Decentralisation and community stakeholders' engagement for better mental health services development in the conflict-affected regions of Ukraine

Vitalii Klymchuk, Krystyna Vysotska and Viktoriia V. Gorbunova

Abstract

Purpose – *The purpose of this paper is to explore how conflict-affected communities in Ukraine (the Lugansk region) can develop sustainable mental health services in decentralised settings. The main interest focuses on community stakeholders' perception of their problems and solutions that communities can create to achieve better mental health coverage.*

Design/methodology/approach – *A series of roundtables (RTs) (4 RTs, 62 participants overall), accompanied by interactive brainstorming techniques, were conducted with communities' representatives/stakeholders from the East of Ukraine (Lugansk region, a government-controlled area) during the year 2021. Participants (health, mental health, social care workers and administration representatives) were provided with the opportunity to discuss mental health services' development challenges and create affordable solutions for their communities. Results of discussions were submitted to qualitative analysis and offered for review by participants.*

Findings – *Decentralisation in Ukraine led to allocating funds alongside responsibilities for developing the services to communities. Most of the communities appear not to be ready to acknowledge the role of mental health services, entirely relying on the existing weak psychiatric hospital-based system. Awareness-raising interactive capacity-building activities for the community leaders and decision-makers effectively promote community-based mental health services development. Five clusters of challenges were identified: leadership, coordination and collaboration problems; infrastructure, physical accessibility and financial problems; mental health and primary health-care workforce shortage and lack of competencies; low awareness of mental health and available services and high stigma; war, crises and pandemic-related problems. Communities stakeholders foresaw seven domains of action: increasing the role of communities and service users in the initiatives of governmental bodies; establishing in the communities local coordination/working groups dedicated to mental health service development; developing the community-based spaces (hubs) for integrated services provision; embedding the mental health services in the existing services (social, administrative and health care); mental health advocacy and lobbying led by local leaders and service users; increasing capacity of communities in financial management, fundraising; developing services by combining efforts and budgets of neighbouring communities.*

Research limitations/implications – *The study has potential limitations. Participants of the roundtables were mostly appointed by local authorities, so some of them didn't have a motivation for mental health services development. Service users were involved only from the facilitators' side, not from the side of communities; therefore, it was impossible to include their view of problems and solutions. Obtained data were limited to the opinion of local professionals, administration workers and other local stakeholders. The human rights aspect was not clearly articulated in the tasks of the roundtables.*

Originality/value – *To the best of the authors' knowledge, the paper is original in terms of its topic (connecting decentralisation and local stakeholders' engagement for understanding the challenges of mental health services development) and research strategy (engagement of Ukrainian communities, qualitative analysis of the discussion results and applying the best practices and international recommendations to the local context).*

Keywords *Mental health, Mental health services, Community engagement, Conflict zone*

Paper type *Case study*

Vitalii Klymchuk is based at the Mental Health for Ukraine Project, Zhytomyr, Ukraine. Krystyna Vysotska is based at the Mental Health for Ukraine Project, Lviv, Ukraine. Viktoriia V. Gorbunova is based at the Zhytomyr Ivan Franko State University, Zhytomyr, Ukraine.

Received 3 June 2022
Revised 23 June 2022
25 July 2022
8 August 2022
18 August 2022
Accepted 10 September 2022

The paper is written with the support of the "Mental health for Ukraine Project" (MH4U), implemented in Ukraine by GFA Consulting Group GmbH and funded by Switzerland through the Swiss Agency for Development and Cooperation. The project aims to improve mental health outcomes among the Ukrainian population. MH4U provided funds for RTs organisation, transportation and accommodation of participants. The sponsor was not involved in the study design, collection, analysis and interpretation of the data or preparation of the article.

Conflicts of Interest: All authors declare no conflict of interest.

Introduction

Communities are the main actors in the development of community-based mental health services. Just recently, communities in Ukraine received the possibility to become not just recipients of governmental directives but to be fully responsible for their health and social services via decentralisation reform. In the frame of this reform, the term "amalgamated territorial community" was officially installed ("community" is used further as a substitute for this term). Key points of reformation are: neighbouring villages and cities voluntarily can join in one "community"; that amalgamated community receives most of the finances directly from the taxes, paid in its territory and manage them on its own; the community on its own makes decisions about health, social and other services that need to be developed (Oleinikova, 2020). In these circumstances, there is a high risk that needs for mental health services will be less visible and be situated in the last place in the hierarchy of communities' needs. That is especially important in conflict-affected regions. They are more deprived in financial and infrastructural terms and less equipped with modern attitudes towards human rights protection and mental health awareness (Quirke *et al.*, 2022). At the same time, they have more needs for community-based services precisely because of this situation and have resources not available elsewhere – international and national humanitarian non-governmental organisation (NGOs) active in the region.

General Ukrainian context: war, health care reform, mental health concept and action plan 2020–2023

Since 2014 Ukraine has entered the phase of both armed conflict and health care transformation. Armed conflict, provoked by the aggression of the Russian Federation, resulted in a humanitarian crisis with 3.4 million people in need of direct humanitarian assistance (68% – children and women, 38% – elderly), 1.5 million internally displaced persons (50% pensioners, 13% children, 4% people with disabilities), 400,000 veterans; 420 km of "conflict line" (UNHCR, 2022; CARE International, 2021) *(data provided regarding the situation before the escalation at 24 February 2022)*. The conflict was localised mainly in the Donetsk and Luhansk regions (not mentioning the Crimea annexation) before 24.02.2022.

Nevertheless, in the government-controlled territories (GCT) of Ukraine, several reforms were in active process.

Health care transformation, as a response to the needs of the time, led to a change from the old-time Soviet approach to the modern one, with a patient-centred approach, single health-care services purchaser establishment (National Health Service of Ukraine) and further development of family medicine as a primary level of health care [World Health Organisation (WHO), 2019].

One of the results of such transformation was the development and approval by the Ukrainian government of the first-ever general framework for mental health care development – Mental Health Care Development Concept Note 2030 (CMU, 2017). The goal was to provide a condensed overview of the problems, outline the general direction of reform and identify the most critical issues. The Concept Note is the first mental health policy document in Ukrainian history that was officially approved and contains a clear understanding of mental health (according to the WHO definition) as well as fundamental principles of mental health support and guidance towards the transformation of the highly institutionalised system into a community-based model of service delivery with a strong focus on promotion, prevention and human rights.

Consequently, the Mental Health Action Plan 2021–2023 was developed to create the basis for implementing all declared goals in the Concept Note. The next step is to create and harmonise the regional Action Plans with the national. This is the most crucial step, as implicitly, it must combine the interests of communities in each region with respect to best

practices (in mental health promotion, prevention, treatment and rehabilitation), a community-based approach (moving away from the hospital-based psychiatric treatment towards community-based mental health care) and human rights promotion (awareness-raising in human rights among service providers and service users and installing the instruments for human rights protection).

Decentralisation reform and communities' development in the Lugansk region (GCT)

Decentralisation reform [1] means the transfer of powers and finances from state authorities to communities. During this reform, the Ukrainian state executive branch passes on the influence on the local authorities and promotes citizens' participation in decision-making. As a result, neighbouring villages and small cities joined into so-called "amalgamated territorial communities" (referred to here as "communities") that became the complete owners of their finances and services. This reform also creates a solid foundation for accelerating health care reforms and reforms in the social and education areas (Oleinikova, 2020).

Implementation of decentralisation in Luhansk Oblast [government-controlled area (GCA)] also has difficult political and economic conditions. It makes it challenging to process reforms, including setting up mental health services in communities.

As of 2022, the area of the region is 26,684 km^2. The population is 661,028 people. After the occupation of part of the region and the decentralisation process in the Luhansk region, there are four districts, including 26 combined territorial communities (including 544 settlements). The largest population is concentrated in Severodonetsk, Lysychansk and Rubizhne, in the Popasnyansky districts (LOA, 2019).

Until 2014, the Luhansk region was one of the five most powerful industrial and economic regions of Ukraine. As a result of the war, the number of factors that hinder the balanced development of the region has increased, especially in the areas of industrial production, transportation and energy supply. These factors are a recipe for specific social problems.

The level of employment in the region showed a negative trend. In terms of jobs, the Luhansk region ranked last in the ranking of regions of Ukraine (job places per population). Analysis of the balance of labour resources of the Luhansk region showed that most of the economically active population was not registered anywhere and did not receive any income officially. These were illegally employed people and migrant workers (LOA, 2019).

Humanitarian and mental health needs in the Lugansk region (GCA)

The humanitarian needs overview for Ukraine shows that there were 295,000 people in need of humanitarian assistance in the Lugansk region among residents (before 24.02.2022). The most disruptive cumulative impact of war and COVID-19 was on people with disabilities (41,000 residents of the region). Such needs are exacerbated by death and physical injury from shelling, landmine and explosive remnants of war; contamination, COVID-19 as the highest priority health threat, unsafe learning environment and damages to education infrastructure, inadequate water, sanitation, hygiene conditions and food insecurity (WHO, 2021a; OCHA, 2022).

Access to services, such as health, social, education and others, is also hindered. According to data, 66% of households in the Donetsk and Luhansk regions (GCA) reported barriers to accessing general health-care services (OCHA, 2022).

Humanitarian organisations cover some mental health needs. The map of such services is available, launched by the Mental Health and Psychosocial Support Technical Working Group [2]. Those services primarily operate alongside the "line of contact", and the rest of the region is not covered. Twenty-six out of the 250 health care facilities were damaged, destroyed or located in the non-GCT, 30%–70% of health workers have fled conflict-affected areas or been killed (Lekhan *et al.*, 2015). Therefore, the need to develop mental health services in the region is in place.

Decentralisation reform allowed communities to develop their health and social services. The mental health transformation framework provides a legislative ground for mental health services development. Nevertheless, it is not enough – community-led needs assessment and planning for mental health services development are needed. For such purposes, capacity-building and community-engagement activities must be provided for those communities who never even thought about such a topic and do not consider it a priority (namely, for all communities).

Methods

Four roundtables (RT) of two-day duration were conducted with the participation of the local health, mental health, social care workers and administration representatives (September–November 2021) in the Lugansk region (Severodonetsk city).

RTs' methodology aimed to achieve five overarching tasks. Each task was designed to deal with the most significant issues in stakeholders' perception of mental health (Eaton *et al.*, 2011; Hook and Bogdanov, 2021).

Task 1. Dealing with stigma and negative attitudes towards mental health. The objectives of this task were to decrease the level of stigma among participants and to allow them to approach mental health topics without prejudice. Stigma and negative attitudes create a barrier to the development of mental health services (Eaton *et al.*, 2011; Quirke *et al.*, 2021). Several activities were used as the most effective method (Thornicroft *et al.*, 2016): meeting and communicating with a person with lived experience of mental health disorder, watching the record of the interview with another person, working in subgroups for the person's needs analysis and the possibility to fulfil these needs in their communities.

Task 2. Capacity-building in terms of modern knowledge of mental health services development, using the WHO optimal mix of services and instruments for such services development, available in the Ukrainian language [3] (WHO, 2021b). The objective of this task was to increase stakeholders' knowledge of best world practices. Short and interactive presentations were used for this task.

Task 3. Motivation and engagement of community staff to work on mental health services development. The objective of this task was to increase the level of motivation to develop mental health services in the communities. For this task, the activities implemented by other communities were introduced to the participants.

Task 4. Analysis of challenges and problems in communities that block the development of community-based mental health services. The objectives of this task were to help participants to see the service gaps and barriers in their communities and help them to approach them in a problem-solving way in the next stage. It was accomplished using facilitation techniques (Brainstorming, World Café and Complexity Management techniques) (Bens, 2012; Dean *et al.*, 2000; Lindemann *et al.*, 2008).

Task 5. Solutions creation and motivation for their implementation. The objective of this task was to help participants to create working solutions that are feasible to implement in their communities. Based on the identified problems and challenges, participants were facilitated to develop solutions and make action plans to implement them. The same strategies mentioned in Task 4 were used.

Correspondence between tasks and RTs' elements is presented in Table 1.

Each RT was attended by 2–4 representatives of 4–5 different communities (23 communities in total, GCA [4]). Three communities of GCA and 11 communities of non-GCA were inaccessible. The detailed distribution of attendees is presented in Table 2.

RTs were convened by the authors of this article. Invitations to the RTs were sent to communities by the Health care and Social care Departments of Lugansk Oblast Administration. A further selection of participants was made by communities' relevant departments.

The distribution of participants by occupation is outlined in Table 3. Social services representatives (24) include community social workers and administrative staff of social services. Health-care workers include the clinical management of local health-care facilities and doctors (15). Mental health care – is composed of local psychologists and psychiatrists (10). Community administrations are city or village administration workers, such as deputy heads of communities and secretaries (13).

Data from the two RTs' elements, "Barriers on the way to the development of accessible mental health services" and "Ways to deal with barriers, challenges and problems" of all four RTs were recorded and accumulated, then subjected to qualitative thematic analysis to extract the most common and relevant to all communities' issues (Kiger and Varpio, 2020). Results of the study were submitted for review and feedback to all participants of the RTs; gathered feedback was incorporated into the final results.

Results

Following the analysis, all the materials were divided into two parts, according to the logic of RTs. The first part, "Barriers on the way to the development of accessible mental health services", includes challenges, barriers and problems faced by conflict-affected communities in the East of Ukraine. The second part, "Ways to deal with barriers,

Table 1 Corresponds between RT's tasks and elements

	Roundtables' overarching tasks				
Roundtable's elements	*Dealing with stigma and negative attitudes towards mental health*	*Capacity-building*	*Motivation and engagement*	*Analysis of challenges and problems*	*Solutions creation and motivation to their implementation*
Motivation speeches from the region's administration	+		+		
Getting familiar with "Mental health for Ukraine Project"		+	+		
Getting familiar with each other, expectations gathering			+		
Mental Trek – Interactive mental health awareness rising game	+	+	+		
Presentation "Modern approaches to community-based mental health services provision"		+	+		+
Interactive session "Mental health needs assessment in communities" (case-based)	+		+	+	+
Interactive session "Experience of the person with mental health disorder" (live meeting)	+				
Presentation "Best local practices on mental health services development"		+	+		+
Presentation "Instruments for mental health services development, available in Ukrainian"		+	+		+
Interactive session "Barriers on the way to the development of accessible mental health services"		+		+	
Interactive session "Looking back: causes and reasons for barriers"		+	+	+	
Interactive session "Ways to deal with barriers, challenges and problems"		+	+		+
Interactive session "Developing the local Mental health action plan"		+	+		+

Table 2 Distribution of attendees by communities (GCAs)

	Community	*No. of participants*
1	Regional level representees	6
2	Bilovodsk	2
3	Bilokurakynska	2
4	Bilolutska	3
5	Hirska	2
6	Kolomiychiska	3
7	Kreminska	3
8	Lisichansk	3
9	Milovska	2
10	Nizhneteplos'ka	1
11	Novoaidarskaya	4
12	Novopskovskaya	3
13	Popasna	3
14	Rubizhnskaya	3
15	Svativska	1
16	Severodonetsk	4
17	Stanytsia Luhanska	3
18	Starobilsk	3
19	Troitska	3
20	Chmyrivska	1
21	Shyrokivska	1
22	Shulginskaya	3
23	Schastynska	3
	Total	*62*

Table 3 Distribution of participants by occupation

Occupation	*N*
Mental health care	10
Health care	15
Social services	24
Community administration	13

challenges and problems", includes the list of probable solutions foreseen and affordable by communities.

Barriers on the way to the development of accessible mental health services in conflict-affected Ukrainian communities

Five thematic clusters of challenges were identified: leadership, coordination and collaboration problems; infrastructure, physical accessibility and financial difficulties; mental health and primary health-care workforce shortage and lack of competencies; low awareness of mental health, available services and high stigma; war, crises and pandemic-related problems. Identified thematic clusters, sub-clusters and the list of challenges are presented in Table 4.

Under the umbrella of the "Leadership, coordination and collaboration problems" cluster falls three related sub-clusters. The first one is about "Strategic leaderships and coordination". Community members emphasised that community authorities make many decisions on service development, and most of them have low or no interest in mental health services. Another issue raised by participants is about weak political will and leadership attitudes of community authorities. Most of them are still under pressure of

bureaucracy and mundane tasks and demonstrate no thinking "outside of the box". Therefore, communities have no strategy for their mental health services development, coordination bodies are absent, and there was no attempt to undertake communities' mental health needs assessment.

The second sub-cluster is about "Coordinated and collaborative care". Statements were made about the lack of connections between service providers – health-care sectors, social services, education services providers, police, etc., often do not communicate with each other and do not collaborate, formally or informally, around better support for service users. Observations made by the round table facilitators support this vision. Often, participants from one community but different departments were not aware of the duties of each other and how they could provide better support just by coordination of activities. Sometimes an issue is about the absence of officially approved procedures and protocols for such collaboration – worries about breaking the confidentiality, stepping out of the existing work procedures and legislation gaps were expressed. Participants raised concerns about the low communication and cooperation between family doctors and secondary health-care providers.

Table 4 Thematic clusters, sub-clusters and list of challenges

Clusters	*Sub-clusters*	*Problems and challenges*
Leadership, coordination and collaboration	Strategic leadership and coordination	Low interest of community authorities in services development Absence of political will and leadership attitudes Absence of community strategy for mental health services development Absence of coordination body Low capacity in needs assessment and absence of mental health-related data
	Coordinated and collaborative care	Lack of connections between service providers (health, social, etc.) Absence of officially approved algorithms and protocols for such collaboration Low level of communication and collaboration between family doctors and secondary health-care providers
	Service users' involvement	Absence in most of the communities of service users' organisations The reluctance of authorities to communicate with such organisations where they are available
Infrastructure, physical accessibility and financial problems	Infrastructure and physical accessibility of services	Weak public transportation between communities Absence of equipped premises for service delivery Absence of health and social services in general Weak mobile and internet connection
	Financial issues	Low financial capacities of communities Lack of educated managerial cadres Lack of fundraising experience
Workforce shortage and lack of competencies	Mental health workforce	Mental health workforce shortage Lack of competencies in mental health workforce
	Primary health-care workforce	Overloading of family doctors by regular tasks Shortage of Family Doctors Lack of motivation and capacities to deal with mental health conditions
Low awareness in mental health, available services and high stigma	Low mental health awareness	Low awareness of mental health Low awareness in self-help and self-management of mental health conditions Lack of knowledge on basic mental health support to peers
	High stigma	Stigma towards people with mental health conditions Self-stigma and social isolation (patients, parents and caregivers)
	Lack of information about services	No single placement for information about services There is no roadmap for potential service users on access to services, safety in them, etc.
War, crises and pandemic-related problems	Closeness to the conflict line	Shortage of human and other resources Difficult access to services
	COVID-19 impact	Shifting of attention of authorities towards COVID emergencies and away from "non-important topics." Shifting of resources towards COVID response

The third sub-cluster is about "Service users' involvement". Among 23 communities, just two (Severodonetsk and Lysychansk) have such organisations. There are communities of parents of children with developmental disorders and delays. The remaining 21 communities do not have any mental health service users' organisations; therefore, the voice of service users is not heard by local authorities. Another issue is the reluctance of authorities to communicate with such organisations where they are available or with separate service users. That is, as it appeared, is a two-way road. One way is mental health stigma and the necessity to deal with it at the community level. The opposite way – the need for capacity-building activities for establishing such organisations development of their advocacy and lobbying capacities.

The cluster "Infrastructure, physical accessibility and financial problems" contains two sub-clusters. The first one is "Infrastructure and physical accessibility of services". Participants revealed very weak public transportation between communities, so travel to the nearest psychiatric hospital or other specialised health-care services may take one day and more. There is an absence of equipped premises for service delivery in the communities (in some, there is no place for community administration placement, no heaters, leaking roofs, etc.). After decentralisation, the delivery of social services becomes the communities' responsibility. Therefore, there are communities with no social services available. Some communities have no health-care services or even nurses or community health-care workers. An additional burden is created by a weak mobile network and internet connection – it does not allow for online consultancy of other teleservices.

The second sub-cluster is about "Financial issues" and related to the general low financial capacities of communities – both in terms of the level of communities' income and ability to manage finances effectively and respond to the needs strategically. These are connected to the lack of educated managerial cadres and lack of fundraising experience in communities.

Next cluster: the problems related to the "Workforce shortage and lack of competencies"; two sub-clusters of the most common issues were associated with the mental health and primary health-care workforces. As for the *mental health workforce*, communities lack quantity – many communities do not have any psychologists or psychiatrists. Those who have them – have complained about their competencies, both in mental health disorder diagnosis and treatment. Child and adolescents' mental health professionals are scarce all over communities.

Primary health-care doctors are more available; almost every community has a primary health-care centre or ambulatory (a division of the larger primary health-care centre). But some communities still exist without it; they have just community health-care workers (so-called "feldshers"). But in general, their quantity is not enough to respond to the needs. Moreover, they are overloaded with regular tasks and, therefore, reluctant to take care of mental health. Lack of motivation and capacity to deal with mental health conditions were often mentioned commonly by participants.

"Low awareness of mental health, available services, and high stigma" is the fourth cluster of problems faced by communities. Firstly, community members mentioned general *low mental health awareness*. People usually know nothing about mental health, the different mental health conditions and how to treat and support people with mental health conditions. Visible problems are low awareness of self-help and self-management of mental health conditions.

Connected with the above-mentioned awareness problems is a high level of *mental health stigma*. People with mental health conditions face stigma towards themselves, and usually, the more complicated disorders are, the more challenging the stigma and its consequences, including discrimination and even violence. Thus, the self-stigma that leads to social isolation

creates an additional burden. This situation is expected not just for adults with mental health disorders but also for caregivers of children with developmental disorders.

Participants also mentioned *a lack of information about services*. They told about the absence of a single place for details about services and the absence of the roadmap for potential service users on access to services, types of services provided, safety in them, etc. The latter is primarily related to psychiatric facilities existing in the region and local psychiatrists in outpatient secondary health-care facilities.

The last one, but not the least, is a cluster: "War, crises, and pandemic-related problems". Communities in the Lugansk region are *close to the conflict line*, and some are severely affected. It reflects the shortage of human resources and infrastructure problems. Not many mental health professionals wish to live in such communities; mostly, they are part of the mobile teams and temporary clinics that visit communities but are not part of them. Another issue is difficulties accessing services outside the community (mainly specialised health services).

All other problems coupled with the impact of COVID-19 on the communities were devastating but also detrimental as they shift the attention of the local, regional and national authorities towards the pandemic and away from "non-important topics", like mental health or social protection of people with mental disorders.

The classification of the above problems is derived from the communities' representatives' structured work and their attempts to list the problems and classify them. It represents their view and position from the inside of the communities. Indeed, there are a lot of differences between communities, even inside one region – some of them have more resources, some less, some have hospital and psychiatric departments in them and some have nothing except part-time community health workers. Therefore, the described problems are not equally distributed among communities but reveal the most important problems and the most pressured ones and common for them all.

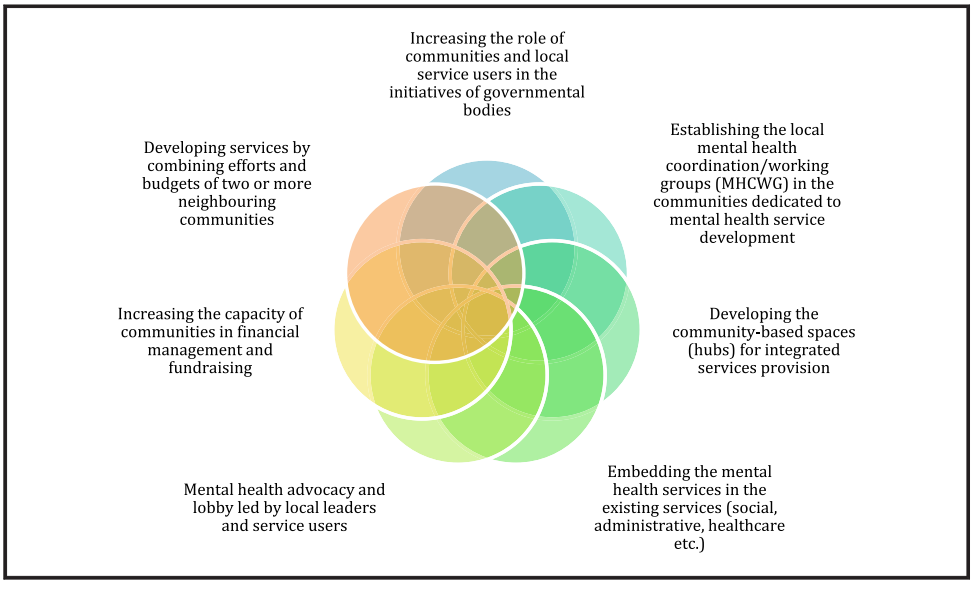
Ways to deal with barriers, challenges and problems

After the problem analysis, the ways to deal with the problems identified were created and explored further by participants. In general, all types of decisions fall into one of seven domains.

Those seven main domains of action were foreseen by communities listed in Figure 1. Among them are increasing the role of communities and service users in the initiatives of governmental bodies; establishing in the communities local coordination/working groups dedicated to mental health service development; developing the community-based spaces (hubs) for integrated services provision; embedding the mental health services in the existing services (social, administrative and health care); mental health advocacy and lobby lead by local leaders and service users; increasing capacity of communities in financial management, fundraising; developing of services by combining efforts and budgets of two or more neighbouring communities.

Increasing the role of communities and local service users in the initiatives of governmental bodies. This was the only type of proposal not related directly to the stakeholders' internal developmental work. Local stakeholders are willing to be helpful to the national authorities (relevant Ministries and National Agencies) and want to be heard in terms of needs and proposals. Joint work on the legislation, orders, etc., will better adhere to the local circumstances, conditions and potential solutions feasible for the communities. Communities' representatives declared readiness to make such input and provide feedback on the documents, orders, etc. Formally such a procedure exists; it is called "consultancy with the public", and each drafted national document before approval undergoes such process. But to be involved, communities must know what to look for,

Figure 1 Domains of actions foreseen by communities' members to overcome mental health challenges



where and when, and because of the diversity of problems, they become easily overwhelmed with it. Therefore, they emphasised the need for organised communication with communities and with service users via separate RTs, workshops, focus groups and other formats dedicated to this aim.

Establishing the local mental health coordination/working groups in the communities dedicated to mental health service development. Those mental health coordination/working groups (MHCWGs) might be established on the initiative of the relevant department (health care, social care or other), local activists or NGOs that advocate for vulnerable populations (children, families in crisis, internally displaced people, veterans, etc.). There is no need for special permissions from higher authorities, as it was earlier, before the decentralisation reform. Nowadays, this is solely in the area of competence of the local community's administration to establish such groups. After establishment, such groups can start with assessing mental health needs in the community and move towards developing the local mental health action plan in line with the National mental health strategy and Action Plan (CMU, 2017, 2021). Such groups can lead awareness-raising activities, initiate services development and training for care providers, strategize mental health service integration, plan the budgeting processes and advocate for finances dedicated to establishing mental health services. Most of the MHCWGs will need additional support, e.g. capacity building activities, coaching and supervision (in terms of instruments for needs assessment, approaches to mental health services development, etc.).

Developing community-based spaces (hubs) for integrated services provision. In the situation of scarce resources, one of the possible actions is not to create many different services in different places but to establish one physical space for various services. Such services may be provided by diverse service providers (depending on the local situation). For example, such a hub might have a place for primary health-care doctors, social workers and visiting psychologists, at some point – to host a mobile team or events provided by a local NGO. If there are children with developmental disorders, it can serve as a place for daycare at least one day per week and evening meetings for parents of such children. Such a local hub can be flexible for service hosting and delivery, timely responding to the needs and make an additional positive impact on community cohesion.

Embedding the mental health services in the existing services (social, administrative, health care, etc.). This was another type of solution, primarily developed by communities where such services and providers exist permanently. The main idea is to equip professionals from the existing services with mental health competencies, support them with supervision and basic regulation and develop referral pathways for the patients who need more intensive support or medication. Some communities have centres for social protection, so social workers there can be trained in mental health assessment and providing structured psychological support. If there are some administrative services in the community, such as "village council" or "village administration", workers can be provided with mental health knowledge. Community health-care workers ("feldshers") might be additionally educated in mhGAP (WHO, 2016) and provide medication and psychological interventions under the support of family doctors or psychiatrists via telemedicine. Available units of primary health-care centres will serve perfectly well if family doctors and nurses are trained in mhGAP. In some schools, there are nurses and psychologists. It creates the perfect ground for embedding child and adolescents' mental health support into education.

Mental health advocacy and lobbying led by local leaders and service users. These activities, if systemically implemented, can have an impact on the mental health awareness of the communities' administrations and lead to decisions in favour of community-based mental health services development. From participants' perspectives, it is unclear who will conduct these advocacy activities and their target audience. Thus, it is important to introduce capacity-building activities in the area of advocacy and lobbying to support local stakeholders, service users, local activists and NGOs.

Increasing the capacity of communities in financial management and fundraising sounded more like a request for support than an action or solution. Communities see possibilities in acquiring funds not just from the state budget, taxes, etc., but from different international and national funds, funding programs, grant schemes and even charities. However, they have little understanding of the mechanisms of such funding and fundraising activities. Another realisation was insightful for the communities – some do not need additional funding. They just need sound financial planning, management and strategy. Therefore, such capacity increase was selected by them as a priority.

Developing services by combining efforts and budgets of two or more neighbouring communities. This domain of actions appeared due to inter-community communication during these two-day events. After getting familiar with the strengths and weaknesses of each other's communities, some groups decided to join efforts and move towards joint services development under mixed budgeting. An example of such a solution might be that one community has premises and social services available, and another provides a mobile psychiatric team that regularly visits the community. Another option is the joint establishment of a mental health hub (mentioned above), equally accessible to members of both communities.

Discussion

This article has explored community stakeholders' perception of their perspectives on mental health services development in the frame of continuing health care, social care and decentralisation reforms in Ukraine. The time of writing the paper was the end of 2021 – the beginning of 2022 and the presented results and discussion do not cover the time after the full-scale invasion started (after 24 February 2022).

Community-based mental health services development is a priority and primary instrument for bridging the gap in mental health, as stated in the Comprehensive Mental Health Action Plan (WHO, 2021c). All the evidence suggests that this approach has the widest perspective (Troup *et al.*, 2021; Jordans and Kohrt, 2020). The Ukrainian National Mental Health Concept Note supports this as a policy direction. It is stated that there will be actions

towards "providing accessibility of mental health support in the communities" via "decentralisation and development of the outpatient services" (CMU, 2017).

In the Ukrainian Mental Health Action Plan 2021–2023, there is just one important statement connected with those actions – "1.1. Development of the regional plans for mental health care development" (CMU, 2021). Decentralisation allowed communities to become "owners" of their development, and therefore, the involvement of the communities in such processes is crucial. Without their inclusion, it will be impossible to build those regional plans. In that case, all those plans become just formal statements without a discernible impact on the life of people with mental health conditions. At the same time, as seen from the analysis of results, communities face numerous challenges and addressing them without appropriate capacity-building activities will be impossible.

An organised set of RTs with a double-aimed methodology – to provide capacity-building activities in community-based mental health service delivery and to involve communities in their own assessment of needs and problems along with solution creation – proved to be an effective way towards local stakeholders' engagement and activation. They demonstrated readiness to fight stigma, collaborate with regional and national authorities and invest in a better quality of life for people with mental health conditions.

A significant unexpected outcome worth mentioning is creating a network of communities or "meta-community" of mental health activists. Communication of participants continued after the RTs, intending to support each other, share best practices and explore experiences of each other.

Based on the explored problems and solutions, some additional recommendations can be made. For the national authorities, it is essential to proactively involve conflict-affected communities in collaboration during legislation development and implementation of the Action Plan 2021–2023. During such involvement, it is important to clearly articulate the need for the participation of community members with lived experience, their carers, family doctors, social workers, administrative staff along with mental health professionals. It is also vital to change legislation to open the possibility of task-shifting in providing mental health care by family doctors, social workers and other lay professionals (Shahmalak *et al.*, 2019; Lange, 2021). Clear recommendations for the communities about better mental health service development methods must be developed and disseminated. It is recommended to include mental health needs assessment methodology (WHO, 2012), the WHO optimal mix of services model (WHO, 2009), guidance on the work of working\coordination groups, coordination of service provision and task-shifting approaches (Hoeft *et al.*, 2018; Ayer and Schultz, 2020).

Limitation of the study

The study has potential limitations. Participants of the RTs were mostly appointed by local authorities, so some of them did not have a motivation for mental health services development. Service users were involved only from the facilitators' side, not from the side of communities; therefore, it was impossible to include their view of problems and solutions. Obtained data were limited to the opinion of local professionals, administration workers and other local stakeholders. The human rights aspect was not clearly articulated in the tasks of the RTs.

Conclusions

Ukrainian communities from conflict-affected regions face many challenges towards the development of community-based mental health services. All of them fall into the five clusters: leadership, coordination and collaboration problems; infrastructure, physical accessibility and financial problems; mental health and primary health-care workforce

shortage and lack of competencies; low awareness of mental health, available services and high stigma; war, crises and pandemic-related problems.

Despite the devastating effect of the crises (war and COVID-19), decentralisation reform allowed communities to develop their service models. Additional capacity-building activities for such communities are essential to direct their energy and resources in the evidence-based direction: towards increasing their role in the initiatives of governmental bodies; establishing better local coordination of services' development; developing creative solutions for services' delivery (community-based hubs for integrated services provision or embedding mental health in the existing structures); mental health advocacy and lobbying; increasing capacity in financial management; combining efforts and budgets of neighbouring communities.

There is a lot to be done by joining communities, regions and national efforts to implement the National mental health vision fully. It is essential not to forget about the potential of communities' stakeholders in this large-scale process, involving them in decision-making, making them a partner and not just executors of the orders produced by national authorities. To achieve this, the need for the dissemination of explored RTs' methodology is foreseen. Establishing local mental health coordination groups with the aim of making mental health needs assessments and developing local mental health action plans might be the next step, followed by capacity-building activities for those coordination groups.

Increasing local capacity to manage mental health services development is especially important for the conflict-affected regions. In the under-resourced regions with exacerbated needs hidden from the central government and high unpredictability of the situation, the decisions of the local administration and local professionals play the main role. Those decisions must be made with a high-level awareness of the role that mental health needs are playing and the value of the mental health of people in communities.

The results of the study were preliminary published in the non-peer reviewer preprint (Klymchuk *et al.*, 2022).

Notes

1. https://decentralization.gov.ua/about
2. https://www.humanitarianresponse.info/en/operations/ukraine/mental-health-and-psychosocial-support
3. www.mh4u.in.uawww.edu.mh4u.in.ua
4. Government-controlled area.

References

Ayer, L. and Schultz, D.J. (2020), *Mental Health Task-Shifting in Community-Based Organizations: Implementation, Impact, and Cost-Evaluation of the Connections to Care Program*, RAND, USA.

Bens, I. (2012), *Advanced Facilitation Strategies: Tools and Techniques to Master Difficult Situations*, John Wiley & Sons, USA.

CARE International (2021), *The Most under-Reported Humanitarian Crises of 2021*, London.

CMU (2017), "Kontseptsiia rozvytku okhorony psykhichnoho zdorovia v ukraini na period do 2030 Roku (2017). Cabinet of ministers of Ukraine (2017, December 27). [Mental health care development concept note in Ukraine for the period of up to 2030]", available at: http://zakon3.rada.gov.ua/laws/show/1018-2017-%D1%80 (assessed 12 December 2021).

CMU (2021), "Action plan 2021-2023 for the implementation of the mental health care development concept note in Ukraine for the period of up to 2030. Cabinet of ministers of Ukraine. (in Ukrainian). ПЛАН заходів на 2021-2023 роки з реалізаці Концепці розвитку охорони психічного здоров'я в Украні на період до 2030 року", available at: https://zakon.rada.gov.ua/laws/show/1215-2021-%D1%80#Text (assessed 13 December 2021).

Dean, D., Orwig, R. and Vogel, D. (2000), "Facilitation methods for collaborative modeling tools", *Group Decision and Negotiation*, Vol. 9 No. 2, pp. 109-128.

Eaton, J., McCay, L., Semrau, M., Chatterjee, S., Baingana, F., Araya, R., Ntulo, C., Thornicroft, G. and Saxena, S. (2011), "Scale up of services for mental health in low-income and middle-income countries", *The Lancet*, Vol. 378 No. 9802, pp. 1592-1603.

Hoeft, T.J., Fortney, J.C., Patel, V. and Unützer, J. (2018), "Task-sharing approaches to improve mental health care in rural and other low-resource settings: a systematic review", *The Journal of Rural Health*, Vol. 34 No. 1, pp. 48-62.

Hook, K. and Bogdanov, S. (2021), "Mental health care in Eastern Europe and Central Asia: an analysis of needs and a call for greater investment", *The Lancet Regional Health – Europe*, Vol. 10, p. 100182.

Jordans, M.J. and Kohrt, B.A. (2020), "Scaling up mental health care and psychosocial support in low-resource settings: a roadmap to impact", *Epidemiology and Psychiatric Sciences*, Vol. 29, p. E189, doi: 10.1017/S2045796020001018.

Kiger, M.E. and Varpio, L. (2020), "Thematic analysis of qualitative data: AMEE guide no. 131", *Medical Teacher*, Vol. 42 No. 8, pp. 846-854.

Klymchuk, V. Vysotska, K. and Gorbunova, V. (2022), "Decentralisation and community engagement for better mental health services development in the conflict-affected regions of Ukraine", 27 April 2022, PREPRINT (Version 1) available at Research Square, doi: 10.21203/rs.3.rs-1394881/v1.

Lange, K.W. (2021), "Task sharing in psychotherapy as a viable global mental health approach in resource-poor countries and also in high-resource settings", *Global Health Journal*, Vol. 5 No. 3, pp. 120-127.

Lekhan, V., Kaluski, D.N., Jakubowski, E. and Richardson, E. (2015), "Reforming the Ukrainian health system at a time of crisis", *Eurohealth Incorporating Euro Observer*, Vol. 21 No. 2, pp. 14-17.

Lindemann, U., Maurer, M. and Braun, T. (2008), *Structural Complexity Management: An Approach for the Field of Product Design*, Springer Science & Business Media, Germany.

Lugansk Oblast Administration (2019), "Social-economical analysis of Lugansk region (in the Ukrainian language). Соціально-економічний аналіз Луганськo області", available at: http://loga.gov.ua/sites/default/files/collections/profil_lugansk_17_10_2019-2-opracovane_22.10.2019.pdf (assessed 12 December 2021).

OCHA (2022), "Humanitarian needs overview. Ukraine. United nations office for the coordination of humanitarian affairs", available at: https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/ukraine_2022_hno_eng_2022-02-10.pdf (assessed 16 December 2021).

Oleinikova, O. (2020), "Decentralisation reform: an effective vehicle for modernisation and democratisation in Ukraine?", *Decentralization, Regional Diversity, and Conflict*, Palgrave Macmillan, Cham, pp. 311-338.

Quirke, E., Klymchuk, V., Gusak, N., Gorbunova, V. and Sukhovii, O. (2022), "Applying the national mental health policy in conflict-affected regions: towards better social inclusion (Ukrainian case)", *Mental Health and Social Inclusion*, Vol. 26 No. 3, doi: 10.1108/MHSI-01-2022-0002.

Quirke, E., Klymchuk, V., Suvalo, O., Bakolis, I. and Thornicroft, G. (2021), "Mental health stigma in Ukraine: cross-sectional survey", *Global Mental Health*, Vol. 8, p. e11, doi: 10.1017/gmh.2021.9.

Shahmalak, U., Blakemore, A., Waheed, M.W. and Waheed, W. (2019), "The experiences of lay health workers trained in task-shifting psychological interventions: a qualitative systematic review", *International Journal of Mental Health Systems*, Vol. 13 No. 1, pp. 1-15.

Thornicroft, G., Mehta, N., Clement, S., Evans-Lacko, S., Doherty, M., Rose, D., . . . Henderson, C. (2016), "Evidence for effective interventions to reduce mental-health-related stigma and discrimination", *The Lancet*, Vol. 387 No. 10023, pp. 1123-1132.

Troup, J., Fuhr, D.C., Woodward, A., Sondorp, E. and Roberts, B. (2021), "Barriers and facilitators for scaling up mental health and psychosocial support interventions in low-and middle-income countries for populations affected by humanitarian crises: a systematic review", *International Journal of Mental Health Systems*, Vol. 15 No. 1, pp. 1-14.

UNHCR (2022), "Registration of internal displacement in Ukraine", United Nations High Commissioner for Refugees, available at: https://www.unhcr.org/ua/en/resources/idp-dashboard (assessed 12 December 2021).

WHO (2009), *Improving Health Systems and Services for Mental Health*, World Health Organization. Geneva.

WHO (2012), *Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for Humanitarian Settings*, World Health Organization. Geneva.

WHO (2016), *mhGAP Intervention Guide for Mental, Neurological and Substance Use Disorders in Non-Specialized Health Settings: mental Health Gap Action Programme (mhGAP)*, World Health Organization. Geneva.

WHO (2019), *Ukraine: Review of Health Financing Reforms 2016–2019: WHO–World Bank Joint Report*, World Health Organization. Geneva.

WHO (2021a), *Access to Healthcare Services for Older Persons and Persons with Disabilities Living in Eastern Ukraine along the'' Line of Contact'' (No. WHO/EURO: 2021-2038-41793-57267)*, World Health Organization. Regional Office for Europe, Kopenhagen.

WHO (2021b), *Improving Health Systems and Services for Mental Health: Mental Health Policy and Service Guidance Package (No. WHO/EURO-2021-34580-34580-57140)*, World Health Organization. Regional Office for Europe, Kopenhagen.

WHO (2021c), *Comprehensive Mental Health Action Plan 2013–2030*, World Health Organization. Geneva.

Corresponding author

Vitalii Klymchuk can be contacted at: vitaly.klymchuk@gmail.com