping-Jordan *et al.*, 2015; Hasanović *et al.*, 2006; Karam *et al.*, 2016; Kienzler, 2019; Kucukalic *et al.*, 2005; Maukera and Blignault, 2015; Patel *et al.*, 2011; Sharma and Piachaud, 2011; Ventevogel *et al.*, 2011, 2012, 2022; World Health Organization, 2013). As the mental health infrastructure across Donetsk and Luhansk is not uniform, multiple constellations and levels of service provision should be considered (in line with the balanced care model as described by Thornicroft and Tansella, 2002). The starting point of the scenarios is the number and type of existing services within a locality. The below options describe models of service delivery that ensure a minimum level of access to services and could provide a foundation for further service development over the longer term.

Option 1: for cities with developed mental health services Primary care services act as gatekeepers to the broader system and the centre of the referral network. Patient pathways are based upon the primary care provider's initial assessment and management of mental health disorders. More complex cases are referred to the community mental health service (either a standalone mental health centre or the psychiatric department in the city general hospital). Emergency cases would be directly admitted to the psychiatry department in the city public hospital. Complex or severe disorders would be referred to the regional or oblast psychiatric hospital. Following discharge from specialist services, patients are supported either in a community mental health centre or by their primary care provider.

Option 2: for cities with no accessible psychiatric hospital Complex cases would be treated in the psychiatric department of the city general hospital or a community mental health centre, with the support of the professionals from the nearest psychiatric hospital, using telemedicine technology). Primary care providers would manage the management of less complex mental health disorders.

Option 3: in small cities and villages in the catchment area of primary care centres Management of mental health disorders by primary care providers. Individuals with severe

conditions would be cared for via telemedicine and mobile teams comprising a psychiatrist, psychologist and social worker.

Option 4: in rural areas with low levels of accessibility Assessment and management, including basic psychological interventions, would be undertaken by trained nurses or feldshers (local name for the community health workers) under the supervision of primary care centre. Care of severe conditions is provided via telemedicine and mobile teams comprising a psychiatrist, psychologist and social worker. Feldshers could undertake the provision of medication[1].

Option 5: in areas near the contact line (grey zone) with poor levels of accessibility Assessment and management are undertaken by mobile teams, including a mental health professional, or a social worker, nurse, feldsher or primary care doctor with additional training in mental health. Individuals with more complex disorders could be cared for using telemedicine and receive their medication from a mobile team.

Each local application of community-based service delivery would co-exist, linked via service mapping and referral pathways and delivered jointly or alongside social care services and other service providers (such as the police, emergency services, the education sector and humanitarian agencies). Quirke *et al.*, 2020 describe how community-based service delivery might be facilitated at the national level. The LITs and CC could determine the level of service afforded in each local setting.

Target particularly vulnerable groups and disadvantaged populations

Whilst extant literature emphasises the importance of ensuring comprehensive mental health service delivery available to the general population within conflict-affected settings, the mental health needs of particularly vulnerable and disadvantaged populations in these settings should also be explicitly addressed (Patel *et al.*, 2011). Three particularly vulnerable groups residing in Donetsk and Luhansk are IDPs in government-controlled territories, persons living within 20 km on both sides of the contact line and people living in non-government-controlled areas.

We recommend implementing a range of activities that specifically seek to support the mental health of these particularly vulnerable groups. Firstly, we recommend using the social care and education system as additional entry points for mental health services. In many instances, social workers, school psychologists and other community workers or volunteers will be the first point of contact for vulnerable populations. This is particularly true for issues related to mental health (Weissbecker *et al.*, 2017). The reform and rebuilding of the Ukrainian mental health system in Donetsk and Luhansk should therefore seek to establish and formalise links between primary care, mental health services, social services and NGOs to ensure access to and support vulnerable populations. Secondly, reform should build on the existing work undertaken by Medicines Sans Frontier (MSF) to provide psychosocial support services to those living within 20 km of the contact line and non-government-controlled areas. MSF mobile teams and clinics operate within these settings, providing psychological support to those unable to access formal health services. Reform may seek to build on this work by commissioning mobile and interdisciplinary teams as a core component of service delivery models within Donetsk and Luhansk. Thirdly, the development of telemedicine and online psychosocial support networks will support those living within 20 km of the contact line and those in non-government-controlled regions in particular.

We note that the above recommendations feature in earlier recommendations relating to the adaptation of service provision according to existing local infrastructure. These are reiterated to emphasise the importance of any mental health reform in the East, providing access to services and support to vulnerable populations as a distinct and specific objective. Formal mental health reform must account for the challenges presented by the contact line and non-government-controlled territories and proactively identify solutions to ensure support to the vulnerable populations that reside in these settings.

Embed MHPSS humanitarian actors' activities into the local care pathways

The mental health and social support sub-cluster (under the health cluster) was established under the United Nations Office for the Coordination of Humanitarian Affairs at the beginning of the war. This sub-cluster has recently transformed into the technical working group with a greater focus on developmental activities (see its website here). MHPSS activities have concentrated on the contact line and actors joined under the MHPSS TWG deliver a range of services, including mental health promotion, to care for people with severe mental health disorders.

Many best practices and innovative models of care have been introduced under this humanitarian umbrella, and it is in the interest of the Eastern Ukrainian population that these models and best practices are embedded into the local and state care system. Namely, local care pathways should be developed that consider the established referral systems between MHPSS humanitarian actors. This will ensure continuity of care for patients and ensure that gaps in service provision are filled during mental health reform. This can be facilitated through LITs or CCs under the local administrations by including MHPSS actors.

In addition, evidence-based instruments for mental health and psychological support have already been translated, adapted and piloted in these settings (for example, the mhGAP implementation guide, as well as PM+). A number of mental health professionals have also been trained in their use. To ensure the sustainability of these interventions and their efficacy in improving the quality of care delivered, training in the use of these tools and other capacity-building initiatives need to be implemented across the region in a coordinated manner. Ukrainian national and local governments should fully capitalise on the expertise and experience of MHPSS actors during mental health reform. Professionals from these organisations have an in-depth understanding of local needs. They can provide unique insights informing local and national policy-making activities, local mental health action plans and service development. It can be achieved in many ways, for example, by including MHPSS actors in the previously described LITs and CCs.

Feasibility of applying these recommendations

Whilst this article presents a hopeful vision for mental health reform in the East, there are many challenges associated with realising mental health reform. At a national level, these include resistance to reform among some stakeholders (Romaniuk and Semigina, 2018; Semigina and Mandrik, 2017; World Health Organization and World Bank, 2019), as well as political instability and economic instability. Furthermore, the funding allocated to health services and mental health services, in particular, needs to be increased (Lekhan *et al.*, 2007). However, there are several facilitators of change in Donetsk and Luhansk oblasts that are not present elsewhere. These include a declining number of psychiatric hospitals and a weaker lobby for only mental health services in psychiatric institutions. There is also the continuing presence of humanitarian organisations and missions that bring unique expertise and resources to local communities. Furthermore, there is a greater acknowledgement of the importance of mental health by local authorities and community leaders because of the harsh living circumstances resulting from the conflict. The need to resolve the consequences of the humanitarian crisis may accelerate the adoption of mental health reform compared to other regions.

Strengths and weaknesses

This article summarises the literature on mental health reform in conflict-affected settings and applies key findings to Eastern Ukraine. This article has drawn on various sources, including peer-reviewed journals and grey literature and made several practical recommendations. Nevertheless, potentially relevant information could have been contained in sources that were excluded based on their publication in another language (i.e. not in English). Indeed,

while the included studies provided rich examples of mental health reform implemented in conflict-affected settings, further research is required to better understand the mechanisms for effecting sustainable mental health reform in conflict-affected settings (Baignana *et al.*, 2005; Epping-Jordan *et al.*, 2015; Kienzler, 2019; Patel *et al.*, 2011).

Conclusions

The need to reform the mental health system in Ukraine is well-recognised and a vision for a mental health system that is community-based and has a focus on prevention and promotion has been agreed upon by the Ukrainian Government. The ongoing conflict in Donetsk and Luhansk oblasts presents unique challenges in implementing this reform and the impetus to make sustained improvements to meet the substantial needs of the population. International literature suggests that priorities for reform in these regions include raising mental health awareness and reducing stigma; developing the capacity of local authorities in the development and coordination of services; tailoring mental health service provision according to the availability of services and population need; targeting the needs of particularly vulnerable groups; and embedding the activities of MHPSS humanitarian actors in local care pathways.

Note

1. Feldshers are health-care professionals who provided ambulatory and limited emergency care, often in rural health settings. In Ukraine, these professionals are not formally trained or licensed.

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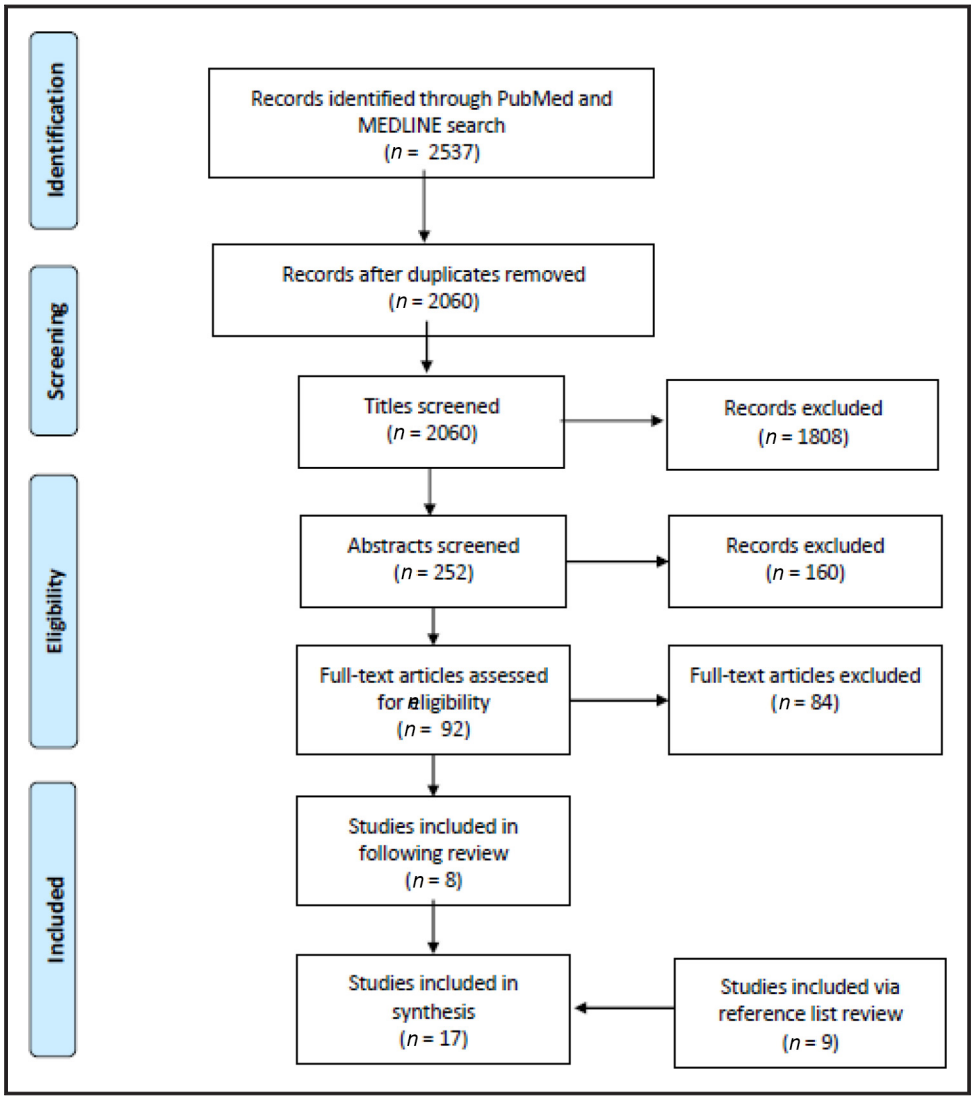
Appendix 1

Table A1 Table of included articles

Year	*Author(s)*	*Title*
2005	(Baignana *et al.*, 2005)	*Mental Health and Conflicts: Conceptual Framework and Approaches*
2005	(Kucukalic *et al.*, 2005)	*Regional collaboration in reconstruction of mental health services in Bosnia and Herzegovina*
2006	(De Vries and Klazinga, 2006)	*Mental health reform in post-conflict areas: a policy analysis based on experiences in Bosnia Herzegovina and Kosovo*
2006	(Hasanović *et al.*, 2006)	*Post-war mental health promotion in Bosnia-Herzegovina*
2011	(De Val D'Espaux *et al.*, 2011)	*Strengthening mental health care in the health system of the occupied Palestinian territory*
2011	(Patel *et al.*, 2011)	*Transitioning Mental Health and Psychosocial Support: From Short-Term Emergency to Sustainable Post-Disaster Development*
2011	(Sharma and Piachaud, 2011)	*Iraq and mental health policy: a post-invasion analysis*
2011	(Ventevogel *et al.*, 2011)	*Psychosocial assistance and decentralised mental health care in post-conflict Burundi (2000–2008)*
2011	(Zwi *et al.*, 2011)	*Decision-makers, donors and data: factors influencing the development of mental health and psychosocial policy in the Solomon Islands*
2012	(Ventevogel *et al.*, 2022)	*Integrating mental health care into existing systems of health care: during and after complex humanitarian emergencies*
2012	(Ventevogel *et al.*, 2012)	*Improving access to mental health care and psychosocial support within a fragile context: a case study from Afghanistan*
2013	(Abuazza, 2013)	*The Arab Spring movement: a catalyst for reform at the psychiatric hospital in Tripoli, Libya*
2013	(World Health Organization, 2013)	*Building back better: sustainable mental health care after emergencies*
2015	(Epping-Jordan *et al.*, 2015)	*Beyond the crisis: building back better mental health care in 10 emergency-affected areas using a longer-term perspective*
2015	(Maukera and Blignault, 2015)	*A decade of peace: Mental health issues and service developments in the Solomon Islands since 2003*
2016	(Karam *et al.*, 2016)	*Lebanon: mental health system reform and the Syrian crisis*
2019	(Kienzler, 2019)	*Mental Health System Reform in Contexts of Humanitarian Emergencies: towards a Theory of "Practice-Based Evidence"*

Appendix 2. PRISMA flow diagram

Figure A1.



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