MENTAL HEALTH IN TRANSITION

Assessment and Guidance for Strengthening Integration of Mental Health into Primary Health Care and Community-Based Service Platforms in Ukraine

WORLD BANK GROUP

CONTENTS

LIST OF ABBREVIATIONS

AUD	Alcohol Use Disorder
AA	Alcoholics Anonymous
AIDS	Acquired immunodeficiency syndrome
ASIST	Alcohol, Smoking and Substance Involvement Screening Test
ATO	Anti-Terrorist Operations
AUDIT	Alcohol Use Disorders Identification Test
CBO	Community-based Organization
CBT	Cognitive Behavioral Therapy
CETA	Common Elements Treatment Approach
CHW	Community health worker
CMD	Common Mental Disorder
DALY	Disability Adjusted Life Years
EACBTI	European Association for Behavioral and Cognitive Therapies
EMDR	Eye Movement Desensitization and Reprocessing
GDP	Gross Domestic Product
GIP	Global Initiative of Psychiatry
GIZ	Deutsche Gesellschaft für Internationle Zusammenarbeit (GIZ) GmbH
GP	General Practitioner
HIV	Human immunodeficiency virus
IDP	Internally Displaced Person
IHD	Ischaemic Heart Disease
IMC	International Medical Corps
INGO	International nongovernmental organization
MDM	Medicines Du Monde
MH	Mental health
mhGAP	WHO Mental Health Gap Action Program
MHPSS	Mental Health and Psychosocial Support
MNSD	Mental, Neurological and Substance Use Disorders
MoH	Ministry of Health
NCD	Noncommunicable disease
NGO	Nongovernmental organization
OHT	OneHealth tool
PAF	Population attributable fraction
PFA	Psychological First Aid
PHC	Primary Health Care
PHQ-9	Patient Health Questionnaire – 9
PMSAC	Primary Medical Sanitary Assistance Center
PTSD	Posttraumatic Stress Disorder
ROI	Return on Investment
TB	Tuberculosis
THE	Total Health Expenditure
UAH	Ukrainian Hryvnia (currency)
UCU	Ukraine Catholic University
UNHCR	United Nations High Commissioner for Refugees
UNHS	Ukraine National Health Services
UPA	Ukrainian Psychiatric Association
USAID	United States Agency for International Development
WHO	World Health Organization
WHO PM+	Problem Solving Plus (WHO manualized intervention)
WHO SH+	Self Help Plus (WHO manualized intervention)
WTF	War Trauma Foundation
YLD	Years Lost due to Disability
YLL	Years of Life Lost

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I. EXECUTIVE SUMMARY

Introduction

Ukraine is undergoing important reforms in the health system, and there is an increasing interest among national as well as international actors in improving mental health services. Ukraine has a **centralized mental health care system** with services provided mainly through psychiatric clinics and 90% of funding contributed to psychiatric hospitals. There is a lack of community level mental health care, and limited provision of mental health care and support by nonspecialized staff such as general doctors and family physicians. National level discussions of plans to improve mental health care include provision of community-based care to support persons with mental health problems, including the integration of mental health into primary health care. In large part due to the conflict in the East which has lasted for over three years, there has been **increased efforts among civil society organizations and international actors** to address mental health needs, especially among conflict affected populations including IDPs and veterans. However, to date there has been no systematic assessment focusing on mental health as part of the health system and through community level organizations, which also explore help seeking and barriers to care. **The aim of this assessment is to provide recommendations to inform policy and operational guidance for strengthening integration of mental health into primary health care and community-based service platforms in Ukraine under the reform program.**

Methods

This assessment provides an overview and analysis of available mental health services and supports, as well as of community perceptions and ways of help seeking. The assessment focuses on **3 pilot regions (Lviv, Poltava, Zaporizhia)** and on **common mental disorders (CMDs)** including depression, anxiety, post traumatic stress disorder (PTSD), and as well as **alcohol use disorder (AUD).** Methods used include **Desk Top Review** (e.g., Ukraine national policies and plans pertaining to mental health, peer-reviewed publications, and reports on mental health), **Stakeholder Interviews at national and regional** levels, and **qualitative interviews** to assess **formal and informal mental health services and supports** (provided by mental health specialists and nonspecialists as part of the health care system as well as through community mental health service platforms) and to assess **community demand for services, help seeking, coping, and barriers to mental health care.**

Results

Health and mental health are closely related. Over 90% of deaths are caused by non-communicable diseases (NCDs) in Ukraine, with harmful alcohol use as a major risk factor. Research suggests that about 30% of people in Ukraine will experience a mental disorder in their lifetime. Alcohol use disorder is more common among men, while anxiety and depression are more common among women. In comparison to other countries, Ukraine has especially high rates of depression. **Poor mental health in Ukraine is tightly inter-connected with poverty, unemployment, and feelings of insecurity,** compounded by the effects of the conflict. IDPs, older persons and those living in the East are especially vulnerable. Research and our data show that **CMDs and AUD have wide ranging impacts and consequences** including poor health; excess deaths; impaired functioning and resulting financial, social and family problems; as well as stigma and discrimination.

The Ukraine health system and mental health services are in need of reform. Only 2.5% of the total health budget is dedicated to mental health, and the **majority (89%) of funding goes toward inpatient mental health care.** Due to **insufficient government financing** of the health system, the population is required to pay for outpatient and inpatient pharmaceuticals (which are often expensive), as well as provide unofficial **remuneration** to medical personnel. The **mental health system is centralized,** with most staff and services concentrated in psychiatric and narcological hospitals and inpatient units. **Available interventions** by specialized mental health care providers and in-state facilities are **often not evidence based.** Some private practitioners and private rehabilitation centers offer such interventions, but others offer interventions that may be ineffective or harmful. Although protocols exist, **primary health care providers are often reluctant to address CMDs or AUD** due to lack of skills and limited time. Informal community providers such as **clergy** can be an important source of mental health support.

There has been a proliferation of **civil society organizations and nongovernmental organizations (NGOs)** providing mental health interventions, but efforts are not always coordinated and in line with best practices; they may be focused on specific populations only (e.g., IDPs and veterans), and sustainability remains a challenge.

Overall, the mental health system is **lacking continuity of care** as a result of limited communication between providers from different professions or between different agencies and organizations. There is also **confusion and mistrust among the general public about what information about their mental health status is shared,** leading to persons **not seeking help** or spending more money and resources to seek help (e.g., longer distance, private services).

Among **human resources** for mental health, there is a high number of psychiatrists in the system, with lower numbers of psychologists, psychotherapists, and social workers. Educational and training opportunities at state universities do not offer foundations and skills-based training in evidence-based treatment for CMDs and AUD. Many private

institutions offer training for psychotherapists, which is not always based on evidence. Psychologists and psychotherapists **can often not afford training opportunities** to acquire needed skills. At the same time, psychologists and psychotherapists practice **without licensing and oversight. International actors** have initiated programs to build capacity in mental health, but efforts are not always coordinated or do not make use of lessons learned and global guidelines.

Studies suggest that most people (up to 75%) with CMDs and AUD in Ukraine do not access care. **Barriers to care** include stigma and shame, fear of psychiatry and lack of trust in the health system, lack of information and awareness, high cost of treatment, fear of having a public record as being diagnosed with mental illness, and geographical distance.

Using secondary data from the OneHealth tool, the **health impact and cost of intervention scale-up** was pre-modeled over the period of 2017 to 2030. Treatment costs for addressing selected priority mental health conditions (depression, anxiety disorders, AUD, bipolar and psychotic disorders) included medication, outpatient and primary care, inpatient care, and program resources (e.g., training). The model shows that with scale-up of treatment for selected mental disorders in Ukraine, over **4.7 million years of healthy lives can be restored by the year 2030,** with **AUD accounting for most cases** reached and years restored. The total cost per head of population would increase, from US$2.80 to US$10.90. It can be estimated that the economic value of restored productivity with treatment of common mental disorders over this period amounts to more than $800 million for depression and $350 million for anxiety disorders. This means that **for every $1 invested in scaled-up treatment of common mental disorders in Ukraine, there will be $2 in restored productivity and added economic value.**

Conclusions and Recommendations

This assessment has several **limitations**, including being limited to specific mental disorders only (CMDs and AUD), being limited geographically (to three pilot oblasts), using desktop review and qualitative methods only, and focusing on mental health within the health system and community level platforms and not on social and educational sectors.

Recommendations should be prioritized to initially focus on strengthening coordination and leadership for mental health and to build on past experiences and global guidance in expanding and initiating key pilot projects focusing on regions with high need and successful collaboration with regional actors. Overall recommendations from this assessment include **strengthening coordination, communication, and information sharing.** This pertains to improving communication and coordination among donors and implementing partners for supporting mental health programming and reform in Ukraine. There is also a need to strengthen referral pathways among different formal and informal service providers in the health and social systems and to foster communication, information sharing, and multidisciplinary teamwork while protecting patient confidentiality. Because the **organization of mental health services** is still centralized and focused on psychiatry,

mental health services must be decentralized from hospital-based care toward outpatient care and community-based services, including integration with primary health care. At the same time, **financing for mental health must be strengthened** with increased budget allocations as well as coverage of treatment (including psychotropic medications) for persons with CMDs and AUD. Public health initiatives (e.g., taxing alcoholic beverages), as well as comprehensive and evidence-based treatment options must be available for persons with AUD. Given the interconnectedness of mental health with NCDs as well as infectious diseases, **physical and mental health care must be integrated and provided collaboratively.** Although there has been a strong focus on trauma and PTSD in the context of the conflict in the East, it is important to take a public health approach and consider the much higher burden of depression and AUD at the country level. While it is important to tailor mental health services to different groups (e.g., older persons, veterans) it is also crucial that services must be accessible to all segments of the population. There is a significant need to build the capacity of **human resources** in Ukraine, including offering educational programs that provide needed qualifications in evidence-based psychological interventions; providing official licensing, certification and oversight for practicing psychologists and psychotherapists; building the capacity for identification, management, and referral of persons with CMDs and AUD among primary health care providers, as well as strengthening the role of social workers and various nonspecialized and community providers. Lastly, it is important to **raise awareness and provide information** to the general public about mental health problems and how to choose qualified providers of mental health services. There is also a need and opportunity to support and create consumer-led mental health advocacy groups and strengthen engagement of persons recovering from mental illness and their family members.

We hope that findings and recommendations from this assessment will be useful in informing concrete steps for addressing mental health as part of the health reform and in informing mental health programming supported by various national level and global actors.

II. ASSESSMENT GOALS AND METHODS

1. Focus and Goals

This assessment provides an overview and analysis of available mental health services and supports, as well as community perceptions and ways of help seeking. The assessment focuses on **3 pilot regions** (Lviv, Poltava, Zaporizhia) and on **depression, anxiety, PTSD, and alcohol use disorders** and covers the following elements:

- Desktop review (e.g., Ukraine national policies and plans pertaining to mental health, peer-reviewed publications and reports on mental health)
- Stakeholder interviews at national and regional levels
- Assessment of formal and informal mental health services and supports provided by:
  - Mental health specialists and nonspecialists as part of the health care system
  - Community mental health service platforms (e.g., NGOs, clergy)
- Assessment of community demand for services, help seeking, coping, and barriers to mental health care
- Analysis of secondary data to estimate cost of intervention scale-up and return on investment

The aim of this assessment is to provide information and recommendations that help inform policy and operational guidance for strengthening integration of mental health into primary health care and community-based service platforms in Ukraine under the reform program. It is our hope that results and recommendations will be discussed by key stakeholders in Ukraine to guide the development of the national mental health policy and plan, and to inform funding, concrete actions, and program priorities over the coming years.

2. Methods

The assessment was carried out over a 5.5 month period by an International Medical Corps Assessment team including: an IMC Senior Global MHPSS Advisor, MH Project Manager, MH Project Officer and Translator based in Kyiv, as well as two interns based in the United States. The following activities were carried out over the project period:

	MONTH					
ACTIVITY	APR	MAY	JUN	JUL	AUG	SEP
Preparatory Activities						
Identify and hire additional project staff						
1.1. Desktop Review and Development of Methods and Tools						
Conduct desktop review						
Develop and adapt project methods, tools and questionnaires						
1.2. National and Regional Level Stakeholder Meetings						
Conduct national level meetings						
Conduct regional level stakeholder meetings						
1.3. Data Collection and Analysis						
Assessment of mental health services						
Conduct assessments among community members						
Enter and analyze data and discuss recommendations						
1.4. Dissemination of Findings						
Produce and disseminate assessment report for review						
Disseminate and discuss final report						

2.1. Desktop Review

The desktop review compiled **literature and data from over 131 sources,** which were reviewed and documented in a categorized Excel spreadsheet, which classified literature and data by a) academic literature (55 items reviewed), b) grey literature (24 items reviewed), c) assessment reports (16 items reviewed), and d) policy documents (36 items reviewed). The primary search engines were PubMed, PILOTS Database, PsycINFO, mhpss.net, MHInnovation network, and Google Scholar. A variety of key words were utilized in this search, including but not limited to: Ukraine, Internally displaced populations, Mental Health, Alcohol use disorders, Depression, Anxiety, Epidemiology, At-risk, Suicide, Global Mental Health, PTSD, Psychiatry, and Psychology. Additionally, **37 Ukrainian and Russian language documents** (including conference reports, peer reviewed publications, newspaper and media articles and blogs, policy documents, and reports) were reviewed.

2.2. Key Informant Interviews and Discussions

Interviews and discussions with national level stakeholder key informants were held in Kyiv. Data from health facilities, key stakeholders, and key informants were also collected during three visits in each region (Lviv and Zaporizhia and Poltava). The following data was collected:

SUMMARY OF DATA SOURCES

Information from Key National and Regional Level Stakeholders

Stakeholder Interviews	Number	Attendance at three national level conferences to collect information
National government (e.g., Ministry of Health, Ministry of Social Affairs, Ukrainian Research Institute of Social and Forensic Psychiatry, and Drug Abuse MoH)	3	• **MoH National Consultation** on the Development of Mental Health in Ukraine, Kyiv, April 5–26, 2017 • **Kyiv Annual Psychiatry Conference:** Psychiatry of the 21st century: issues and innovative decisions, April 27–28, 2017 • **National Conference on 'Implementation of the IASC Guidelines** on Mental Health and Psychosocial Support in Emergency Settings in Ukraine: Experience, Practice, and Next Steps', Kyiv, June 14–15, 2017
Professional association (Association of Psychiatry)	1	
Regional government (e.g., chief psychiatrist)	4	
UN agency (e.g., WHO)	3	
INGO (e.g., MDM, WTF, GIP)	3	
Universities (e.g., University Kyiv-Mohyla Academy, Ukrainian Catholic University)	4	
International agencies and donors (e.g., USAID, Swiss Development Cooperation)	2	

Information from Oblast Regions

Health Facilities	*Total*	Lviv	Poltava	Zaporizhia
Mental hospital/dispenser	***5***	2	2	1
Narcology dispenser	***3***	1	1	1
Central Rayon Hospital with narcology unit	***1***	–	1	–
Central Rayon Hospital with psychiatric unit	***9***	4	2	3
Polyclinics	***22***	10	3	9
Feldsher points	***5***	2	1	2
Nongovernment and Community-Based Organizations				
NGOs and CBOs	***18***	7	6	5
Alcoholics Anonymous (AA) groups (including family members)	***2***	–	2	–

SUMMARY OF DATA SOURCES				
Service Providers	***Total***	**Lviv**	**Poltava**	**Zaporizhia**
Psychiatrist	***15***	7	4	4
Narcologist	***4***	1	2	1
Psychologist (including gov and private)	***33***	12	14	7
Neurologist	***1***	–	–	1
Social worker	***12***	2	7	3
Family Dr/GP*	***39***	10	16	13
Feldsher	***5***	2	1	2
Clergy	***3***	2	1	–
Mental Health Service Users (15 male, 9 female)	***Total***	**Lviv**	**Poltava**	**Zaporizhia**
Depression	***7***	2	1	4
PTSD	***7***	5	1	1
Anxiety	***5***	3		2
AUD	***3***	2	1	1

*Response rate: While the vast majority of respondents we approached were willing and often glad to participate in interviews and discussions to share their experience, several family doctors/GPs declined participation. This included 8 in Lviv, 3 in Poltava, and 5 in Zaporizhia resulting in a response rate of 71% for this group. Reasons given for not participating were lack of time (e.g., patients were usually waiting) and being tired after a long day (e.g., when approached during afternoons or evenings with less patients present).

Assessment tools were adapted from the WHO (2017 draft) mhGAP Situation Analysis Tool-Framework and included national, district, and facility level questions. Assessment tools were also adapted from the WHO/UNHCR (2012) MHPSS Assessment Toolkit for Humanitarian Crises and included the following: "Checklist for integrating mental health in PHC in humanitarian settings," "Template for desk review of preexisting information," "Participatory Assessment I: Free listing and ranking of problems with further assessment on daily functioning and coping," and "Participatory Assessment II: Example Questions for Key Informant Interviews on Distress and Supports in Different Population Subgroups."

Assessment tools were piloted during the assessment and were further refined and simplified with the goal of ensuring that questions were tailored to the context,and were practical and relevant.

2.3. Analysis of Secondary Data: Mental Health Impact, Investment, and Return on Investment Analysis

Analyses of mental health impact, intervention scale-up, and return on investment were performed with support from WHO using existing data from the OneHealth tool. Detailed methods and results are presented in Chapter 7.

III. RESULTS

1. Background and Context

1.1. Sociopolitical Context

Located in Eastern Europe, Ukraine is the second largest country in the European region and is bordered by the Black Sea, Moldova, Romania, Hungary, Slovakia, Poland, Belarus, and Russia. The majority of the population in Ukraine is concentrated in and around major urban areas of Kyiv, Kharkiv, Donetsk, Dnipropetrovsk, and Odessa.[2]

Ukraine became an independent state in 1991 following the dissolution of the Soviet Union. In the late 18th century, the territories that make up contemporary Ukraine were split between the Austro-Hungarian and the Russian Empires. During the period of Soviet rule (1920 until 1991), Ukraine experienced a number of crises, including two large-scale famines, Stalinist purges, and a nuclear accident in Chernobyl in April 1986. After it gained independence, Ukraine has gone through a number of political transitions, most notably the "Orange Revolution" in 2004, prompted by a rigged presidential election, and most recently, large protests in 2014's "Revolution of Dignity," which led to occupation of Kyiv's central square (Maidan) and a change in the presidential administration. In 2014, the Russian military occupied Crimea and supported separatists in taking over portions of Luhansk and Donetsk oblasts in the East. The conflict in the East, referred to as an Anti-Terrorist Operation (ATO) by the Ukrainian government, has led to continuous fighting and loss of lives, both military personnel and civilians. The conflict has taken the lives of 2,000 soldiers and 8,000 civilians, and wounded 20,000 people. Approximately 3.8 million people remain in need of humanitarian assistance, and about 1.5 million people are internally displaced.[1] Internally displaced persons (IDPs) have settled throughout Ukraine, searching for security, affordable housing, and livelihoods, with the majority of them (over half) staying in Donetsk and Luhansk regions in eastern Donbas near the conflict zone.[3] Since the Revolution of Dignity, and in large part due to the annexation of Crimea and conflict in the East, the country has seen a dramatic drop in GDP and purchasing power with a substantial number of Ukrainians finding employment abroad, mostly in the EU and Russia.[4]

TABLE 1.1: UKRAINE SOCIO-DEMOGRAPHIC INDICATORS				
Population	**National**	**Lviv**	**Poltava**	**Zaporizhia**
Total population[5]	42,541,633	2,514,762	1,417,832	1,737,175
Urban population (% of total)[5]	69.1	60.9	61.9	77.2
Other Socio-Demographic Indicators				
Population below 14 years old (% of total)[2]	15.51			
Population above 65 years old (% of total)[2]	16.05			
% and number of internally displaced persons	1,627,738[6]			
Languages[5]	Most people speak both Ukrainian and Russian. First languages: Ukrainian (67.5%), Russian (29.6%), Crimean Tartar-, Moldavian-, & Hungarian-speaking minorities (2.9%)			
Ethnicities[2]	Ukrainian 77.8%, Russian 17.3%, Belarusian 0.6%, Moldovan 0.5%, Crimean Tatar 0.5%, Bulgarian 0.4%, Hungarian 0.3%, Romanian 0.3%, Polish 0.3%, Jewish 0.2%, other 1.8% (2001 est.)			
Religions[7]	Orthodox Christian 65.4%, Not religious 16.3%, Other Christian 7.1% Others Greek Catholic 6.5%, Protestant 1.9%, Islam 1.1%, Roman Catholic1.0%, Judaism 0.2%			
GDP	93.27 billion[8] GDP per capita: $2,185[9] Lower-middle-income group			
Government type	Semi-presidential republic[2]			
Administrative divisions	24 oblasts[2]			
Literacy rate (%)	Total population (aged 15 years >): 99.76%[10]			
Human development index	84 (out of 188)[11]			
Per capita income	$8,200[2]			
Life expectancy at birth	71.8[2]			
Infant mortality Rate	8 deaths/1,000 live births[2]			

1.2. General Health Aspects

Ukraine has one of the worst health profiles in the European region, characterized by high mortality, morbidity, and disability rates (see Table 1.2). General health in Ukraine **declined after the breakup of the Soviet Union** in 1991, with a documented decrease in life expectancy and standard of living, while rates of mortality increased, especially from cardiovascular disease, accidents, and *causes related to alcohol.*[12] Self-rated physical health of Ukrainians is lower than in Russia and other parts of Europe.[13] **Life expectancy** in

TABLE 1.2: KEY HEALTH INDICATORS	
Life expectancy at birth: 71 years[14] (European Union average: 81.1[17]) • 66.2[11] years for men (European average: 78.5[17]) • 76 years for women[11] (European Union average: 83.9[17])	**Top 10 causes of death:**[14] • Ischaemic heart disease (48%) • Stroke (17.1%) • HIV/AIDS (3%) • *Cirrhosis of the liver (2.5%)* • Other: Lung cancers (2.1%), colon and rectum cancers (1.8%), chronic obstructive pulmonary disease (1.6%), stomach cancer (1.3%), self-harm (1.3%), breast cancer (1.2%)
Prevalence of key risk factors for NCDs;[15] • **Current tobacco smoking:** male 49%, female 14% (percentage of the population aged 15 or older who smoke any tobacco products, 2011) • **Total alcohol per capita consumption:** male 22.0, female 7.2 (consumption of pure alcohol in litres, per person aged 15+ during one calendar year) • **Raised blood pressure:** male 47.7%, female 43.1% (percentage of the population aged 25 or older having systolic blood pressure > 140 mmHg and/or diastolic blood pressure > mmHg) • **Obesity:** male 15.9%, female 25.7% (percentage of the population aged 20 or older having a body mass index (BMI) > 30kg/m2)	

Ukraine has shown a gradual increase of about 3 years between 2000 and 2012 but is still low compared to other European countries.[14] An estimated 90% of deaths in Ukraine are caused by **noncommunicable diseases.[15] Risk factors** such as smoking, excess drinking, unhealthy diets, lack of physical exercise, and pollution align with the leading causes of death in Ukraine.[16]

Infectious Diseases

With one of the fastest growing human immunodeficiency virus (**HIV) epidemics** in the world, Ukraine continues to have thousands of new infections each year. The epidemic has a particularly negative impact on a number of vulnerable populations in Ukraine, including those affected by conflict, people who inject drugs, sex workers and their partners, men who have sex with men, and incarcerated individuals. It is estimated that nearly half of the HIV-infected persons in Ukraine may not know they are infected, and many of the new infections are estimated to be in conflict-affected areas.[18] The **Tuberculosis (TB) epidemic** in Ukraine is characterized by widespread multidrug resistant tuberculosis, as well as relatively high mortality from untreated or inappropriately treated TB, and increasing TB/HIV coinfection rates.[19] Comorbidity between HIV/AIDS and TB is high. An assessment in 2016 showed that 19.8% of all persons with TB were HIV infected in Ukraine. In 2015, TB caused an estimated 65% of all reported deaths among persons living with HIV. Comorbid cases of HIV/TB are a major cause of mortality, with causes of death linked to late presentation, delayed initiation of ART, and a high prevalence of MDR-TB. It has been recommended to reduce fragmentation in services in Ukraine, make testing for HIV more readily available, integrate HIV and TB services at the primary care level, and increase collaboration and linkage between NGOs and community-based services.[20]

Social Determinants of Health

Other key factors such as the **poor economic performance of the country and deficiencies accumulated in the health system** have impacted broad social determinants of health (poverty, housing, employment, etc.).[16] Widespread job loss due to disruptions in industry, transport, and enterprise activity along with declining exports and imports as a consequence of hostilities with Russia has deteriorated economic activity for Ukraine.[3] Indeed, low socioeconomic factors (material situation), female gender, geographical region (living in villages rather than cities), and psychosocial factors (low control over life) have been identified as determinants of health, while good family relationships emerged as a protective factor in research studies.[13]

2. COMMON MENTAL DISORDERS AND ALCOHOL USE DISORDER IN UKRAINE

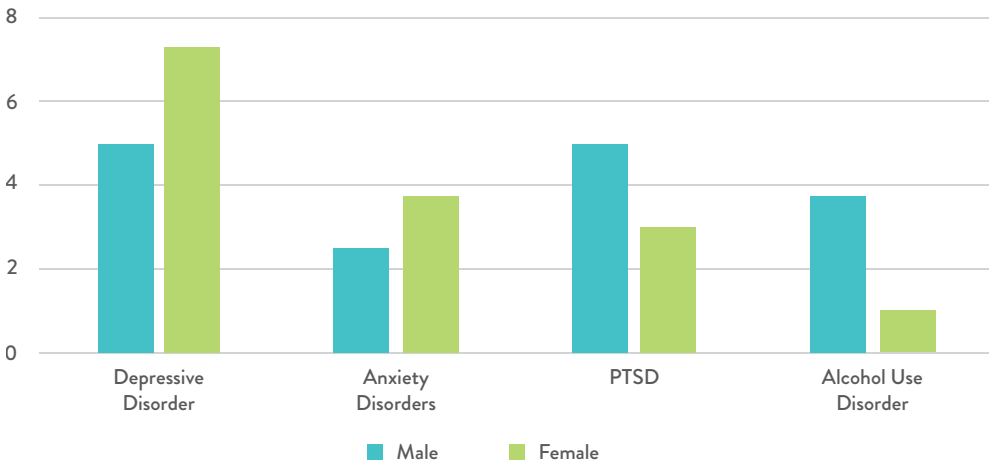
2.1. Prevalence

It is estimated that **globally, one in four people will experience a mental disorder during their lifetime.**[21] The prevalence of mental health problems is often even higher in countries affected by socioeconomic problems such as poverty, and by violence and conflict.

Estimates for Ukraine: Epidemiological statistics and sound research on the prevalence of mental disorders in Ukraine is a relatively new field,[22] with few reliable statistics and epidemiological studies.[23] The first national psychiatric epidemiological study was completed in 2002.[12] Detailed estimates of prevalence from different studies are presented in Table 2.3. It should be noted that different methods and study samples as well as methodological limitations result in varied estimates. It is difficult, for example, to distinguish between mental disorders and normal stress reactions among conflict affected populations by using surveys. Therefore, studies may overestimate prevalence rates in conflict affected populations.

It has been estimated that close to **one-third of the population in Ukraine experienced at least one mental disorder** in their lifetime. **Gender differences** exist with PTSD and alcohol use disorders more common among men, while depression and anxiety disorders are more common among women (see Figure 2.1).[12]

Figure 2.1: Common Mental Disorders and Alcohol Use Disorder in Ukraine by Gender (%)



Trends across Countries in the Region

Prevalence of depressive disorders is especially high in Ukraine compared to other countries, while alcohol use disorder is also high compared to most other countries (except for Lithuania and the Russian Federation). Anxiety disorders, on the other hand, are most prevalent in EU countries (see Figures 2.2–2.5).

Figure 2.2: Prevalence of Depressive Disorders (%)

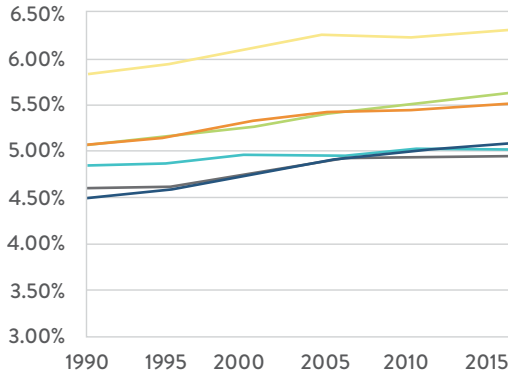


Figure 2.3: Prevalence of Anxiety Disorders (%)

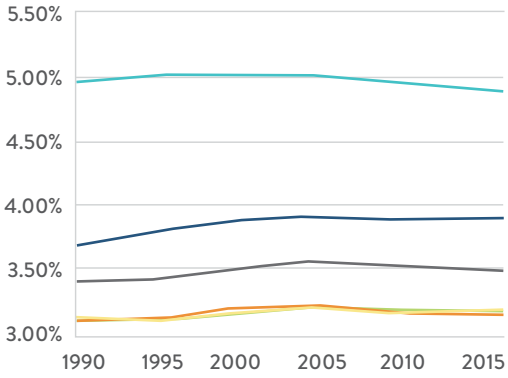


Figure 2.4: Prevalence of Alcohol Use Disorder (%)

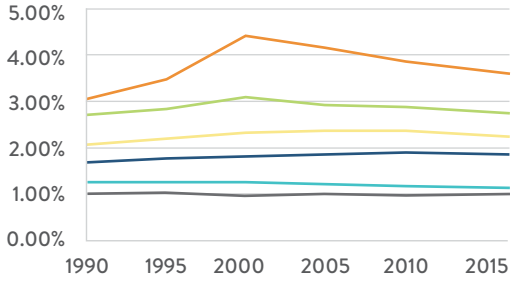
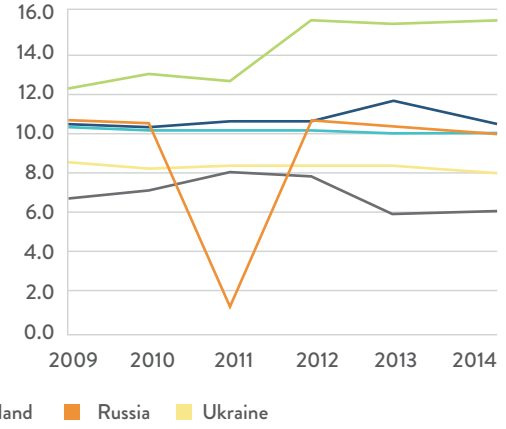


Figure 2.5: Per Capita Pure Alcohol Consumption, Litres per Capita, age 15+ (%)



2.2. Risk Factors and Social Determinants

Social determinants of health include daily living conditions (e.g., healthy physical environments), fair employment and decent work, social protection across the lifespan, and access to health care. Social determinants of health are also related to distribution of power, money, and resources, including equity in health programs, public financing, economic inequalities, resource depletion, healthy working conditions, gender equity, and political empowerment.[28] Social determinants have also shown strong links to mental health.[29]

TABLE 2.2: PREVALENCE RATES IN THE REGION (%)

Prevalence Rates	Ukraine	EU Average	Georgia	Lithuania	Poland	Russian Federation
Depressive Disorder (all ages) total[24]	**6.31**	**5.02**	4.96	3.90	5.07	5.51
Male	5	4.12	4.23	3.00	4.44	4.32
Female	7.39	5.85	5.62	4.65	5.64	6.49
Anxiety Disorders (all ages)[24]	3.18	4.89	3.46	3.17	3.88	3.12
Male	2.45	3.29	2.61	2.46	2.81	2.41
Female	3.78	6.36	4.22	3.76	4.85	3.71
Alcohol Use Disorder (all ages)[24]	2.26	1.12	.98	2.82	1.89	3.72
Male	3.71	1.81	1.63	4.69	3.25	5.84
Female	1.08	.48	.4	1.26	.67	1.97
Alcohol Consumption*[25]	8.06	10.17	6.13	15.19	10.71	10.12
Male[26]	22[27]	–	12.6	24.4	19.8	23.9
Female[26]	7.2[27]	–	3.4	7.9	5.8	7.8

*Pure alcohol consumption, litres per capita, age 15+, 2014

Research on risk factors and social determinants in Ukraine

Geographical differences: Research has shown that the prevalence of mental disorders and risk factors vary between different regions in Ukraine,[12, 30, 31] as does the availability of trained mental health professionals.[32] The **eastern region** of Ukraine has been linked to higher rates of suicide[33, 34] and the Kyiv and eastern regions of Ukraine have been linked to a **higher prevalence** of mental disorders, specifically mood, anxiety, and alcohol use disorders.[12]

Recent studies attribute at least some differences in mental disorders to **increased conflict and violence** that have recently disproportionally impacted the eastern region.[35, 36, 37] Host populations in conflict affected areas and displaced persons experience various stressors such as exposure to violence, loss (e.g., homes, family members, communities), unemployment, decreasing incomes, increasing costs of utilities, and difficulties with housing, and accessing basic needs and services.[36, 38] Resulting social problems include family conflicts and isolation[39] while feelings of distrust and political divisions negatively affect social cohesion.[40]

Internally Displaced Persons (IDPs): Studies suggest a **high prevalence of common mental health problems among IDPs** (see Table 2.3). A recent report of IDPs in Zaporizhia found that the common stressors among this population included difficulty finding employment and financial challenges, not feeling accepted by the host community, conflicts in the family, damaged psyche, alcohol abuse, fear of the future, loneliness/lack of communication, and feelings of loss,[41,42] which can all increase the risk for developing mental health problems. Indeed, one recent study found that mental disorders in IDPs were significantly associated with cumulative trauma exposure, more recent displacement, and poor economic situations.[41]

TABLE 2.3: PREVALENCE DATA AND RISK FACTORS FOR UKRAINE FOR DIFFERENT POPULATION GROUPS

Mental Disorder	Prevalence	Risk Factors
Any mental disorder[12] (general population)	31.6% (lifetime) 10.6% (population prevalence)	• Older age • Low education level • Residing in eastern Ukraine
Mood disorders (including bipolar I and II disorders, dysthymia, MDD)	Total: 9.1%[49] (12-month prevalence) Total: 15.81%[12] (lifetime) Males: 9.72%[12] (lifetime) Females: 20.78%[12] (lifetime)	• Being a woman[12] • Older age • Inadequate financial status • Low education • Being from the East and Kyiv regions • Being no longer married (divorced, separated, or widowed) • Being a homemaker • Being retired • Protective factor: being a student
Depression General population	Total: 6.31%[24] (2015), 14.59%[12] (lifetime) Males: 5%,[24] 8.61%[12] (lifetime) Females: 7.39%,[24] 19.48%[12] (lifetime) Females (2005): 11.3% (12-month MDD).[12] Urban: 17% Rural:[46] 18% Total (2015): 22% Males: 11%[46] Females: 11%[46]	• Risk increases with age in both men and women[12]
IDPs	Total: 22%[47] Males: 16%[43] Females: 25%[43] *Both IDPs and veterans:* 21%[41] (2016)	• Older age • Being female • Lower income levels[47] • Recent displacement • Exposure to adverse events
ATO veterans[46]	*Both IDPs and Veterans:* 21% (2016)	
Older adults (age 50–91)[48]	Total: 11.5% Males: 7.1% Females: 14.4% (12-month prevalence)	• Previous diagnosis of MDE before age 50 • Poor self-assessment of physical and mental health • In men: living alone, reporting 5+ physician visits in the past year, role impairment • In women: poverty, lower education, other medical conditions, history of an anxiety disorder before age 50, impairment in cognition and self-care
Anxiety disorders General population	Total: 6.10%,[12] 7.1%,[49] 13.49[12] (lifetime) Males (lifetime): 3.96%[12] Females (lifetime): 7.86%[12] Total (2015):[24] 3.18% Males: 2.45% Females: 3.78%	• Being female • Living in regions other than the West • No longer being married (divorced, separated, or widowed) • Being a homemaker[12]
IDPs	Total: 18%[47] Males: 13%[47] Females: 20%[47] *Both IDPs and veterans:* 1%[41]	• Ages 18–59[47] • Being female[47] • Poor household economic situation[47]
PTSD General population	Total (2015): 8% Males: 5% Females: 3% Urban: 5% Rural: 3%46	
IDPs	Total: 32%[47] Males: 22% Females: 36% *Both IDPs and veterans:* 46%[41]	• Older age • Being female • Lower income levels[41] • Recent displacement • Exposure to adverse events, cumulative exposure to trauma both witnessed and experienced

TABLE 2.3: PREVALENCE DATA AND RISK FACTORS FOR UKRAINE FOR DIFFERENT POPULATION GROUPS

Mental Disorder	Prevalence	Risk Factors
Alcohol use disorder General population	Total: 4.9%,[27] 13.49%[12] (lifetime) Males: 9.3%[27] Males (2005): 26.46%[12] (lifetime prevalence rate) Females: 1.1%,[27] 2.89[12] (lifetime) Total (2015):[24] 2.26% (population) Male: 3.71% Female: 1.08% *IDPs and veterans:* 4% (alcohol dependence)[41]	• Being male (nine times more likely in men than women)[12] • Females: ages under 25 years and 25–34 years[12] • Having only a primary education[12] Males: ages 26–34 & 35–54 years:[50] • No longer being married and under age 55[12] • Having only a secondary education[50] • Being in the workforce (even if unemployed)[50] • Living in the Southeast (as opposed to the West) • Those who are a parent of child under the age of 18 living at home[50]
Heavy episodic drinking* (general population)	Total: 22.6%[27] Males: 35.2% Females: 12.1%	
Heavy alcohol use	Total: 22%[50] Males (2005): 38.7%[50] (12-month prevalence)** (2001): 15%[51]*** Females (2005): 8.5%[50](12-month prevalence)** (2001): 2%[51]*** *IDPs and veterans:* 7%[41]	Males:[50] • Age group of 26–34 years and 35–54 years • Living in the Southeast (compared to the West) • Having a secondary education (i.e., high school), those considered in the workforce (even if currently unemployed) • The parent of a child under the age of 18 living at home Females[50] • Being younger, specifically between the ages of 18–25 years • Living in the Southeast • Considered in the workforce (even if currently unemployed)
Suicide General population	Total: 24–32 per 100,000 8.2%[33] (suicide ideation, lifetime prevalence), 21.2 per 100,000[52] 38.2% (planners and attempt) Males: 37.8 per 100,000, 7,992 suicides,[52] 5.8%[33] (suicide ideation, lifetime), 28% (attempt) Females: 7.0 per 100,000,[52] 1,724 suicides,[52] 10.1%[33] (suicidal ideation, lifetime), 22.4% (attempt)	Ideation:[33] Being female[33] • Younger age • Tragic life events/ trauma history[33] • Parental history of depression[33] • Prior history of psychiatric and alcohol disorders • Comorbid disorders (i.e., anxiety, depressive, intermittent explosive & AUD) Suicide:[52] Males: being between 45–54 years old Females: being aged 65 and older Suicide:[34] • Living in eastern Ukraine • Economic hardship • Interpersonal conflict • Alcohol or drug abuse • Depression • Family history of suicide • Tragic life events

* Defined as consumption of at least 60 grams or more of pure alcohol on at least one occasion in the past 30 days.

** Heavy alcohol use in men defined as consuming >80 g of ethanol in a typical drinking day, or consuming either >to 60 g 3–4 days/week or >40 g nearly every day. Heavy alcohol use in women defined as at least monthly consumption of >60 g of ethanol in a typical drinking day or consuming either >45 g 3–4 days/week or >30 g nearly every day.[50] For example, 14 g of ethanol would be roughly equivalent to 1.5 ounces of distilled spirits, one glass of wine, or 1 beer (12 ounces). Based on these calculations, 80 g of pure ethanol is roughly equivalent to 8.55 ounces of distilled spirits, 6 glasses of wine, and 6 twelve ounce beers. Sixty grams of ethanol is roughly equivalent to 6.4 ounces of distilled spirits, 4 glasses of wine, and 4 twelve ounce beers.

***A cross-sectional study conducted in 2008 using data from 2001 examined the epidemiology of heavy alcohol drinking in eight former Soviet Union countries including Ukraine. Heavy drinking was defined as the consumption of at least 21 beers (80+ pure alcohol), 750 g wine (90+ g pure alcohol), or 200 g strong spirits (86+ g of pure alcohol). The reported typical amounts of alcohol consumed were converted from liters into grams of alcohol per week assuming one beer contained 40 g of pure alcohol, a 750 g bottle of wine contained 90 g of pure alcohol, and a bottle of 500 ml of vodka or other strong spirits contained 215 g of pure alcohol. High weekly alcohol intake was defined as >210 g in males and >140 g in females. Fifteen percent of males reported heavy alcohol drinking/week (>210 g of pure alcohol), while 2% of females reported heavy alcohol drinking/week.[51]

IDPs and veterans: Practitioners and studies have noted a high burden of mental health problems among military personnel and internally displaced persons.[35, 43, 44] A report of veterans in Zaporizhia found that the most common stressors included feeling unsupported and betrayed by the government, having difficulty finding employment, poor health care, and problems with alcohol.[42] One study in Kyiv and Zaporizhia found that both IDPs and veterans often experienced continued stress related to exposure to traumatic events and feelings of social isolation and hopelessness. Difficulties with adaptation and reintegration into society were also noted, with over half experiencing mental health problems such as PTSD (see Table 2.3).[41] It is also important to note research suggesting that substance use including alcohol use disorder is more prevalent among conflict affected populations and veterans. PTSD is also a risk factor for substance abuse.[45]

Risk factors for mental disorders: Factors that have been associated with a **higher risk** for mental disorders in Ukraine include **older age** (except alcohol use in younger women), **gender** (female gender for depression and anxiety disorders and male gender for alcohol use disorder), **lower education, unemployment, living in the eastern region of Ukraine,** as well as **no longer being married** and experiencing **life stressors**[12] (see Table 2.3 for details). These risk factors were **similar for IDPs and the general population.** In **older adults,** depression is also associated with experiencing chronic health problems.

Assessment Findings on Social Determinants and Risk Factors

The factors found in the literature are similar to the factors key informants described as contributing to mental health problems in Ukraine (see Table 2.4). This includes **poverty, unemployment, conflict in the East,** and resulting displacement, as well as stressful life events. Key informants also mentioned anxiety about the conflict in the East and **access to medical services** as a stressor.

These assessment findings are consistent with **global research** from various countries which have shown consistent relationships between social inequalities, poverty, and mental health problems.[53] It is likely that poverty affects mental health via factors such as the experience of insecurity and hopelessness, as well as increased risks for poor physical health and being exposed to violence.[53] On the other hand, mental health problems can also contribute to lower educational achievements, unemployment, and increased poverty, setting up a **vicious cycle.**

However, it is also important to note that while these factors increase risk, they are not determinative of mental illness. The complex interplay of bio-psychosocial factors underlying the development of mental illness continues to be investigated. Furthermore, it is also important to consider not only risk but also protective factors such as social support[54] and the accumulation of positive and negative effects over the lifespan.[55]

TABLE 2.4: FACTORS CONTRIBUTING TO MENTAL DISORDERS DESCRIBED BY KEY INFORMANTS (STAKEHOLDERS, SERVICE PROVIDERS, SERVICE USERS)

All

- **Poverty** and economic situation
- **Unemployment**
- **Conflict in the East** (e.g., anxiety about conflict, participation in military operations, sense of losing purpose in the military conflict)
- **Hereditary predisposition**

Lviv	Poltava	Zaporizhia
• **Internal displacement** and related loss of social and financial stability • **Family conflicts** • **Access to medical services and medications** (e.g., unaffordable or poor quality medication) • **Life threatening experiences** (e.g., car accident)	• **Social isolation and lack of support** (e.g., family, social services) • **Negative coping** strategies, (e.g., alcohol) • **Death of loved ones** State **neglect for veterans**	• **Internal displacement** and related loss of social and financial stability • **Family conflict** and relationship problems • **Access to medical services and medications** (e.g., unaffordable medication, no medical insurance) • Repeated **negative life events** and difficult personal circumstances (e.g., loss) • **Disturbing and chaotic news** on TV and the Internet

It appears that poor mental health in Ukraine is tightly interconnected with poverty, unemployment, and feelings of insecurity, compounded by the effects of the conflict. Persons who are IDPS, older people, and living in the East seem to be especially vulnerable.

2.3. Impact and Burden

Untreated mental health problems do not only affect individuals and their ability to function, earn an income, and raise children, but they also impact whole families and communities. This high cost of untreated mental health problems is especially significant in Ukraine, which is trying to advance economic, political, and health care reforms in the context of dealing with ongoing political instability, high rates of unemployment, and current armed conflict and displacement.

Global studies have found differences in **life expectancy,** showing that people with severe mental disorders die on average 10–20 years earlier than the general population.[56,57] There is growing evidence linking mental disorders (including dementia, schizophrenia, alcohol and drug use disorders) to a higher mortality compared with the general population.[58] Differences in mortality result from both **attributable deaths** (i.e., deaths directly caused by alcohol use, for example) as well as **excess deaths** (e.g., higher risk of death from cardiovascular disease among people with depression).

Health Impact: Deaths Directly Attributable to Mental Disorders

Alcohol Consumption and AUD

Alcohol patterns in Ukraine are similar to those in Russia, have common cultural and historical roots, and are exacerbated by conditions and alcohol policies during the Soviet period.[59] In Ukraine, **home distillation** from sugar (samogon) is deeply rooted in tradition. Prior to the dissolution of the USSR, Ukraine was a leading producer of sugar. Following Ukrainian independence sugar production decreased, but home distillation remains common (especially in rural areas), and the illegal market for alcohol is large. Therefore, it is estimated that unrecorded consumption makes up almost two-thirds of all alcohol consumption.[59] Alcohol use starts in adolescence. One study in Kharkiv demonstrated that 76% of adolescents between the ages of 15–18 had used alcohol over the past year.[60] It has been suggested that the social construction and normality of the drinking culture in Ukraine does not encourage healthy lifestyles.[59]

Excessive alcohol consumption has directly been linked to deaths. The top causes of alcohol attributable deaths among men in Ukraine include **homicide, septicemia (blood poisoning), influenza and pneumonia, undetermined injury, accidental drowning, and suicide.**[59]

Deaths related to excessive use of alcohol largely occur among **working-age males.** It is estimated that **40% of deaths among working-age males** and 22% of deaths among **working-age** females between the ages of 20 and 64 are attributable to the effects of alcohol in Ukraine.[59] Alcohol attributable deaths for males and females in 2007 were very similar to the rates in 1980.[59] Ukrainians whose deaths were due to excessive use of alcohol lost an average of about 33 years of life.[59]

Comparison with countries in the region: The risk of dying of an alcohol attributable cause is 7 times higher in people from the eastern part of Europe compared to the Mediterranean region.[61] Deaths attributable to AUD are lower in Ukraine than in some of the other eastern European countries (except Georgia) but still higher than in the European Union (see Figure2.6 and Table 2.5).

Figure 2.6: Deaths Attributable to AUD, Total (%)[24]

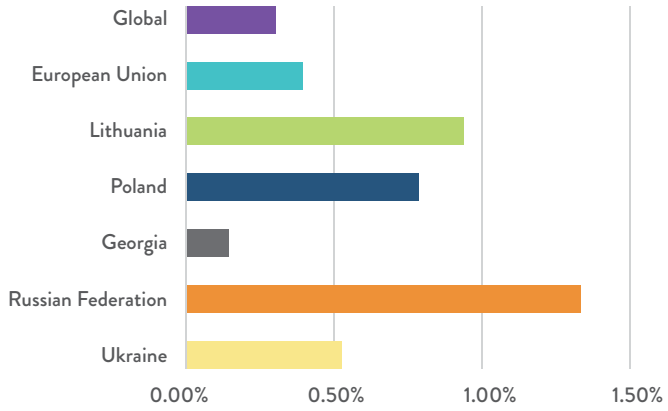


TABLE 2.5: DEATHS ATTRIBUTABLE TO AUD AND TO ALCOHOL USE IN UKRAINE AND THE REGION (%)[24]

	Ukraine	Russian Federation	Georgia	Poland	Lithuania	European Union	Global
Deaths attributable to AUD (total)	.52	1.34	.07	.81	.94	.38	.25
Males	.79	2.06	.12	1.37	1.48	.62	.38
Females	.25	.59	.02	.18	.4	.15	.08

Suicide

Suicide as a cause of death is also closely linked with common mental disorders and alcohol use. Ukraine has one of the **ten highest suicide rates in the world** (ranging from 24–32 per 100,000[12]) and suicide falls under the category for the **3rd highest ranking cause of death in Ukraine.** Globally and in Europe, suicide is ranked the second leading cause of death among young adults aged 15–29.[62]

Health Impact: Years of Life Lost (excess deaths)

Mental health problems also indirectly contribute to excess deaths by increasing the risk for developing physical health conditions, suffering injuries, engaging in unhealthy lifestyles (e.g., smoking, poor diet, physical inactivity, obesity), not seeking or being able to access health care, and not complying with medical regimens.

Globally, mental disorders have been linked to higher rates of death due to coronary heart disease, stroke, type II diabetes, respiratory diseases, and some cancers.[58] Indeed, it is estimated that about 80% of premature deaths in people with mental, neurological, and substance use disorders are due to physical illnesses, particularly cardiovascular disease, including stroke and cancer.[58]

Research has shown that:

- **Major depression** is a risk factor for ischaemic heart disease.
- **Posttraumatic stress disorder** (PTSD) has been associated with increased deaths caused by ischaemic heart disease (IHD), neoplasms, and intentional and unintentional injuries.[58]
- **Alcohol use** has been connected to tuberculosis, lower respiratory infections, multiple cancers, cardiovascular and circulatory diseases, cirrhosis of the liver, pancreatitis, epilepsy, diabetes mellitus, injuries, and interpersonal violence.

Regional and global trends: Regionally, the Russian Federation ranks by far the highest in terms of years of life lost (YLL) due to alcohol use, followed by Lithuania, Ukraine, and Poland, with the European Union countries and Georgia ranking much lower (see Table 2.6).[58]

TABLE 2.6: ESTIMATED YLL FOR ALL AGES BY CAUSE, SEX, AND WHO MEMBER STATES, 2015 [24, 60]

	Ukraine	Russian Federation	Georgia	Poland	Lithuania	European Union	Global
Alcohol Use Disorders							
Rate (Per 100,000)	283	682	33	283	422	119	66
Male	477	1182	62	526	741	200	113
Female	119	256	6	58	148	42	19

Note: The YLL (years of life lost) correspond to the number of deaths multiplied by the standard life expectancy at the age at which death occurs. The basic formula for YLL is the following for a given cause, age, and sex: YLL = N x L, where N = number of deaths and L = standard life expectancy at age of death in years.[64]

Although there is no country level data available for YLL due to CMDs, natural history models of **depression** suggest there were more than 2.2 million excess deaths globally in persons with major depressive disorders, with a particularly high rate of death in **older persons.**[58] To date there is insufficient information about excess death associated with **anxiety** disorders.

Impact on Disability

Mental health problems affect a person's ability to function, such as carrying out day-to-day tasks, performing at work, and/or establishing or maintaining relationships with others. Good mental health and psychosocial well-being are essential for adapting to new situations and challenges, as well as for coping with crises.

Mental illness is one of the great invisible burdens on all societies, **accounting for 4 of the 10 leading causes of disability worldwide.**[65] By 2030, **depression alone** will be the third highest cause of disease burden in low-income countries and the second highest in middle-income countries.[66]

In Ukraine, mental neurological and substance use disorders are the **second leading cause of disability burden** in terms of disability adjusted life years (DALYs).

TABLE 2.7: LEADING DISABILITY GROUPS AS PERCENTAGE OF TOTAL DALYS (2015) (%)[67]

	Ukraine			European Union
	Male	Female	Total	Total
Cardiovascular diseases	33.89	37.85	35.67[68]	18.84[24]
Neuropsychiatric conditions	*11.3*	*16.5*	*13.8*	*15.2 (European region)*
Malignant neoplasms	15.3[69]	10.4	12.5[69]	15.4 (European region)
Unintentional injuries:	5.86	2.7	4.44	3.93
Infectious and parasitic diseases	1.9	1.08	1.53	2.01

Note: One DALY (Disability Adjusted Life Year) can be thought of as one lost year of "healthy" life. DALYs for a disease or health condition are calculated as the sum of the Years of Life Lost (YLL) due to premature mortality in the population and the Years Lost due to Disability (YLD) for people living with the health condition or its consequences: DALY =Y LL + YLD.[70]

TABLE 2.8: ESTIMATED DALYS FOR ALL AGES BY CAUSE, SEX, AND WHO MEMBER STATES, 2015[24] (RATE PER 100,000)

	Ukraine	European Union	Georgia	Lithuania	Poland	Russian Federation	Global
Depressive Disorders[24] total	1,063	815.68	823.76	924.42	849.13	903.98	736.06
Male	822.35	660.76	692.35	710.57	732.71	694.27	613.64
Female	1,266.75	963.62	943.91	1,108.30	957.32	1,082.56	860.48
Anxiety Disorders[24] total	277.01	422.87	303.44	277.02	339.43	271.27	334.32
Male	211.88	281.29	226.37	213.86	243.11	208.93	242.40
Female	332.16	558.06	373.89	331.34	428.93	324.36	427.75
Alcohol Use Disorders[24] total	498.19	224.33	126.13	691.32	463.72	1,036.33	151.87
Male	824.19	367.21	215.45	1,183.36	830.97	1,731.00	252.35
Female	222.20	87.89	44.47	268.24	122.49	444.80	49.74

Note: To estimate YLD **(Years Lost due to Disability)** for a particular cause in a particular time period, the number of incident cases in that period is multiplied by the average duration of the disease and a weight factor that reflects the severity of the disease on a scale from 0 (perfect health) to 1 (dead). The basic formula for YLD is the following (again, without applying social preferences): YLD = I x DW x L, where I = number of incident cases, DW = disability weight, and L = average duration of the case until remission or death (years).[70]

Figure 2.8: Depressive Disorders Estimated DALYs for All Ages per 100,000

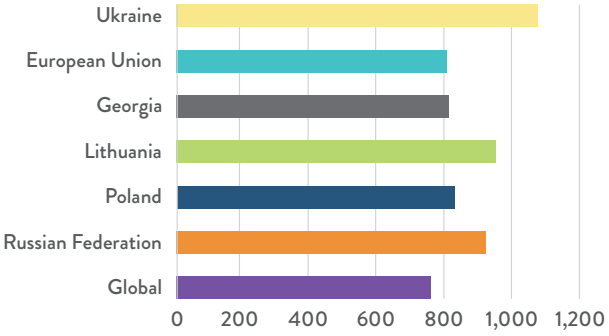
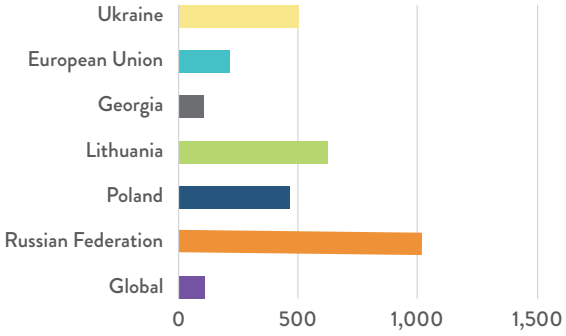


Figure 2.9: Alcohol Use Disorders Estimated DALYs for All Ages per 100,000



Among all mental, neurological, and substance use disorders, the **disability burden in Ukraine is by far the highest for depressive disorders,** followed by drug use disorders, alcohol use disorder, anxiety disorders, and schizophrenia (see Table 2.8 with associated Figures 2.8 and 2.9).

Regional country comparisons: In comparison with other countries in the region, Ukraine has a high disability burden for depressive disorders and alcohol use disorders (with a higher burden in Russia and Lithuania) while European Union countries on average have a higher burden of anxiety disorders compared to Eastern Europe (See Figure 2.10).

Years lost to disability are also by far the highest for depression in Ukraine, followed by alcohol use disorders and anxiety disorders (see Table 2.9).

Figure 2.10: Anxiety Disorders Estimated DALYs for All Ages per 100,000

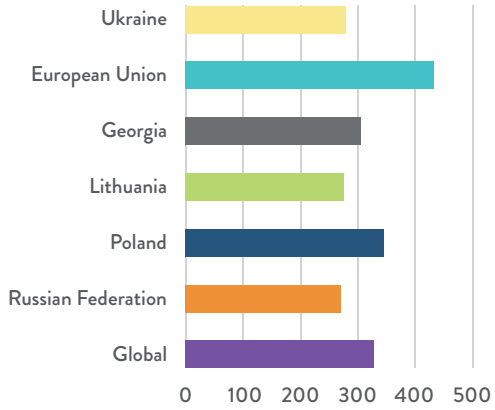


TABLE 2.9: ESTIMATED YLDS FOR ALL AGES BY CAUSE, SEX, AND WHO MEMBER STATES, 2015 (RATE PER 100,000) [24]

	Ukraine	European Union	Georgia	Lithuania	Poland	Russian Federation	Global
Depressive Disorders total	1,063.00	815.68	823.76	924.42	849.13	903.98	736.06
Male	822.35	660.76	692.35	710.57	732.70	694.27	613.64
Female	1,266.75	963.62	943.91	1,108.30	957.32	1,082.56	860.48
Anxiety Disorders total	277.01	422.87	303.44	277.02	339.43	271.27	334.32
Male	211.88	281.29	226.37	213.86	243.11	208.93	242.40
Female	332.16	558.06	373.89	331.34	428.93	324.36	427.75
Alcohol Use Disorders[24] total	214.80	105.25	93.16	269.41	180.58	354.33	85.76
Male	347.00	228.29	153.41	442.82	305.16	549.21	139.55
Female	102.87	45.84	38.08	120.30	64.82	188.38	31.08

Note: To estimate YLD **(Years Lost due to Disability)** for a particular cause in a particular time period, the number of incident cases in that period is multiplied by the average duration of the disease and a weight factor that reflects the severity of the disease on a scale from 0 (perfect health) to 1 (dead). The basic formula for YLD is the following (again, without applying social preferences): YLD = I x DW x L, where I = number of incident cases, DW = disability weight, and L = average duration of the case until remission or death (years).[70]

Other Impacts

Mental health problems also have a significant economic impact due to lost productivity and labor participation, which is discussed in Chapter 7. Several other impacts of mental illness which should be taken into consideration (despite the absence for population-based data for Ukraine) also include family impacts such as:

- **Caregiving time and resources** invested by family members to support persons with mental health problems (e.g., taking time off work, financial impact, stress, burnout, and health problems among caregivers).
- **Secondary impact on child health and development,** including the impact of alcohol consumption during pregnancy, maternal depression, anxiety disorders among parents affecting children, and violence in the family. Mental disorders

among parents and caregivers have been found to be predictive of poor child development and growth, mental health problems among children, and lower educational achievements in school.

Perceived Impact of mental health problems

The IMC assessment asked key informants about the impact of mental health problems among persons in Ukraine. They named a wide range of impacts, consistent with prior research and population data, including **poor health behaviors, impairment in day-to-day functioning,** and **financial problems.** Important aspects also include negative effects on **relationships** (e.g., deteriorating relationships and social isolation) and **secondary impacts** on family members. **Negative responses from the family or community** such as feeling stigmatized, excluded, and discriminated against were also listed.

TABLE 2.10: IMPACTS OF MENTAL DISORDERS DESCRIBED BY KEY INFORMANTS (INCLUDING SERVICE USERS AND SERVICE PROVIDERS)

General

- **Inability to function**
- **Social isolation** *from* others but also *by* others due to emotional outbursts, mood swings, and loss of connection with friends and family for AUD
- **Poor health behaviors** (e.g., smoking, overeating, overweight)
- **Loss of hope and faith** or confidence in future that anything could change for better
- **Stigma** of having been labeled mentally ill or with AUD, and consequently discriminated against by being excluded from social activities and employment opportunities

Common Mental Disorders	Alcohol Use Disorder
• **Difficulty being in public or around large groups due to** hypervigilance, e.g., riding public transportation is seen as life threatening (veteran with PTSD) • **Family relationships** deteriorate, family conflicts due to feeling aggressive, nervous, irritated or blaming others • **Loss of control** over decisions in life • **Suicidal tendencies** • **Health problems related to stress and poor mental health** (e.g., hypertension, ulcers)	• **Financial problems** • **Loss of employment** • **Relationship and family conflict,** inability to start a family, lost trust of family members • **Loss of parental rights** • **Difficulty asking for help** even if it is available because of shame and fear of stigma, as well as it would be a confession of a problem • **Societal problems** (e.g., growth in petty crime, homelessness, violence) **Impact on family members** • **Challenging to help** (e.g., person with AUD blames others and does not want help) • **Taking all responsibility** for the person with AUD

3. MENTAL HEALTH POLICY, LEGISLATIVE FRAMEWORK AND LEADERSHIP

3.1. Mental Health Financing and Legislation

Mental Health Expenditure

Ukraine allocates about **2.5% of total health care expenditure to mental health** (about **$5 per capita,** see Table 3.1). This amount is slightly higher than other upper-middle-income countries who spend on average about US$2 per head of population on mental health, but is still low compared with high-income countries who spend an average of $58.[71] This allocation is still not proportionate to the public health and economic burden these disorders cause. Furthermore, **89% of the mental health budget in Ukraine is allocated to inpatient psychiatric care,** which is higher than in other countries (see Table 3.1) and leaves little funding for accessible community-based services.

TABLE 3.1: TOTAL HEALTH AND MENTAL HEALTH EXPENDITURE OVERVIEW

	Ukraine[32]	Lithuania[72]	European Union Average	Russian Federation[73]
Health expenditure (% of total GDP)	7.6% (2012, WHO) 7.1% (2014, WB)	6.6%	9.9%[72] (2011) 10.04%[74] (2014)	5.40% (2009) 7.07%[75] (2014)
Mental Health Budget as % Total Health Budget	2.5%[32]	7%[76]	–	–
Per capita health expenditure per year (US$)	$203 (2014)[77]	$1,718 (2014)[78] $1,063 (2014)[79]	$3,612[80]	$893[81] (2014)
Per capita mental health expenditure per year (US$)	$5	–	–	$10.23
Resources used for inpatient medical services	52%	44.30% (2010 public health expenditure)	–	59% (2009 funds for medical care distribution)
Resources used for inpatient psychiatric care	89%[32]	49%*	–	–

*The primary source of mental health financing is social insurance. The national health insurance system allocates a set amount of money per inhabitant for primary mental health care. After active lobbying, the amount of money allocated per inhabitant for municipal mental health rose from the equivalent of $0.7 in 1997 to $2.8 in 1999. Of the insurance funds, 49%, 37%, and 14% are directed toward inpatient services, psychotropic drugs, and outpatient services, respectively.[82]

Mechanisms for Overall Health Services Financing

Sources of health financing: Most health financing comes from general government revenues raised through **taxation** (VAT, business income taxes, international trade, and excise taxes). Personal income tax is not a significant contributor to total revenues. There are no taxes specifically earmarked for health financing. However, the progressivity of the taxation system in Ukraine is **undermined by the scale of the shadow economy** (up to 40% of GDP), and wealthier citizens who evade taxes pay proportionately less.[83]

Regional budgets and decision making: Budgetary funds are pooled at the national and local levels, as local governments retain a proportion of the taxes raised in their territory. Additional inter-budgetary transfers also support poorer local authorities who cannot raise as much revenue. **Regional administrations and local governments have the right to determine the structure of their expenditure** and decide how to use the transferred resources (e.g., for the health or education system).

Budget allocations: Allocations and payments are generally related to the capacity and staffing levels of individual facilities (e.g., number of beds) rather than to the volume or quality of services provided.

Budget flexibility: The possibility of transferring funds between budgets at different levels of the system is limited, leading to a fragmented system of service delivery and duplication of services while creating barriers to the optimal use of hospital infrastructure. This approach has been cited as **one of the main sources of inefficiency in the Ukrainian health system.[32]**

Health Expenditure

Of the Total Health Expenditure (THE) in Ukraine, **54.9% was from prepaid government sources** in 2012, which is low in international comparison (see Table 3.2), and **private spending on health (45.1%** of THE in 2012) is dominated by **out-of-pocket payments.[32]**

The bulk of **government expenditure** (52% in 2012) **pays for inpatient medical services,** with only a relatively small proportion (4.3%) going to outpatient services and public health.[32] The share of public spending on medicines and medicinal devices is very low at only 1% (in 2012) and has decreased over time, as most pharmaceutical costs for both outpatients and inpatients are born by patients.[32] **Private expenditure** primarily consists of out-of-pocket payments, which are high due to the **high cost of pharmaceuticals,** which are generally purchased at full cost price by patients.[32] Since the beginning of the global financial crisis in 2008, **pharmaceutical prices** have increased considerably (by 40–70%), largely as a result of **currency devaluation.[90]** There are some voluntary **health insurance schemes;** their impact is marginal, contributing less than 1% to THE. Over the past 10 years, the private insurance business sector for health has continued to develop, although no mental health services are covered by insurance.

TABLE 3.2: HEALTH EXPENDITURE COMPARISON

	Ukraine[32] (2012)	Lithuania[72] (2011)	European Union	Russian Federation[73] (2009)
Public expenditure on health (%)	54.9%*	71.3%*	76.3%[72]	64.4%
Private expenditure on health (%)	45.1%**	28.7%	13.7%[84]	35.6%
Out-of-pocket payment (% private expenditure on health)	93.9% (2014)	97.3% (2014)	62.9%	80.9%
Government health expenditure (% general government spending)	11.5%*** (WHO)	12.6%***	16%[85]***	8.5%
Government health expenditure (% GDP)	4.2%**** (WHO)	4.7%****	7.8%[86]****	3.5%
Private households' out-of-pocket payment on health as % of total health expenditure	42.3% 46.22%[87] (2014)	27.9% 31.27%[88] (2014)	13.94%[84] (2014) *****	45.85%[89] (2014) *****

*Public sector health expenditure as % of total health expenditure.

**Private sector health expenditure as % of total health expenditure.

*** Public sector expenditure on health as % of total government expenditure.

**** Public sector health expenditure as % of GDP.

*****Out-of-pocket health expenditure % of total expenditure on health.

Covered Health Services

In the former Soviet Union, entitlement to health services was a universal right, embodied in the constitution. Thus, despite that many former Soviet countries shifted from state-funded health services to social health insurance during the 1990s, most were required to maintain provision of services for everyone regardless of how much they could contribute.[91] Officially, Ukraine has a comprehensive **guaranteed package of health care services** provided free of charge at the point of use as a constitutional right.[32] There is a defined list of health care services to be provided by publicly owned health care facilities for free, as well as standard volumes of care (e.g., emergency care, outpatient polyclinic care).[92] However, the costs for these **services are not backed by meaningful funding,** and it is left up to the individual health facilities to decide which services will be provided free of charge and which ones require payment. This is problematic given already high hospitalization rates and length of stay, and has led to a lack of transparency and expansion of informal payments in the system.[32]

People with **mental disorders** have the right to receive **free medical care in inpatient facilities** (e.g., psychiatric hospital, a psychoneurological dispensary or hospital) and can receive free or discounted medical products.[93] However, once a person is **discharged from the hospital** and goes to the **outpatient** phase, the medication has to be paid by the patient.

In practice however, psychiatric patients also frequently need to contribute to pharmaceutical costs as inpatients.[32, 94] Household surveys showed that **90.7% of inpatients had**

to pay for their pharmaceuticals themselves. One study has shown that 92% of the population claim they are **afraid of financial hardship** in case of serious illness.[95]

Benefits for People with Disabilities Including Mental Illness

Certain categories of people are entitled to benefits (e.g., outpatient medicines) including patients with very serious diseases, war and labour veterans, and some people with specific disabilities, which can also **include severe mental illness,** (i.e., severe depression or anxiety disorders subdivided into three disability categories according to severity, with Group I the most severe and Group III the least limiting). Persons with disabling mental disorders (Group I or II) and low income can also receive monthly **cash benefits** and may be entitled to a **pension.**[96] Ukraine also provides monetary assistance for **persons who provide constant care to** persons classified in the disabled Group I or II as a result of a mental disorder.[97]

Informal Payments and Bribes

The volume of informal payments is almost equal to the volume of formal payments for services (8–10% of THE and 22% of household expenditure).[32] Patients are willing to make out-of-pocket payments as a way of **trying to ensure better quality or more attentive care.**[32] Survey data from 2011 found that **57% of outpatients and 70% of inpatients** had paid out of pocket when accessing care. Informal payments account for roughly **20% of the total salary funds.** This perceived need to pay, whether or not it is entirely accurate, acts as a significant **barrier to care.**[32]

> "All narcologists want money (informal payments), because that's the only way for them to earn a living"
> — Narcologist in Poltava

Due to **insufficient government financing** of the health care system, the population is required to pay for outpatient and inpatient pharmaceuticals (which are often expensive) as well as provide unofficial **remuneration** to medical personnel.

Psychiatric Hospital Admission and Consent

In Ukraine, a person can be hospitalized in a psychiatric institution voluntarily at their request or with their informed consent.[93] Until the age of 14, children can be admitted to a psychiatric institution upon request or with the consent of their parents or another legal representative. A person who is considered to be disabled under the law can be admitted to a psychiatric institution with the consent of their guardian. According to the law (Law of Ukraine "On Psychiatric Care," Article 14), admission to a psychiatric institution **without their own or their legal representatives informed consent** is possible if their examination or treatment is only possible in inpatient settings and the person has been diagnosed with a severe mental disorder as a result of which they pose a direct danger to themselves or others, or are not able to independently meet their basic vital needs at the level that ensures livelihood. In June of 2016 the Constitutional Court added amendments to Article 13 which **requires a court decision for Involuntary admission.**[93]

3.2. Health and Mental Health Policies, Framework, and Reform

Health Reform

Several changes in the health sector have been initiated and realized since independence. Three phases of the reforms were to be implemented over a four-year period (2010–2014), and started with changes to health financing to reduce fragmentation and prioritize primary care. In **2016, the government adopted a health reform package** that includes: (i) transforming health care financing, including the creation of a national purchasing entity, the Ukraine National Health Services (UNHS); (ii) modernizing primary health care; (iii) improving access to pharmaceuticals; (iv) addressing noncommunicable diseases; and (v) creating an integrated National Public Health Institute for disease control and prevention. The package of reforms was approved in October 2016, and the current leadership of the Ministry of Health is taking active steps toward implementing the reform measures.[98]

Ukraine now also has to fulfill a number of obligations in the public health sector under the framework of the **EU Association Agreement.** In February 2017, the Ministry of Health unveiled its three-year health care reform plan that would bring Ukraine's health care system more closely in line with **European practices** by transferring most patient care from hospital treatment to primary care and prevention, increasing the efficiency of health care spending, stimulating better practices among doctors and hospitals, and ensuring citizens' access to a package of primary health care services free of charge.

Specific reform **plans starting in 2017** include:

- Establishing contracting mechanisms for primary care in line with the principle **"money follows the person,"** and turning away from the current inefficient funding mechanism based on the number of hospital beds.[99]
- All public health care services will be administered by one institution, the **Public Health Center** (Order No. 604 of 18.09.2015 Creation of the Centre for Public Health of Ukraine),[100] which will develop health care contracts with hospitals for budget-funded health care services.
- In line with the **decentralization** reform being pursued by the current government, regions and hospitals will begin to exercise greater local control over the health care systems servicing their communities.
- Priority will be given to **disease prevention,** which is reflected in the primary health care reform, financing of this sector in general, and the creation of the Public Health Center.[98, 101]

Mental Health Leadership and Reform

There is **no separate mental health department** at the Ministry of Health (MoH) but the possibility of creating a National Centre for Mental Health is under consideration. There are **several specialists who are tasked with aspects of mental health at MoH** including: Two Mental Health Advisors to the Acting Minister of Health; a Mental Health Consultant to the MoH who is an associate professor and tasked with leading on the 2017 Concept of Mental Health, as well as advising on psychotherapy, psychological rehabilitation, and rehabilitation of ATO veterans; a director of the Ukrainian Research Institute of Social and Forensic Psychiatry and Narcology of the MoH who has been leading key initiatives in psychiatry; and a Deputy Director of the Ukrainian Research Institute for Social and Forensic Psychiatry at the MoH who leads initiatives on forensic psychiatry and issues of children with autism.

Mental health reform is included in the overall health care system reform in Ukraine. Plans to improve mental health care include the integration of mental health care in primary health care, provision of services through multidisciplinary teams, and provision of community-based care to support persons with mental health problems to live in the community.[102] Several efforts have taken place over the past few years to support the development of national mental health policy and concept notes as outlined below.

- **Substance Abuse Policy** formulated in 1997[76]
- **Mental Health** Policy formulated in **1988.**[103] Components included prevention, treatment, and rehabilitation.[76]
- **The Concept of the State Special-Purpose Comprehensive Program for Mental Health Development in Ukraine for 2006–2010**[104] which outlined the issues and challenges of mental health, including the economic burden of mental disorders, the reasons behind the inefficiency of psychiatric care, and the need for both medical and social problems of the society to be solved. The concept outlines ways to solve challenges, including protecting persons with mental health problems from stigmatization; development and implementation of protocols and standards; effective communication between primary and secondary medical care; development of regulatory documents; and mental health care training for medical care staff.
- **The Plan for the Development of Mental Health Services to the Year 2020** covered a range of measures to overcome the trend for institutionalization of people with mental disorders, including creation of an integrated system of psychiatric care facilities, specialized services, and primary care services.[105]
- **The Reform of Child and Adolescent Mental Health Services** was formulated in **2013,** as part of wider health care reforms in Ukraine by the Ministry of Health, the Association of Psychiatrists, and mental health service user groups and endorsed by UNICEF.[16] The concept outlined various needed changes including: moving psychiatric services closer to where the young people live; the separation of adult and child psychiatric services; access to evidence-based medicines for children

with psychiatric illness; and providing services in outpatient facilities or existing multi-profile children's hospitals.[32]

- **The Concept of the State Program for Mental Health Development in Ukraine up to 2020**[106] outlines an analysis of the origin of the problems behind the inefficiency of psychiatric care and ways to solve challenges, including standards for diagnostics and treatment, creation of a national database, reforming the educational system, and enhancing research. More ways to solve challenges may include developing partner relationships, engaging patients and relatives, supporting the role of primary health care in overcoming stigmatization of mental health and using prevention measures, early detection, timely referral to a psychiatrist, and supervision under the guidance of a psychiatrist, transition to providing community-based mental health care and medical and social support by a multidisciplinary team consisting of a psychiatrist, psychiatric nurse, psychologist or therapist, and social worker.
- **The Concept of the National Mental Health Program in Ukraine for the period until 2025**[107] defines the problems and challenges, analyses reasons behind those problems, and sets the goal of the program to create a holistic, efficient mental health care system that operates in a unified interagency space and safeguards human rights and freedoms.

The **Concept Note of the State Targeted Mental Health Program in Ukraine Lasting Till 2030 (2017)** has been developed under leadership of the MoH and is the third Mental Health Concept Note, but it is the **first which was approved by the Cabinet of Ministers.** This Concept Note was developed over several stages, which included a National Consultation in April 2017, followed by public discussion and review of the Concept Note, which allowed experts from all regions of Ukraine and representatives from governmental institution medical facilities, NGO, and International Nongovernmental Organizations (INGOs) to comment on the document. The Concept Note takes into account several aspects, including the problems that exist now and ways to solve them by: raising **awareness about mental health and mental illness,** decreasing discrimination and human rights violations, mental health promotion and prevention (including suicide prevention), **regulation of professional activity** (e.g., psychologists, psychotherapists) in line with international standards, supporting professional **competence in mental health** among specialists and generalists, bringing **educational standards** for mental health in line with international standards, monitoring standards and quality of care in line with international protocols. Some problems may be solved by improving accessibility of mental health services through **decentralization**, outpatient assistance, crisis services, **provision of mental health at the primary health care level**, development of multidisciplinary teams and referral pathways, **tailoring approaches** to the needs of certain groups (e.g., IDPs, ATO veterans, mothers and children, older persons), and improving the effectiveness of funding for mental health.

Overall, many **different efforts have taken place over the years** to improve mental health in Ukraine, with common themes including decentralization and the need for

community care. Although key stakeholders have noted that it is unlikely that mental health will receive more funding and resources, it is still hoped that a reform of the system, re-allocation of resources and more efficient financing mechanisms will lead to sustainable changes in mental health systems and services. Many stakeholders also feel significant momentum for mental health reforms driven by Ministry of Health leadership and increased donor interest. **The next steps under the leadership of the Ministry of Health include formulating a mental health policy and plan, which is based on the 2030 Concept note.**

4. ORGANIZATION OF MENTAL HEALTH SERVICES

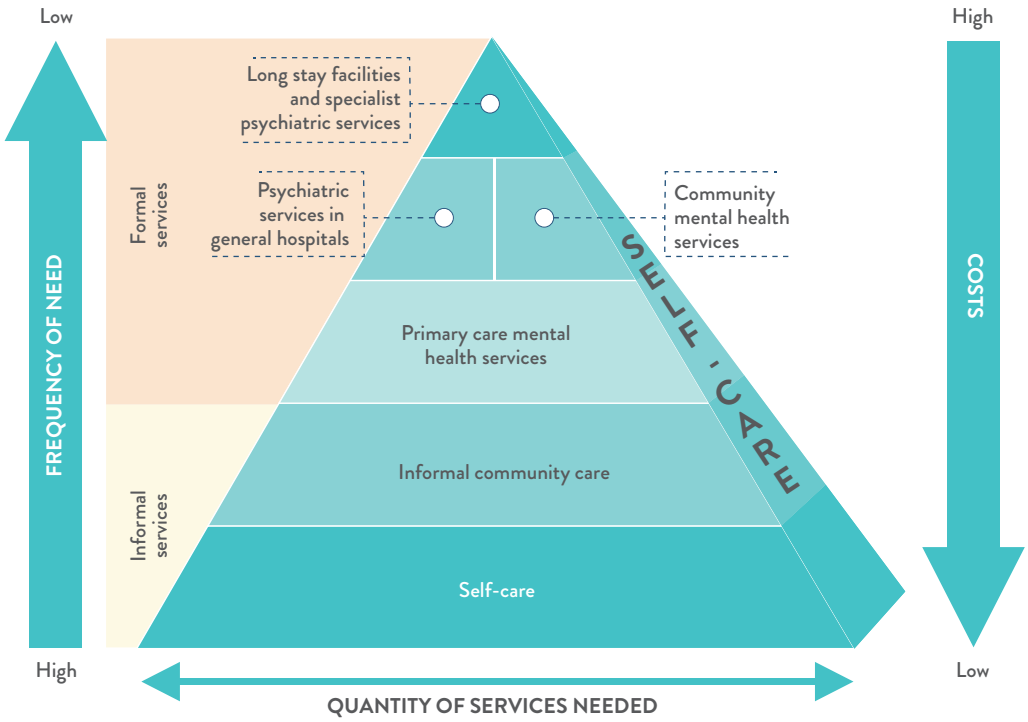
4.1. Overview and Structure of the General Health and Mental Health System

The national Ministry of Health coordinates and governs the core statutory health system, while parallel systems are governed through their respective ministries. The **regional health authorities** are accountable to the MoH for the implementation of national health policies within their territory. They are responsible for the regional health care facilities, which primarily provide specialized and highly specialized services, as well as emergency care services. Most medical services are provided to the population in facilities that are under local governments at the regional, district, or municipal levels.[32] In Ukraine, a highly centralized model of decision making in the health system inherited from the Soviet era has gradually been replaced by a system in which authority has been passed to local administrations and self-governing bodies. The health system is a complex, multilayered, sometimes parallel system in which responsibilities in the health care sector are fragmented among central government (the Ministry of Health and many other ministries and public authorities), as well as 27 regional administrations and numerous administrative bodies at regional, municipal, district, and community levels. **Geographic gaps in available health services** exist. A survey showed that 7% of households in urban areas and 30% of households in rural areas lack available primary care centers, health centers, dispensaries, and pharmacies.[108] The private sector in the Ukrainian health system is small and consists mostly of pharmacies, diagnostic facilities (inpatient and outpatient), and privately practicing physicians. These are financed mostly through direct payments from the population.[32]

Organization of Mental Health Services

Based on WHO's recommendations, mental health service organizations should follow a pyramid structure (see Figure 4.1), involving different types of services and including informal community care as well as formal and specialized services. Self-care and informal community care should be utilized most frequently (bottom of the pyramid), followed by **primary care services for mental health.** If the lower levels of services on the pyramid are available and accessible, the more specialized and expensive mental health services should be utilized less frequently.[109]

Figure 4.1: WHO Service Organization Pyramid for an Optimal Mix of Services for Mental Health



As with general health care, the contemporary Ukrainian system of mental health has largely inherited the organizational structure, strategies, and practices from the Soviet system.[110] Currently, the **mental health care system in Ukraine is centralized** and is comprised of psychiatric and narcological hospitals, outpatient clinics, psychiatric departments in hospitals, psychiatric agencies working under other governmental ministries, polyclinics which may have psychiatrists or even psychologists on staff, as well as a small number of private health care facilities. Community-based mental health care options, including mental health provided at the primary health care level by trained and supervised general health care providers, are currently limited or absent in the mental health system.[32, 110, 111, 112] Psychosocial support at the community level and crisis psychological support, as well as self-care and mental health promotion are also insufficiently developed.[110]

Table 4.1 shows the different levels of mental health and general health facilities, including psychiatric beds, where applicable.

The health system in Ukraine largely focuses on capacity for inpatient psychiatric treatment with **90% of funding allocated to inpatient psychiatric care** at hospitals. There are **89 psychiatric and narcological hospitals** in Ukraine (2015)[32] which have a total of 44,224 beds **(98 beds per 100,000 population).**[32] This is comparable to the Russian Federation (109 beds per 100,000), Lithuania (106), but **much higher** than countries who already have more decentralized care such as Poland (39) and Georgia (28).[115]

TABLE 4.1: OVERVIEW AND STRUCTURE OF MENTAL HEALTH AS PART OF THE GENERAL HEALTH SYSTEM (2016 NUMBERS)[113, 114]

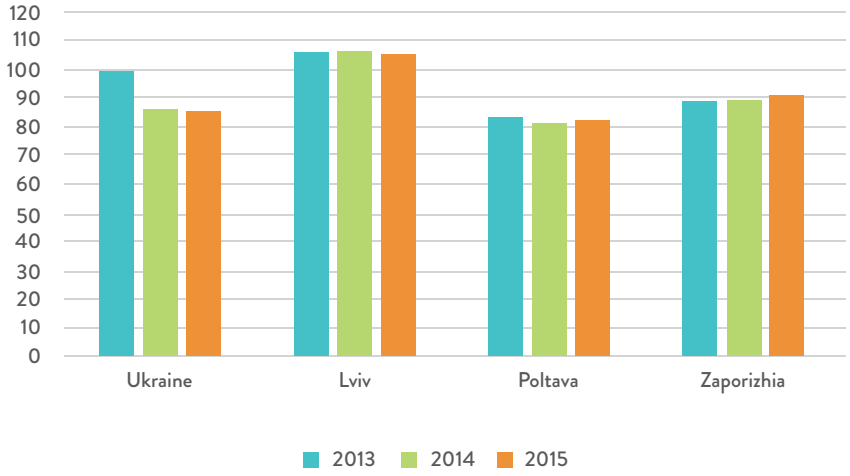
Type of Health Facility or Service	Types of Staff and # of Beds	Ukraine	Lviv	Poltava	Zaporizhia
Psychiatric hospital	Psychiatrists, psychologists, psychotherapists, social workers, doctors, nurses	62	2	2	4
	Number of beds	28,469	1,930	930	1,137
Narcological dispensary	Narcologists, psychologists, psychotherapist, social workers, doctors, nurses	33	1	3	1
	Number of beds	2,457	225	165	130
Psycho-neurological dispensary	Psychiatrists, psychologists, psychotherapists, social psychologists, social workers, doctors, nurses	22*	2	2	2
	Number of beds	913	125	60	195
Narcological hospital	Narcologists, psychologists, psychotherapists, social workers, doctors, nurses	2	0	0	0
	Number of beds	348	0	0	0
Rehabilitation centers (for substance use)**	Narcologists, psychologists, psychotherapists, nurses, social workers, doctors, nurses	Not known	3	4	2
Oblast hospitals (with psychiatric beds)	Psychiatrists, psychologists, psychotherapists, doctors, nurses	1	0	0	0
	Number of beds	30	0	0	0
City Hospitals (with psychiatric beds)	Psychiatrists, narcologists, social workers, doctors, nurses	11	2	0	0
	Number of beds	600	50	0	0
City hospitals (without psychiatric beds)		1,837	18	–	–
Central Raion Hospitals	Psychiatrists, narcologists, social workers, doctors, nurses	448	19	25	20
Central Raion hospitals (with psychiatric beds)	Psychiatrists, narcologists, social workers, doctors, nurses	7	2	0	0
	Number of beds	137	40	0	0
Polyclinics	GP, family doctor, nurses, sometimes psychia-trists, psychotherapists	5,656	268	323	274
Other primary health care (PHC) clinics	GP, family doctor, nurses	94	11	1	2
PHC urban	GP, family doctor, nurses	1,743	19	92	135
PHC rural	GP, family doctor, nurses	3,750	193	236	144
Feltsher points	Feltsher/family doctor, nurses	13,133	996	618	357

* 12 without inpatient, 10 with inpatient unit.

**There are no government rehabilitation centers, and the number of private rehabilitation centers is not tracked or known. This number is from the commonly used Manual for Drug addicted 2014 edition with the list of rehabilitation centers such as NGOs, Charity Foundations, and LLCs.

Note: A narcological hospital/dispensary treats addiction and substance-abuse related disorders (the focus of narcology) whereas a psycho-neurological hospital/dispensary treats psychiatric disorders. The difference between a hospital and a dispensary is that a hospital can (but doesn't always) treat a wide range of diseases (e.g., Central Raion Hospital, whereas a dispensary focuses on a specific sphere, i.e., narcology, psycho-neurology, and tuberculosis, etc. In practice, the two can be similar in terms of services provided.

Figure 4.2: Availability of Psychiatric Beds per 100,000



In 2008, Ukraine started to focus on integrating mental health treatment into outpatient care and reduced the number of beds (e.g., Lviv Oblast Clinical Psychiatric Hospital has reduced 250 beds since 2008). From 2013–2015 the number of psychiatric beds for adults in Ukraine was reduced significantly, although changes were not seen equally in all oblasts, with Lviv having the highest number of beds relative to the population (see Figure 4.2).[46] **Bed occupancy** is high (e.g., 96% in Lviv oblast).

Psychiatric services in general hospitals are mostly focused on outpatient services (only .65 beds per 100,000).[116]

The **cost and length of stay in psychiatric hospitals is high.** The cost per bed per day includes medication (e.g., $5–8 per day in Lviv), although patients are often asked to purchase their own medication. In 2012, the average length of stay in a psychiatric hospital was **53.5 days** for adults.[117] This is also high compared to other countries such as Lithuania (20.8 days) and Poland (29.3 days).[118]

4.2. Available Mental Health Services and Interventions

Treatment Protocols and Prescription Authority

There are considerable deficiencies in the system of developing and supporting **professional competencies** among mental health practitioners and related specialties,[110] and the lack of evidence-based practices in Ukraine is seen as a real challenge.[119] Most recently, an association of specialists has been created under the MoH, which is tasked

> "I've been working here for 37 years. I can tell what a person is suffering from intuitively. I don't even have to talk to the patient."
> — Psychiatrist in Lviv

with the development and implementation of guidelines and protocols for the treatment of mental disorders, and protocols for depression and PTSD have recently been created.[110]

Each medical institution within the health system **has internal protocols** for the identification, assessment, treatment, referral, and follow-up of different mental disorders including CMDs and AUD, which are based on protocols approved by the Ministry of Health of Ukraine.[107,120] In April 2017, the Minister of Health updated the law to **allow Ukrainian doctors to use European treatment protocols.**[107] However, contemporary **evidence-based protocols** on mental health services delivery are still **used unsystematically** in Ukraine.[104]

The newly developed government protocols for PTSD[121] and depression[122] also outline the **role of primary health care doctors.** According to these protocols, doctors should identify PTSD and depression (using specified screening instruments such as the PHQ-9), provide **psycho-education and basic psychological interventions** (depending on their competency), and can also **prescribe some psychotropic medications including antidepressants** (e.g., for sleep disorders, depression, anxiety, PTSD) and **benzodiazepines** (e.g., for short-term management of anxiety). According to the law,[123] psychotropic medications can only be prescribed by **medical institutions and doctors who have a license.**[124]

Interventions Provided by Mental Health Specialists

Based on our assessment, the **most common interventions** used by specialized professionals for patients with CMD and AUD are summarized in Table 4.3. **Evidence-based psychological interventions** for depression, anxiety, and PTSD (e.g., CBT, CBT-TF, EMDR) or for AUD (e.g., motivational interviewing, peer support, 12 step model) were **mostly not provided by mental health professionals at state facilities.** Such interventions were at times offered by professionals in private practice, working at private universities (e.g., UCU) working or at private rehabilitation centers. On the other hand, the **professionals in private practice** offered a range of interventions with **some being evidence based** and some being outdated or even potentially harmful.

Similarly, private rehabilitation centers (for drug and alcohol use disorders) were described as being of **varying quality.** Several key informants (service providers and mental health (MH) service users) expressed concern about the "Closed type" rehabilitation centers which provide medication only and keep clients locked up with little information regarding available services. Many of these centers are not licensed and there is no strict legal regulation of such centers.

Coordination of Care

We also found that **outpatient care was fragmented** with mental health care professionals providing different interventions with little communication between each other and limited roles. Psychologists and psychotherapists, for example, stated they could not diagnose

TABLE 4.3: INTERVENTIONS PROVIDED BY MENTAL HEALTH SPECIALISTS

Health Facilities	Interventions Provided	
	Pharmacological	Psychosocial and psychological
Psychiatric hospitals and inpatient units	• **Pharmacological treatment** (free of charge; although patients are often asked to pay)	• Psychological and disability **assessments** by psychologists • **Psychological interventions and activities:** occupational therapy, art therapy, hypnosis, acupuncture, Individual counselling
Narcology inpatient unit (drug and alcohol use disorders) Inpatient stay (ranging from 8 days in Lviv to 21 days in Poltava and Zaporizhia) Referral to psychiatrist if mental disorder suspected	• **Detoxification and management** of withdrawal symptoms (IV and medication)	• Many do not have psychosocial or psychological interventions • Some offer psychological interventions (by psychologists, psychotherapists, and social workers), based on 12 step model
Private rehabilitation centers Lviv: $222 per month Zaporizhia: From $100 to $1,000 per month	• **Pharmacological management** of withdrawal symptoms	• **Group and individual counseling** (inpatient and outpatient) • Motivational interviewing • Relaxation techniques and meditations • Peer-to-peer motivational talks and sharing of experiences • Dovzhenko Method (hypnotic coding)—was invented in the Soviet Union by Dr Dovzhenko—patients are made to think that they have no alcohol obsession • **Custodial treatment** at locked facilities with social case work provided by social workers
Outpatient mental health services in hospitals and polyclinics Almost one-third of polyclinics visited had at least one psychiatrist, while some also had psychologists and psychotherapists.	Psychiatrists: • **Pharmacological treatment** (patients have to pay)	Psychiatrists • Psychiatric assessment • **Psycho-education** Psychologists • Assessment • Several psychologists noted that they did not assess for mental disorders because this was outside their scope of work • **Psycho-education** about symptoms of mental disorders • **Basic counseling** and discussion • **Often no evidence-based interventions** available
Private psychologists and psychotherapists		• Cognitive behavioral therapy (CBT) • Eye movement desensitization and reprocessing (EMDR) • Mindfulness • Gestalt therapy • Psychodynamic therapy

because this was beyond their role, so they did not differentiate whether a patient actually had anxiety or depression but provided different psychotherapeutic interventions regardless. On the other hand, psychiatrists would diagnose, but then provided basic medication management only and did not communicate with psychologists or psychotherapists about interventions offered and patient care (even if they worked in the same building).

> **I spent 21 days at an inpatient state facility** but did nothing there. I got vitamins, IVs, lunch, I slept, smoked a lot of cigarettes, drank coffee and watched TV. There was no psychologist or psychotherapist, the doctor asked how I was feeling then left. **The day I got out I started drinking again.**
>
> —Person recovering from AUD in Lviv

Similarly, **psychiatrists would not treat alcohol and drug use disorders while narcologists would not treat other psychiatric conditions** and those professionals would only cross-refer to one another. Given the frequent comorbidity between alcohol use disorders and common mental health problems (especially AUD and PTSD), and the reluctance or inability of patients to see more than one provider, fragmentation of care, and not receiving needed care is often the result. The lack of coordination between the two disciplines has also been pointed out as problematic by numerous health care and rehabilitation professional key informants during this assessment.

Many psychologists, psychotherapists, and social workers in government clinics reported having **multiple jobs and roles,** including having their private practice in addition to their work in state-run institutions or NGOs. At times, they reported asking patients coming to see them in public health facilities to come to their private practice instead. One psychotherapist in a government polyclinic reported referring patients who were feeling depressed or anxious to her own private homeopathy practice. This is problematic and calls into question ethical concerns as homeopathy is not regulated or recommended for people experiencing mental health problems.

At times however, having multiple roles also led to **more integrated systems and service provision.** In Poltava, for example, a social worker works part-time at a narcological dispensary and part-time at an NGO ("Prostir Nadii," Space of Hope), which supports people with alcohol and substance use disorder using the AA model. She helps patients connect to the NGO and attend groups after they leave inpatient treatment at the narcological dispensary. These multiple roles are more likely in areas with a higher density of public and NGO services and initiatives.

Interventions Provided at the Primary Health Care level

Studies show that the average patient visits primary care four times per year and the official referral rate is 4.7%.[125] The percentage of active physicians in Ukraine working in primary care is 17.1%.[125] Case identification and provision of intervention and referral for persons with mental disorders at the primary health care level is limited.[104] **Government**

TABLE 4.4: INTERVENTIONS PROVIDED IN PRIMARY HEALTH CARE

	Total	Lviv	Poltava	Zaporizhia
Number of family PHC providers interviewed and number (and percentage) giving a yes response	39	10	16	13
Assessment of mental disorders				
Assess for PTSD, anxiety, or depression or for AUD?	100% (39)	100% (10)	100% (16)	100% (13)
Note: *Many report using "visual" diagnostic assessment (not asking specific questions)*				
Use **standardized questionnaires** for assessments (e.g., national protocol scales such as PHQ-9)?	0% (0)	0% (0)	0% (0)	0% (0)
Use **scales from Pharmaceutical** industry (for CMD only)?	18% (7)	2% (2)	13% (2)	23% (3)
Notes: *Many noted they were reluctant to talk to patients about mental health because 'everyone' had stress and anxiety due to the political and economic situation, they did not think they could convince patients to see a psychiatrist, they felt this would impact the patient provider relationship negatively ("patients will think I say they are crazy"), and many did not feel confident asking further questions. Some noted that they had state protocols for depression but no time (10 min per patient).*				
Interventions provided for mental disorders				
Provide **basic psycho-education** about nature of condition?	100% (39)	100% (10)	100% (16)	100% (13)
Provide an **information leaflet** on CMDs or AUD?	5% (2)	10% (1)	6%(1)	0% (0)
Note: *Several health facilities have information posters about negative effects of alcohol use and AUD displayed in the hallways*				
Provide **psychosocial interventions** (e.g., emotional support, stress management)?	60% (23)	80% (8)	44% (7)	62% (8)
Note: *Some of those responding "yes" noted that interventions provided were not according to a specific protocol, and most noted they had no knowledge of such interventions and that this was not part of their responsibilities. Regarding alcohol use, some noted they had conversations trying to motivate the person.*				
Provide **pharmacological interventions for CMDs?**	21% (8)	40% (4)	6% (1)	23% (3)
Notes: *Most described providing mild herbal sedatives (e.g. valerian root, nootropics), and some prescribed psychotropic medication such as antidepressants and anxiolytics. Only one person prescribed an antidepressant from the essential drug list and in line with the protocol for depression (fluoxetine).*				
Referral for patients with mental disorders				
Provide **referral** to a **psychiatrist** if CMD is suspected?	100% (39)	70% (7)	100% (16)	100% (13)
Provide **referral** to a **narcologist** if AUD is suspected?	100% (39)	100% (10)	100% (16)	100% (13)
Provide **referral** to a **psychologist or psychotherapist** (non-pharmacological) or if **CMD** is suspected?	25% (10)	0% (0)	43% (7)	23% (3)
Provide **referral** to a **psychologist or psychotherapist** (non-pharmacological) or if **AUD** is suspected?	0% (0)	0% (0)	0% (0)	0% (0)
Note: *Many report using an official referral (sealed with stamp) to a psychiatrist/narcologist at the respective Central Raion Hospital (even if a psychotherapist or psychologist was available in the same polyclinic). Few referred to psychologists at NGOs. Some noted that they would refer to a private rehabilitation center for AUD one person noted providing referral to their own church for persons with AUD.*				
Record Keeping and Follow-up				
Follow up and monitor effectiveness of treatment while patient is under care of psychiatrist or psychologist or narcologist	0% (0)	0% (0)	0% (0)	0% (0)
Note: *Many noted that there is only an **informal and unofficial way to follow up** and share information if you know your colleague personally or you are friends. Officially it is **prohibited to share this information** between service providers, and only patients can share their own information. However, **many patients do not want their GP to know about psychiatric treatment.** Some noted it would be useful if a psychiatrist can share information for continued follow-up by the GP.*				
Monitor and treat patients who refuse to see a psychiatrist (CMD only)	0% (0)	0	0	0
Note: *Many noted that they will **accept if a patient does not want to see a psychiatrist** and will not intervene further as treatment should be voluntary. One GP provided psychological sessions (including for people with CMDs and AUD) in the church in his free time since he is not limited with time there and can attend to people's needs better.*				

protocols have been developed for the identification (e.g., specific questions to ask), management (including prescription of selected psychotropic medications), and referral (in the case of no improvement) for persons with **mild to moderate depression and PTSD at the PHC level. However, our assessment showed that few providers are reporting that they identify, provide interventions, refer or follow up with persons experiencing mental illness** (see Table 4.4. for details). Similarly, feldshers, who work at the community level, reported that their role in supporting persons with mental disorders was very limited. They described that they could only refer patients to the Central Rayon Clinic or call an ambulance in case of violent outbursts due to psychotic episodes.

Informal Community Care

Clergy and Faith-Based Groups

Our assessment showed that clergy are often an important source of emotional support, especially in Western Ukraine. Key informants described that many people trusted clergy more than mental health professionals and that clergy were easily accessible and free of charge. They also noted that mostly **older or very young people turned to them** (less people between the ages 30–55). Clergy (in Lviv and Poltava) described doing the following when persons appear depressed, anxious, or are struggling with alcohol use:

- Talking and discussing problems
- Helping people identify their strengths and weaknesses as a part of healing
- Fostering insight and acceptance
- Encouraging people to turn for help (e.g., to others who can help, to God)
- Praying
- Suggesting meditation
- Listening to their confession
- "Healing with words"

Clergy and mental health professionals organize social activities: Several mental health service providers also reported working together with clergy to organize events and refer patients or colead support groups together. One priest described working with mental health professionals such as psychologists and narcologists to organize weekend trips out of the city for persons with psychological problems. They enjoy nature and go to a monastery with the aim of promoting mental health and supporting persons affected by mental health problems (including CMDs and AUD). He noted that, **"It is easier to open up while taking a walk in the forest."**

Training in mental health: Clergy described having received some training in mental health during their time in the seminary, as well as through additional courses and training opportunities. This included seminars on mental health at Ukrainian Catholic University (UCU, Lviv) as well as an educational program lead by the Dragomanova National

Pedagogical University and Christian Educational and Research Centre, on "Psychological Counselling and Chaplaincy" in Poltava. Clergy (in Lviv) also described referring people to mental health services at UCU.

Alcoholics Anonymous (AA)

AA is a faith-based group for addicted and co-addicted persons, and AA chapters exist throughout Ukraine in most major cities. AA follows the 12 Step Program, which has been found effective for persons struggling with drug and alcohol addictions. AA also uses a peer support model, with persons who have been successful in recovery assisting others who are still struggling to stay alcohol or drug free. Our assessment found that AA groups in Ukraine include groups for those recovering from drug and alcohol use, mixed gender groups, female only groups, as well as separate groups for family members. Several key informants who were recovering from alcohol use **described AA as being helpful in their recovery** (also see Chapter 6).

Folk and Alternative Medicine

Many people who feel that the available health care system is not meeting their needs and they **do not trust doctors and the health care system,** turn to folk and alternative medicines for support.[32] There are about 4,000 registered alternative medicine practitioners in the country, but informants suggest a number at least 10 times higher. They have minimal connection with mainstream health care. A small proportion of these practitioners are medical professionals specializing, in folk and alternative medicine. Most do not possess any medical training, and up to **70% of these alternative healers have no accredited professional training or certification.[32]** About **5.5 million people receive services** from these alternative healers.[32] Most live in rural areas, but a number of richer urban residents consult with such healers.[126] The government has made several attempts to regulate this field,[127] and such practitioners are forbidden to assess psychological health and to treat various disorders including drug addiction and mental disorders that require immediate hospitalization. According to several key informants, healers are **frequently accessed by persons with CMDs.** We also spoke to one person practicing homeopathy who admitted she could not diagnose or treat mental disorders but would still counsel persons experiencing feelings of anxiety and depression and would recommend herbal remedies for them.

Self-Care, MH Promotion and Awareness Raising Programs

It has been widely noted that there is insufficient **awareness** about mental health in the Ukraine, which results in stigmatization and not seeking professional help. There are also no significant efforts for the promotion of mental health and **prevention** of mental disorders in line with global guidelines and research.[104] Indeed, **our assessment** showed there were no programs to promote mental health at the national level or the target oblasts.

TABLE 4.5: AVAILABILITY OF MENTAL HEALTH INFORMATION AND PROMOTIONAL ACTIVITIES AT SITES VISITED

	Flyers and Pamphlets	Posters	MH Promotion Activities
Health facilities	No	Some of the health facilities visited, including polyclinics, had posters about alcohol use which focused on negative health and social effects (e.g., family violence, health consequences)	No
NGOs and academic	Some had psycho-educational materials about common mental disorders and alcohol use disorder, including signs and symptoms, ways of coping, and where to seek help (UCU)	Some had posters about coping with stress, positive coping methods, and available mental health services	Yes, community recreational and social activities organized for target groups (e.g., veterans and IDPs)
Public spaces	No	Some had advertisements about private rehabilitation centers (drug and alcohol use)	No

Almost all key informants (e.g., doctors, psychologists, psychiatrists) talked about the **necessity of providing at least information and psycho-education** about CMDs and AUD.

We found that **information provided at health facilities was minimal** and focused on negative consequences (e.g., of alcohol use). **NGOs often had extensive mental health promotion materials** and community activities, but these tended to focus on specific target groups (e.g., IDPs, veterans, and their families) and not the general population and were not widely available (see Table 4.5.).

Some organizations even actively **discourage against accessing mental health services.** A recent exhibition "Psychiatry—industry of death" was held in Odessa (2016) and Kyiv (June 2017) and organized by the church of Scientology. It featured people in white coats with fake blood trying to encourage those experiencing mental health problems to join Scientology instead of seeking mental health care (see *http://cchr.org.ua/category/vyistavka-psihiatriya-industriya-smerti/ and http://nv.ua/ukr/opinion/van_voren/naukova-kijivska-fantastika-1322773.html*).

4.3. Mental Health Rights and Advocacy

There is **limited participation and engagement** of individuals with mental disorders and their family members in planning, implementing, and evaluating mental health services, and also some resistance from the established mental health workers to change the system.[104] Our assessment found a limited number of existing organizations that mainly focus on severe mental disorders, intellectual disability, and patient rights, while there appears to be less of a focus on advocacy for the needs of persons with CMDs and AUD (see Table 4.6).

TABLE 4.6: MENTAL HEALTH SERVICE USER ORGANIZATIONS IN UKRAINE

Name of Organization	Activities
All-Ukrainian Disabled Users of Psychiatric Care—user	Raises the level of knowledge of people with mental disorders and intellectual disabilities in line with national and international standards, laws, and conventions. Helps mental health service users in knowing their rights, and protecting them in the framework of international and domestic legislation. Not very active at this time.
Charitable Relief Society for Disabled Persons and Intellectual Disabilities "Dzherela"	Nonprofit public organization of parents and specialists from Kyiv, created with the assistance of Global Psychiatry Initiative in 1994. Development and implementation of individual measures, projects, and programs (e.g., awareness raising) aimed at the protection of rights, rehabilitation, and social adaptation of persons with intellectual disabilities and their families.
Step People	In Zaporizhia a new organization, "Step to People," is being started by a former psychologist who has worked for many years in government psychiatric institutions and has seen a need to focus on patient rights. The organization will organize groups for families and family members of hospitalized patients to inform them about their rights, advocate their interests and connect them to relevant services and supports (e.g., lawyers or NGOs). They also plan psycho-education and awareness raising activities to reduce stigma.

4.4. Availability and Cost of Psychotropic Medicines

The availability and cost of psychotropic medications that arose as a key challenge from the literature, as well as key informant interviews and findings, are summarized below:

Cost

- The **costs** of psychiatric medication emerged as a **major barrier and key challenge** in this assessment based on key informant interviews, as well as the literature review.[128]
- Psychiatric patients have to **purchase their own medications** in an outpatient setting, but also frequently need to contribute to pharmaceutical costs as inpatients.[32]
    - Sometimes there are **delays in the procurement** process, and hospitals cannot provide the patients with medications in time.
- The **list of free-of-charge medications** approved by the Cabinet of Ministers **does not include any psychotropic medications.**
- There is an **absence of insurance to cover** psychiatric medications.
- Psychotropic medications are available for free or at reduced costs for specific groups (people belonging to disadvantaged or vulnerable populations, and people with socially significant or especially serious illnesses). However, in practice they often **still need to pay out of pocket** for medications they are prescribed.[32]

Prices in Target Oblasts

- Our assessment (see Table 4.7) shows that
  - The **price** of **generic antidepressants,** which are part of the WHO essential drug list, varies between different pharmacies and locations between **$1.17 to $1.94** per month for the same medication.
  - The price of **other antidepressants** ranges between **$2>27 to $29.88** per month.
  - The price of **antianxiety medication** (national list only) ranges from **$11.79 to $21.42** per month.
  - The price of **mood stabilizers** is $0.95 to $8.55 per month.
  - **Other medication** (reportedly often recommended by service providers interviewed although not part of clinical guidelines for anxiety and depression) includes nootropil (**$0.02** per month)
- With an average **monthly wage** of $200 (slightly lower in Poltava and Lviv) costs are 0.6% to 0.9% of the monthly wage for generic antidepressants to 15% of the monthly wage for more expensive anti-depressants.

Availability

- In addition to the high cost of medicine, there is no national system for ensuring supply of psychotropic medication outside of **major cities.**[32]

Prescribing Patterns

- **Pharmaceutical companies have a significant influence on prescribing patterns;** they have aggressive marketing practices, advertise pharmaceuticals in the mass media, hold free seminars for medical generalists and specialists (including family doctors, GPs, and psychiatrists), and reward doctors who prescribe their products.[32]
- There is a high level of **overprescription among physicians,** who often prescribe expensive brand-name pharmaceuticals instead of less expensive generics, and at times disregard rational prescribing policies in favor of more tailored approaches.[129]
- However, psychiatrists in our assessment also noted that they recommend medicines **based on the financial status of a patient.** If the patient is able to pay, they prescribe more modern medications.

Consumer Demand

- There is a **demand for newer and more expensive medications.** There are generic antidepressant medications which are purchased with government budget costs and often prescribed to patients at a low cost (amitriptyline, fluoxetine, diazepam).[130] However, practitioners have noted that patients often complain about the side effects and quality of medications, and want to obtain a more expensive new generation of medications that have less side effects and are perceived to be more effective.

Pharmacy Practices

- Pharmacists may offer substitutes for indicated medications without consulting the prescribing physician, and some will reward physicians who advise their patients to choose a particular medication.[131]

Cost Regulation

- The government adopted a number of potential solutions to curb rising pharmaceutical prices, including expanding the **list of pharmaceuticals subject to state price regulation** to cover almost the entire Essential Medicines List (903 generic drugs or 85% of all registered drugs in Ukraine), but **psychotropic medications are not included.**[132]

In sum, although generic psychotropic medications are relatively low in cost, they are not covered by the government, there is no regulation in prices and patients may be directed towards more expensive medications by their doctor or pharmacist or may prefer such medication believing it to be of better quality. Not being able to access needed psychiatric medication creates a heavy burden for the patients' families, reduces access to treatment, hampers compliance, and decreases its efficacy.[32]

4.5. Available Mental Health Services Supported by NGOs and Civil Society Organizations

The recent conflict and high numbers of IDPs and persons suffering from distress have led to a **proliferation of volunteer and civil society organizations** aiming to address mental health problems and provide psychosocial support. Several international agencies have also started to implement mental health and psychosocial support programming or to work with local partners. Despite the increased attention to mental health, strengthening of international cooperation,[135] and increased civil engagement around these issues, several challenges have been noted by key informants:

- **Insufficient coordination among agencies, state bodies, and NGOs** when providing support to people with mental health problems.[104]
- **Lack of coordination between NGOs** also remains a challenge at the regional oblast level, and there is not a systemic approach to joint planning and implementation.[104]
- **No accountability and no mechanism to ensure quality care** leading to concerns regarding quality, ethics, and security.[104]
- International NGOs and agencies often engage local partners **in short-term training** (e.g., one week), simply translating western approaches with **no continued follow-up, supervision, or mentoring.**

TABLE 4.7: AVERAGE COSTS OF PSYCHOTROPIC MEDICINES FOR CONSUMERS IN THREE OBLASTS (IN $USD)

	Average Dosage per Person		Zaporizhia				Lviv		Poltava		Zaporizhia	
	per day (mg)	per month	mg per pill	Pills per pack	mg per package	# of packs per	Price per pack	Price per month	Price per pack	Price per month	Price per pack	Price per month
Generic Antidepressants (WHO essential list of medicines and national list)												
Amitriptyline #25	75	2,250	25	25	625	3.6	0.43	**1.55**	0.47	**1.69**	0.54	**1.94**
Amitriptyline #50	75	2,250	25	50	1,250	1.8	0.65	**1.17**	0.67	**1.21**	0.66	**1.19**
Fluoxetine #10	20	600	20	10	200	3	0.64	**1.92**	0.65	**1.95**	0.65	**1.95**
Fluoxetine #20	20	600	20	20	400	1.5	0.99	**1.49**	1.07	**1.61**	1.06	**1.59**
Other Antidepressants (national list only)												
Mirtazapine	30	900	30	20	600	1.5	19.92	**29.88**	18.4	**27.6**	17.96	**26.94**
Escitalopram	10	300	10	28	280	1.07	7.88	**8.43**	7.85	**8.40**	6.49	**6.94**
Melitor	25	750	25	28	700	1.07	12.82	**13.72**	12.28	**13.14**	11.37	**12.17**
Zalox (sertraline)	50	1,500	50	30	1,500	1	9.5	**9.5**	8.37	**8.37**	9.21	**9.21**
Paroxetine	30	90	20	30	600	0.15	19.31	**2.90**	18.16	**2.72**	18.17	**2.73**
Stimuloton (sertraline)	37.5	1,125	100	28	2,800	0.4	14.22	**5.69**	14.79	**5.92**	12.73	**5.09**
Generic Antianxiety Medication: anxiolytics (national list only)												
Adaptol (mebicar) #20	450	13,500	300	20	6,000	2.25	5.74	**12.92**	6.22	**14.0**	5.93	**13.34**
Adaptol (mebicar) #20	450	13,500	500	20	10,000	1.35	7.63	**10.30**	8.73	**11.79**	8.77	**11.84**
Buspirone	15	450	5	20	100	4.5	4.42	**19.89**	4.59	**20.66**	4.48	**20.16**
Buspirone	15	450	10	20	200	2.25	7.07	**15.91**	7.26	**16.34**	7.2	**16.2**
Gidazepam #20	100	3,000	20	20	400	7.5	2.58	**19.35**	2.68	**20.1**	2.71	**20.33**
Gidazepam #10	100	3,000	50	10	500	6	3.1	**18.6**	3.23	**19.38**	3.57	**21.42**
Other: national list only												
Nootropil (piracetam)*	3,600	108	800	30	24,000	0.0045	3.78	**0.02**	4.1	**0.02**	4.53	**0.02**
Mood Stabilizers												
Lithium (glutalit)	900	27,000	300	20	6,000	4.5	1.8	**8.1**	1.9	**8.55**	1.86	**8.37**
Carbamazepine	600	18,000	200	20	4,000	4.5	0.75	**3.38**	0.75	**3.38**	0.76	**3.42**
Valproate sodium (clonazepam)	1	30	2	30	60	0.5	Price per pack: 1.9 Price per month: **0.95****					

Source: Ukraine online directory for pharmacies and medicines, https://tabletki.ua/

* Indicated for the treatment of myoclonus and possibly for improvement of memory and attention but used 'off label' for other conditions as well; interviewed service providers used it for anxiety and depression (although current studies are experimental and some side effects such as depression, insomnia, nervousness, and irritability have been found in younger (1–2%) and more frequently older persons (6–9%).[133,134]

** There are only six pharmacies where we found this medication, and they are not in our target regions. So, we used average price for Ukraine.

- The focus of training and capacity building is often not based on a needs assessment or on public mental health principles and may **focus on single problems or disorders** (e.g., trauma, PTSD) without taking a broader approach.
- **There is insufficient state financing for local NGOs,** which is significant, as private or INGO **financing is unstable, unsustainable and grant based.**
- While many volunteers (including psychologists and psychotherapists) have been offering their services for free to civil society organizations, the numbers of **volunteers continue to decline** due to 'volunteer fatigue' and the pressure of finding stable work.

Volunteers

There has also been a proliferation of volunteers in recent years, who offer their services to different organizations or travel **to conflict affected areas independently.** The following challenges were reported by key informants:

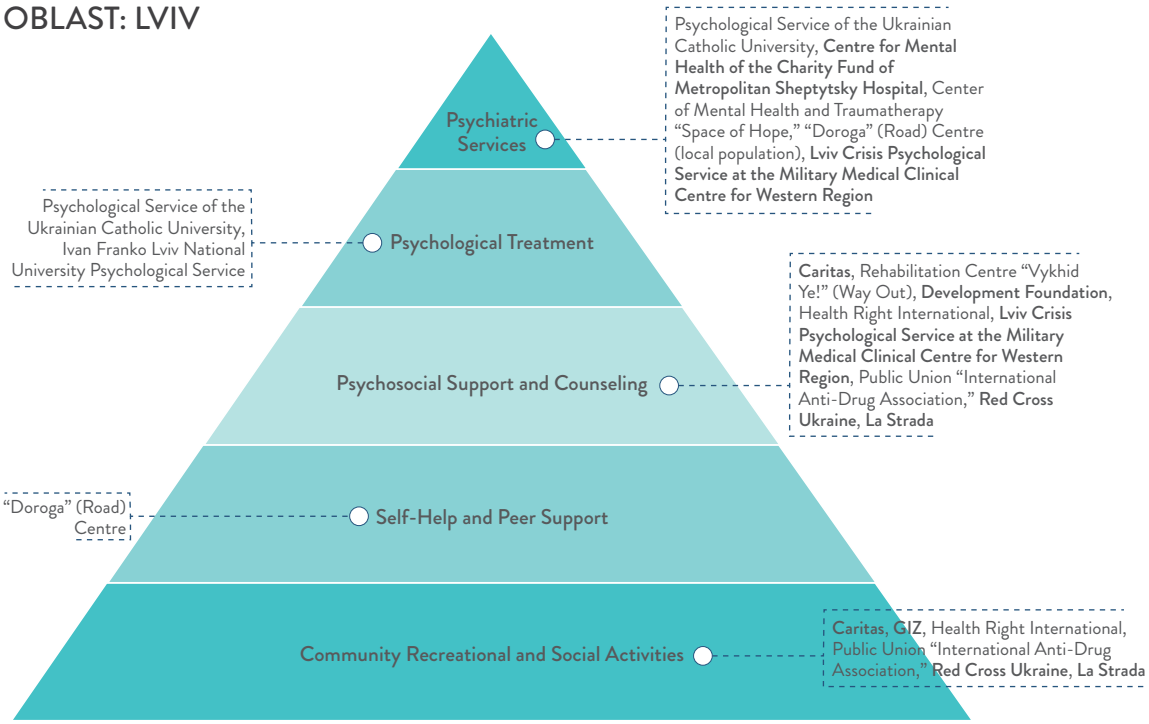
- Volunteer psychologists often try to help **without the needed skills and qualifications.**
- There are doubts about the professional level of psychologists and other specialists who are **working now with veterans and IDPs without relevant skills** and knowledge of mental disorders.
- There is often **no formal training or preparation** for volunteer psychologists.
- Volunteer psychologists can experience **burnout,** and may not consider if they are healthy enough themselves to provide services.
- There is **high inconsistency in terms of practices and skills** among professionals and volunteers.
- **Sustainability** is a challenge given that providers are often operating outside of an established system or formalized structure that can support continued efforts, pay a regular salary, and enforce quality assurance control. Volunteer psychologists may not work for a sustained period of time because they are not paid.
- As a result the affected population is not receiving appropriate psychosocial care and support.

A mapping of community organizations in target oblasts (see Figure 5.1) showed that:

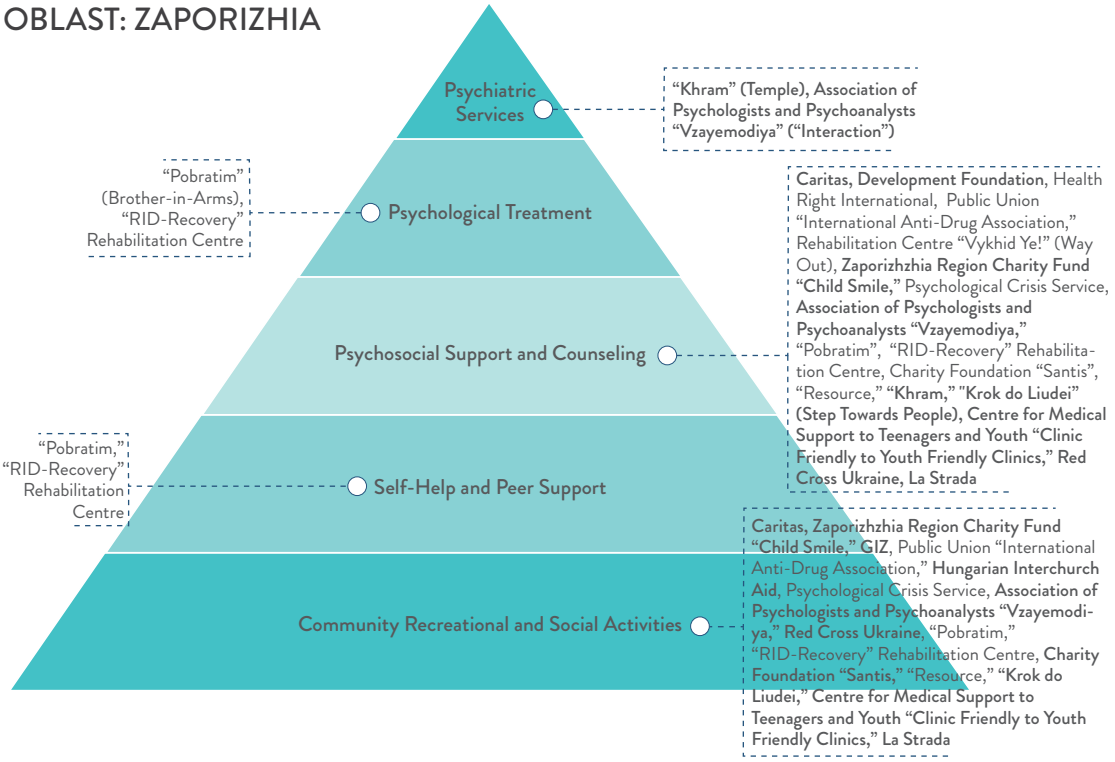
- Community organizations are most heavily **active in areas with large concentrations of IDPs** such as Zaporizhia, while Poltava has the least number of community organizations.
- Community organizations often specifically and exclusively **target IDPs, veterans, and family members of veterans,** while services may **not be available to the general population** or may only be available at cost.
- Most organizations offered general recreational and social activities as well as psychosocial support, while **few offered psychological interventions for CMDs and AUD.** Even fewer offered evidence-based interventions.

Figures 5.1: WHO Service Organization Pyramid for an Optimal Mix of Services for Mental Health

OBLAST: LVIV

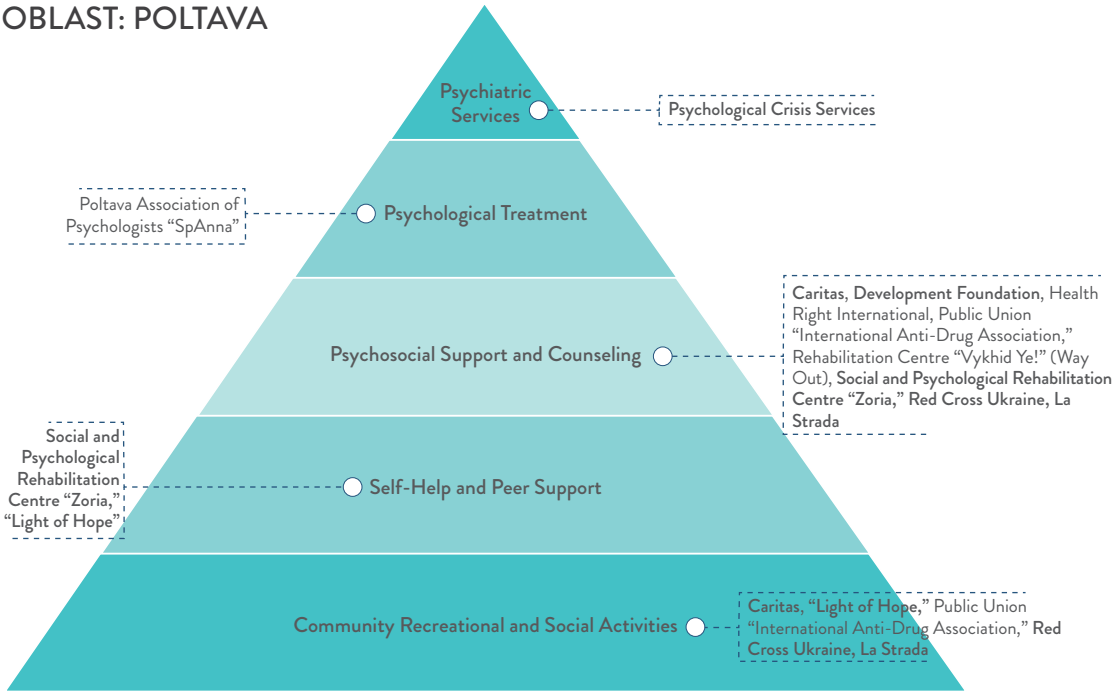


OBLAST: ZAPORIZHIA



Figures 5.1: WHO Service Organization Pyramid for an Optimal Mix of Services for Mental Health

OBLAST: POLTAVA



4.6. Continuum of Care: Identification, Referral, Follow-up, and Information Sharing

Identification Referral and Follow-up

Effective case identification, referral and follow-up emerged as one of the **key challenges** in this assessment from the literature/reports as well as key informant interviews:

- Although protocols and screening instruments exist, **assessment and identification** of persons with CMDs and AUD at the general health care level are still very **limited.**
- **Referrals** for CMD and AUD between providers are **rare.**
- Doctors tend to refer to a psychiatric clinic only **if inpatient treatment is necessary** (e.g., in case of suicidal tendencies).
- Referrals and follow-up occurs **mostly informally based on personal relationships.**
- There is a **lack of coordination for mental health referrals and follow-up communication between NGOs and government services.**
- Referral pathways from **NGOs to specialized mental health care remain weak,** with many local NGOs lacking knowledge or being unable to make such referrals.[136]

As a result, clients themselves often have to make decisions about where to seek help and whether or not they will seek help from a psychologist or psychiatrist.

Multidisciplinary Teamwork and Communication

Based on our assessment including key informant interviews and the literature, there is a **lack of a multidisciplinary approach** (e.g., cooperation between various actors, and between doctors and psychologists).

- There is often **no or limited communication or coordination** to meet the needs of people with CMDs and AUD (e.g., between narcological and alcohol dispensaries and village clinical points).
- Communication between various stages of patient care (e.g., referral, follow-up) occurs mostly through **informal channels.**
- There is a **lack of integration and communication between different levels of health care** (e.g., family doctors and GPs have a medical card for each patient with a disease history and diagnoses. If a patient is referred and receives care from a psychiatrist or psychologist, their diagnosis is kept confidential and not shared with the PHC provider).
- Lack of communication between different providers and levels leads to **fragmented care** (e.g., a patient with a prescription for medication from a psychiatrist follows up with the local Rayon level neurologist who changes the prescription, with no information exchanged between providers).
- Many providers stated that **confidentiality and existing laws prevented them from sharing information with other providers.**
- Many key informants noted strong **needs for strengthening multidisciplinary teamwork** and implementation of models of community care.[137]

In 1999, mental health professionals from Ukraine and Kazakhstan provided recommendations based on a **study tour** in the **United States.** Part of the recommendations **included training family physicians, nurses, psychologists, and social workers** to diagnose and treat those with mental health or substance abuse problems, refer patients with more complex disorders to specialists, and develop an approach based on **joint family practitioner–mental health professional case management.** Based on a **collaborative model of care,** the researchers highlighted the importance of early detection and management of mental disorders which requires training of service providers at the primary practice level.[138]

In sum, the system is **lacking continuity of care and a multilayered comprehensive mental health system.** Persons with CMDs and AUD are often not referred; there is limited communication between providers from different professions (e.g., GPs, psychologists, psychiatrists) or between different agencies and organizations (e.g., government and NGO).[104]

4.7. Mental Health Information Systems and Confidentiality

Health Information System

There is a unified electronic health information system for specific reporting from the regional level upward, but at the municipal and community levels, reporting is done on paper using standardized forms.[32] A large number of medical facilities still do not have a computerized system. Therefore, doctors or nurses manually record patients and share this information with the statistics department.

Mental health information collected includes the number of outpatients and inpatients seen by the providers, number of outpatient/inpatient departments in the region, number of beds (for adults and children), and number of doctors. For patients receiving inpatient care, facilities collect information about the types of disorders. Quarterly, statistical information is sent from the health facility statistics department to the statistics department in Kyiv. However, this data is not officially available or analyzed for planning of mental health services.[139]

Psychiatric Reviews Required for Employment

Persons applying for certain jobs have to undergo mandatory initial and periodic psychiatric reviews.[140, 141] Applicants have to submit a clearance certificate from both narcological and psychiatric dispensaries that confirms the applicant has no contraindications including:

- **Psychiatric contraindications** include "chronic disorders (diseases) that are accompanied by clouding of consciousness, perceptions and thought process disorders, disorder of will, emotions, intellect or memory, which destroys or substantially limits the person's ability to adequately perceive the reality, their psychological condition and behavior." [142] If a person suffered a severe mental disorder not earlier than 5 years ago, this person has to undergo an additional psychiatric outpatient or inpatient examination.
- **Narcological contraindications** include "alcohol, drug, and chemical abuse."[143]

Jobs affected by this regulation include: underground and surface mining and operational divisions of gas extraction, production, and transportation; those who have to keep or bear arms or explosives when on duty; police; firefighters; mine rescuers; gas rescue teams; emergency medical service personnel and public health personnel; employees of the nuclear industry; drivers of vehicles; workers of railway transport and metro; aircraft staff, workers of food industry, medical, and educational facilities (who have direct contact with people).

Jobs also include (for narcological contraindications): workers exposed to certain raw materials and substances, including alcohol; workers exposed to high voltage, explosive materials, firearms; firefighters; transportation workers, aviation, and marine personnel; and public-sector applicants.[144]

Although an employer can ask for the narcological and psychiatric examination to be conducted at their cost and ask the potential employee to present a certificate on contraindications, it is important to note that (according to Article 6 of the Law of Ukraine "On Psychiatric Care") **only the person or person's legal representative has the right to get access to and use confidential data on the status of person's mental health and psychiatric help.**

> Turning to Psychiatric Ward is stigmatized. God forbid you'll be put on the registry. Once you're labelled "a psycho," they'll try to get rid of you.
> —Social worker, Poltava

However, there is also an **official registry** for persons with alcohol and substance use disorders and for psychotic disorders, which inpatient facilities (e.g., psychiatric and narcological inpatient units) report into. However, this does not include persons with common mental disorders (e.g., anxiety and depression).

Concerns about Confidentiality and Information Sharing among Key Informants

- Many people believe that a **registry of persons with mental illness** bans those registered from occupying numerous positions;
- Persons worry that seeking care for CMDs and AUD will be recorded as part of their record with consequences such as **not getting employment.** Even some family doctors noted "If I write down this person has depression they will not get employed;"
- A diagnosis of mental disorder may not be legally discriminatory, but it is in the minds of doctors and law enforcement, **leading to discrimination in practice;**
- There is a **low level of trust among the public in the confidentiality** of their information if they receive mental health care;
- **Persons with AUD are indeed registered** but it is possible to **avoid registration by paying a bribe,** however many cannot afford this and therefore do not seek treatment; and
- **As a result, persons reported not seeking care,** seeking anonymous treatment (e.g., private provider) or treatment outside of their oblast (also see Section 6.3 on barriers to care).

Perceptions and Concerns about Information Sharing and Confidentiality

Our assessment showed that there was **confusion about what information can legally be shared, with whom, and how information can be used** as summarized on the previous page.

In sum, there are **legal limitations** for the exchange of information about patients with mental disorders at different levels of the health system and outside the system to protect patient confidentiality. However, there is **confusion and mistrust among the general public about what information is shared,** leading to not seeking help or spending more money and resources to seek help (e.g., longer distance, private services).

5. HUMAN RESOURCES AND TRAINING FOR MENTAL HEALTH

5.1. Number and Distribution of Human Resources

The **mental health workforce** under the Ministry of Health is shown below. According to staffing standards, every psychiatric hospital department and every mental health clinic is required to have at least one psychologist. In reality, the numbers are much lower.[32] **Compared to other countries** and the WHO EURO region, the number of psychiatrists is high in Ukraine (11.6 per 100,000) but the number of psychologists per 100,000 is lower (1.3 in Ukraine vs. 2.7 In EURO region; see Table 5.1). Indeed, it has been pointed out that there is insufficient use of psychologists and psychotherapists in the Ukraine health system.[32]

TABLE 5.1: REGIONAL NUMBER AND DISTRIBUTION OF HUMAN RESOURCES

Staff	Ukraine		Lithuania		EURO Region	Russian Federation	
	Number	Per 100,000	Number	Per 100,000	Per 100,000	Number	Per 100,000
Psychiatrists	5,271	11.6	553[145]* 220**	18.26 7.27	7[71]	11.06[146]	11.61[148]
Addiction specialists (narcologists)	1,522	3.4	Not Reported	–	–	–	Unknown
Psychologists	611	1.3	105**	3.47	2.7	2.61	5.42
Social workers	712	1.5	160**	5.28	1.7	–	1.56
General doctors working in psychiatry	227	0.5	Not Reported	–	–	–	Unknown
Nurses	13,063	752[32]	202[72]*** 365[12]****	722[72] 11.54	824[73]*** 24.1	–	46.26[147] ***

*practicing psychiatrists, majority being residents (2011)

**includes municipal MH centers and workforce

***MH Nurses

****Data from 2009

Oblast Level Number and Distribution of Human Resources

Current practices of human resources planning and management of the state-run health system do not follow a coherent model, and the availability of psychiatrists and trained mental health providers **varies greatly between regions.**[32] There are comparatively few psychotherapists available in Zaporizhia and fewer psychiatric nurses in Poltava compared to other regions for example (see Table 5.2). The shortage of mental health care professionals has been exacerbated in conflict affected areas, where facilities have been reduced and services are often not available.[148] Professionals in Ukraine have noted the challenge of **low salaries for health care providers,** including mental health professionals.[47, 149] There are also differences in salaries with those working in rural areas being paid less and some leaving for work in Poland or the EU.

TABLE 5.2: MENTAL HEALTH WORKFORCE NUMBERS IN UKRAINE

	Ukraine per 100,000 in 2016	Lviv per 100,000 in 2016	Poltava per 100,000 in 2016	Zaporizhia per 100,000 in 2016
Psychiatrists staffing position	7.67	8.69	8.16	9.84
(occupied post)	6.80	8.46	7.39	8.09
(individual person)	5.87	8.19	6.64	6.73
Psychotherapist staffing position (unit)	0.56	8.69	8.16	0.68
(occupied post)	0.40	8.46	7.39	0.36
(individual person)	0.36	8.19	6.64	0.23
Psychologists staffing position (unit)	0.53	0.04	0.16	0.06
(occupied post)	0.40	0.04	0.14	0.06
(individual person)	0.38	0.04	0.14	0.06
Psychiatric nurses staffing position (unit)	160.5	16.25	1.5	12.5
(occupied post)	152.75	16.25	1.5	12.5
(individual person)	147	16.25	0.5	10
Social workers staffing position (unit)	1.5	0	0	0
(occupied post)	1.5	0	0	0
(individual person)	2	0	0	0

Figure 5.1: Distribution of MH Professionals in Ukraine

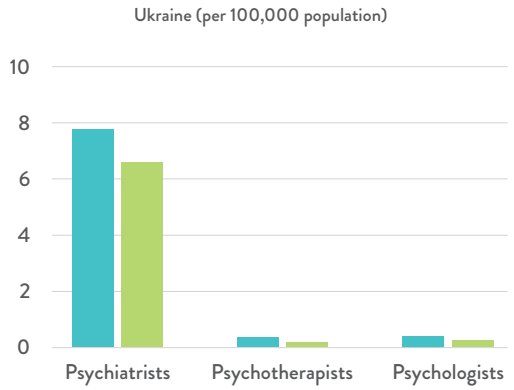


Figure 5.2: Psychiatrist Posts in Ukraine and 3 Oblasts

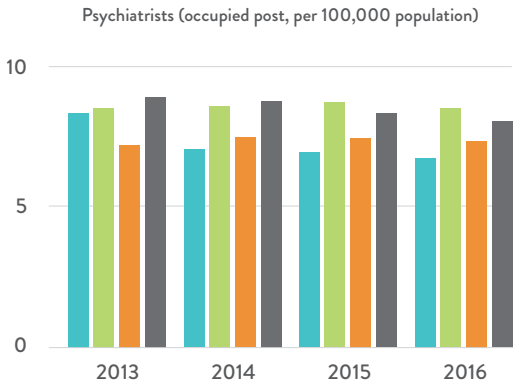


Figure 5.2: Psychotherapist Posts in Ukraine and 3 Oblasts

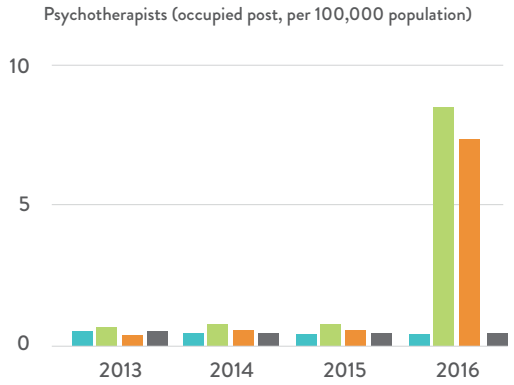
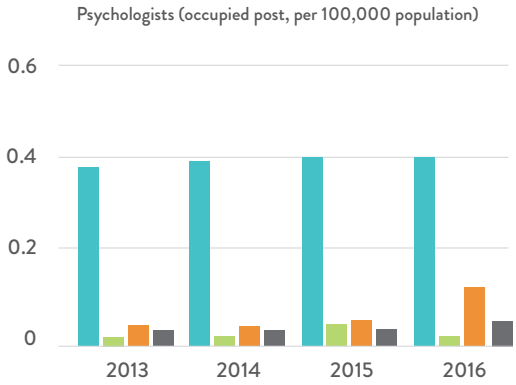


Figure 5.2: Psychologist Posts in Ukraine and 3 Oblasts



Note: Occupied post: One occupied post can be split between various part-time professionals.
Data without Crimea and ATO territory.

Trends over time

The number of psychiatrists (staff positions) in Ukraine decreased by 15% (between 2013 and 2015), while the number of psychotherapists substantially increased in some oblasts (Lviv and Poltava). The number of psychiatrists is still largest compared to other mental health professionals (see Figures 5.1–5.4).

TABLE 5.3: OVERVIEW OF MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT RELATED PROFESSIONS

Institution Type and Years of Study	Degree	Place of Internship and Duration	Further Education and Training	
Psychiatrist				
Medical university (6 years)	Specialist	Hospitals and polyclinics (2 years)	Can continue training to receive a Master's of Medicine or Doctor of Medicine	
Psychotherapist				
Public university (6 years pre-service + internship + post-service specialization	Specialist doctor (generic)	Hospitals and polyclinics (2 years)	Postgraduate programs in Ukrainian universities	
Private university (4 years, requires BA in psychology/ psychiatry/sw)	Psychotherapy certificate (Gestalt, CBT, other)	–	Additional psychotherapy courses. Private only	
Example: Ukrainian CBT Institute, Lviv (4 years)	EACBTI certified pscyhotherapists	N/A	Additional psychotherapy courses	
Medical Psychologist				
Public medical university (6 years)	Specialist of medical psychology	Hospitals and polyclinics (2 years)	Can continue training to receive a Master's of Medicine or Doctor of Medicine	
Private university (6 years)	Master's of Psychology	–	Postgraduate programs in Ukraine and abroad	
Psychologist				
Private university (nonmedical) (5–6 years)	Master's of Psychology		Postgraduate programs in Ukraine and abroad	
Public university (nonmedical) (4 years)	Bachelor's of Psychology		Master's of Psychology	
Social Worker				
Public university (4 years)	BA Social Work	Internship optional and can take place during program	Masters from several Ukrainian universities, training in workplace, scholarship for PhD abroad	
Nurse				
Medical college (3–4 years with middle school diplomas 2–4 years with HS diploma)	Associate (junior specialist) of Nursing, Bachelor's of Nursing	Pharmacies, work placement during 3 years of study	Bachelor's and Master's of Nursing	

	Common Career Options	Main Institutions Offering Degree	Cost ($)
	Public sector hospitals or private clinics	14 universities across the country, e.g., Kyiv Medical University, Kharkiv Medical University	**Public:** With state grant: Free Without state grant: $800/year **Private:** $1,000–$1,200/year
	Public sector hospitals or private clinics	Kyiv National Medical University, Zaporizhia National Medical University, Kharkiv Academy of Post Graduate Studies	**Public:** With state grant: Free Without state grant: $800/year
	Private sector	Kyiv Gestalt University, Ukrainian CBT Institute, Kyiv Gestalt and Psychodrama Institute	$400/semester
	Private sector	Note: Not recognized by state medical institutions	$400/semester
	Working in public sector hospitals or private clinics	Kyiv National Medical University, Vinnytsia National Medical University, Kharkiv National Medical University	With state grant: Free Without state grant: $800/year
	Public sector hospitals, private clinics, personal practice, NGOs	Ukrainian Catholic University, Kyiv Institute of Modern Psychology and Psychotherpay	$1,000–$1,200/year Scholarships available at UCU
	Public sector hospitals, private clinics, personal practice, NGOs	Ukrainian Catholic University, Kyiv Institute of Modern Psychology and Psychotherpay	$1,000–$1,200/year Scholarships available at UCU
	NGO, INGO, private sector companies, HR, etc.	Kyiv National University, Zaporizhia National University, Lviv National University	With state grant: Free Without state grant: $700/year
	Schools, hospitals or place of internship	NaUKMA, Lviv National University, Taras Shevchenko Kyiv National University	Free (with state grant) Public (without state grant) $800/year
	Working in public sector hospitals or private clinics	Bukovina State Medical University Vashkov Medical College of Nursing, Lutsk Basic Medical College	Free (with state grant) Public (without state grant) $500/year

5.2. Professional Education and Training

University Education

An overview of academic qualifications in mental health–related fields is shown in Table 5.3. It is important to note that providers are **only allowed to work in medical institutions** (e.g., psychiatric hospitals, polyclinics) if they have a **degree/diploma from a medical university** (e.g., certified medical psychologist or psychotherapist). Key informants also noted the following about university level education in mental health–related fields:

- **Psychologists and psychotherapists** who have received masters degrees from **public universities** have none or **very limited practical training,** receive no clinical supervision, and have no formal training on addressing CMD and AUD in line with global guidelines.
- The situation is **similar for social workers** who have limited practical training experience and knowledge of evidence-based psychosocial support approaches.
- **Less than half of the psychologist and psychotherapist** graduates actually practice due to **low salary.**
- Many psychologists and psychotherapists work in **governmental clinics and also have private practices.**
- Additional training to become **'psychotherapists'** in specific psychological interventions from **private training institutions** is available at cost and with a **limited evidence base and oversight and often not in line with evidence-based interventions** (e.g., some estimate that the vast majority of psychologist/psychotherapist study Gestalt-therapy in Zaporizhia).

> "**Everything I learned at my own expense** and state gave me nothing. I earn $50 month for working part time at the polyclinic, but summer school costs $153 per week and I have to take time off work. The state does not invest in our education, I can **diagnose a patient and do not know what do do later,** this is the worst and the saddest."
>
> —Psychotherapist, Lviv

5.3. Continued Education and In-service Training

Mandated Continued Education

Professionals have government mandated continued education requirements as outlined below. The requirements can be fulfilled with oblast-level public universities and academies of postgraduate studies. They also have to take regular certification exams to verify professional competency.

	Psychiatrists	Psychotherapists	Psychologists	Social Workers	General Practitioners	Nurses
Requirements for continued education	Once every 5 years	Once every 5 years	Once every 5 years	Optional	Certification every 5 years	Once every 5 years

TABLE 5.4: PERCEIVED OPPORTUNITIES, CHALLENGES AND NEEDS REGARDING CONTINUED EDUCATION AMONG KEY INFORMANTS	
Psychologists and Psychotherapists	
Available training opportunities	• Courses at the **public university** (e.g., Kharkiv Medical Academy of Postgraduate Education) • Courses at the **private university** at cost (e.g., CBT training, UCU) • **Conferences** at the Oblast Psychiatric Hospital • Training by **pharmaceutical representatives**
Perceived challenges for training	• Low quality training for psychologists is offered through **private institutions** without necessary certifications or oversight • High interest in **evidence-based approach** training but this is only offered at private universities or training institutions at **high cost**
Perceived MH training needs	• Very interested in new information and training • Evidence-based treatment approaches • How to treat patients with trauma
Family Doctors and GPs	
Training opportunities (in service)	• **Monthly training workshops** at the Raion Hospital (with different topics each month including MH) for doctors, feldshers and nurses • Seminars about mental disorders (CMDs), treatment with new psychotropic medications, and using screening instruments are **offered by pharmaceutical companies** • **Self-study** using the Internet • Courses at the **public university** (e.g., Danylo Galytsky University (Lviv), Medical Academy of Postgraduate Education, Zaporizhia, Poltava Medical College) • **Conferences** (4–5 conferences organized per year)
Perceived MH training needs	• Not enough time was spent on mental health at university (e.g., only one semester of MH 6 classes total) • CMDs were only covered superficially and alcohol use disorder was not represented • Very interested in receiving MH training; need to dedicate more time for this

Specialized and general service providers noted that many continued education opportunities were available but that higher quality training courses also came at a higher cost. Many expressed the desire to learn more about mental health if courses were available (see Table 5.4 for details).

5.4. Capacity Building in Mental Health Supported by International Actors

There are many international organizations working in the Ukrainian health sector, but their activities have mostly focused quite narrowly on specific areas such as sexual health, HIV/AIDS and TB in the past.[32] However, donor interest in mental health has increased since the conflict in the East and several international NGOs and agencies have supported

TABLE 5.5: OVERVIEW OF CAPACITY BUILDING IN MENTAL HEALTH SUPPORTED BY INTERNATIONAL ACTORS

Geographic Locations	Number and Types of Trainees	Training Topics	Training Duration (theoretical and supervision) and Trainers	Target Facilities	Notes
WHO Ukraine in Collaboration with MoH					
Past (6 months project): MH teams: Odessa, Dnipropetrovsk, Slavyansk, Sumy Current: Odessa	26 mobile team staff (psychiatrists, psychologists, nurses, and social workers	Management of depression, PTSD, suicide, bipolar, psychosis, PD (based on Ukrainian protocols and WHO mhGAP), service provision skills (e.g., multidisciplinary teamwork, intake and referral, care planning), psychosocial interventions (e.g., stress management, activity scheduling, psycho-education, sleep hygiene), CBT	5 days + continued 2 hr supervision, via skype every 2 wks Trainers: 2 international trainers and two staff from the Institute of Social Psychiatry and Narcology of MoH (psychiatrists and medical psychologist) One educational visit to Lithuania undertaken by chief psychiatrist with WHO support	Community outreach by mobile teams (based in psychiatric clinics)	Most clients utilizing service had psychotic disorders (72%) followed by depression (10%) and anxiety disorder (10%)
WHO Ukraine					
Planned: Donetsk, Lugansk	To be determined (psychiatists, psychologists, doctors)	Management of priority mental health conditions using WHO mhGAP Intervention Guidelines	Training to be developed Trainers: one international psychiatrist trainer with local counterparts (psychiatrists) to be trained as trainers	Community outreach by mobile teams	
MDM, UK					
Current: Lugansk Stanitsa Popasna and Svatove raions	347 participants Mobile team staff (doctor, midwife, nurse, psychologist) Staff at Primary Medical Sanitary Assistance Centers (PMSAC)	Management of CMDs based on WHO PM+ Manual targeting psychologists, PFA	Training and materials currently being developed. Trainers: One international Mental Health Coordinator and national MH supervisor	Community outreach by mobile teams Feldsher-midwife points and ambulatories of PMSACs	Plan to deliver 3 more trainings for apx. 180 trainees to mid-level health staff of PMSACs

TABLE 5.5: OVERVIEW OF CAPACITY BUILDING IN MENTAL HEALTH SUPPORTED BY INTERNATIONAL ACTORS

Geographic Locations	Number and Types of Trainees	Training Topics	Training Duration (theoretical and supervision) and Trainers	Target Facilities	Notes
Johns Hopkins University, (CETA Project), USA					
Current: Kyiv Zaporizhia Kharkiv (Target: IDPs and veterans)	34 participants (psychologists, psychotherapists, social workers, veterans) 10 of them in Zap.	Management of depression, PTSD, anxiety, alcohol use, suicide/violence according to CETA treatment model (developed by JHU) based on CBT	2 weeks training with supervision every 2 weeks Trainers: international trainers (psychologists)	Facilities where trainees are already working (e.g., NGOs, Gov.)	Services will target IDPs, veterans, and family members only
Lithuanian Government Project of Support					
Current: Poltava and Dnipro Planned: Lugansk	60 participants: psychiatrists, psychologists, nurses social workers	Screening methods (e.g., ASIST, AUDIT), management of PTSD, drug and alcohol use, multidisciplinary teamwork	6 workshops over 6 months and a 1-week training course followed by educational visit to Lithuania for study tour Trainers (Lithuanian): head of the team, psychiatrist, psychologist, social worker, occupational therapist, nurse	Psycho neurological dispensary, psychiatric hospital, narcological dispensary, hospital for veterans	
War Trauma Foundation, Netherlands					
Current: Odessa, Slavyansk, Dnipro, Sumy Potential: Lviv, Ivano-Frankovsk, Chernivhiv, Uzhgorod	34 participants (3 Psychiatrists, 21 Psychologists, 5 Family doctors, 3 Nurses, 2 Community workers	Management of depression, PTSD, acute stress, substance abuse, suicide, grief, developmental disorders, psychosis, (based on WHO mhGAP), service provision skills (e.g., community-based patient centered model, M&E of nonclinical staff, referral mechanisms)	2 weeks Trainers: international and national psychiatrists	PHC, Central Raion Hospital and Psychiatric Hospitals, Psychosocial rehabilitation centre where mobile units operate	WTF also aims to establish mobile MH teams similar to WHO project

TABLE 5.5: OVERVIEW OF CAPACITY BUILDING IN MENTAL HEALTH SUPPORTED BY INTERNATIONAL ACTORS

Geographic Locations	Number and Types of Trainees	Training Topics	Training Duration (theoretical and supervision) and Trainers	Target Facilities	Notes
GIZ, Germany					
Zaporizhia	50 participants (Psychologists, psychiatrists in mobile teams)	Trauma-focused therapy (based on STAIR CBT, CPT, EMDR) Building capacity of mobile teams and Centers of Social Services for Families and Youth to provide psychosocial support to ATO veterans and their family members	3 days Trainers: international psychologists Plan to follow up with national and international trainers over 5 months period	On-site training (where psychologists work)	
Pobratim, Ukraine					
Melitopol	8 participants (4 crisis psychologists for free, 4 for $500	Management of PTSD, acute stress, narcology (drug and alcohol use)	7-month course education from May–Dec 2017 Further follow-up and supervision planned	On-site training (where psychologists work)	

capacity building in mental health for Ukrainian professionals. Our assessment identified several key initiatives (listed in Table 5.5) and found that:

- There are several **promising capacity building efforts** which are based on global guidelines and best practices (e.g., WHO mhGAP Intervention Guidelines, WHO PM+) and which could be scaled up and used by other international organizations and national actors
- **Links to other countries (e.g., Lithuania)** have already been made (e.g., study visits, professional exchange, see section below for details)
- **Different materials, protocols, and approaches** are used by different actors and are not always consistent with national or global (WHO) protocols and guidelines
- Some capacity building efforts are only short-term trainings which are **missing important components of continued follow-up and supervision**
- **Trainees are not always receptive** to new approaches in line with evidence-based guidelines if they have spent many years practicing different models
- Many capacity building efforts target only staff serving **conflict-affected populations including IDPs, as well as veterans** driven by international donor interest.

Professional Knowledge Exchange and Experience of other Eastern European Countries

Other post-Soviet countries have been facing similar challenges related to the overwhelming reliance on institutionalization and high levels of stigma associated with mental disorders. Several of these countries have taken steps toward mental health reform, which can help provide insight into the need for change and possible best practices.

Lithuania, another post-Soviet country that is now part of the EU, had started to reform their mental health system in line with a community-based approach and empowerment of consumers. There has been a move away from inpatient care toward **community-based mental health centers** with multidisciplinary teams (e.g., psychologists, psychiatrists, social workers, mental health nurses). Although efforts have somewhat stagnated due to economic difficulties, there are many lessons learned which have been published and are relevant to Ukraine.[150] Furthermore, there has been continued professional exchange and support from Lithuania to establish community-based mental health care in Ukraine (see Table 5.5).

Another example is **Georgia,** which began to prioritize mental health reform in the 1990s through long-term commitment and strategies. A recent case study identified the following areas as essential to reform:[151] developing a clear Mental Health Plan (with a focus on recognizing and addressing differences in need based on geography, actions to link existing services and addressing financial and geographical barriers to care, creation of community-based services and **integration of mental health into primary care**); improving research capacity to use evidence for informing policy and practices; Integrating existing services and developing care for vulnerable groups (i.e., the need for psychosocial rehabilitation and creating space for input from service users); and overcoming stigma and resistance to reform. The case study highlights the importance of **relying on NGOs to creatively implement small-scale interventions that could later be scaled up to national level strategies** after their effectiveness was shown, the need for translation of mental health publications into the local language, the reliance on NGOs and other entities with lobbying power to use data and programming to influence policy makers to adopt legislation, and the need for the government to **increase funding to support improvement of existing mental health services.** In addition, the adoption of laws and strategies to protect patient rights was noted as a milestone in Georgia's mental health reform, as was the actual deinstitutionalization of large psychiatric hospitals closing and relocating beds into existing hospitals. However, according to one key informant with extensive experience working in Georgia, it is also important to note that Georgia experienced **problems due to privatization** of some mental hospitals, which were not profitable and not sufficiently resourced with beds and services.

There are also other examples of cooperation and information exchange for improving mental health services between Ukraine and other Eastern European countries (e.g., Poland) and other European countries (e.g., France, Germany). However, it has also been noted that these efforts are not always known by different donors or by organizations implementing projects, which results in not making use of **lessons learned.**

TABLE 5.6: POSITIVE AND NEGATIVE EXPERIENCES TOWARD RECOVERY

Name	Background	Main Activities
Ukrainian Psychiatric Association (UPA)	Based in Kyiv, founded in 1991 by Dr. Gluzman in response to the culture of "coercive psychiatry" in the Soviet Union and to establish a commission to review complaints about civil rights violations by mental health authorities[152, 153]	**Monitoring political abuse of psychiatry & advocacy activities:** The experts of the Committee are advocating for the interests of people with mental disorders in the courts and providing juridical and social assistance to them. **Research and technical guidance:** The Association is conducting sociological, epidemiological studies as well as publication of analytical materials to provide a basis for reforming the mental health system.[154] **Publication and translation of educational materials:** Together with the The Global Initiative of Psychiatry (GIP) they translated and published more than a hundred high quality manuals and books. However, they are currently not used by the public educational system.
Ukrainian Psychiatric Nurses Association	Created by the initiative of UPA	Advocating for improvement of the status, working conditions, and skills of psychiatric nurses
Ukraine Scientific Society of Neurologists, Psychiatrists and Narcologists	Founded in 1995 in Kharkiv	Comprehensive research of nervous, mental, and substance abuse disorders; development of treatment approaches and standards, their implementation into practical health care and educational activities in communities; support for young scientists; and reforming of mental health services in Ukraine, protection of patients' and health professionals' rights. The Society takes an active part in elaboration of new legislation concerning mental health.[155]

5.5. Professional Associations Licensing and Accreditation

Professional Associations

Since Ukrainian independence, various professional associations have been created, including those for mental health professionals (Table 5.6 summarizes information from our assessment).[110] There are also other professional associations such as the Ukrainian Association of Psychotherapists, which offers educational programs (e.g., group psychotherapy, family system therapy) and the Ukrainian Association of CBT (with 200 members, 30 out of them have been accredited with European certificates.)

TABLE 5.7: SUMMARY OF CONCERNS BY KEY INFORMANTS
There is no professional licensing or regulation
• There is **no formal registration, licensing, or regulation** (e.g., ethics, professional standards) of **psychology and social sciences** professionals • **Psychologists and psychotherapists do not need licenses or certification to practice** • Having a certificate from a workshop or a degree in psychology qualifies a person to work as a psychologist (including in social services, NGOs, or private practice)
There is a lack of quality control, accountability, and ethical oversight
• There are **no mechanisms** to promote **professional ethics** and punish ethical violations • The **types of approaches used are varied** with some being evidence based and some are based on outdated, uninformed, or potentially harmful approaches
Many service providers practice unofficially and under the radar
• Many psychologists and psychotherapists practice unofficially, and only a **small proportion** of actively practicing mental health professionals are **officially registered** with governmental bodies • There is **no publicly accessible database** of private mental health specialists and facilities • Many privately practicing psychologists and psychotherapists do not register, so as to avoid paying taxes and many do not have a permanent office for counseling but rent premises in different locations. They may advertise their services only through word of mouth or social media (e.g., Facebook)

Licensing and Accreditation

The Ministry of Health develops and approves state quality standards and clinical protocols, and is responsible for the organization and implementation of mandatory accreditation of health care facilities and the issuing of licenses to legal entities and individuals involved in medical services or the production and sale of pharmaceuticals and medical equipment.[156] Key informants and the 2017 Ukraine MH concept note have noted the absence of systemic implementation of professional standards and of quality control of mental health services delivery. There is a clear need for 5.7 licensing bodies with support from professional associations. Main concerns are summarized in Table above.

6. USE AND DEMAND FOR MENTAL HEALTH SERVICES

6.1. Attitudes toward People with Mental Illness

Attitudes toward people with mental illness can often be negative and can further discourage people from disclosing mental health problems to others and from seeking help. Key informants described various negative attitudes common in the community, which put **blame on the person** suffering from common mental disorders or alcohol use (see Table 6.1).

TABLE 6.1: ATTITUDES TOWARD PEOPLE WITH MENTAL ILLNESS DESCRIBED BY KEY INFORMANTS

CMD	AUD
• **Viewed as trivial,** "Everyone goes through it," "everyone has issues," "you need to get over it" • **Blamed on character flaws and personal weakness,** MH problems are labeled "High Society Whim," caused by lack of discipline, person is seen as "deficient," depression seen as "laziness" • **Seeking help seen as weakness** • **Lack of inclusion,** the community is not ready to accept the person back when they return from MH institutions	• **Lack of inclusion,** the community is not ready to accept the person back when they return from substance use treatment facilities • **Negative perceptions,** common people do not understand that alcoholics are people too, consider them to be of lower level

6.2. Coping and Help Seeking for Common Mental Disorders and Alcohol Use Disorder

Coping

Key informants recovering from mental health problems were asked about ways in which they had tried to cope in the past (see Table 6.2). Most people had tried to find out more on their own by reading and researching the Internet; several had found self-help books, some of which were based on best practices, while others had more questionable content (e.g., authors making promises not consistent with scientific literature). Most also described engaging in relaxing activities and reaching out to friends. Many negative coping strategies also emerged such as self-medication and using drugs and alcohol to cope.

TABLE 6.2: WAYS OF COPING WITH MH PROBLEMS ON THEIR OWN AMONG MH SERVICE USERS INCLUDING POSITIVE COPING AND NEGATIVE COPING STRATEGIES

All

- **Reading self-help books** and **MH literature** (e.g., positive psychology, pop psychology, motivational literature, relaxation, and breathing practices)
- **Recreational and relaxing activities** (e.g., sports, hobby, painting, swimming, meditation, contact with nature)
- **Communication** with friends or peers for support (e.g., in person or via Facebook, groups)
- **Prayer and going to church**

Depression	PTSD and Anxiety	AUD
• **Proper nutrition** (e.g., nuts, green tea) • **Self-medication** with antidepressants (e.g., as recommended by a friend) and over the counter (e.g., valerian) • **Working and scheduling too much** to avoid thinking • **Isolation from others** and counting on self only	• **Alcohol use** (often seen as legitimate common way of coping; society starts treating use as problematic when it affects others, e.g., through violence) • **Drug use**	• **Tried to control** the amount of alcohol • **Denial,** didn't perceive this as an addiction. • **Transitioned** to soft liquor

Sources of Information about Where to Find Help

Most key informants reported researching the Internet or relying on friends and family for suggestions on where to find support for mental health problems. Fewer reported receiving information and referrals from health and social service providers (see Table 6.3). This seems consistent with the literature reporting that most persons in Ukraine rely on **personal recommendations and informal networks when making decisions about accessing health services.**[157,158]

TABLE 6.3: SOURCES OF INFORMATION AMONG MH SERVICE USERS ABOUT CMDS, AUD AND WHERE TO FIND HELP

All

Media, Internet (e.g., Facebook), newspapers and magazines

Depression	PTSD and Anxiety	AUD
• **Reading on their own** • **Friends, family** • **Social services and health professionals,** e.g., social services referrals to free psychological services, doctor in the hospital • Peers undergoing similar problems	• **Reading on their own** (e.g. popular psychology) • **Friends** • **Leaflets** (e.g., from MSF about what stress is) • **Social services and health professionals** (e.g., medical professionals, social workers)	• **Family** • **AA groups,** ads are widely posted in public places and transport • **Street advertisements**

Help Seeking from Formal and Informal Service Providers

Globally, data show that the vast majority of people who need help for mental health problems are not receiving it, with WHO estimating an overall 20.4% prevalence of mental disorders with only 4.9% receiving treatment.[159] A 2005 survey in Ukraine indicated that 75% of respondents with major depressive disorders and suicidal ideations never sought professional help.[12] Similarly, a recent (2016) cross-sectional survey of IDPs in Ukraine with common mental health problems (depression, anxiety, PTSD) showed that only a minority of them (180 of 703) had sought care, indicating a **treatment gap of 75%.**[47]

Mental health service utilization data from Ukraine also suggest that few people are utilizing mental health outpatient services when considering the likely prevalence of common mental disorders and other mental health problems (see Table 6.4).

TABLE 6.4: PEOPLE UTILIZING MENTAL HEALTH SERVICES 2016 IN UKRAINE

	Number of People in Mental Hospitals	Number and % of People Receiving Services in Mental Health Outpatient Facilities	% of People Receiving Services for PTSD	% of People Receiving Services for AUD
Ukraine	15,566	2,774,700 (6.5%)	0.04%	1.10%
Lviv	873	145,815 (.34%)	0.02%	1.43%
Poltava	528	118,288 (.28%)	0.01%	1.33%
Zaporizhia	905	105,565 (.25%)	0.01%	1.08%

Note: Since the conflict in 2014, PTSD has been used as a separate category in MH statistics. Separate data for depression or other anxiety disorders are not tracked.

Data from: Психічне здоров'я населення України Аналітично-статистичний довідник за 2013–2015 роки (Mental Heals of population of Ukraine 2013–2015).

In our assessment, we have limited information about this treatment gap because we only spoke to people with CMDs and AUD who had actually received mental health care. However, most key informants in our assessment reported seeking help from various formal and informal providers before receiving the support they needed (Table 6.5). Persons with CMDs reported seeking help from government psychiatrists as well as private or NGO psychologists. Some also sought help from social services and clergy. Those with AUD often spent time in an inpatient narcological dispensary as the first step for seeking help, and used private rehabilitation centers at a later time if their families could afford it.

These findings are in contrast to the 2016 study of help seeking among IDPs with common mental disorders (N = 180). When they did seek care, they approached neurologists (84 persons), pharmacists (82 persons), psychologists in the community (74 persons), therapist/neurologists in the hospital (73 persons), NGO or volunteer at a center for mental health or psychosocial support (72 persons), or family doctors (67 persons).[47]

TABLE 6.5: HELP SEEKING FROM FORMAL AND INFORMAL SERVICE PROVIDERS		
Depression	PTSD and Anxiety	Alcohol Use Disorder
• **Psychiatrist at hospital inpatient** unit (if severe) • **Private psychologist** (private, cost ranging from 100 UAH ($3.70) per session in Poltava, 200–800 UAH ($7.40–$29) in Zaporizhia). • **Social services** in every city and for free (however there is little trust to this service) • **Priest** (often first contact, especially in Lviv	• **Government psychiatrist** (pharmacological treatment, but often seen as ineffective) • **Private psychiatrist,** e.g., at the hospital has a private psychotherapeutic practice (200 UAH = $7.4 per consultation) • **Free NGO or university psychologist** (e.g., UCU, for free for ATO Veterans and IDPs) • **Social workers,** e.g., at centers for IDPs	• **Narcological dispensary and psychiatry hospital** (21 days, inpatient), to get detox, medication, stop alcohol use • **Private rehabilitation center** ($222 per month on average, inpatient and outpatient options) has medication treatment and psychosocial support, 12 Step program, mentoring and public service for others. • **Private locked rehabilitation center** (inpatient, medication only)

A 2002 National Mental Health Survey in Ukraine found few people sought care for mental health problems. When they did seek care, respondents went to a **general health provider** or **folk healer.**[12,111] Other literature similarly suggests that those Ukrainians seeking care are more likely to seek care through a general medical provider than a specialized mental health professional.[12]

However, one survey (2010) of community members (Vinnitsa and Kyiv) found that family doctors and GPs were not preferred as the first contact for mental health and psychosocial problems. Only 32% of participants reported that a woman aged 35 with psychosocial problems related to work would see a family doctor/GP, 7% said a man with a suicidal inclination would see a family doctor/GP, and 35% said that a man aged 52 with an alcohol addiction problem would see a family doctor/GP.[125]

Overall, some studies suggest that **family doctors/GPs are a common first point of contact** for persons with common mental disorders and alcohol use problems, while others suggest **clergy, traditional healers, pharmacists, and specialized mental health professionals** are also common. The data collection methods, geographical regions, and participants vary between studies, and data from self-reports are less reliable than actual service utilization data. Regardless, many studies have shown that persons with CMDs often seek care from a GP for mental health related symptoms (e.g., problems sleeping, fatigue, loss of energy), and that therefore primary health care presents an important first entry point and opportunity for identification. Still, all potential first points of contact need to be considered in order to ensure timely case identification and support.

TABLE 6.6: POSITIVE AND NEGATIVE EXPERIENCES TOWARD RECOVERY

Positive experiences, support and services that helped recovery from mental illness and AUD

Depression	PTSD and Anxiety	Alcohol Use Disorder
• **MH literature** and self-help (e.g., pop psychology books from Ukraine and other countries) • **Meditation and relaxation** techniques • **Reflective activities** (e.g., reading, art activities) • **Support from friends,** e.g., they are helpful if they are in the same situation (IDP)—then they understand how you feel and give you support. • **Peer to peer groups** • **Psychotherapist** individual consultations (CBT, mindfulness, meditation, homework).	• **Meditation and relaxation** techniques • Reading • **Being included in family activities** (e.g., my daughter had a wedding and she involved me in the organization process, that helped me a lot to feel that I was useful) • **Family support** and not staying alone • **Staying busy and engaged at work** • **Psycho-education,** e.g., learning more about the nature of MH problem • **Individual Professionals** • **Psychotherapist** consultations • **Social worker** (NGO: UCU) in addition to psychotherapy help with other health issues and suggest peer-to-peer group and training	• **Positive recreational and social activities,** e.g., traveling, hiking, sports, personal reflections, and "seeing that a sober life is possible" • Having a **daily routine and activity schedule** for each day • **"Tough love" from family,** financial support from family and friends stopped, family understood that support is only making things worse • **Family attending AA family group,** e.g., mother started to go to the co-addicted group • **AA,** 12-step program • **Peer-to-peer support,** cohabitation with other recovering addicts which fosters responsibility, AA and communication with people who have the same experience • **Private rehabilitation center** Doroga (Way), with psychosocial support, homework, mentoring and public service for others • **Individual psychological counseling**

Negative experiences with supports and services that made recovery more difficult

Depression	PTSD and Anxiety	Alcohol Use Disorder
• **Lack of emotional support from family** (e.g., parents only gave basic needs/practical support) • **Lack of awareness** about nature of disorder **among family** • **Seeing many different service providers** (e.g., doctors, psychologists, psychotherapists) with different approaches and no results • **Seeing a psychiatrist for medication only**, e.g., psychiatrist was not bad but his treatment was only by medication, and it helped sometimes but my thoughts didn't change	• **Lack of emotional support from family** (e.g., parents only gave basic needs/practical support) • **Lack of awareness and understanding from family and friends** (e.g., family did not understand what was going on or what kind of support to provide, friends gave advice but not relevant for me) • **Seeing a psychologist and feeling worse,** e.g., my first experience with psychologist was not successful. She is a colleague, she is good person but didn't help, it was a gestalt therapy after few sessions I felt worse than before	• **Narcology dispensary and psychiatry hospital, provided medication only,** no psychotherapeutic interventions or follow-up (e.g., started drinking alcohol the same day I left dispensary). • **Locked rehabilitation center,** has bad reputation and no psychotherapeutic interventions

Positive and Negative Experiences When Seeking Help

Our assessment also asked mental health service users about their positive and negative experiences when seeking help from friends, peers, and formal and informal service providers (see Table 6.6). They described positive coping strategies and receiving support from family and friends, as well as evidence-based psychological interventions (e.g., CBT, mindfulness based interventions) as helpful. People with AUD had positive experiences with private rehabilitation centers and AA groups.

Key informants also described negative experiences, such as lack of understanding and support from friends and family, receiving only medication (e.g., from psychiatrists, narcologists), which was not enough to help them, and seeing psychologists or psychotherapists for interventions that did not help or made them feel worse. Persons with AUD also described negative experiences at government narcological inpatient units and locked private rehabilitation centers, where there was only medication support and no attention to their psychological well-being and no support for recovery.

6.3. Barriers to Care

Several barriers to receiving mental health care have emerged in the literature, as well as in our assessment, and include historical roots of mental health care, barriers in the health system, and lack of knowledge or stigma (see Table 6.7).

These barriers include the following:

Psychiatry as punishment: During the later years of Soviet rule in the 1960s–1970s, when the regime became reluctant to convict people of anti-Soviet action directly, psychiatry emerged as a key instrument of political repression. Political and religious dissidents were diagnosed with types of schizophrenia and subjected to abuse and torture in psychiatric institutions. Although this practice was discontinued following independence, psychiatry's troubled past as a mechanism of repression hangs heavy over mental health care today.[129] Indeed, key informants described that psychiatry is seen as a punitive system and a recommendation for psychiatric help is seen as a punishment by some, including veterans.

Stigma and shame: Given the history of the Soviet Union's punitive use of mental health treatment, continued stigma related to inpatient care has been reported in the literature and affects willingness among Ukrainians to seek mental health treatment.[12] Stigma and shame also emerged as barriers in our assessments with several key informants stating they would be ashamed to seek care and would prefer to seek help anonymously.

Fear of having a public record: Many key informants also stated that they would be concerned about having a 'public record' stating that they are mentally ill, have a substance use disorder or are seeking mental health treatment. They were worried about having employment restrictions and suffering discrimination as a result. Persons with AUD were

TABLE 6.7: BARRIERS TO SEEKING MENTAL HEALTH CARE LISTED BY KEY INFORMANTS

Categories of Barriers	Depression	AUD
Psychiatry as punishment and intimidating	• Psychiatry is seen as punitive • Psychiatry is closed off and non-transparent • People are terrified of psychiatric hospitals especially in rural areas	
Stigma and shame	• **Depression is not seen as a serious** disorder • **PTSD is not talked about** in the military	• **Feeling of shame,** it's difficult to ask for help even if it is available • **Reclusiveness of people with AUD,** they do not share their experiences
Fear of having public record of being diagnosed with MH problem	• Fear of discrimination	• Fear to be **registered as alcohol dependent** and being discriminated against • People seek to avoid official diagnosis
Lack of awareness and information	• Lack of information about treatment options	
Lack of trust	• **Public health care system not trusted** and seen as corrupted and inefficient • **Quality of MH professionals is not trusted** (e.g., you never know what kind of psychologist you meet, and whether they can help you or not) • In **social services,** psychologists work for free but the quality is not perceived as good • **Perceived misdiagnosis and incompetence** in state institutions contribute to lack of trust and keeps people from seeking help	
	• People with no MH problems do not understand the value of psychologists; they even **laugh, thinking that psychologists are not serious professionals** that can help people • **Unqualified psychologists** deter people from seeking treatment	• **Varying quality of rehabilitation centers** Lack of state-wide certification program makes verifying treatment effectiveness difficult
Negative previous experience	• **Heard of or had negative experiences** with seeing psychiatrists or psychologists and not being helped	
High cost of treatment	• **High costs of medications,** prescriptions unaffordable for many village residents • **High cost of private therapist** and there is no guaranty that it helps you	• **High cost for private rehabilitation center** ($222) per month
Geographical access and distance to service providers	• Difficulty accessing **public and private mental health** facilities, programs, and MH professionals, particularly in **rural areas** and for IDPs as they are often only available in oblast capital and large cities • Roads can be exhausting, **difficult to reach for people physically and financially** • **Insufficient numbers of staff** (e.g., psychiatrists, social workers) in rural areas (both)	
	• PTSD treatment unavailable in **army** • **Lack of in-village pharmacies** cause difficulty in obtaining prescription medications, particularly for persons with impaired mobility	• **AA groups are in all cities,** but there are private rehab centers and state-run narcological dispensaries **only in major cities** • It is difficult getting patients in rural areas care in case of alcoholic delirum

concerned about being **registered as alcohol dependent** when seeking free treatment at a state narcological dispensary, and to lose their driver's license and be subject to other employment limitations as a result. They stated that it is possible to get treatment (e.g., doctor in the government narcology dispensary and psychiatry hospital) **without getting on the record if paying a bribe.** However, this is difficult to afford and anonymous treatment is also expensive.

Lack of understanding and awareness: Consistent with the literature, our assessment also found that there is a lack of understanding and awareness about mental disorders and ways to seek help. The general community often does not know the difference between psychology and psychiatry in terms of treatment methods and approaches. Psychosocial support is a relatively new concept and often not well understood.[160] There is also no differentiation between serious and common mental disorders among the population, and many assume that hospitalization is always required.

Lack of trust and negative experiences with providers: There is a lack of trust toward the health care system in Ukraine in general. Previous studies and assessments have found that community members often did not have positive experiences seeking care from the only available specialists (psychiatrists).[161] One study found that IDPs and veterans in Zaporizhia stated that they would seek out mental health services if they felt professionals were competent and could be trusted.[161] Similarly, our assessment found that people do not trust the public health care system and the qualifications of mental health professionals. Several key informants described having heard about others having negative experiences with providers, or having such experiences themselves.

High cost of treatment: As discussed in the previous section on psychotropic medication, the high cost of medication prescribed can often be a barrier. Although generic antidepressants on the WHO essential drug list (fluoxetine and amitriptyline) may be relatively affordable, many patients receive prescriptions or suggestions (e.g., from friends) for more expensive medications. Similarly, treatment by private practitioners or in private rehabilitation centers can come at a high cost. In the 2016 study of adult IDPs with CMDs in Ukraine, the average cost for respondents that had paid for **care was $107 over the previous 12 months,** while the average cost for **medicines over the previous 12 months was $109.**[43] To put this in context, the average wage per month in Ukraine during that 12-month period was $193.[43]

Limited geographical access. Geographical access emerged as a challenge, especially in rural areas where mental health professionals are lacking.

In general, our findings are also consistent with the study of IDPs with CMDs which showed that the most common reasons for not seeking care included: believing they could get better using **their own medications,** the **high cost of health services** and medication, **not being aware** of where they could find help, **lack of understanding by health care providers, poor quality of services,** and **stigma/embarrassment.**[43]

Overall, our key informant interviews with persons recovering from CMDs and AUD showed that those who were **most successful** in receiving effective treatment had **supportive family or friends** who encouraged them to get treatment, **lived in major cities** where they could access high quality programs or **met criteria to access NGO** supported programs **for free** (e.g., IDPs, veterans), and had an **interest and ability to find information** about mental disorders and AUD (e.g., Internet access). It is likely that many people without these opportunities remain without access to treatment.

Differences in Help-Seeking Patterns

It has been noted that there is insufficient attention to providing **tailored mental health services** in a way that considers the specific needs of different segments of the population.[104]

Regions: Research in Ukraine suggests that differences in mental health needs and help seeking depend on a number of factors, including location (e.g., living in the East).[12, 50] It may be the case that availability of resources, cultural differences, or closeness to other parts of Europe, etc., may impact differences.

Age: Several key informants including service providers noted that **younger people were seeking mental health services more readily** than older persons. This may in part be explained by the history of psychiatry in Ukraine as oppressive, which is remembered more clearly by the older generation. It is also possible that younger persons can more readily access information about mental health and available services (e.g., on the Internet, social media). Data from International Medical Corps (IMCs) project with a radio station in Ukraine, which features mental health topics, suggests that older persons are more likely to listen to the radio, while younger persons are more likely to listen to radio programs and podcasts online.

Rural areas: It has also been suggested by key informants that persons in rural areas are more likely to trust and confide in people within their communities and may not always access services in bigger cities or respond well to mobile teams of outsiders. This offers a potential avenue for persons living or working at the village level, such as clergy and social workers, to be important first contacts for basic support and linkage to more specialized services as needed.

Veterans and military: Our assessment results corroborated with several studies that noted low service utilization, particularly among men and the military. Soldiers and veterans do not want to be seen as weak by accessing services and talking to therapists. At the same time, veterans reported that mental health services were not available or they did not trust the quality of services offered by military psychologists. Key informants also reported that veterans felt that psychologists who had never joined the military would not understand them. Indeed, in a summary report of the socio-economic impact of internal displacement and veteran return, it was found that nearly **one-fourth of all veterans sought some form of psychosocial counseling,** but most **found the**

support inappropriate and sub-par. The survey also noted several reasons preventing veterans from getting psychosocial support, which included a lack of professional psychologists (47% of all veterans interviewed), dissatisfaction with the quality of work from psychologists, and not having access to the type of counseling approach they were seeking (i.e., problem solving, family, partner, and parenting counseling). **Stigma** preventing access to psychosocial services accounted for around 29% of veterans surveyed.[162] Our assessment findings showed **families of veterans** were often the ones trying to convince them to seek services for mental health or alcohol use problems. When veterans were asked what kind of mental health support they would prefer, they stated being more **comfortable sharing problems with peers** who were also in the military, accessing service points that provide **multiple services** (e.g., education, information, legal, and not only mental health), and talking with mental health providers who were **competent,** professional and would respect confidentiality. Our assessment also found that programs that build trust and relationships with veterans through community, family, and social activities and excursions are more successful in engaging veterans in seeking more specialized help.

7. ADDRESSING COMMON MENTAL DISORDERS AND ALCOHOL USE DISORDERS IN UKRAINE: IMPACT, COST OF SCALE-UP AND RETURN ON INVESTMENT

7.1. Introduction and Methods

The **health and economic costs of CMDS and AUD** are considerable (also see Chapter 2). From a public health perspective, it is useful to estimate the impact as well as the **benefits and costs of scaled-up treatment,** which can provide relevant information in support of greater investment in the future. This assessment therefore includes an analysis using secondary data and the OneHealth tool to estimate impact, cost of scale-up, and return on investment for the treatment of CMDs and AUD. These results together with the other assessment findings help inform recommendations, including prioritization and allocation of resources for mental health.

The **economic and social benefits of better mental health** include intrinsic value (improved well-being) and also instrumental value, in terms of being able to form and maintain relationships, to study, work, or pursue leisure interests, and to make decisions in everyday life. Therefore, possible benefits include (a) the **health impact** referring to improvement in the health and/or functional status of the target population, (b) the **social impact,** given improvements in social functioning or participation, and (c) the **financial impact,** given that interventions may lead to being able to go back to work, work more productively, or improve their financial situation.

Assessment of these benefits—and relating them back to investment costs to establish the rate of return—can be achieved by estimating current and future levels of mental ill-health as well as effective intervention coverage in a population, and then determining the economic impacts of improved mental health outcomes, particularly rates of labour participation and productivity.[163]

A **return on investment analysis** comprises two components: the cost of program implementation and the monetary value of subsequent benefits. These cost and economic benefits are used to calculate the return on investment (ROI) through the following formula:

Return on Investment = (Improved Productivity + Well-being + Income Generation) – Investment Costs/Intervention Costs

7.2 Health Impact Assessment

Methods and Tools Used

The recently developed mental health module of the **inter-UN OneHealth tool (OHT)** was used to generate estimated numbers of persons with mental disorders residing in Ukraine. The OneHealth software tool has been developed by WHO and other UN agencies to strengthen health system analysis, costing, and financing scenarios at the country level (*http://www.who.int/choice/onehealthtool*). OHT has been used in earlier ROI studies, notably the global ROI analysis carried out by Chisholm et al. (2013) for depression and anxiety disorders.[163] Estimates are based on UN population projections and the latest Global Burden of Disease prevalence estimates. We also used OHT to calculate expected numbers of cases for the next 13 years until 2030, which is in line with the time frame of the Ukraine national mental health Concept Note.

Modeled Interventions

Analysis of interventions was largely restricted to treatment since the evidence on prevention of mental disorders was comparatively weak and currently of low generalizability to low- and middle-income country settings. In line with WHO's mhGAP Intervention Guide,[125] modeled interventions included basic psychosocial treatment for mild cases, and either basic or more intensive psychosocial treatment plus medication for moderate–severe cases. Moderate–severe cases of depression were split into first-episode and recurrent episode cases. Staff providing interventions include both nonspecialized and specialized staff (e.g., PHC doctors, nurses, CHWs, psychologists, social workers, etc.).

Health Impact of Treatment

The health impact of treatment of CMDs was expressed primarily in terms of a proportionate improvement in the rate of remission—equivalent to a shortening of the duration of an episode of illness—and the average level of disability or functioning:

- *Anxiety disorders:* the rate of remission following treatment improved by 60% (from 7.5% to 12% of cases) and disability level improved by 12–17%
- *Depression:* the rate of remission increased by 25–35% (depending on the intensity of intervention), and disability level improved by 6.5–14%

For more severe mental disorders, the health impact of interventions was modeled through the average level of disability or functioning (22–38% improvement before adjustment for non-adherence). These effect size estimates were adjusted (downward) by 30% to account for expected levels of non-adherence in treated populations. Thus, for example, basic treatment of mild cases of depression raised the remission rate by 25%, or 18% after allowing for non-adherence; this is equivalent to reducing the average length of an episode from 7 months to 6 months. Intervention effects were restricted to the year in which they were obtained; that is, treatment did not dynamically change disease rate estimates for future years. In the case of maintenance treatment of recurrent depression, however, a 40% reduction in the rate of recurrence was also modeled.

For all interventions, the **summary measures of health gain** in the population were **cases averted and healthy life years gained.** Healthy life years are computed with reference to country-specific life tables that are already built into the OHT model, and reflect the time spent by the population in a particular state of health with a known degree of disability.

For alcohol use disorders, which includes all individuals who consume hazardous and harmful levels of alcohol (not just those with alcohol dependence), brief psychosocial intervention was included, plus the following population-based strategies:

- an increase in excise taxes on alcoholic beverages;
- enforcement of bans or comprehensive restrictions on alcohol advertising, promotion, and sponsorship;
- enforcement of restrictions on the physical availability of retailed alcohol; and
- enforcement of drunk driving laws and blood alcohol concentration limits, for persons with hazardous and harmful alcohol use.

Alcohol use is a risk factor for many diseases and injuries. Sex-specific relative risks for each disease and injury category were multiplied by the prevalence of hazardous and harmful alcohol use to form population attributable fractions (PAFs).

Modeling Intervention Scale-up

Modeling of the health impact and cost of intervention scale-up uses a 13-year scale-up period, in line with the newly proposed Mental Health Plan in Ukraine, and assumes a linear increase in service coverage for a range of common and more severe mental disorders. Baseline and target levels of coverage for the years 2017 and 2030 are shown in Table 7.1.

7.3 Cost Assessment

Treatment costs relied on previous cost-effectiveness studies and resource need profiles garnered from existing treatment guidelines and costing tools. Key categories of resource use included medication, outpatient and primary care, inpatient care, and also program

TABLE 7.1: INTERVENTION BASELINE AND TARGET COVERAGE FOR SELECT PRIORITY MENTAL HEALTH CONDITIONS

Intervention Coverage	Baseline Coverage (2017)	Target Coverage (2030)	Absolute Increase
Psychosis			
Basic psychosocial treatment and antipsychotic medication	20%	50%	30%
Intensive psychosocial treatment and antipsychotic medication	5%	20%	15%
Bipolar disorder			
Basic psychosocial treatment and mood-stabilizing medication	20%	50%	30%
Intensive psychosocial treatment and mood-stabilizing medication	5%	20%	15%
Depression			
Basic psychosocial treatment for mild cases	5%	20%	15%
Basic psychosocial treatment and antidepressant medication of first episode moderate–severe cases	10%	30%	15%
Intensive psychosocial treatment and antidepressant medication of first episode moderate–severe cases	5%	20%	15%
Intensive psychosocial treatment and antidepressant medication of recurrent moderate–severe cases on an episodic basis	5%	20%	15%
Intensive psychosocial treatment and antidepressant medication of recurrent moderate–severe cases on a maintenance basis	1%	20%	19%
Anxiety disorders (including PTSD)			
Basic psychosocial treatment for mild cases	5%	20%	15%
Basic psychosocial treatment and antidepressant medication for moderate–severe cases	10%	30%	20%
Intensive psychosocial treatment and antidepressant medication for moderate–severe cases	5%	20%	15%
Alcohol use disorders (including hazardous and harmful use)			
Brief psychosocial treatment	5%	50%	45%
Population-based alcohol prevention strategies (full implementation level)	20%	100%	80%

resources, which include program management and administration, as well as training and supervision. Program cost estimates were taken from the mhGAP costing tool.

Country-specific unit costs of inpatient and outpatient care were taken from WHO-CHOICE (*http://www.who.int/choice/country/country_specific*), adjusted to 2013 price levels. The estimated unit cost of an outpatient visit in Ukraine (for the year 2013) was US$7.23, and the unit cost of an inpatient day was US$41.05. Anti-depressant drug costs were based on the median price for generically produced fluoxetine published in the International Drug Price Indicator Guide, adjusted upward for the cost of transport and distribution. Total costs in a given year for a country are arrived at by multiplying resource

use needs by their respective unit costs to give a cost per case, which is then multiplied by the total number of cases expected to receive a particular intervention (given by prevalence multiplied by the population in need multiplied by coverage).

7.4. Results

Number of Persons with Mental Disorder Reached

Scaling up mental health services from current to target levels of coverage over the period 2017–2030 is expected to result in a **three-fold increase in numbers of persons in need with severe and common mental disorders who are reached** (from an estimated 345,000 cases to 941,000 cases). In addition, scaling up of brief interventions for persons with **hazardous and harmful alcohol use to 50% of those in need would mean that nearly five million of these people would be reached by 2030.** Data for CMDs and AUD only is shown in Table 7.2.

TABLE 7.2: CASES REACHED WITH SCALE-UP OF SERVICES FOR CMDS AND AUD

Cases Reached	Depression	Anxiety	AUD
Baseline (2017)	**90,208**	99,325	511,845
By 2030	**271,040**	290,739	4,677,900

Health Impacts: Healthy Life Years Gained

Total population health gain over the period 2017–2030 is shown in Figure 7.2. Health impacts of scale up for mental disorders are modest at first, reflecting the marginal increase in coverage, but increasing over time to the point that 90,000 years of healthy life will be restored in the year 2030. Given the high prevalence of hazardous and harmful alcohol use, the health **impacts of scaled up alcohol control strategies are substantially greater,** amounting to a little over 500,000 healthy life years gained by 2030. For the period as a whole, the cumulative number of **healthy life years** gained through scale-up of all modelled interventions is **4.7 million**.

Costs of Scale-up

The total cost of scale-up (in US$) is shown in Figures 7.3 and 7.4, both by disease and by category of cost; the total cost associated with estimated baseline coverage levels in 2017 is $123 million (approximately one-half of which is inpatient care) rising to over $400 million in 2030. The largest disease contributor to overall cost is bipolar disorder, driven by the relatively higher cost of mood-stabilizing medications (e.g., lithium, valproate) compared to generic antidepressant and antipsychotic medication, as well as substantial expected inpatient care costs. Scaling up brief interventions for alcohol use disorders is also a major contributor on account of the large target population in need. Inpatient care

Figure 7.1: Number of Cases Reached

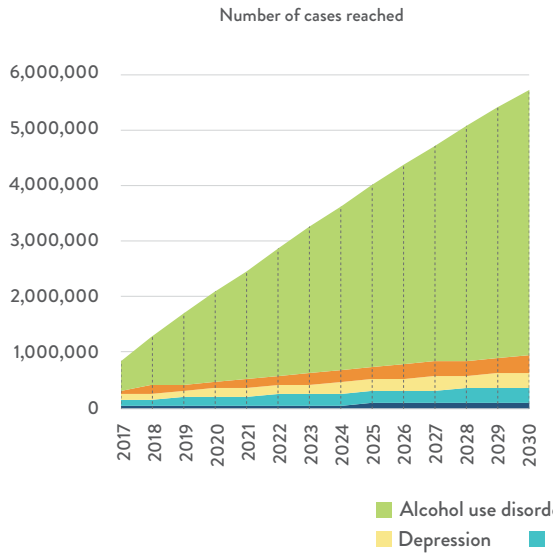
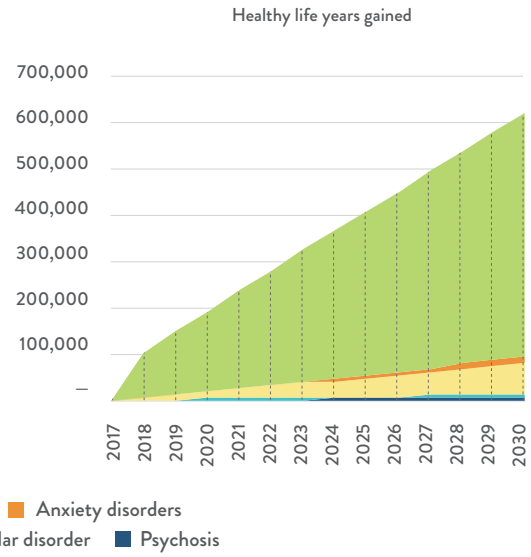


Figure 7.2: Healthy Life Years Gained



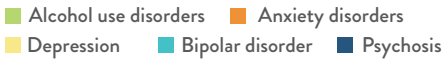


Figure 7.3: Cost of Scaling Up—by Disease

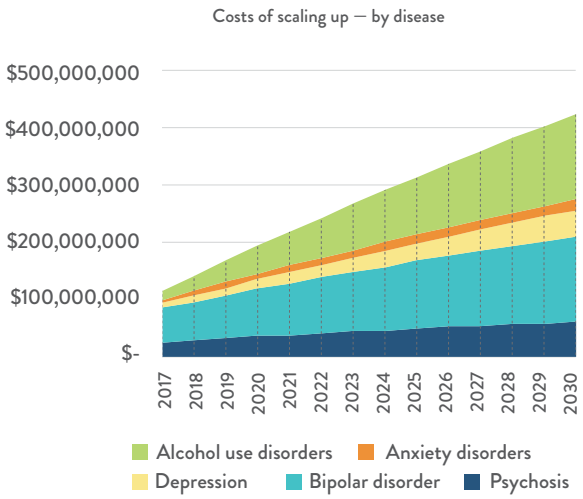
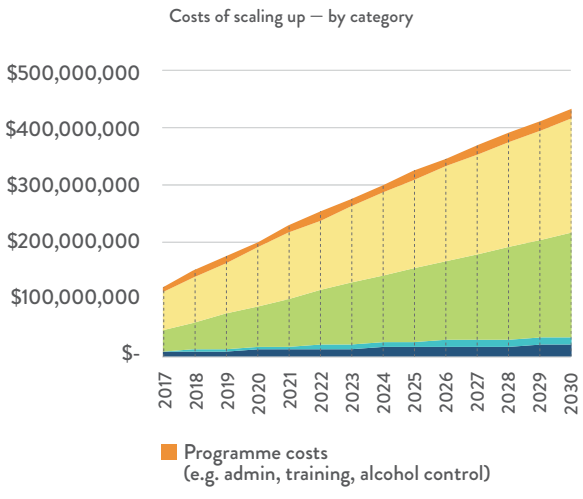
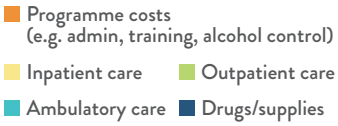


Figure 7.4: Costs of Scaling Up—by Category





represents the largest contributor to overall costs. The cost per head of population shows a corresponding increase, from US$2.80 to US$10.90.

Given that total health spending in Ukraine amounts to just over 7% of GDP (equivalent to US$203 per capita in 2014), and out of that amount 2.5% is estimated to be spent on mental health care, approximately US$5 per capita. Close to a **100% increase in government mental health care expenditure** would therefore be required if target levels of coverage are to be reached, particularly if persons with mental disorder are to be protected from the potentially impoverishing cost of out-of-pocket payments of medication, tests, and private consultations.

7.5 Return on Investment Analysis

Persons with common mental disorders and AUD experience functional impairment and symptoms (e.g., fatigue, being jumpy, being intoxicated from alcohol) which makes it more difficult for them to function optimally at work, to seek out employment opportunities, or to maintain employment. Indeed, research has shown that mental illness does not only impact the health and well-being of affected persons and their families; it also has significant economic consequences for employers and governments, as a result of diminished productivity at work, reduced rates of labour participation, foregone tax receipts, and increased welfare payments.[163]

In 2010, **worldwide, an estimated US$2.5–8.5 trillion in lost output** was attributed to mental, neurological, and substance use disorders, depending on the method of assessment used. This sum is expected to nearly double by 2030 without significant investment in treating mental disorders.[163]

The benefits of mental health interventions and relating them back to investment costs to establish the rate of return, can be achieved by estimating current and future levels of mental ill-health as well as effective intervention coverage in a population, and then determining the economic impacts of improved mental health outcomes, particularly rates of labour participation and productivity. Using established methods, it is also possible to monetize the intrinsic value of improved mental health, although these benefits fall outside the realm of the real (measured) economy. Based on the methods and findings of a recent global ROI analysis of 36 large countries from around the world,[163] it is possible to **identify for Ukraine both the economic impact of lost productivity due to common mental disorders** (depression and anxiety disorders), and also the **monetary value and internal rate of return of investing in its more appropriate treatment.** Data are not currently available to assess these impacts for severe mental disorders or for alcohol use disorders.

Productivity losses can be assessed both with respect to whole days out of role/off work (absenteeism) and also partial days of impaired activity while an individual is at work. Based on findings from the World Mental Health Survey, it is estimated that compared to adults without CMDs, **persons with depression and anxiety disorder had 23–30 more days out of role** per year.[164] Allowing for the rate of labour participation, it is estimated that over the period 2017–2030 the economic value of **lost days of production amounts to an average of $850 million per year for anxiety disorders, and $425 million per year for depression.** The combined economic value of this lost productivity (US$1.275 billion) greatly exceeds the estimated cost of current mental health expenditure or projected service scale-up.[104]

In terms of the impact of effective treatment of depression and anxiety on productivity, there are very few studies showing the extent to which effective treatment can get people back into work, and where measured, estimates are subject to local factors such as prevailing levels of unemployment. Based on the few studies available internationally,

TABLE 7.3: SUMMARY OF COST OF SCALE-UP AND RETURN ON INVESTMENT FOR DEPRESSION AND ANXIETY DISORDERS

	Depression	Anxiety	CMDs Total
Investment: Cost of scaled up treatment 2017–2030	$ 380 million	$ 183 million	$ 563 million
Return: Value of restored productivity 2017–2030	$ 846 million	$ 349 million	$ 1,195 million
ROI: Ratio of restored productivity to cost of scale-up	2.2	1.9	2.1
Return: Value of restored health 2017–2030	$ 922 million	$ 143 million	$ 1,065 million
ROI: Ratio of restored productivity and health to cost	4.7	2.7	4.0

we conservatively estimate that 5% of those who are of labour force age and are treated for depression or anxiety are able to return to work, and that for those who are already working, there is an increase in productive working time equivalent to about 20 days or one working month per year. These returns to productivity were subsequently mapped to the prevailing rates of labour participation and GDP per worker in Ukraine, based on available data from the International Labour Organization (ILO) (2013). The difference in GDP between a status quo scenario versus one representing scaled up treatment and consequently enhanced productivity provides our summary measure of economic benefit. It is estimated that the economic value of restored productivity over the period 2017–2030 amounts to more than $800 million for depression and $350 millions for anxiety disorders (Table 7.3) (in each case more than twice the cumulative cost of scale-up). Accordingly, it is possible to conclude that for every **$1 invested in scaled up treatment of common mental disorders in Ukraine, there will be $2 in restored productivity and added economic value.**

In addition, it is possible to place a monetary estimate on the intrinsic value of better health. This can be done by associating each year of healthy life gained through intervention by a multiple of GDP. In the Lancet's *Commission on Investing in Health*, Jamison et al. (2013) determined that the value of a one-year increase in life expectancy in low- and middle-income countries is 2.3 times per capita income, and for the world as a whole, 1.6 times per capita income (using a discount rate of 3%). Stenberg et al. (2013) attributed two-thirds of that derived value to the instrumental component (which is measured directly via the labour force outcomes described above), leaving the remaining one-third for the intrinsic benefits of health (equivalent to 0.5 times per capita income). A total of **542,000 healthy life years are estimated to result from scaled up treatment of CMDs over the period 2017–2030;** valued at $1,811 each (GDP * 0.5), this results in an **economic value of over $1 billion, or an average of $75 million per year of scale-up.** When these intrinsic benefits of better health are added to the instrumental benefits of restored production, the ROI evidently improves, to 4.7 for depression and 2.7 for anxiety disorders.

IV. DISCUSSION AND RECOMMENDATIONS

Assessment Limitations

This assessment had several limitations which affect recommendations and conclusions that can be drawn from this assessment. First, the focus of this assessment was **limited to common mental disorders and alcohol use disorder only.** There are several other priority mental health conditions which are important from a public health perspective. This includes severe and chronic conditions such as psychotic disorders and bipolar disorder, which cause significant disability, impact family members, and are associated with higher rates of hospitalization. It will be important to include addressing these disorders in the mental health policy and plan and Ukraine health reform. Suicide was not investigated in depth but is high in Ukraine and connected to AUD as well as CMDs. Mental health problems among children, such as developmental disorders, or intellectual disabilities among adults and children were also not considered despite the importance of these conditions in the Ukrainian context. Further attention by the Ministry of Health and its partners are needed to address the needs of persons affected by those disorders as well.

Second, the focus on three oblasts specifically means that this assessment has **geographical limitations,** although efforts were made to include information about Ukraine more broadly, such as capacity building efforts. Yet, there are considerable differences between oblasts, including cultural and socio-demographic aspects, as well as access to and quality of mental health services and programming. Key informants involved in mental health programming have also stated that it has been easier to involve some oblasts in pilot programs than others. Odessa for example, which has been a pilot site for some promising new community mental health approaches, was not included in this assessment.

Third, the assessment methods used included **desktop reviews and collection of mostly qualitative data,** although we have presented quantitative data in this report as part of the literature review. The data we collected were limited since they did not include representative samples and all different types of possible respondents. Furthermore, qualitative data analysis do not allow for presenting firm estimates of the scope or scale of certain problems including descriptive data or comparative analyses.

Fourth, we were only able to include those **respondents who were willing and able to talk with us, and we did not talk to all different types of key informants.** We were not able to talk with persons with mental health problems who had never accessed

mental health services, for example. We also only talked with service providers who had interest and time in discussing mental health issues (e.g., response rate from GPs/family doctors was 71%). Furthermore, although nurses were present during some of the interviews with doctors, they generally deferred to doctors and we did not speak with them separately. Therefore, our findings are not fully representative of all types of informants and service providers.

Fifth, this assessment focused on **mental health as part of the health system and community based services,** although it is also important to consider more specialized mental health services, including care through institutions as well as services provided under different ministries. A recent report on **social care homes** that serve as a permanent residence for persons with severe and disabling mental and neurological disorders, for example, highlights challenges and provides key recommendations. Global guidance (WHO Quality Rights) on supporting individuals in institutions exists as well and should be considered when reforming the health system. Furthermore, different ministries in addition to MoH are also relevant for meeting the needs of persons with CMD and AUD. **Social services** under the Ministry of Social Policy for example, include the Centers of Social Heath for Family, Children, and Young People, which has staff stationed in smaller towns all over the regions. Staff includes qualified lawyers, psychologists, and social workers, who are important target groups for further assessment and capacity building. The **school system** under the Ministry of Education is also important to engage, given that many psychologists work within the school setting. Some efforts have been under way with support from international donors to provide psychosocial support training to school psychologists, and this is an important area for additional exploration and programming.

Regardless, we hope that findings and recommendations from this assessment will be useful in informing and prioritizing concrete steps for addressing mental health as part of health reform and in informing mental health programming supported by various national level and global actors.

Recommendations

The aim of this assessment was to provide information and recommendations that help inform policy and operational guidance for strengthening integration of mental health into primary health care and community-based service platforms in Ukraine under the reform program. This assessment synthesizes key findings and presents recommendations to inform the mental health policy and plan, donor funded projects, and prioritization of specific areas for intervention.

Recommendations are based on the assessment findings within the context of global guidance for strengthening and organizing mental health services by WHO, evidence-based practices, and national level priorities expressed in the mental health Concept Note and by key stakeholders.[165]

A broad range of recommendations is outlined below, which will take **concerted efforts of various stakeholders,** including government actors, international donors, service providers, INGOs, and community-based organizations (CBOs) as well as mental health service users. **Recommended considerations for prioritizing specific actions** for improving mental health services include feasibility (i.e., technical, administrative, and legal), financial and resource availability, long-term sustainability, acceptability, potential secondary or indirect consequences, equity, and potential for transition from pilot project to full implementation.[165]

Discussions with key national stakeholders to determine strategies and prioritization of actions will be needed to decide on the way forward. The following outlines some overall considerations:

- Initial focus on **strengthening coordination and leadership** for mental health (e.g., among government actors, donors, INGOs, CBOs), in line with global guidelines, can contribute to more effective use of resources, information sharing, and coordinated efforts.
- Mental health services should be **strengthened as a whole** (e.g., community services need to be available before scaling down inpatient care, and specialized providers need to be available to train and support nonspecialist workers).
- Interventions that have the potential to reach large numbers of people in need and are expected to have considerable impact and/or return on investment could be considered for prioritization. This includes increasing **consumer awareness** (e.g., positive coping, where to seek care, avoiding ineffective and expensive services, medications), **self help** and addressing conditions such as **depression, suicides, and AUD.**
- Although building capacity at the primary health care level remains important, significant efforts are also needed to **build the skills of practicing specialists** (e.g., psychologists) and to improve availability of existing specialized professionals at general health facilities and more remote geographic regions. These specialists are also needed for linking to and supporting primary health care providers.
- Continuation or initiation of **key pilot projects** focusing on regions or cities with high need, available resources, and successful collaboration with regional actors can build momentum and serve as a **proof of concept for later scale-up.**

1. Coordination, Communication, and Information Sharing

1.1 Improve communication and coordination among donors and implementing partners in support of the Ukrainian government's efforts to reform its mental health system

International cooperation and support for mental health has increased, especially in light of the current conflict in the East. Important capacity building efforts and opportunities for training and professional exchange have been initiated or are being planned. However, many key informants have also noted that these efforts are often not coordinated among donors or implementing partners. As a result, these efforts may not make use of lessons learned; use different methods, approaches, and protocols (some of which may not be evidence-based or in line with global or national guidelines); or lack sustainability.

Recommendations

Increase coordination among donors, government actors, and international organizations by creating a broader task force (e.g., under MoH), holding regular national level coordination meetings (e.g., facilitated by MoH, INGOs with coordination experience), and continuing to organize key meetings for information exchange and joint planning in line with global best practices, national level priorities, and mental health reform efforts.

Use **coordination mechanisms and events** to plan joint efforts and pilot projects that build on what has already been done and emphasizes sustainability and potential for scale-up. Involve regional level actors from other countries and access **global platforms** to share information and learn from others.

1.2 Strengthen referral pathways among different formal and informal service providers in the health and social systems

Our assessment showed that persons with mental health problems access various different points in the health system and the community including nonspecialists (e.g., family doctors) and informal or community service providers (e.g., clergy, NGOs). Yet, they are often not identified or referred to needed services. Reasons for this include not knowing where or how to refer, being reluctant to mention mental health, or not having a personal connection to a mental health service provider. The national mental health Concept Note also points to the need for developing common referral systems and mechanisms across different services (e.g., health system, social services) and different organizations (e.g., government, NGOs) with clear roles and responsibilities.[104] There is a need for different formal and informal service providers to **identify persons** who may potentially have mental health problems and to **make appropriate referrals,** share relevant information, and **follow up**. Service users also shared concerns about the confidentiality of their information, so referrals need to be transparent and made with consent.

Recommendations

- **Map available mental health services** provided by health and social services or NGOs at the oblast level and make this information available to formal and informal providers. IMC has provided a mapping tool and directory in Zaporizhia, and such mapping could be scaled up by INGOs or CBOs.
- **Conduct mental health referral workshops** involving different types of professionals from different organizations and agencies so they can share information about the services they provide and get to know each other. Given that most referrals are provided 'informally' (through personal contact), getting to know other providers can facilitate connections. Such workshops have been organized by INGOs such as IMC and could be continued and also taken up by regional level health authorities or CBOs.
- **Develop common referral mechanisms and forms which can be used by different providers.** Such forms should document the consent to referral and information sharing by the person referred, with the same copy given to the referring provider, patient, and referral point. Global IASC referral guidance and sample forms are available, have been adapted and translated (by IMC), and could be further developed and disseminated as part of referral workshops and endorsed by national and regional level health authorities.

1.3 Strengthen communication, information sharing, and multidisciplinary teamwork

Mental health care provision is often **fragmented** with different providers offering different types of interventions to the same person, with little coordination or communication (e.g., a narcologists, psychiatrists, psychologists, psychotherapists, GPs/family doctors, social workers). This is also relevant given that many people with CMDs and AUD have multiple needs in addition to mental health (e.g., employment, financial assistance, housing, violence and protection issues) which require different providers and the coordination of different sectors including health, social, and other services. Our assessment and previous research also show the relevance of such diverse services and supports given social determinants of mental health and that poverty and other life stressors increase the risk for CMDs and AUD and vice versa. The mental health Concept Note expresses the need for strengthening effective communication between providers and creating an e-health system which helps manage the different needs for services of the population and can be used to exchange information. Various key informants have highlighted the need for cooperation and continuity between various aspects of treatment (e.g., pharmacological and psychotherapeutic) and various actors (psychologists, doctors, social workers). It is also important to note that persons seeking mental health care are confused about what information is shared with whom and are **concerned about confidentiality and discrimination** if is it known they received treatment.

Recommendations

- Recognize the **value and importance of different interventions and professionals** (e.g., psychologists, psychotherapists, social workers, doctors and nurses) **from health and social sectors** in addressing mental health as well as other needs (e.g., employment, housing).
- Develop **common systems and procedures for information sharing,** including common databases and forms as well as information exchange between providers (e.g., different levels of health care, health and social services).
- **Introduce multidisciplinary teamwork** involving different professionals who share information and coordinate care to effectively meet multiple needs. Models of multidisciplinary teams have already been pilot tested in Ukraine (e.g., WHO mobile team project, Lithuanian support project) and could be further expanded.
- Develop **clear care pathways** for different types of nonspecialized and specialized professionals which include assessment, identification, treatment, referral, and follow-up.
- **Clearly communicate to patients** what information is shared with whom and for what purpose and ensure obtaining and documenting consent. This includes developing or updating relevant national level protocols by MoH as well as using appropriate processes among specialized and nonspecialized service providers.
- **Review current systems of information sharing and registration** of persons with mental disorders to ensure persons can seek care **without fear of discrimination and negative repercussions** (e.g., employment restrictions). Such review would have to be undertaken under the leadership of MoH with implementation and dissemination of clear information at the regional level and by health professionals.

2. Organization of Mental Health Services

2.1 Decentralize mental health services from hospital-based care toward outpatient care and community-based services

The mental health system in Ukraine continues to provide services primarily through inpatient institutions, with an estimated **89% of all mental health resources allocated to inpatient facilities and long inpatient stays** (average of 53.5 days). These numbers are especially high compared to other countries in the region. The current model of health care in Ukraine also **incentivizes inpatient stays** by covering psychotropic medications for inpatients only and making budget allocations based on available beds. This type of care is associated with higher cost of treatment, segregation of people with mental health problems, and less accessible services. Furthermore, psychiatrists and psychologists are heavily concentrated in hospitals and in big cities. It is also recognized in the 2017 Ukraine MH Concept Note that the existing focus on provision of mainly psychiatric care

in inpatient specialized institutions leads to ineffective care and high expenses. From the **mental health service user perspective,** inpatient services are more stigmatized and less accessible, while evidence-based interventions in outpatient and community settings provide support for multiple needs (e.g., employment) and have been described as successful. As shown in the ROI analysis, the majority of CMDs and AUD in Ukraine can be addressed through community based-care rather than inpatient care in the longer term. At the same time, all levels of mental health care (including inpatient care and self care) need to be strengthened for a well functioning mental health system.

WHO **recommends a pyramid model of organizing mental health services** (see Chapter 4) which can reduce the cost of mental health treatment, while stigma and the shortage of mental health professionals can be addressed, and early detection of mental disorders is more likely.[165] The Ukraine 2017 MH Concept Note[104] states that improved access to mental health will be achieved through decentralization, which includes development of outpatient care and outreach (e.g., in-home support, outpatient mental health centers, mobile teams, etc.), providing mental health at the primary care level, reorganization of resources from the tertiary to secondary level, and developing referral and communication mechanisms between providers and level of care. Consistent with this, five **principles for successful deinstitutionalization** have been identified by global experts: community-based services must be in place (e.g., outpatient MH services, evidence-based care, social services for housing, employment, etc.); the health work force (including professional associations) must be committed to change; political support at the highest and broadest levels is crucial; timing is key (e.g., emergency situations and crises can serve as opportunities for change);[166] and additional financial resources are needed.[167] The recommendations outlined below are especially relevant for MoH and policy makers tasked with the health reform and with organizing mental health services. They are also relevant for donors and implementing organizations seeking to support national level efforts.

Recommendations

- **Support national and regional level leaders** in mental health who can reach key decision makers, engage a broad range of stakeholders, and mobilize political will for change. This also includes involving skilled and motivated young people.
- **Strengthen mental health service provision** (including identification, assessment, evidence-based treatment, support, referral, and follow-up) **at all levels** of the pyramid through capacity building, development of protocols and task shifting (also see recommendation Section 3 on education and training of human resources):
    - **Expand the number of psychiatric inpatient units in general hospitals** to reduce reliance on centralized tertiary institutions;
    - **Allocate specialized mental health professionals** (e.g., through restructuring, incentives) to ensure that psychiatrists and trained psychologists and psychotherapists are available at a broad range of health facilities (e.g., Raion hospitals, polyclinics), which increases geographical coverage;

- Conduct **community outreach** of multidisciplinary teams which include specialized mental health professionals to local village levels for people with severe mental disorders (e.g., psychotic disorders) as piloted in the WHO supported model;
- **Address mental disorders at the primary care level** through timely identification, management (pharmacological and psychosocial) and referral to mental health specialists when needed (e.g., severe and complex cases); and
- **Create and strengthen community level entry points** for identification and referral of persons with mental disorders (e.g., by feldshers, clergy, CBOs).

- **Strengthen social and community services** for persons with mental illness (e.g., help with accessing benefits, housing, employment) in order to meet multiple needs that also impact mental health.
- Ensure **adequate salaries** for health and mental health professionals, including those working in rural areas
- **Include metrics** such as interventions provided, patient improvement, and patient satisfaction in **monitoring and evaluating health services** and contributing to accountability.
- Use **lessons learned** for the provision of mental health care from other countries in the region (e.g., Lithuania, Georgia).

2.2 Strengthen mental health coverage and financing

The **budget** allocated to mental health in Ukraine is still comparatively low (compared to other countries) and **still not proportionate to the public health and economic burden** of mental disorders. Due to **insufficient government financing** of the health system, the population is required to pay for outpatient and inpatient pharmaceuticals (which are often expensive) as well as provide unofficial **remuneration** to medical personnel. Persons with CMDs and AUD also incur significant costs by accessing different service providers including psychologists in private practice or purchasing expensive medications. The 2017 Ukraine MH Concept Note describes that effectiveness of mental health funding will be improved as part of the general health reform and will include expanding mental health service provision, and developing and implementing mechanisms of intersectoral financing, as well as searching for non-state sources of funding. Although many stake-holders felt that it would be unlikely for the mental health budget to increase, our analysis examining cost of scale-up suggests that per capita spending for mental health would need to be doubled (from about $5 to $10) to achieve significantly increased coverage of key priority mental health conditions. Investing in mental health, however, appears to make sense from an economic perspective, given the impairment in functioning and reduced ability to work among those with mental disorders. Our return on investment analysis suggests that every **$1 spent on scaling up treatment for common mental disorders will result in $2 of economic return.** The following recommendations would require continued **advocacy by various stakeholders as well as leadership from MoH.**

Recommendations

- Consider **increasing spending on mental health** to scale up coverage and evidence-based interventions across specialized, nonspecialized, and community settings.
- Ensure that treatment (inpatient and outpatient, including evidence-based interventions and psychotropic medications) for priority mental health conditions (including CMDs and AUD) is available free of charge and included in the **basic package of health services** (the 'service basket').
- Include **psychotropic medications** in the list of medicines subject to cost regulations and price caps.
- Include generic psychotropic medications (on the WHO essential drug list) in the national list of medicines which should be **provided free of charge**
- **Consider coverage of accredited providers offering evidence-based interventions** for the treatment of mental illness. This should include accredited private providers, especially in areas lacking adequate mental health services and given the current shortage of providers offering such interventions.
- **Shift financing** from being dependent on inpatient bed capacity to being based on actual mental health services and needs ("money follows the patient"). This would be consistent with the changes already planned under the broader health reform.

2.3 Establish public health initiatives and strengthen services available for people with alcohol use disorders

Alcohol use in Ukraine has strong cultural traditions. The prevalence and burden of AUD is significant in Ukraine and contributes to increased mortality and poor health, especially among working age males. This assessment also showed that persons with AUD often do not have access to appropriate and effective interventions and are concerned about being registered and restricted from employment opportunities. Research has shown that unemployment and alcohol use can reinforce each other and that finding gainful employment and new meaningful activities is an important part of recovery from AUD. Global guidelines outline that priority actions for controlling excessive alcohol consumption and contributing to the reduction and prevention of AUD need to **target both supply and demand.**

Recommendations

- Provide **evidence-based psychosocial interventions for AUD** (e.g., motivational interviewing, 12 step program, positive coping) at **state run narcological facilities** by hiring and/or training qualified staff (e.g., psychologists, psychotherapists, and social workers) who are working as part of a multidisciplinary team. This would require training and capacity building of staff, as well as updated regulations and guidance for hiring managers at health care facilities about needed professional

qualifications and skills of providers. Oversight, quality control, and supervision mechanisms would also need to be in place at facilities to ensure provision of adequate care and accountability.

- **Provide outpatient psychosocial interventions** (e.g., continued provider-led support groups) and follow-up for patients discharged from narcological inpatient units. Staff at inpatient facilities and community level CBOs and support groups (e.g., AA) need to collaborate in linking patients to needed services and following up.
- Build capacity of **primary health care providers** in identifying persons with hazardous alcohol use and utilizing appropriate interventions, which can also improve overall health and reduce NCD risk (also see Subsection 2.4).
- Support persons recovering from AUD in **accessing educational and employment opportunities.** This also includes advocating for the rights of persons with AUD and working with educational institutions and employers to identify suitable opportunities. Collaboration between health and social sectors as well as civil society organizations is needed in this regard.
- Ensure that persons identified with AUD or with hazardous and harmful alcohol use in **conflict with the law** have **access to appropriate treatment and community support.**
- Establish **mandatory licensing and accreditation for rehabilitation centers** (for drug and alcohol use). Centers which continue to not meet accreditation standards and represent safety concerns should not be allowed to operate. This requires firm leadership from MoH as well as the support and strengthening of professional associations.
- The following recommendations which address the supply side of hazardous alcohol consumption require advocacy and political leadership across different sectors (e.g., health, social, and judicial systems):
    - Consider **an increase in excise taxes on alcoholic beverages.** Resulting funds can also be directed toward addressing AUD;
    - Enforce **bans or comprehensive restrictions** on alcohol advertising, promotion, and sponsorship;
    - Enforce **restrictions on the physical availability** of retailed alcohol;
    - Enforce drunk driving laws and blood alcohol concentration limits for persons with hazardous and harmful alcohol use.

2.4 Provision of integrated physical and mental health care

Mental and physical health are closely interconnected. **Mental health problems and alcohol use are likely to contribute to physical health problems. NCDs** are the main cause of mortality in Ukraine with contributing factors such as alcohol use and unhealthy lifestyles. Research shows that persons with mental health problems often engage in poor health behaviors (e.g., overeating, poor nutrition, smoking, lack of exercise), which

contribute to NCDs. Furthermore, persons with mental health problems are less likely to seek needed health care and are less compliant with medical regimens. This is again especially relevant in Ukraine, where medical compliance is important not only for NCDs but also for **infectious diseases** such as HIV/AIDS and TB, which have a high degree of comorbidity with mental health problems and a high burden in Ukraine.[168] Research shows that the life expectancy of people experiencing mental health problems is shorter, which can largely be attributed to physical health problems.

On the other hand, **physical health problems can contribute to poor mental health** as well. Persons living with HIV are more likely than the general population to experience mental disorders, such as depression, anxiety, suicide, and substance misuse.[169, 170] Chronic and life threatening diseases such as cancer (which ranks among the top causes of death in Ukraine) can also significantly impact mental health and well-being.

Collaborative care and linkages between different types of health services such as NCDs and infectious diseases with mental health have been recommended. There is some evidence that excess mortality among people with mental disorders can be reduced through evidence-based treatments and improved screening and treatment provided by community-based collaborative care teams.

Recommendations

- Train and work with **health staff who are involved in treating common consequences of alcohol use** (e.g., cardiologists) to provide basic interventions and referral for patients with problematic alcohol use and AUD.
- Provide **collaborative care** for persons with CMDs and AUD, ensuring that **physical health problems are addressed** as well. This requires links and communication between different types of health and mental health professionals.
- **Ensure timely identification intervention** for mental health problems **among people suffering from physical health problems such as NCDs and infectious diseases.** Considerable funding continues to be allocated by international actors to combat HIV/AIDS and TB in Ukraine. Addressing mental health through capacity building of staff and referral links should be a key part of such programs.
- Provide **community-based interventions which promote a healthy lifestyle** and can be helpful for mental health as well as physical health problems (e.g., physical exercise has been shown to help people with depression, activities such as healthy cooking classes or nature walks promote physical health as well as social support). Such interventions can be suggested by health care staff and implemented by community level organizations and providers (e.g., CBOs, Clergy).

2.5 Ensure focus on priority mental health conditions with high public health impact and/or return on investment such as depression, suicide, and alcohol use

The prevalence and burden of depression and AUD is higher than other countries in the region, except for Russia and Lithuania. Ukraine also has one of top 10 suicide rates in the world, and **suicide is associated with both depression and alcohol use disorder.** At the same time, basic public health measures and mental health interventions have a high return on investment for these disorders. Due to the fluid political situation in Ukraine, the fighting in the East, and resulting higher levels of psychological stress, there has been an increased focus among donors and NGOs on treating PTSD. Some civil society organizations and NGOs, for example, have focused exclusively on PTSD treatment and training or suggested stand-alone centers or services for trauma and PTSD. Furthermore, government statistics track the number of persons with PTSD and AUD but not those with depression accessing services. While trauma and PTSD are important issues to address, it is also critical to consider that depression is much more prevalent when considering Ukraine as a whole. Economic hardship and conflict related stress can also increase the risk for depression (and not only PTSD). Furthermore, this assessment has shown that **interventions to address depression have a high economic return on investment,** which is about twice that of anxiety disorders (see Chapter 7). Different mental health and social problems often co-occur (e.g., PTSD together with substance use), which calls for a more comprehensive approach. It should also be noted that global guidelines do not recommend a stand-alone focus on specific disorders such as PTSD/trauma for mental health services but rather a comprehensive approach addressing different mental health priority conditions.

Recommendations

- **Do not focus capacity building efforts or stand-alone services on only trauma and PTSD.** This recommendation is specifically relevant for international organizations and professionals offering their help. The coordination mechanisms outlined in the first set of recommendations can also serve as a platform for discussions about designing programs in line with global guidelines and national efforts.
- Consider focusing on multiple priority mental health problems with **public health significance** including (but not necessarily limited to) **depression, suicide, and AUD.** This recommendation is relevant for developing training curricula and protocols for health and mental health professionals by MoH and academic institutions but also for international actors planning to implement or support mental health programs.
- Include depression (and not only PTSD and AUD) in **government statistics** of persons accessing services.
- Invest in **suicide prevention and intervention** strategies (e.g., promoting responsible media reporting, including the issue of suicide in capacity building of health and mental health professionals, raising awareness about suicide via the media, and community discussions).[171, 172]

2.6 Ensure that mental health services and outreach are accessible to everyone, while being tailored for reaching different population groups

Our assessment and other studies show that different population groups have different ways of accessing services as well as different preferences and concerns about receiving mental health care. Given that most people (about 75%) with mental health problems do not access care in Ukraine, there is a strong need to increase help-seeking behaviors. Those less likely to access mental health services and more difficult to reach include men, veterans, and older persons. At the same time, data from previous research and this current assessment suggest ways to reach those populations. The 2017 MH Concept Note also explains that mental health services must be sensitive to the needs of specific target groups (e.g., children and youth, mothers, veterans, IDPs, persons with disabilities and chronic physical health conditions, older persons). It is also important to note that some mental health programs are focused exclusively on specific populations (e.g., veterans, IDPs), providing free and accessible services to those groups but not to other vulnerable persons in the population (e.g., persons affected by economic hardship) or to people with mental illness in general. Providing mental health services to specific populations such as IDPs only, can increase tensions with host communities. Global guidelines recommend that mental health **services should be accessible to all.**

Recommendations

- Ensure considerations to **reach different target groups** with mental health services through different entry points and outreach including veterans (e.g., peer-to-peer support workers supervised by psychologists as a first intervention, engagement in social and structured activities, involvement of families), persons in rural areas and older persons (e.g., engaging community members such as clergy who often come into contact with older persons, engaging families), hard to reach family members who are reluctant to access treatment (e.g., through family engagement and family therapy), and young people (e.g., through the Internet, social media). Making efforts to reach different target groups is an important part of providing mental health services through government or CBO providers.
- Do **not provide mental health services free of charge to specific groups only** (e.g., IDPs, veterans) but ensure all segments of the population can afford and access services. This recommendation is especially relevant for donors, INGOs, and CBOs.

3. Education and Training of Human Resources

Education and training of human resources is one of the key mechanisms to make evidence-based interventions for CMDs and AUD widely available and accessible. There are currently not enough mental health professionals trained in such interventions in Ukraine to meet the needs of the population. It has also been noted (in the 2017 Ukraine MH Concept Note) that educational standards in mental health need to be brought in line with relevant international standards, and that professional competencies need to be built and regulated.

There is a significant need to **develop and implement protocols** and monitor quality of services. This includes accessible and evidence-based guidelines and protocols for specialists and nonspecialists, covering pharmacological interventions, psychotherapeutic methods, and other psychosocial interventions. Although some protocols already exist and providers are now allowed to use international protocols as well, there is still a need for training and **capacity building in using these protocols.**

It is also important to note that capacity building should involve **all levels of different formal and informal service providers,** including specialized staff (e.g., psychologists, psychotherapists), general health care providers (e.g., doctors nurses), social service providers (e.g., social workers) and community level workers and supports (e.g., clergy). Each of them has an important role to play in supporting persons with mental illness and working as part of a well functioning and connected pyramid of mental health services.

3.1 Offer educational programs that provide needed qualifications in evidence-based psychological interventions and psychotherapy

There are currently no public academic programs available for training professionals (e.g., psychologists, psychiatrists, social workers) in evidence-based interventions to treat CMDs and AUD (e.g., CBT). Professionals wishing to obtain such qualifications generally have to **pay to attend private universities** and training courses, which are also **not always evidence based.** As a result, the quality of services provided by professionals such as psychologists and psychotherapists for mental health problems **varies widely,** with some approaches being not effective or even harmful. This also further undermines the trust of the general public in mental health services and discourages people from seeking treatment. Professionals with evidence-based skills are likely to be in private practice or private rehabilitation centers (for AUD) rather than public health and social services, which makes such **interventions inaccessible** to large parts of the population. Furthermore, key informant service providers have **emphasized the need for appropriate** training, often not knowing which training approach to choose and not being able to financially afford existing training opportunities. Some training opportunities supported by international organizations in most recent years have often been **short term** (e.g., a few days) and do **not offer the needed continued follow-up** and on the job supervision to practice skills. Other programs with international support have already started developing and adapting **evidence-based manuals and materials that can be used** (e.g., WHO PM+, SH+). A considerable number of psychologists and psychotherapists in Ukraine practice in various settings (e.g., government, private, NGO, volunteers), but they often have a limited scope of work (e.g., assessment and referral only) and limited skills and are therefore **underutilized.**

Recommendations

- Provide **in-service training** and continued follow-up and on the job supervision on evidence-based approaches for CMDs and AUD (e.g., CBT, CBT-TF, motivational interviewing and peer support for AUD) to currently practicing professionals such as psychologists, psychotherapists, and social workers. This training can be offered or expanded as part of existing and new initiatives of capacity building supported by international actors and agencies.
- Ensure that **capacity building programs offered by INGOs** are evidence based and provide longer-term follow-up and **on the job supervision.** This can be promoted by engaging INGOs in coordination structures (see Section 1 of the recommendations).
- Integrate **evidence-based interventions into curricula at public universities** including undergraduate and post-graduate levels. This could be supported by academic partnerships and professional exchange with universities in other countries.
- **Engage in partnerships with professionals** and exchange programs with universities from other countries to build qualifications of Ukrainian professionals and build on experiences of organizations with a history of assisting countries in the region, such as GIP. One major university (JHU) is already discussing the integration of one evidence-based approach for CMDs with the National University of Kyiv-Mohyla Academy.
- **Update current curricula and training materials** in line with global guidelines and best practices in mental health. This also includes continued translation of relevant text building on efforts of the Ukrainian Psychiatric Association supported by GIP. Such guidelines and materials can be used and integrated by the leadership and professors at academic institutions.
- Make use of **evidence-based manuals** and materials covering interventions for CMDs and AUD which have **already been developed, adapted, and translated** with international support, and which can be used and scaled up among psychologists and other professionals (e.g., WHO PM+, WHO SH+, JHU CETA). This is especially relevant for international organizations and teams who want to build the capacity of Ukrainian professionals.

3.2 Provide official licensing, certification, and oversight for practicing psychologists and psychotherapists

Currently there is no licensing or oversight of practicing psychologists and psychotherapists. As a result, consumers are unsure which professionals to choose, and some professionals practice without needed qualifications and training, which can be **ineffective or even harmful** for persons with mental illness. Furthermore, there is no accountability or complaints mechanism, which contributes to the lack of trust and confidence among the public. The need for licensing of professionals was also expressed by several key stakeholders, as well as in the 2017 MH Concept Note.

Recommendations

- Regulate professional practice of psychologists and psychotherapists by **requiring certification and licensing** supported by professional associations and in line with **European standards.** Leadership for this would be needed by MoH to ensure that laws and regulations are in place, while professional associations need to be supported and strengthened to provide needed certification and oversight and promote accountability.
- Support oversight and **accountability through professional ethics boards** and complaints mechanisms for mental health service users. Professional associations need to be supported to establish such mechanisms with the active participation and engagement of mental health service users.

3.3 Build the capacity for identification, management, and referral of persons with CMDs and AUD among primary health care providers

Globally, the integration of mental health into primary health care has been recognized and recommended as one of the key ways to make mental health services available and accessible to large parts of the population. In Ukraine, the integration of mental health inducing identification, basic management, and referral of CMDs and AUD has been recommended by professionals and by officials on the policy level (including the 2017 MH Concept Note), and requires capacity building of general health professionals.[128] Clinical protocols to address common mental health problems, such as PTSD and depression at the PHC level already exist, but our assessment showed that providers often do not feel that they have the needed skills and knowledge to apply them. Promising pilot initiatives supported by international actors have already started to include PHC providers in capacity building for mental health, and to link them with teams of more specialized mental health providers for continued supervision, oversight, and referral. In addition, mandated continued education requirements already exist which can also be used for capacity building in mental health.

Recommendations

- Continue **developing and updating clinical protocols** to provide interventions for persons presenting with CMDS, AUD (and other priority mental health conditions) at the PHC level, in line with international guidelines such as the **WHO mhGAP-Intervention Guidelines.[173] Curricula and protocols** should cover **identification** (e.g., questions to ask), **basic management** (e.g., psycho-education, basic psycho-social interventions, and for doctors-rational prescription of generic antidepressant medication and avoiding expensive medications or herbal supplements as a first-line treatment) and **referral** as well as **follow-up** (including communication with more specialized providers). Key professionals at the MoH already engaged in mental health protocol development can play a leadership role with support from international actors.

- Provide **in-service training and continued on-the-job supervision and mentorship** to PHC providers (including family doctors/GPs, nurses, felshers) according to their specific roles. Ensure to **involve specialized mental health professionals** (e.g., psychiatrists, narcologist) in the provision of training and supervision as well as in the planning for continued referral and consultation. Efforts in capacity building by international agencies in this regard can be continued and expanded while longer term scale-up needs to be planned by MoH.
- Ensure that protocols and practical aspects of training are included in the **academic training curricula** for health care providers. Universities who are training doctors, nurses, and other health care professionals play a key role and can be supported by international actors.
- Include mental health training and refresher training in **mandated continued education requirements** for health professionals and in other training opportunities (e.g., seminars, conferences) at the national ad oblast level.

3.4 Build capacity for basic psychosocial support and linking with services among various nonspecialized informal and community providers

Mental health service users in this assessment reported reaching out to many different mental health professionals as well as nonprofessionals and community members. They can serve as an important first entry point, provide basic psychosocial support, and link people to services. Furthermore, persons with CMDs and AUD often do not seek mental health services at all, but may approach other providers with different needs (e.g., social services). Persons with mental health problems also reported that community inclusion and support have played a significant role in their recovery. In short and in line with global guidelines, supporting people with mental health problems can not only be the task of mental health professionals but needs to be taken up by different sectors (e.g., health, social, education), service providers and community members (e.g., clergy, NGOs). Our assessment showed that community level providers such as clergy are already often providing basic mental health support, while civil society and community groups and volunteers are engaged in providing psychosocial support and at times referral. They can also play an important role in promoting positive attitudes toward people with mental illness in their communities and can ensure to include those affected and their families in community activities and events.

Recommendations

- Provide **workshops** about mental health, **basic psychosocial support** and referral to nonspecialized and community workers. Several local and international NGOs already have developed, adapted, and translated psychosocial materials that can be used (e.g., WHO Psychological First Aid Guidelines). This can be taken on by civil

society organizations with relevant expertise or international support, as well as through regional initiatives by mental health service providers.

- **Strengthen connections and referral links** between nonspecialized and community providers and mental health professionals (e.g., through referral workshops described in Section 1 of the recommendations)

3.5 Consider strengthening the role of social workers within the mental health system

Although this assessment did not specifically focus on the social service system, we learned that social workers are widely available for Ukrainians living outside of major metropolitan areas, particularly in smaller cities. Social workers are also often working in health facilities with NGOs, and they conduct outreach. Given the high co-occurrence of mental health and social problems (e.g., financial hardship) it is also likely that they encounter individuals and families affected by CMDs and AUD. Building capacity of social workers in identifying persons who need help, providing basic evidence-based psychosocial support, and linking to other professionals as needed, would be another sustainable way to improve accessibility of care. Kyiv-Mohyla National University, for example, is developing an additional training module for social workers which helps them support persons experiencing psychological distress.

Recommendations

- Provide classroom-based and practical **training for social workers** as part of their university curriculum, as well as in-service training (for those already working) in the identification of persons with mental health problems, basic psychosocial support, and referral. Academic and INGO partnerships can help support and establish such training.
- Include social workers in **multidisciplinary teams** as part of a comprehensive service model.

4. Mental Health Knowledge, Awareness, and Self-Help

4.1 Raise awareness and provide information to the general public about mental health promotion, mental illness, and on how to choose qualified providers of mental health services

Different studies and this assessment suggest that most people rely on family and friends or search for information (e.g., online) when looking for a mental health care provider. Those affected by CMD and AUD often delay seeking help due to lack of information and spend considerable amounts of **time and money on treatment that may be ineffective,**

unnecessary, or even harmful (e.g., self-medication, expensive psychotropic medication, folk healers, unqualified providers). At the same time, most people affected **may not seek help at all** due to lack of trust in the system, and stigma.

Our assessment also showed that there is a lack of awareness and knowledge about mental disorders with many community members **stigmatizing and blaming** those affected. Some key informants recovering from CMDs and AUD also described that they felt **unsupported by family and friends** who did not know how to respond or excluded them from social activities. On the other hand, family members can play an instrumental role in encouraging people with mental illness to seek help. **Social support is also an important factor in helping people recover** from mental illness, as supported by the literature and several key informants in our assessment.

The 2017 Mental Health Concept Note also described the need to increase awareness about mental health and overcoming stigma through the media, community discussions, educational resources and programs, and also involving persons with mental disorders and their families, as well as professional associations.[104]

Recommendations

- Develop a **directory of certified mental health service providers** including government and community-based organizations, as well as rehabilitation centers (for alcohol and drug use) that offer evidence-based psychological treatment approaches for CMDs and AUD (e.g., CBT), which is accessible to the general public (e.g., Internet, information booklets at health and social services) at the oblast level. Similar directories for other types of professionals such as lawyers already exist, and such a registry of providers and facilities is also mentioned in the 2017 National Mental Health Concept Note. This directory could be developed building on the mapping and coordination efforts mentioned in Section 1 of the recommendations.
- Provide information to the public (e.g., public nationwide awareness campaigns, information leaflets, Internet, media, community discussions) explaining the **types of mental health professionals** (e.g., psychiatrists, psychologists, psychotherapists) and **services,** correcting **common misconceptions** (e.g., about inpatient treatment, confidentiality) outlining different types of mental health problems, describing positive **coping methods** (e.g., relaxation, social activities, physical exercise), warning against negative ways of coping (e.g., smoking, alcohol and drug use), and providing guidance on **how to choose an appropriate provider** and **what to avoid** (e.g., self-medication). Various actors can be engaged in implementing different activities including government, civil society, NGOs, media (e.g., radio, TV, newspaper representatives) and service users. Those with experiences in using mental health services should be actively engaged and can help with appropriate messaging.
- **Provide information to the community, family, and friends of those affected by mental disorders on how they can be supportive.** This includes developing and providing **information leaflets** for friends and family members of those affected on

how they can help (many examples exist from higher income countries) at several access points (e.g., general health facilities such as polyclinics, social and community services).

- Involve communities, family, and friends in **discussion events and information sessions** on mental health promotion and how to be supportive to persons experiencing mental health problems.
- **Engage people recovering from mental illness** and their families in **sharing their experiences** (positive and negative) with others, including how they were able to find help and what helped them in their recovery (e.g., community discussions, radio or video clips). Create programming that engages persons recovering from CMDs and AUD and highlights key positive messages (e.g., anyone can develop MH problems and this is not a character flaw, where to find more information, how to cope or help others cope, treatment can be effective and recovery is possible). Engage young people and activists who are motivated to get involved.
- **Train service providers as well as service users in media communication,** how to speak to the media, and how to communicate stories and messages (e.g., via social media, websites).
- Work with **media representatives** on how to **responsibly and accurately report** about persons with mental health problems (e.g., respecting confidentiality, not portraying them as violent and flawed) and about suicide.
- Establish a **national hotline** to provide basic support and information about available services for persons experiencing CMDs, suicidal ideas, and AUD. Those staffing the hotline need training and supervision in basic psychosocial support and crisis management, as well as risk assessment, management and support of persons with suicidal ideas, and linking callers with appropriate services.

4.2 Support and create consumer-led mental health advocacy groups and engage persons recovering from mental illness and family members in higher level discussions and decision making

Our assessment found that existing advocacy organizations mainly focus on more severe mental disorders, intellectual disability, and patient rights while there is less of a focus on advocacy for the needs of persons with CMDs and AUD. There is also **little positive visibility of persons recovering from CMDs and AUD** in the general public. Some local efforts by individuals have started (e.g., in Zaporizhia) but need wider level engagement and support. Persons recovering from CMDs and AUD have also been absent from national level discussions and conferences about mental health, although they would offer a valuable perspective as they are 'experts by experience'. Furthermore, visibly engaging people with mental disorders sends a strong signal that they are a **valued part of the community** and persons with important skills and abilities. Research on stigma and mental health has shown that it is often not enough to simply provide information to the population but

that having "positive contact" with persons recovering from mental illness is key in changing attitudes. This means that visibly engaging people with mental illness and their family members in discussions, sharing their experiences, using their abilities, and taking on leadership roles does not only provide important input for decision making about mental health services but is also instrumental in fighting stigma.

Recommendations

- Support or create **consumer-led mental health advocacy groups** at national and oblast levels. Make use of the experiences of existing consumer-led organizations and identify and support persons recovering from mental health problems who are willing, able, and motivated to take on leadership roles.
- Promote **networks** and information sharing among existing groups and newly created groups and initiatives.
- **Engage persons** recovering from CMDs and AUD in sharing their experiences and highlighting positive contributions to their communities (e.g., as part of communication campaigns and events mentioned in Subsection 4.2). This also includes engaging **public and respected figures** who have recovered from mental health problems in sharing their experiences.

4.3 Consider making information and self-help interventions for CMDs and AUD available online (e-mental health)

It has been estimated that most people (up to 75%) suffering from CMDs and AUD in Ukraine **do not seek help** for reasons such as lacking information, stigma attached to mental illness and the mental health field, and not having trust in providers. However, the vast majority of key informants reported seeking information online and finding self-help websites and books helpful. Many also stated that they **would prefer to seek help for mental health problems anonymously** (even if this meant travel to another oblast or additional payment to see a private provider). As of 2013, it is estimated that 41.8% of the population in Ukraine has **access to the Internet,** and use of Internet and social media is most common among young persons.[174] Although this is relatively low for countries in the region and much less than EU countries (75.5% in 2013), this still represents a large part of the population that can be reached, especially younger persons. Research from higher income countries has shown that e-mental health interventions offered online can be effective for treating depression and anxiety disorders.[175] WHO is currently testing such an intervention in a lower middle-income country (Lebanon). WHO is also developing a printed Self-Help Plus manual (for CMDs) which is currently being piloted in different countries including Ukraine (by IMC). Furthermore, WHO has tested an alcohol and health web-based self-help intervention tool in four pilot countries (Belarus, Brazil, India, and Mexico).[176] Although those interventions require resources to develop, especially at the beginning, the public health impact can be considerate given the wide reach and the cost-effective model of self-help.

Recommendations

- **Develop and pilot e-mental health** interventions for priority mental health conditions (e.g., depression and AUD which have an especially high public health and economic impact in Ukraine). International partner organizations and donors may be able to provide technical and financial support for such projects.
- **Link** general (e.g., family doctors, GPs) and specialized providers with available e-mental health interventions, so they can offer them to patients and continue to follow up (some research suggests follow-up by a provider makes these interventions more effective).
- Consider **developing self-help materials** using different platforms (e.g., as booklets or recordings using WHO Self-Help+ manual). Such materials could also be integrated with current or planned programs offering mental health support by civil society and international actors. In the longer term, these materials could also be integrated with the provision of government health services (e.g., by psychologists, general health care providers).

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