Personal Reflection

Bringing Problem Management Plus to Ukraine: Reflections on the Past and Ways Forward

Anna E. Goloktionova[1] & Monica Mukerjee[2]

[1]MA, Mental Health Coordinator, Medicos del Mundo Mission, Ukraine, [2]MSc, Recognising, Engaging and Supporting Those living with Ongoing, Recurrent violence and its Effects (RESTORE) Project Lead, Médecins Sans Frontières, Barcelona, Spain

Abstract

This personal reflection describes the experience of two mental health programme coordinators who have supported the implementation of Problem Management Plus in conflict-affected Eastern Ukraine. Their reflection highlights the successes of the methodology and the challenges in ensuring the ownership and support for the national scale-up.

Keywords: pilot, Problem Management Plus (PM+), scale-up, sustainability, Ukraine

Introduction

Six years of violence have had profound consequences on more than 5 million people in conflict-affected Donetska and Luhanska oblasts of Eastern Ukraine. Frequent military escalations and ceasefire violations backdrop the lives of those living near the 427 km "contact line," which is approximately the same length as the French-German border. As of July 31, 2020, at least 3,367 civilians have been killed and more than 7,000 injured since the beginning of the conflict (UN Office of the High Commissioner for Human Rights, 2020)

In August 2015, Medicos del Mundo (MdM) started an emergency healthcare response for people impacted by violence. Since then, MdM has offered a comprehensive package for internally displaced persons (IDPs) and host communities based on three pillars of primary health care, sexual and reproductive health care, and mental health and psychosocial support (MHPSS). These pillars have developed into an ongoing emergency and recovery program for Donetska and Luhanska oblasts, comprising the direct delivery of services through multidisciplinary outreach teams, donation of medical consumables and equipment to hospitals, and implementation of mhGAP from 2019 and of Problem Management Plus (PM+) from 2017 until the present.

Both co-authors have had managed MdM's PM+ programme at different times: from April 2016 to February 2018, (co-author) coordinated MHPSS activities, including the inception and pilot of PM+, and from February 2018 until the present, (author) has been responsible for the coordination of MHPSS activities including the further roll-out of PM+. Together in this reflection, we wish to share our collective experience as well as our reflections on PM+'s future use.

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Mental Health in Ukraine

Armed conflicts significantly impact population wellbeing. The protracted crisis in Eastern Ukraine is not unique in this regard and has precipitated a myriad of psychological and psychosocial consequences for those who have experienced forced displacement and separation from loved ones, disruptions in employment and education and ongoing fear and uncertainty.

Following the onset of the crisis in 2014, the MHPSS needs in Eastern Ukraine dramatically transformed from those during peace. The public medical system, however, was unprepared for the surge and complexity of cases related to a conflict. At the time of the national military conflict emergency, the state policy on mental health was nonexistent. Inherited from the Soviet era, Ukraine's mental health services was composed of centralised structures established as a part of the *Semashko* model of health care. National mental health services were

Address for correspondence: Anna E. Goloktionova, Mental Health Coordinator, Medicos del Mundo Mission in Ukraine. Office 2, 44 Honchara, Kyiv 01054, Ukraine.
E-mail: mhco.ukraine@medicosdelmundo.org

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based on psychiatric care, namely in-patient and drug-based treatment for acute conditions. Social services for people with mental disorders were absent at the primary care and community levels. Interventions not involving medication, including psychological counselling, were often only available from the private sector. Furthermore, trust in MHPSS services was weak among the public. Ukraine's mental health system historically had been associated with human rights violations and consequently was linked to strong stigma and societal misbeliefs and misconceptions about MHPSS problems.

In this context, the Ukrainian mental health system was not equipped to deal with large numbers of people suffering psychologically from issues linked to an armed conflict. In line with building back better phenomena, the crisis has brought public attention to the gaps and discrepancies of the existing system, and in 2017, the Mental Health Care Development Concept Note in Ukraine for the period of up to 2030 was adopted. The drafting process of the national mental health plan followed, although its approval is pending 3 years after.

Recognising the challenges facing the public health system in 2015, MdM first worked with local authorities to deploy psychologists with primary care mobile teams, train doctors and nurses to better identify signs and symptoms of MHPSS problems and run community-awareness sessions to dispel myths about mental health and increase knowledge on the psychological consequences of violence.

People attending consultations with MdM psychologists conveyed many ongoing problems and stressors due to the economic and social disruptions linked to the crisis–financial difficulties, family separation, alcohol abuse, military presence and domestic violence. Patients reported numerous signs of emotional distress, such as mental fatigue, inability to complete daily tasks, fear, anxiety, loss and psychosomatic complaints.

At MHPSS awareness sessions, participants described some of the barriers that prevented them from seeking help, such as the lack of accessible and affordable MHPSS services, complications in the referral system, lack of trust in the health system, possible stigma and judgement from others and financial worries linked to the high cost of psychiatric treatment. They appreciated having the opportunity to receive care from MdM but doubted it would ever be possible from the national health system.

MHPSS concerns were echoed by public health staff who attended MdM's trainings. Doctors and nurses expressed an urgent need for appropriate treatment methods, protocols and training to support patients suffering from psychological symptoms. Health staff in rural areas tried their best to deal on their own with these issues as they presented with patients, but found it difficult to decide between a wide array of possible approaches, many of which were not evidence-based or effective. This challenge was only compounded by the influx of short-term training workshops provided by humanitarian actors, which were sometimes poorly coordinated and not always designed within the frame of global standards. As a result, many health staff reported feeling burdened, and in some cases, burned out, from emotionally supporting patients without proper methodological structure or follow-up after trainings.

Why PM+?

Considering these challenges, MdM began to ask how we could better support the Ukrainian public system to assist people affected by MHPSS issues linked to the conflict. In line with momentum for national level reforms on mental health, we hoped to pilot an evidence-based MHPSS intervention. In addition to having evidence of potential effectiveness and utility in Ukraine, we wanted an approach that could empower people suffering socially and economically from a conflict that did not have a clear end. Moreover, we required a method that allowed us to train and supervise service providers quickly while equally ensuring minimal harm for those receiving and giving care.

Though it had not been tested before in Ukraine (and was not translated in Ukranian or Russian), PM+ resonated with us for several reasons as we searched for possible methodologies. We could see the immediate value of a transdiagnostic approach to MHPSS in Ukraine, where we understood the current system often relied on outdated diagnosis-based classifications and did not appropriately train providers on the identification of psychological disorders. Furthermore, because PM+ was a structured intervention, we hoped its framework for sessions could give better boundaries to counsellors so they felt more able to support others and to mitigate further burnout.

We were also drawn to the fact that PM+ was intended for situations of adversity rather than contexts of "emergency" or "development". This felt refreshingly inclusive amid debates on whether Eastern Ukraine was still a "humanitarian crisis" or ready for "recovery". These distinctions, though useful for some stakeholders, did not do much in changing the lived realities and difficulties many on the contact line faced.

We could also see how problem-solving approaches countered creeping narratives of helplessness that had begun to appear in media discourses of how the crisis had "traumatised" and paralysed Eastern Ukraine. Although the conflict had caused numerous negative repercussions, there was no doubt from our experience already that agency and community support had also helped many endure. We wanted to find a way to reinforce these foundations in our programme. Because of its practical exercises and action-oriented spirit, PM+ seemed like an obvious means to show how psychological support could enable tangible changes in people's lives, just as medicine and material support could.

Carrying out PM+ in Ukraine

Our initial hopes to try PM+ in Ukraine took us on a journey from March 2017 until August 2020. Starting with the translation into Russian and Ukrainian and contextual adaptation of WHO's materials, MdM then implemented three cycles of PM+ (including training and supervision of counsellors delivering services to clients), resulting in over

100 community-based helping delivering services for more than 300 clients.

The contextual adaptation of PM+ included revising training materials from research trials (at that stage the PM+ facilitation training manual was under development). We supplemented information and skills building on empathy, reflection, paraphrasing and open-ended/closed questions in the Basic Helping Skills section. We added more practice and application with PM+ strategies for participants to try for themselves to improve trainees' familiarity with the tools and principles of self-care.

We also created a workbook to be used by clients throughout their PM+ sessions. The rationale behind a workbook was to better structure sessions that had less scripts available for counsellors to rely on (e.g. managing problems). The workbook also created more opportunity for personalisation during psychoeducation with clients, as they could reflect on how certain information applied to them, especially in sections for homework. The workbook was a tangible tool that clients were able to keep after the program had ended to reinforce self-help based on the strategies. After implementation, the workbook demonstrated impact and value as an extension of the PM+ intervention.

After materials were translated and adapted, we planned a pilot with 14 rural-based nurses who were trained and supervised as counsellors. The pilot aimed to encourage the integration of mental health in primary health care and showcase the use of evidence-based MHPSS practices in Ukraine.

The nurses in the pilot were supervised by MdM staff. The supervision process included individual meetings and on-site observations, as well as group supervision sessions to discuss challenges and revise training on counselling skills and PM+ protocol. On average, each counsellor was supervised for over 3.5 hours per two clients. The project resulted in 38 clients completing the PM+ session protocol. On average clients' emotional distress decreased 50% upon completion of the intervention, with functioning improving 30%.

The nurses who participated as counsellors described a paradigm shift. By the end of the programme, nurses reported a deeper acknowledgement of the link between mental health and physical health, and an improved professional efficacy from learning to better manage work-related stress. The intervention also made changes in clients' wellbeing more visible to the practitioners due to progress monitoring with PM+'s assessment tools. It was a demonstration that "words can heal"; it even could be measured by the changes in the weekly monitoring scores and post-assessment.

Although successful in exploring the relevance of PM+, the pilot did not have a sustainable continuation. Political will to integrate mental health in primary health care settings has been hesitant alongside the delayed National Mental Health Care plan adoption process. Once supervision and support from MdM ceased, counsellors did not continue to deliver PM+. Many factors, such as a lack of available confidential space in health facilities, counselling being added on top of nurses' existing normal workload, low recognition in the value of mental health among peers and limited interest or encouragement from administration, were not possible to resolve through PM+ alone.

Nevertheless, the pilot gave MdM an indication that PM+ was feasible to implement in Eastern Ukraine. It also provided MdM with evidence to advocate for integrated and community-based MHPSS in the region and gain transitional funding for the scale-up of PM+ in 2018–2019. In this next project, MdM aimed to use PM+ as a means to build effective community-level psychosocial support, particularly in areas of Luhanska and Donetska with high concentrations of IDPs. Fifty-four counsellors employed by local Social Protection and Education Departments and local NGOs providing psychosocial support to IDPs, veterans and the local population were trained and supervised to deliver PM+. Many trainees had a previous academic background in psychology, (i.e. school psychologists, NGO MHPSS providers) and were already delivering MHPSS services to the target population. The service modality was also different, due to the specialists being placed within municipalities and urban areas with more options for referrals and opportunities for employment and social integration through available social networks.

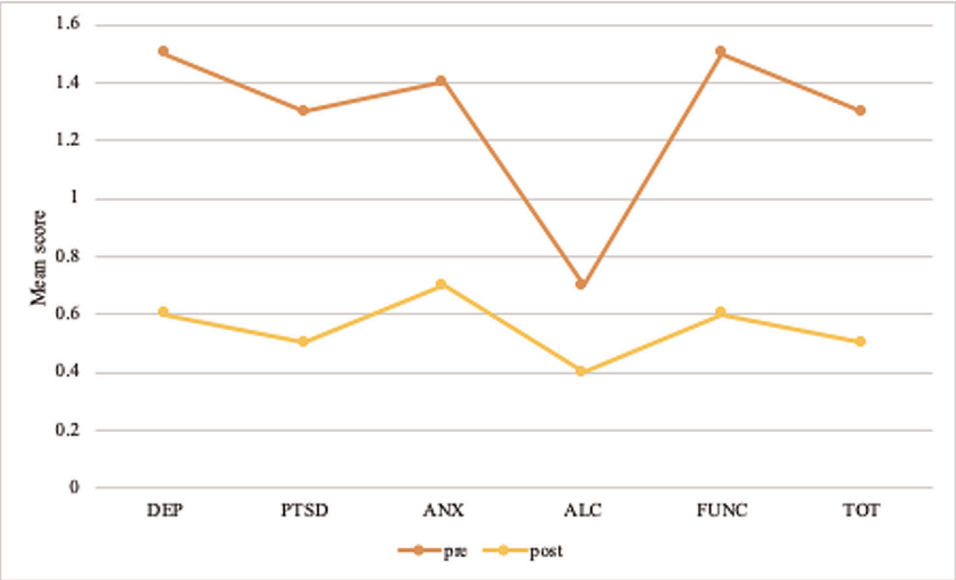
MdM adapted the supervision process by establishing a cascading structure with on-site, individual and group supervision. The PM+ supervisors' pool was drawn from the participants of the PM+ core training based on observations of skills, after the counselling of at least one client under MdM supervision was completed. A one-day supervision training was delivered to the nominees.

In seven municipalities of Luhanska and Donetska oblasts, PM+ was delivered to 139 clients. The MHPSS problems of clients included interpersonal problems (40%); economic hardships (25%), health-related problems (13%), grief and loss (11%), gender-based violence (5%) and other (7%). Again, we found significant changes from the intervention. Participants scored lower on each indicator of mental health distress after they underwent the PM+ intervention. Figure 1 below showcases the differences in mental health scores before and after the intervention.

PM+ again showed it was an efficient tool in reducing MHPSS symptoms. Nevertheless, the sustainability of the intervention again became unclear for the project. Maintaining PM+ trained counsellors was difficult for many of the same institutional barriers that faced the nurses in the pilot. These included lack of workspace, limited material and supervision support, unclear scope of work for counsellors and limited political will, pending the national adoption of the National Mental Health plan.

MdM still continues to advocate for support for mental health care in Ukraine, in part through implementation of PM+ in Donetska and Luhanska oblast. In 2019–2020, MdM supported 55 more counsellors to help a further 128 clients. MdM is currently at the final stage of conducting final evaluations with the trainees to assess their

Figure 1: *Differences in Mental Health Scores Before and After PM+ Intervention.*
Note. Data were collected as a part of client pre- and post- programme assessment. Population size = 138 individuals. The assessment tool used the Mental Health Assessment Inventory validated and tested in Ukraine by Johns Hopkins University and the National University Kyiv Mohyla Academy.



professional confidence with PM+ and views on future applications.

Reflections

During MdM's journey with PM+ in Ukraine, we found successes and problems that could be relevant for others looking to implement and scale up this intervention. In Ukraine, where professionalisation and hierarchy are highly valued, there was some scepticism among national mental health specialists that an intervention could train nonspecialists to effectively provide psychological support. Despite this concern, like in other contexts, client outcome data indicate PM+ can be effective in Ukraine.

But why does PM+ work? Over the years, the authors have speculated and debated. Is it the methodology? Or is it due to other factors that have been identified with successful MHPSS interventions and services? We believe one of the key reasons behind PM+'s success was because it eased protracted isolation among clients and helped foster trust. The sessions allowed clients to connect with a support system, represented by a counsellor who resides in the same community. Likewise, even the workbook extends this relationship and keeps the client connected between and after sessions. The workbook may also help materialise the psychological support and structure clients' practice, but it's hard to believe the impact of the intervention would be the same without a positive relationship with a counsellor.

Our project data focused on the impact of PM+ on clients, but we also observed benefits in those who provided it as counsellors. Evaluations highlighted that basic counselling skills and empathy remained the most challenging areas for counsellors to apply with clients rather than the PM+ session protocols in themselves. Despite this, over time counsellors expressed that using PM+ decreased feelings of burden with clients and increased their confidence to safely connect with those seeking help.

We imagine this also may be in part because of PM+, but also because of the support that training and supervision provided counsellors as a whole. Skill development in communication and counselling still remains a gap in the Ukrainian educational system. Participating health professionals, school psychologists and social workers confirmed they had not previously learned brief counselling methods or frameworks in an interactive training set-up, using roleplays, demonstrations, or group discussions. The notion of technical supervision was also new for many, and with some counsellors even openly speaking about having a perception of a supervisor as a "controller" at the start of the programme rather than a source for support. Sharing experiences and repeated practice during supervision sessions with PM+ tools, exercises to develop counselling and listening skills and roleplays were novel for participants. This process likely laid a safe foundation for counsellors to address challenges and work on professional competences.

Although PM+ provides a framework to guide counsellors to facilitate specific sessions, it certainly has limitations. Most obviously from our experience, the methodology of PM+ does not inherently define or recommend how a programme using this intervention could or should be practically implemented and sustainably maintained. In many ways, these are the central questions that could make or break any intervention (regardless of methodology). For example, how many supervisors and counsellors are needed for PM+? What types of local structures should be involved and how should they support an existing PM+ programme? Should provision of PM+ be compensated additionally or considered part of ongoing work for service

providers? Should training in PM+ be integrated with national institutions for professional validation? These questions? – and many others – are dependent entirely on the implementer of PM+ and careful exploration of the local context of the planned implementation site.

Conclusions

There are many future questions about how to hand over PM+ and other similar interventions to the national system. An evaluation is being planned to revisit the sustainability of client outcomes after 1 year and more. It also intends to look at the extent to which trained counsellors are using the methodology, and which forms it takes, that is, integrating PM+ sessions in their MHPSS interventions, or following standardised protocol. Exploring the amount and types of resources to maintain counselling that would have facilitated more active application of PM+ will be the aim of evaluation.

Compared to the moment when MdM first considered even trying PM+, there has since been an exuberant enthusiasm and wide-ranging experimentation of the intervention around the world. Many are drawn to the methodology (like we were) and can imagine its potential. But we caution fellow MHPSS practitioners to remember PM+ is not a panacea for all individuals' problems or all dilemmas facing mental health systems. It remains effective but one element that needs attention and resourcing to address conflict-related needs.

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Conflicts of interest

There are no conflicts of interest.

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