The *Lancet Psychiatry* Commission on mental health in Ukraine

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Executive summary

The Russian invasion and annexation of eastern Ukraine and Crimea in 2014, along with the ongoing war since February, 2022, have inflicted incalculable damage to Ukraine with many deaths and injuries, massive population displacement, and extensive physical and emotional trauma. These events put an immense strain on the general health-care and mental health-care systems. For many years the mental health-care system in Ukraine was dominated by large psychiatric hospitals and residential institutions focusing on biological therapies; it was a system known for neglect, abuse, and human rights violations. While coping with current stressors, Ukraine is looking to the future with recovery initiatives and reforms to bring its health and social infrastructures to meet the needs of the Ukrainian people and international standards. This *Lancet Psychiatry* Commission was convened to identify the current mental health needs in Ukraine, and to outline a plan for a future, in which Ukrainians receive evidence-based care through a system that values human rights and lived experiences of people with mental illness. The Commission included five workgroups, each examining specific opportunities for change, development, and modernisation of the Ukrainian mental health-care system, along with requirements for success in clinical services, clinical training, research, forensics and legal advocacy, and finance. Workgroups built upon Ukraine's pre-war efforts to create a modern mental health-care system, while simultaneously looking at a 5–10-year horizon for bringing Ukrainian mental health care, training, research, and legal practices in line with international standards, which the country must meet in preparation for its expected European Union (EU) membership. 40 experts in mental health, health economics, law, science, and epidemiology, along with people with lived experience of mental illness, from 12 countries, joined to create this Commission.

Part 1: Community-based mental health care and a vision for a new network of Ukrainian mental health-care services

The current high prevalence of depression and anxiety in Ukraine requires the application of rapidly implementable and scalable solutions that can also be provided by properly trained non-specialists in primary care settings that are readily accessible to all Ukrainians. To achieve this transformation and ensure optimal service coverage, the Commission recommends using a stepped-care approach. The provision of some low-intensity services and interventions should be shifted from specialised mental health workers to non-specialised personnel within the health sector and beyond, while ensuring appropriate training and supervision and use of emerging digital solutions. This approach will allow for a scaling-up of the management of common mental disorders in primary health care, while establishing a referral system with standardised assessment tools for more complex disorders. Most importantly, this strategy will facilitate the transition of people currently in institutions into the new community-based services as they become available.

Part 2: Training and education of the mental health workforce

Ukraine requires a large, skilled, multidisciplinary mental health workforce. Workforce expansion will be made possible only by implementing substantial revisions of undergraduate medical education curricula, as well as clinical training. Reform of training and education of the mental health workforce should begin with an assessment of the national training needs that considers current and future requirements of mental health-care services. This assessment will allow formulation of a national mental health workforce plan, or a similar overarching guiding document, which will outline the resources and structures necessary for longer psychiatric training experiences for medical students and residents. These recommendations will be aligned with European standards and quality assurance, as well as the necessary steps for adopting the European Union of Medical Specialists' psychiatry frameworks for training and continuing medical education.

Part 3: Rebuilding mental health research capacity and infrastructure

Rebuilding and reforming mental health-care services will require revitalised research infrastructure. Mental health research funding should be consistent with the prevalence and effects of mental disorders within the entire Ukrainian health-care system. More Ukrainian research funds should be allocated to mental health, for both applied research and implementation science. The Government and funding bodies should initiate funding targets for key topics, such as post-traumatic stress

disorder (PTSD) and the impact of war on veterans and families who have been affected by violence or separation. The research should take place across multiple settings (hospital, community, and primary care) and be done by multi-disciplinary mental health research teams. Research on the social and economic effects of deinstitutionalisation should guide the development of community services. Ukrainian researchers should be invited to visit programmes, within and outside Ukraine, that offer mental health support for people living with trauma or in conflict zones. The purpose of such initiatives is to develop skills of Ukrainian researchers and to establish collaborations to facilitate the implementation and evaluation of innovative services in Ukraine.

Part 4: Reform of advocacy and legal principles regarding mental health

Ukraine should make every attempt to revise its mental health laws to best reflect international standards with respect to autonomy, capacity, competence, guardianship, coercive treatment, advocacy, and other related issues. The laws must be fundamentally amended to be human rights-based and person-oriented, and should include the assumption of capacity and prioritise consent. Strict limitations and legal oversight should be implemented regarding restricting individual liberty, including a procedure for appeals with requisite legal aid. Involuntary intervention should be restricted to situations in which it is absolutely necessary, with explicit time limits, strong multi-disciplinary oversight, and effective legal remedies. Human rights principles should be integrated into legal dispositions, including addressing the risk of harm to self and others, based on multi-disciplinary assessments and rehabilitation possibilities, and with peer support. Finally, mental health conditions should be decriminalised.

Part 5: Resourcing the future of mental health

Not only is the total financial support for Ukrainian mental health care disproportionately low relative to the needs of the population, but a major share of resources is allocated to institutional care rather than evidence-based community services. Financial investments and a gradual shift in resource allocations to meet the needs of patients in their communities will be more effective and sustainable than current practice. To reach more people with mental health conditions in need of care and support, the Ukrainian Government should increase investment in mental health (from 3% to 4·5% of total health spending); at least 5% of the budget for mental health should be allocated to preventive measures. In view of the current macroeconomic conditions and security priorities, implementation of the proposed measures in the short term is likely to require external donor assistance; however, a community-based approach to care and an evidence-based focus will reap the benefits of effectiveness and efficiency.

Conclusion

Ukraine has faced extraordinary adversities in the past 10 years. However, among the incredible stresses, the country has remained focused on working towards a better future, including improving its health-care and mental health-care systems. Recognising the perilous road ahead, the *Lancet Psychiatry* Commission shares the Ukrainians' powerful sense of hope and unequivocally supports Ukraine's bid to join the community of nations and meet international standards for clinical care, medical education, research, legal protection, and funding.

Introduction: History and vision for change

Ukraine, the largest democratic country in Europe, has been faced with a perfect storm of challenges. From 1922 to 1991, it was part of the Soviet Union where the mental health-care system was dominated by large psychiatric hospitals and residential institutions focusing almost exclusively on biological therapies. The system was well known for neglect, abuses, and human rights violations.[1,2] As Ukraine emerged from the Soviet era into independence, it underwent massive political, economic, and social changes. The Russian annexation of eastern Ukraine and Crimea in 2014, and the ongoing full-scale war since February, 2022, have inflicted incalculable damage to the country, including to its health-care systems.

The protracted war in Ukraine and its anticipated effects on the mental health and wellbeing of the country's citizens were the impetus to creating this Commission. While coping with the current stressors, Ukraine is also looking ahead to the future with recovery plans that aspire to transform Ukraine's many systems to meet or exceed international standards. The Commission's priority was to analyse the current Ukrainian mental health-care system and formulate recommendations that will serve as a roadmap for a reform that is consistent with European Union recommendations and international standards to the extent possible during the war, while also preparing for the post-war period (panel 1).

The Commission recommends building a network of mental health-care services, based on available data and the needs resulting from the ongoing war, while also attending to perceptions and attitudes towards mental health and help-seeking behaviours among the Ukrainian population. The Commission appreciates that Ukraine must consider available mental health resources and infrastructure, prior achievements in mental health policy development, efforts to created innovative mental health services and interventions within and beyond the health sector, and the global knowledge available about good mental health-care systems practices and services.

The Commission considered existing facilitators and barriers that can influence transformation of the mental health-care system and services in Ukraine. The Commission recommends reforming Ukrainian mental health laws, especially those that apply to individual

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***Panel 1:* Commission methods**

The Commission brought together a diverse group of experts from 12 countries (Australia, Belgium, Canada, Israel, Japan, Lithuania, Norway, Sweden, Switzerland, the UK, Ukraine, and the USA), each with different experiences and knowledge, to think broadly about the many possibilities for the revitalisation of the Ukrainian mental health-care system. The 40 members of the Commission were specialists from many fields, including mental health, health economics, law, science, and people with lived experience of mental illness, who all contributed to the formulation of the Commission and its recommendations.

The Commission was composed of five workgroups, each focusing on a specific aspect for supporting change, development, modernisation, and requirements for success: clinical services, clinical training, research, forensics and legal advocacy, and economics. The workgroups outlined plans for continuing Ukraine's pre-war and war-time efforts to build a modern mental health system, while simultaneously looking at a 5–10-year horizon for bringing Ukrainian clinical care, training, research, and legal practices in line with international standards, especially those necessary for Ukraine to join the EU.

The initial Commission consultation meeting took place in May, 2023. 55 meetings (including all-commission meetings and separate working group meetings) took place in the following 9 months, online and in person. Additionally, substantial individual efforts have broadly assessed and realistically appraised the situation in Ukraine today, with an informed perspective on future needs.

A shared goal was transformational change to address the needs of the country during the war and after the victory. The Commission studied relevant documents, grey literature, and conferred with international and national organisations (eg, US National Academy of Sciences, WHO, European Union of Medical Specialists, World Psychiatric Association). A comparative analysis examined the mental health education and training systems in Ukraine and the EU, leading to identification of the elements necessary to support the transformation of the Ukrainian mental health education system to align with its counterparts in the EU. A service reconfiguration analysis was done to estimate resource implications of shifting from the current, predominantly institutional model to a community-based model of service delivery. Three virtual focus groups were held by the Commission. The focus groups comprised early career and experienced mental health researchers, some of whom stayed in Ukraine during the war, while others temporarily relocated to other regions of Europe. They identified various barriers to mental health research, including poor funding, insufficient international collaboration, and outdated infrastructure. Each focus group contributed to increased understanding of the pressing needs and priorities within the current mental health-care system, including war-related research and development.

This collaborative process led to a consensus on how to address the multidimensional requirements of the mental health-care system for Ukraine today and in the future. The Commission is a synthesis and consensus statement of evidence-based recommendations.

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autonomy, consistent with recommendations of the World Psychiatric Association's Expert Committee[1] and the standards of the UN Convention on the Rights of Persons with Disabilities (CRPD).[3] The Commission acknowledges the crucial role of health promotion and prevention, but deferred these issues for subsequent planning and reports.

Mental health care, education, and research have received special attention from the Government and the First Lady of Ukraine, Olena Zelenska. The 2017 National Mental Health Policy statement articulates the Ukrainian vision for creating a comprehensive and efficient mental health-care system that uses resources of all public sectors, ensures improved quality of life for Ukrainians, and respects human rights.[4] Ukrainian mental health experts (both in Ukraine and abroad), as well as international colleagues, have rallied around this cause. This *Lancet Psychiatry* Commission outlines plans for a future in which all Ukrainians will have access to high-quality, community-based mental health care through a system that values human rights and meets the needs of different population groups across the lifespan.

Part 1: Community-based mental health care and a vision for a new network of Ukrainian mental health-care services

The Commission developed a consensus that Ukraine should develop a network of community-based mental health-care services. A sequence of incremental steps of change should be designed to facilitate progression from the current system towards a community-based mental health-care system.

Before 2017, the Ukrainian mental health-care system focused on treatment and tracking (called dispanserisation) of people with severe mental disorders. This strategy was delivered through a network of inpatient and outpatient psychiatric services, in which 89% of all mental health budget was directed to inpatient care.[5] The services offered by the health-care sector were complemented by a network of neuropsychiatric nursing homes (internats), with about 40 000 beds, which were managed by the social care system. Additionally, some psychiatric services were available in general hospitals, along with brief psychological interventions provided in maternal health clinics.[6] The psychological services in educational institutions were largely limited to assessments done by school psychologists with no follow-up services available. This system provided treatment coverage of varying quality, relying primarily on pharmacotherapy and directed at treatment of psychoses and substance use disorders. The most prevalent disorders, such as mild-to-moderate depression and anxiety, were not well covered. Psychiatric services were often associated with human rights violations.[6]

Since the Government's adoption of the Concept Note[7] for mental health development in 2017, Ukraine has undertaken a series of steps, with support from WHO, to introduce new mental health-care services and interventions. Among these new services are community mental health teams (CMHTs), responsible for providing recovery-oriented care for people with severe mental disorders[8] and management of common mental disorders in primary health-care settings with the use of the WHO Mental Health Gap Action Programme (mhGAP).[5] The scope of mental health-care services contracted by the National Health Service of Ukraine (NHSU) for the period 2020–23 is shown in the appendix (p 1). The 2019 law on social services enabled a legal framework for supported accommodation and other social services that can be used for people with mental disorders.[9] The efforts in the public health and social sectors were

complemented by community-based psychosocial services and interventions provided in the non-governmental sector, as a part of the emergency response.[10]

In 2022, with the support of the Ukrainian First Lady and in response to the increase in mental health problems as a result of the war, the Government of Ukraine launched the All-Ukrainian Mental Health Programme.[11] Building upon the aforementioned achievements and service developments, this programme mobilised the efforts of governmental institutions, professional and scientific communities, non-governmental organisations (NGOs), international partners, and businesses. The goal is to address the immediate needs of a population affected by the war and create a comprehensive mental health-care system capable of meeting the long-term needs of all Ukrainians. The programme is aimed at raising mental health awareness, fostering a culture of self-help, enabling development of protective and supportive environments, and building a comprehensive mental health-care system and services. To realise these efforts, many service sectors were mobilised, such as health, welfare, education, labour, sport, youth affairs, culture, law enforcement, defence, the non-government sector, and businesses.

Stepped-care approach to mental health care in Ukraine

WHO describes community-based mental health care as that provided in primary health care, district or regional general hospitals, social services, community mental health centres, small-scale residential facilities, by community mental health teams, and as a part of psychosocial rehabilitation programmes, among others.[12]

The WHO model network of community-based services (figure 1) shows the pathway for a stepped-care approach to service provision, with equitable distribution of resources across mental health needs, and hospital and community settings. This model is aligned with the staging approach for diagnosis and treatment of mental disorders, which recognises opportunities for intervention at all stages of the pathway, from wellbeing to severe disorder.[12]

The high prevalence of anxiety and depression,[13] as well as very high prevalence of distress among different Ukrainian populations during the ongoing war, requires innovative and scalable services that can meet the mental health needs at a national scale. For people experiencing psychological distress, the public and private services, as well as NGOs, serve as initial points of contact. Workers at these institutions should be trained to provide basic psychosocial support[14] and create a supportive environment to help people overcome the adversities they are facing.[12] The All-Ukrainian Mental Health Programme calls different sectors and agencies to provide basic psychosocial support to the population, while envisioning a gatekeeping function for primary health care and community social services, particularly in newly established resilience centres. Resilience Centers are community-based facilities designed to enhance the mental health and wellbeing of individuals and families, particularly in response to the challenges posed by trauma, social disruption, and ongoing conflict. These centers play a crucial role in providing psychosocial support and promoting resilience within the community. Resilience centers are integral to strengthening the mental health infrastructure in communities, particularly in Ukraine's context, where resilience and recovery are vital for the population's mental health amid ongoing challenges. The Resilience Centres not only address immediate mental health needs, but also contribute to a long-term culture of community support and resilience, helping people rebuild their lives and strengthen social cohesion in the face of adversity.

Services for depression, anxiety, stress-related disorders, and substance use disorders, which mainly comprise brief structured psychological interventions[15,16] based on cognitive behavioural therapy, mindfulness, acceptance commitment therapy, behavioural activation, and problem solving, among others, should be scaled up. These services should be provided in non-specialist settings by public service providers and the non-governmental sector under the supervision of mental health specialists.[12] Extensive evidence shows that brief psychological interventions can be effectively delivered by non-specialists, which is particularly relevant in low-resource settings. WHO's Self Help-Plus and Problem Management-Plus psychological interventions were introduced in Ukraine to be delivered by social services and NGOs, as a partial response to the mental health crisis created by the war; these interventions can be scaled up in different sectors alongside other interventions to ensure availability of evidence-based care for the most common mental conditions.[11] In the context of Ukraine, brief psychological interventions might also be used in specialist care settings and could serve as an entry point into the delivery of evidence-based psychological therapies for psychologists and psychiatrists who do not receive such training as a part of their formal education.[17]

As part of the aspiration for universal health coverage, primary health care has been central to the ongoing health-care reform in Ukraine since 2017.[18] Care in primary care settings has been central to a cost-effective approach to addressing the mental health care needs that are the result of the war.[19] Efforts to introduce the clinical management of common mental disorders in primary health care in accordance with WHO's mhGAP Programme must be continued and scaled up. Primary health care serves as an entry point to the health-care system. Provision of mental health support in this setting can address a wide range of mental health problems through psychosocial support and pharmacological interventions, while coordinating access to a full spectrum of services for mental health. Training on mental health management needs to be available for all primary health workers as a part of their continued professional development.

Inspired by good practices in EU outpatient psychiatric care,[3,20] Ukraine is developing community-based specialised services, integrated with the general health-care

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See **Online** for appendix

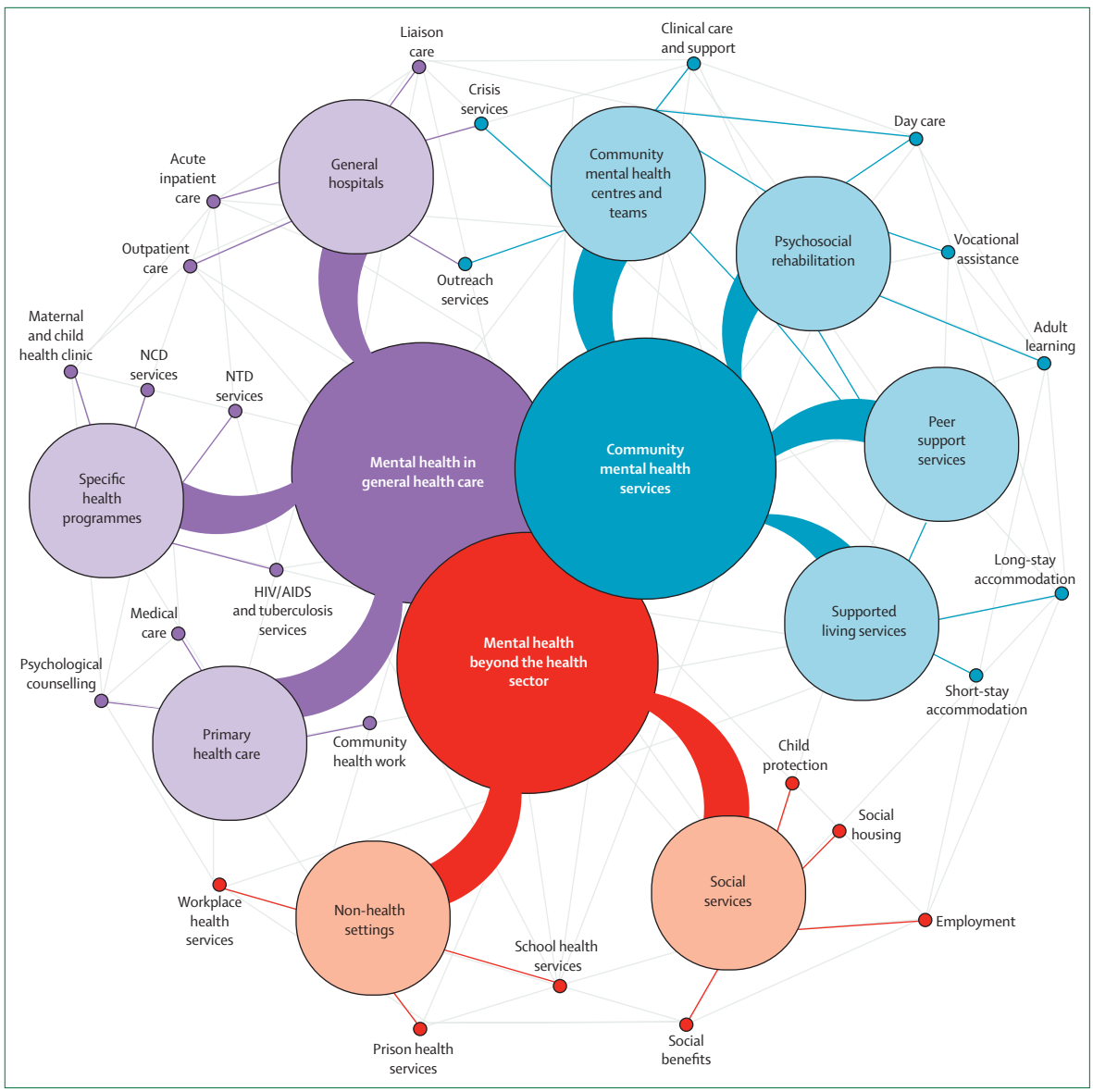

Figure 1: **Model network of community-based mental services**
NCD=non-communicable diseases. Reproduced with permission from WHO.[12]

system. For all residents of Ukraine with moderate-to-severe mental disorders, a network of the existing CMHTs can be expanded and complemented by community mental health centres. According to WHO,[12] community mental health centres and CMHTs are the cornerstone of community-based networks of services that typically address a range of mental disorders in adults, adolescents, and children.[12] These community centres and teams blend clinical services with psychosocial rehabilitation and activities to promote social inclusion and participation in community life.[12] The existing health infrastructure in Ukraine can be used for the development of the mental health centres, which can take on the main role in coordination and provision of community-based specialised care for different population groups, including veterans and their families. Coordinating the engagement of other community services, such as social and legal services, housing, supported living, education, employment, and recreational activities, with primary health care, CMHTs, inpatient and other health services will also be important.

The care for people with severe and chronic mental disorders should be focused on recovery, social inclusion, and treatment in the least restrictive environment necessary to provide safe, effective, and human-centred care.[21] Management of severe mental disorders should shift from a focus on crisis management to risk mitigation and crisis prevention. To achieve this goal, health care and social services personnel must be trained in how to plan care in

collaboration with patients and caregivers. For some people, treatment might include acute inpatient care or appropriately staffed community-based residential care. It is always necessary to have an evidence-based system that supports and encourages timely, stepwise progression to less restrictive, community-based services that are made possible by the provision of clinical and social services, including community integration services, supported housing, vocational training, supported employment, and educational services.

As the focus of mental health care shifts from hospital to community-based care, the needs of individuals with severe mental disorders who require long-term care and the needs of people residing in psychoneurological internats must be addressed. Living conditions, quality of care, community interactions, and human rights should be monitored and improved with the use of WHO's QualityRights Programme,[22] which promotes principles of the UN Convention on the Rights of Persons with Disabilities (CRPD).

To achieve these goals, new standards of care based on human rights principles must be introduced. Long-stay psychiatric hospitals should be gradually scaled down, in parallel with ensured support in the community for the discharged residents, through scale-up of a network of community-based mental health centres and teams complemented by a comprehensive set of interventions beyond the health sector. Ensuring the retention of skilled personnel within these services by offering them training and alternative employment opportunities is important in this process. Alternatives to the internats should be created in the form of supported living services that are person-centred and human rights-based and provide short-stay and long-stay accommodation options as needed. These services should be linking accommodation with rehabilitation services (including vocational assistance, adult education, and training), clinical care for physical and mental health, social services, peer support,[23] and other community services. As these alternative services become available, patients should be transferred to them, when appropriate, and the internats should be scaled down and ultimately closed. Patients who have experienced institutionalised care should be supported with transitional services for their recovery and reintegration into community settings. This transition will require substantial initial investment, but, over time, resources saved from closing or downsizing the institutions can be used for supported living services (see Part 5).

Apart from the centrally purchased essential health-care services provided by the NHSU under the National Programme for Health Financial Guarantees, each administrative region, based on its specific needs, should consider allocating additional resources to support its mental health-care service demands. The pace of service reconfiguration can vary between the regions and more targeted approaches might be required to address region-specific needs and challenges.

Ukraine is reasonably well positioned to implement the stepped-care approach to mental health-care provision. This approach is receiving increasing attention as a rational way of allocating resources across different sectors. For example, at the lowest level in community settings, a step can support people experiencing stress, even in the absence of a specific mental disorder, and might include self-help psychoeducation and stress management resources. The next step might include a single counselling session or brief transdiagnostic psychological intervention by a trained non-specialist staff in the community, for example offered by social services or NGOs. Primary health care can be the next step and the entry point to the health-care system, particularly when clinical intervention is required or the mental health condition is concomitant with a somatic disorder. When these interventions are not sufficient, a referral is made to the specialised outpatient psychiatric service for an assessment and coordination of care within a network of specialist mental health-care services. At this stage, the mental health centre can provide care if the person can and is willing to visit such a centre. Alternatively, CMHTs can provide outreach care aimed at recovery and reintegration into community life. When inpatient treatment is needed for psychosis or self-harm (the final step), the individual should preferably be placed in a mental health bed at a general hospital. The success of such a model depends on easy (barrier-free) access to successive steps, a clear understanding of what types of mental health resources are available for what kind of problem, and a measurement-based care platform to assess severity, complexity, and response to treatment.

Under a stepped-care model, tasks should be shifted from the specialist health-care workers to other staff within and beyond the health-care sector who can provide many low-intensity services and interventions.[24] This change will require capacity building to ensure that non-specialised staff have the competencies necessary to deliver such interventions. The multidisciplinary approach allows nurses, psychologists, and social workers to provide some services (under supervision) necessary to care for people with mental disorders. The specialists will be dedicated to work with patients with the most severe mental disorders. The specialist health-care workforce can provide overall supervision to the process of task-shifting and build the capacity of service providers in other areas of the health-care system and beyond.

Telemedicine and emerging digital solutions might leverage each health-care provider's available time and thereby increase the accessibility of mental health care at various steps.[25] We recommend the implementation of a learning health system[26] based on Ukraine's current E-Health system. This system should include a central data management platform with links to resources on education, social services, medication dispensing, and other services. This learning health system would provide

Panel 2: **Recommendations for transformation to community-based mental health care**

- Continue to develop a comprehensive mental health system, in which all public sectors (eg, health, social, labour, workplace, education, youth affairs, culture, sport, law enforcement, and defence) are engaged in a continuum of programmes and services to improve mental wellbeing and care for those with mental disorders.
- Scale up brief psychological interventions in non-specialised health-care settings and other sectors to ensure access to care for people experiencing stress, anxiety, and depression.
- Continue and scale up efforts to introduce clinical management of common mental disorders in primary health care through psychosocial support and pharmacological interventions utilising WHO's mhGAP. Coordinate access to a full spectrum of services for mental health within the health sector and beyond. Ensure supervision in the management of mental disorders for all primary health-care staff as a part of their continued professional development.
- Continue scaling up a network of community-based services with community mental health centres and teams complemented by a comprehensive set of interventions beyond the health sector, and inpatient services integrated into general health care.
- Promote recovery, social inclusion, and treatment in the least restrictive environment possible as the preferred approach to care for people with severe and chronic mental disorders. In management of severe mental disorders, shift the focus from crisis management to risk mitigation and crisis prevention. Train the multidisciplinary team personnel in recovery-oriented care planning conducted together with patients and caregivers.
- Create supported living and other residential services that are person-centred and human rights-based for people with severe mental disorders as alternatives to large psychiatric hospitals and internats. These services should provide short-stay or long-stay accommodation options linked with rehabilitation. During the transition period, monitor and improve living conditions, quality of care, community interactions, and human rights in the existing institutions with the use of the WHO's QualityRights programme, which promotes principles of the UN Convention on the Rights of Persons with Disabilities.
- Shift provision of some low-intensity mental health services and interventions within the stepped-care approach, from specialised mental health-care workers to other health-care professionals and non-health-care professionals (ie, social workers, teachers, and other trained mental health personnel), ensuring training and supervision for the staff and linking with emerging digital solutions as appropriate. Establish a referral system and patient pathways with standardised assessment tools and criteria for referrals.
- Empower people with lived experience of mental disorders to participate in planning, provision, and evaluation of mental health services.
- Tailor the proposed network of mental health services to the needs of emerging population groups (eg, internally displaced people, veterans, and former prisoners of war), and to different developmental stages across the life course.
- Establish a mental health information system (mental health learning system) with linkages between the different sectors engaged in mental health care to continuously inform development and improvement of the mental health system.

policy makers with the data necessary to evaluate and improve the mental health-care system.

Special considerations for the proposed network of mental health-care services

A life course approach is optimal when planning mental health-care services, particularly in ensuring that children, adolescents, and individuals in older age groups have access to developmentally sensitive mental health care. The unique needs of specific groups, including veterans, former prisoners of war and their families, pregnant women, refugees, internally displaced people, members of the LGBTQ+ community, people in legal detention, and ethnic minorities will require careful attention when planning and implementing these services.

In the context of the ongoing war, veterans and active military personnel constitute a substantial proportion of the Ukrainian population and are at high risk of psychological trauma and blast-related traumatic brain injuries secondary to thermobaric explosives.[27] The mental health effects on these individuals might include PTSD, other psychiatric disorders, suicide, and substance use, and other risky behaviours.[28–31] Especially given the stigma that affected individuals might face, systems of care should ensure that screening and assessment are readily available and that front-line professionals likely to interface with military personnel receive appropriate training and preparation to care for those who are victims of trauma associated with experiences on the battlefield and other fronts of the war. On a populational level, bereavement and prolonged grief disorder are prevalent (in almost nine in ten and around one in nine, respectively) in the context of war-related losses.[32] To optimise accessibility, services tailored to these conditions should be incorporated into the proposed network of mental health-care services and consideration should also be given to specific, military-based psychosocial interventions.

Conclusion

In the face of war, Ukraine's mental health-care system has many challenges including shortage of staff and financing, security issues, overwhelming exposure to stress, and damaged infrastructure. System transformation is often easier to implement in the context of a nation-wide effort to recover from major societal changes, such as the transition from conflict to peace,[33] as long as the resources needed for transformation are available. The increased political commitment for strengthening the mental health-care system with new laws, services, and funding is indicative of the growing public interest in mental health in Ukraine. As Ukraine prepares for the next steps in building a modern and comprehensive mental health-care system by 2030,[4] the country will require continuing popular and governmental support, as well as resources and support from the international community (panel 2).

Part 2: Training and education of the mental health workforce

A 21st century mental health-care system requires an enabled and skilled multidisciplinary workforce that meets the immediate and emerging needs of the settings in both primary care and specialist mental health-care systems. Nurses, psychologists, allied health professionals, family doctors, and specialists in psychiatry are

the core of this mental health workforce. This diverse group requires broad, overlapping capabilities and discipline-specific competencies to function as an integrated and effective multidisciplinary workforce across a spectrum of health care settings—from frontline primary care, to specialist multidisciplinary mental health community teams, to inpatient units. Ensuring the effectiveness and efficiency of this workforce requires integration and deployment of the required skills to meet the communities' needs at the right time and in the appropriate setting.

A mental health knowledge gap among primary care providers in rural settings in Ukraine was identified before the war.[34] Training is needed to prepare primary care providers to address the mental health needs in their communities.[35] Utilising the WHO's mhGAP, Ukraine has initiated training for primary health-care providers, including how to identify and manage mental disorders. Since the implementation of the mhGAP in Ukraine in 2019, more than 51 000 professionals were trained by 2023, including family doctors, paediatricians, therapists, paramedics, and nurses.[36,37]

One challenge in building a contemporary, stepped community mental health-care system in Ukraine is a siloed educational system, with few opportunities for collaboration between professional disciplines (figure 2). The professional bodies responsible for medical specialty education must collaborate to train the staff needed to build an integrated workforce. Special attention should be given to teaching shared or overlapping competencies to build a broad, stepped, community-focused mental health-care system. This refocusing will need to occur across the educational system from undergraduate to continuing medical education (CME) and across all disciplines.

Further specialisation (subspecialty training) is available for individuals who intend to deepen their proficiency in their primary specialisation, or for people who wish to change their primary specialisation. Psychiatrists in Ukraine can further specialise in child psychiatry, narcology, psychotherapy, psychiatric forensic expertise, sexual pathology, and medical psychology. These subspecialty training courses take about 3 months to complete. When physicians with a primary specialty other than psychiatry (eg, family medicine or internal medicine) intend to obtain a psychiatric specialisation, they can enter specialisation training, which lasts at least 5 months. Additionally, psychiatrists who have not practised for 3 years are required to undergo psychiatric subspecialty training again (lasting 3 months). The subspecialty training is provided by medical universities or postgraduate academies, with clinical experience being provided by partner state hospitals or, more rarely, university hospitals. The specific requirements for each subspecialty are very broad, brief, and consist of general and professional tasks rather than competencies.[38] All physicians must obtain at least 50 CME credits per year to continue to practice. With the receipt of 50 CME per year for 4 consecutive years, physicians can apply for a qualification category, which is intended to reflect the physician's level of professionalism and experience.

Ukraine does not have a National Mental Health Workforce Plan, or similar overarching guiding document. Such a mental health workforce strategy to guide effective integration and encourage engagement between the various disciplinary bodies will be required to transform professional education and to meet community needs for a modern, stepped, community-led mental health-care system. Optimisation of digital skills and tools for distance learning, remote clinical supervision, access to electronic health records and other online services, including teleconferencing and telehealth, offer exciting opportunities for medical education. Emerging technologies, including artificial intelligence and related tools, can be useful to overcome language barriers, enabling practitioners to access a broader range of scientific literature and participate in international forums.

Multidisciplinary and public mental health training

As Ukraine transitions to a multidisciplinary, community-based mental health-care system, new demands for innovation in educational and training programmes across disciplines and from undergraduate medical education through to CME will arise. All members of the health-care team, especially individuals in primary care,

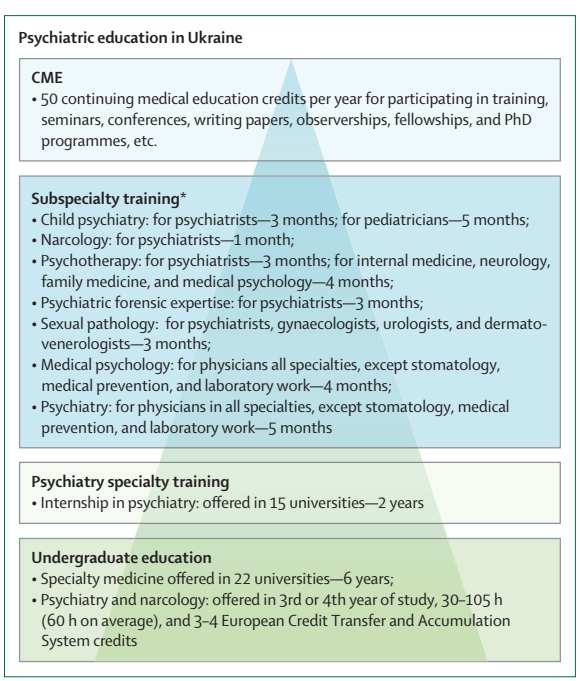

Figure 2: **Overview of the Ukrainian psychiatric education system**
*Order of the Ministry of Health of Ukraine July 25, 2023; number 1347: On approval of the list of specialisation cycles and thematic improvement by medical and pharmaceutical (pharmacology) specialties.

will need additional training in the skills necessary to provide mental health-care services and how to share the responsibilities of mental health care provision. In many cases, these changes will require modifications in practices that have long guided Ukrainian mental health-care services, to create contemporary, effective, efficient, evidence-based, and collegiate patterns of practice that promote collaboration with community organisations. To achieve these practice goals, existing educational programmes will need to include the concepts of multidisciplinary, community-based care, while clinical training will need to be adapted so that trainees in various disciplines learn and practise their skills together. These shifts will require changes in curricula and clinical training experiences for professionals working in multidisciplinary clinics in community settings. Ukrainian CME must be redesigned to promote formation of a multidisciplinary workforce and provide capabilities for participation in a multidisciplinary, stepped, community mental health-care system. Each professional discipline might take a different approach to their new training model, which would include public mental health training; however, ultimately all practitioners must come together in a unified practice model. This process started with the launch of a CME system for nurses and pharmacists in January, 2024.

Psychiatry

The largest burden of Ukrainian mental health care has traditionally rested with psychiatrists who have primarily practised in isolation in institutional and inpatient settings. The transition to multidisciplinary, community-based practice will require substantial changes in medical training programmes at all levels. Psychiatrists will be required to have broad competencies in mental health-care service system leadership, collaboration, education, and training.[39,40] These specialists should be supported to overcome hierarchical barriers to promoting effective teamwork and leadership within the health-care context. Psychiatric training should be guided by mapped educational competencies outlining the knowledge, skills, and attitudes necessary to be a psychiatrist,[40] which can be tested and benchmarked via the European Board Exam.[41]

General effects of the war on medical education

Medical education in Ukraine has been restructured to meet new standards during the war, when it is difficult to continue the provision of high-quality education. Destruction of infrastructure has forced some medical universities and hospitals to relocate from the frontline and from territories occupied by Russia. Students who remained in Ukraine faced major challenges including interruption by air raid alarms, constant shelling, restricted access to online resources, reduced opportunities for in-person clinical training, and a decrease in the number of academic hours.[42–45] These challenges have adversely affected the quality of learning.[46–48] Students' mental health has been particularly adversely affected.[49–53] The war has led to a 21% reduction in the number of domestic applicants to Ukrainian medical schools (from 25 200 in 2019, to 19 924 in 2023).[54] This reduction in the number of applications will lead to fewer medical school graduates and, inevitably, fewer psychiatrists. To address these concerns, funding should be developed and allocated to support medical students who are contributing to mental health care in underserved rural and urban communities. Another strategy would be to design public campaigns to address stigma about mental health careers. Finally, salary supplements could be considered for Ukrainian medical graduates entering psychiatry.

Undergraduate psychiatric education

Changes to undergraduate medical education are necessary in the short term, while the war is ongoing, with many changes likely to be continued after the war. Access to in-person clinical training is of particular concern, as it is necessary for high-quality psychiatric training, and is not easily provided reomotely. Ukrainian medical schools should develop agreements with foreign medical centres to create and provide online curricula, including theoretical education, case discussions, and interactive simulations. Professional bodies, such as the Section of Psychiatry of the European Union of Medical Specialists (UEMS), the European Psychiatric Association, and the World Psychiatric Association might support these initiatives.

With each medical student and potential psychiatrist being ever more precious, special attention to students' mental health and wellbeing is essential. Routine mental health screening should form an integral part of the annual general health assessment for medical students. This screening will help identify risk factors, early symptoms, and opportunities for treatment of mental disorders and prevent the need to interrupt the affected students' medical education. Routine screening also reduces the stigma surrounding mental health. Each medical school should have at least one qualified mental health professional to provide confidential services for students and faculty. This professional should also organise campaigns to address the stigma surrounding seeking mental health-care services among medical students and faculty and to promote mental wellbeing initiatives. Medical schools might wish to invest in physician wellness offices and mental health-care services for medical students and faculty, both in-person and online.[55,56] Equally important is the development of self-help and peer support approaches, including training in psychological first aid.[57]

Sustaining and advancing high-quality and effective undergraduate medical education in psychiatry will require determination and planning. However, with international partnerships and the use of advanced

digital tools (eg, databases, search engines, educational videos, podcasts, simulations, virtual learning environments, social networking sites, blogs, massive online open courses, and AI tools),[58] Ukrainian medical schools will be able to provide excellent medical education. Psychiatry departments should be full partners in this effort and could lead the way by using their global relationships to build networks to provide medical student psychiatry training at the highest levels.

Postgraduate psychiatric education

Ukraine is preparing for a transition from its current 2-year residency programme in general psychiatry to the 5-year training recommended by the UEMS European Training Requirements and the European Personnel Selection Office's Competency Framework.[40] This framework provides a modern training architecture and curriculum, and the reader is referred to these documents for details, such as expected training competencies. The current system does not meet the present needs of the population. Longer training will allow doctors to gain broader experience, such as through community placements and subspecialty training. As the programme develops, it should incorporate digital tools, for instance, distance learning, remote supervision, telepsychiatry, and AI applications, as they become available. Health-related national and international organisations should share resources and funding, and assist the diaspora of doctors who moved abroad and connect them and other experts with doctors who remained in Ukraine. Accreditation for trainers and training centres is important to ensure quality of the training provided and can be aided by appraisal mechanisms, such as European Union of Medical Specialists (UEMS) quality assurance appraisals.

Ukrainian psychiatry must make this transition as soon as the necessary technical and organisational conditions are created. Change to the 5-year psychiatry training programme will require careful consideration and planning by Ukrainian psychiatry faculties. A key challenge is the move to the 5-year programme has the potential to cause a hiatus in newly qualified psychiatrists entering the workforce. Ukrainian psychiatry faculty must address these concerns with a plan to continue the flow of trainees and create opportunities to complete psychiatry qualifications in 5 years of training.

Since the onset of the war in 2022, several changes have been introduced in the postgraduate psychiatry training, such as hybrid and online training including collaborations with institutions in other countries.[59,60] CME requirements have been modified (to allow for more credits in digital skills), and the Ministry of Health now mandates more training in digital skills (eg, learning how to work with electronic medical systems).

Subspecialty training

Subspecialty training in Ukraine is optional and is done after completion of generalist psychiatrist training. The options for subspecialty training are: narcology, child psychiatry, psychotherapy, sexual pathology, psychiatric forensic expertise, and medical psychology (figure 2). Although considerable variations exist between curricula and training processes between countries and institutions,[61–63] there is emerging consensus reflected in a European curriculum, developed by The Child and Adolescent section of the UEMS, recommending a minimum of 3 years for child and adolescent psychiatry training overlapping or embedded in psychiatric training. Based on the UEMS psychiatry and subspecialty curricula, it is anticipated that Ukraine will adopt a 2–3-year Child and Adolescent Psychiatry specialty training embedded in the 5 years of overall training. Addiction psychiatry (replacing narcology) and forensic psychiatry (replacing psychiatric forensic expertise) will require a similar training duration and arrangements. At present, Ukraine does not provide old age and consultation-liaison psychiatry training; these programmes should be developed along with training pathways for greater subspecialisation in neurodevelopmental disorders and neuropsychiatry. Although maintaining a balance between generalist and subspecialist training is a challenge, developing a national mental health workforce plan will guide Ukraine through this complex transition.

CME

All psychiatrists should commit to CME or lifelong learning to ensure ongoing development of their professional practice to a high standard to achieve the best mental health outcomes for patients and communities. These ideals require psychiatrists to adopt a personal ethical attitude of maintaining professionalism. Psychiatrists also need access to quality education and training opportunities, with efficient systems for documenting and reviewing progress and evaluation to ensure CME leads to effective clinical outcomes. Quality CME acts to protect the mental health and wellbeing of the psychiatric workforce, while contributing to improved community advocacy, and reduced stigma. Furthermore, CME in mental health should be accessible to primary care physicians and other specialists outside psychiatry. Ukrainian CME should reflect the needs of a multidisciplinary mental health-care system and workforce and include digital skills and tools for distance learning, remote clinical supervision, access to electronic databases, and other online services, including teleconferencing and telepsychiatry. At present, CME oversight in Ukraine is provided by the Ministry of Health. The UEMS Section of Psychiatry is responsible for accrediting CME and provides a pathway to harmonising CME across European psychiatry; it is recommended the UEMS process be adopted in Ukraine.

Panel 3: **Recommendations for training and education of the mental health workforce**

- Conduct a national training needs assessment of the current and future requirements for the mental health service system and formulate a National Mental Health Workforce Plan or similar overarching guiding document
- Ensure appropriate, equitable, and sustainable funding for mental health education and training programmes
- Provide resources and structures necessary for longer psychiatric training experiences for medical students and residents aligned with European and quality assurance standards, including adopting the European Union of Medical Specialists (UEMS) psychiatry frameworks for training and continuing medical education (CME)
- Support current subspecialty training and the addition of new training pathways in old age, consultation-liaison psychiatry, neurodevelopmental disorders, and neuropsychiatry consistent with European frameworks
- Develop collaborative public mental health training and experiences for professionals participating in multidisciplinary, community-based mental health service teams
- Include mental health in policy initiatives and specify the role of specialist mental health professionals in these initiatives
- Provide psychiatrists with leadership and management training and skills to support multidisciplinary teams, legal reform, care reform, advocacy, stakeholder engagement, capacity building, and community engagement
- Enhance CME programmes to support the psychiatrist leadership and participation in multidisciplinary, community-based service teams and training for other medical specialties and health professionals in line with UEMS CME framework
- Ensure training on human rights and ethical issues, mental health legislation, diversity and non-discrimination needs is incorporated in the curricula for all disciplines in the mental health workforce

Training framework for system change

A community-based approach to mental health care requires close collaboration of psychiatrists with other health professionals, such as general practitioners and community workers. The implementation of WHO's mhGAP Action Programme in Ukraine is a major step towards equipping primary care providers and the non-specialised workforce to address mental health issues within their communities. However, additional comprehensive health-care workforce programmes are needed. These programmes should focus on suicide prevention,[64] screening for substance use disorders and providing care for those affected, mental health-care service utilisation, and enhancing coping behaviours among conflict-affected populations.[65] Considering the adverse effects of military actions on the population's mental health, training programmes must integrate a trauma-informed approach and address occupational stress across various education levels. In resource-limited settings, such as Ukraine, supporting task-shifting approaches is crucial and requires additional training for specialists such as nurses and non-medical workers to expand their care roles.[66] Addressing these areas is essential for developing a holistic approach to mental health care that can effectively meet diverse population needs, particularly in conflict-affected contexts.

Training for the extended mental health workforce

The mental health workforce must be conceptualised to include people with lived experience, carers (formal and informal), family members, and community members, and across service systems. The training for this emerging peer (consumer and carer) workforce needs to be developed. The professional workforce will require the competencies to engage and facilitate interactions with this broader workforce.

A multidisciplinary, community-based workforce will require specialised training for a variety of professionals, including psychologists, social workers, nurses, occupational therapists, and others. Curricula will need to be developed and collaborative clinical experiences created. The Commission recognises the importance of this training; however, the absence of representation from these professions among the Commission members leads to the recommendation that experts from each of these disciplines design appropriate training experiences, and then work with their colleagues in other disciplines to create collaborative transdisciplinary training structures and experiences. WHO's mhGAP might be a useful resource for this process.[37,67,68]

Conclusion

Ukraine's transition to a community-based, multidisciplinary mental health-care system depends on the comprehensive reform of its training and education practices for the mental health workforce. This reform will involve embracing innovative, collaborative educational methods that foster digital proficiency and cross-disciplinary teamwork (panel 3). By integrating these changes with European standards and focusing on trauma-informed care, Ukraine can enhance the effectiveness and reach of its mental health-care services in these challenging times. Effective leadership and ongoing professional development will be crucial for sustaining this advancement and ensuring that the mental health workforce is equipped to meet the diverse needs of the community.

Part 3: Rebuilding mental health research capacity and infrastructure

Historically, Soviet models have dominated Ukrainian mental health research, leaving the country lagging behind European, US, and other models. Since Ukraine gained independence, with the assistance of international colleagues, creative leaders in Ukrainian psychiatry have initiated efforts to remedy these problems. However, the Russian invasion of eastern Ukraine and Crimea in 2014, and the full-scale war in 2022, led to the massive destruction of Ukrainian universities and research facilities, as well as widespread death, displacement, and emigration of mental health academics and researchers. Even in the face of this catastrophe, Ukraine has taken an optimistic view of its future by planning to rebuild the

mental health-care system with a strong, productive psychiatric research enterprise that supports a modern approach to psychiatric practice, training, and science.

The Commissioners focused on developing recommendations for building and sustaining robust Ukrainian research capacity and programmes, including necessary infrastructure, such as: funding; support for early research career development; resource allocation; establishing an optimal balance between basic and applied mental health research; research governance; and defining how best to do research in various settings (ie, hospitals, the community, and primary care). The Commission reviewed relevant, peer-reviewed government and NGO literature on rebuilding research infrastructure in countries experiencing war and disaster. We also obtained data on research funding in Ukraine, consulted experts, and held three focus groups with mental health researchers currently residing in Ukraine or living abroad as emigres and refugees.

The US National Academy of Sciences convened a workshop in September, 2022, that included members of the Academy and prominent Ukrainian scientists to discuss rebuilding research, education, and innovation in Ukraine. The final document offered a ten-point action plan for the recovery of scientific activity in Ukraine.[69,70] Although this document does not specifically mention mental health, the plan is relevant to our Commission. The ten points, together with the results of the focus groups, formed a foundation for our recommendations.

Ukrainian mental health research funding: historical and current

Adequate funding is key to supporting mental health research development. In Ukraine, research funding, already insufficient, has now been depleted as funds are understandably diverted to support the defence efforts. From 2016 to 2019, more than 180 research projects were supported annually by the Ministry of Education and Science; none of the projects focused on mental health (figure 3).[71] In 2020, the Ministry supported one mental health research project, accounting for 0·3% of the Ministry's total research budget, which was a mere 7·8% of all the Ministry's health research funding. Similarly, from 2019 to 2023, the Ministry of Health provided some funding for mental health research, annually supporting five to eight projects with an average annual total funding of US$101 000 (figure 4).[72]

In 2020, the Ukrainian National Research Foundation funded 218 projects, with only one project focused on mental health, accounting for 0·16% of the total budget.[73] In 2021, of 57 successful proposals, two were related to mental health and represented 6·2% of the funded health projects. These projects were allocated $316 100 in total, which was 2·2% of the Foundation's research budget. In 2022, only one mental health project was funded. With the onset of the COVID-19 pandemic, private foundations started to provide funding for Ukrainian NGOs to do field research on mental health and to prepare relevant policy developments for changes in the Ukrainian mental health-care system. Information on the amount of private funding and the research foci is not publicly available; therefore, it is impossible to determine the amount of philanthropic mental health research funding currently available in Ukraine. This apparent shortage of funding makes Ukrainian mental health research extremely difficult to implement at the present time and at least in the near term, going forward.

Focus group results

Three focus groups were held with experienced and early-career Ukrainian mental health researchers, both within and currently outside of Ukraine. These virtual focus groups (appendix pp 1–2) helped the Commission to understand the pressing problems and priority areas for mental health research development during the Russian war on Ukraine and in the post-war period.

For the **database of research projects funded by the Ministry of Education and Science of Ukraine** see https://nauka.gov.ua/projects/

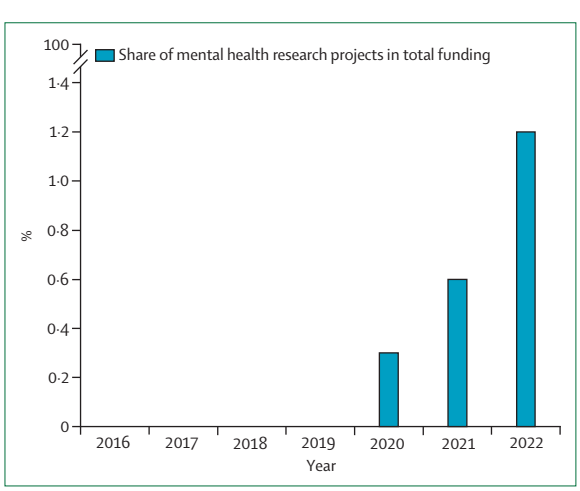

Figure 3: **Share of total funding of the Ministry of Education and Science of Ukraine allocated to mental health research projects**[71]

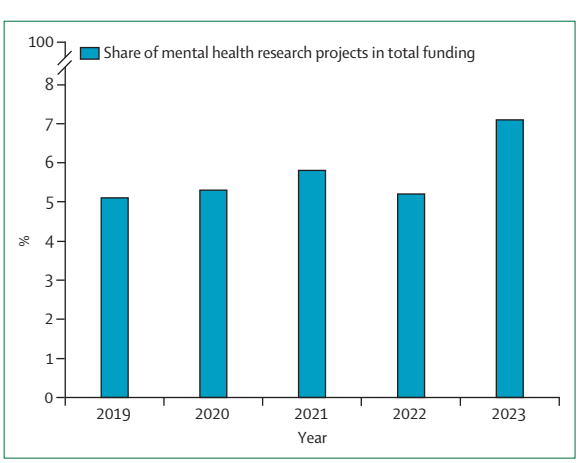

Figure 4: **Share of total funding of the Ministry of Health of Ukraine allocated to mental health research projects**[72]

The first focus group, convened in July, 2023, identified several barriers to mental health research in Ukraine, including a shortage of governmental research support, no funds for attending international conferences, and little access to collaborations with foreign researchers. Improvements in these areas were seen as necessary for obtaining research training and experience and creating opportunities for participation in international funding collaborations and proposals.

The second focus group, convened in August, 2023, identified similar challenges to the first focus group, including insufficient funding and barriers to participation in international conferences and foreign collaborations. The group also reported little access to modern research infrastructure, outdated furniture, and scarcity of computers and laboratory equipment for researchers in Ukraine. Participants agreed that Ukrainian universities need a new model for evaluating the quality of research activity by using contemporary measures of effect (eg, h-index) instead of Ukraine's traditional metrics of academic progress, such as time in a position, and local appointments.

The third focus group, convened in November, 2023, identified the difficulty of building an effective team to complete grant projects and do research as the major barrier to conducting mental health research in Ukraine. The group members were concerned that they cannot provide young researchers with necessary work experience, especially learning how to work in large research teams. Another barrier is that many experienced researchers are not proficient in English, which makes it difficult for them to establish and maintain international research collaborations for themselves and their juniors. Additionally, these investigators do not have sufficient time to focus on their research as they are overloaded with clinical practice obligations. Participants also reported that their work is adversely affected by burnout due to irregular working hours, the constant threat of air strikes, and occasional blackouts. All participants emphasised the need to develop participatory research and increase the share of applied research addressing the implementation of much needed, evidence-based mental health interventions. Experienced researchers did not report any challenges in obtaining funding; however, they suggested that receiving funding from international organisations is much easier than obtaining it from Ukrainian resources, including the Ministry of Education and Science, the Ministry of Health, and the National Research Foundation. Given the current situation and available opportunities, experienced researchers agreed that the priority for the development of mental health research is active networking and access to international conferences for Ukrainian scientists. Ukrainian researchers should be invited to international webinars to form collaborations with members of the international research community.

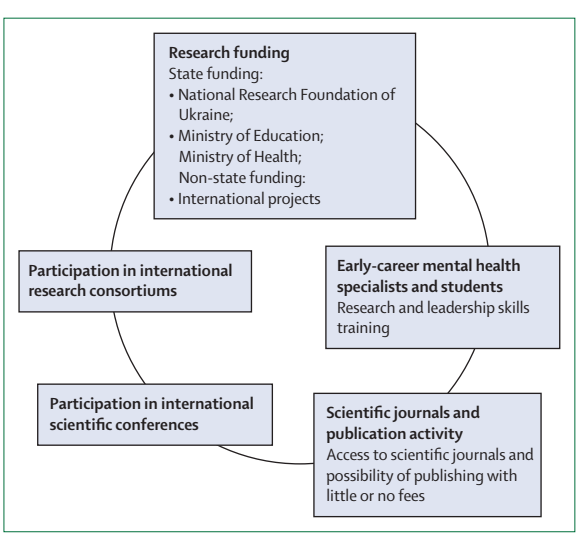

Figure 5: **Proposed research model**

Strengthening mental health research

The Commissioners' view is that Ukrainian decision makers face an acute need for applied health research to improve short-term health outcomes and to build a robust health-care infrastructure for improved long-term health outcomes (figure 5). The Ukrainian health system must implement evidence-based mental health innovations while Ukraine recovers from the trauma of war.

Recovery efforts after the tragic events of the ongoing war offer the opportunity to build a world-class mental health-care system supported by an integrated research infrastructure. A mental health strategic data management platform should be built for use in community and hospital networks providing mental health-care services. A programme of evaluation research is needed, which should be led by Ukraine investigators. The implementation of a harmonised data collection protocol across all mental health-care services will allow the country to create a learning health system,[74] in which data on the prevalence and incidence of mental disorders, and on mental health-care services are collected systematically. Implementable solutions can be developed that meet local needs: evidence should then be collected for evaluation of the effects of the implemented changes.

Building Ukrainian research infrastructure in the learning health system context[74] requires investments in interdisciplinary, basic, and applied health research projects that address existing and emerging mental health-care service system needs (eg, facilities, trained personnel, and inclusion in primary care settings). These investments should build on the developing research support provided by experts outside of Ukraine who have visited the country and supported young investigators, as well as invited them to visit their laboratories and participate in international meetings. The mhGAP programme has been a particular focus of mental health capacity building in Ukraine in over the last decade. The results of this support provide an ideal opportunity to

evaluate implementation and cost-effectiveness of the programme.

Ukrainian mental health research must expand beyond its traditional setting in hospitals into community-based operations and the primary health-care system. Funding should first be focused on rebuilding and enhancing existing, high-quality basic and applied research programmes, followed by evidence-based expansion of research to address the disastrous consequences of the war.[75] Lessons learnt from services and implementation research in low-income and middle-income countries facing similar circumstances[76,77] show that judicious investments in research and clinical services improve population mental health outcomes. This strategy will be successful if supported by policies that transcend the disasters of war, along with international collaborations, improved funding opportunities, and new funded positions for junior researchers who will become the next generation of leaders in Ukrainian mental health.

One model for widespread change management we found particularly applicable is the US National Institutes of Health's Fogarty International Center Research Capacity Building Training Grants. This partnership with local researchers, clinicians, and policy makers planned a change management roadmap that included research applications, which can inform systems and policy transformation. Engaging these stakeholders in the design and plans resulted in system transformation, in both low-income and high-income countries.

Conclusion

The Ukrainian research capacity and infrastructure recovery and transformation will require considerable commitment from philanthropic, humanitarian, and government agencies (panel 4). Success is the only viable option. The international community should not underestimate the important opportunities available as Ukraine rebuilds. Collaborative efforts of Ukrainians with researchers from around the world will not only benefit Ukraine but also inform researchers and policy makers in other countries affected by conflict, war, and trauma. The developing Ukrainian mental health research community, in partnership with international collaborators, will build an equitable, just, and compassionate mental health-care system. This shared effort will lead to continuous improvements in mental health, supported by high quality research and professional training.

As the Ukrainian recovery proceeds, there will be lessons to be learnt. Evaluations must be adequately funded so that the effectiveness of initiatives can be assessed. Metrics must be established and include contributions of mental health research to the social capital of Ukraine, as well as the general health, mental health, and wellbeing of its citizens. Carefully designed trials that measure population indicators of success will distinguish good investments from those that are ineffective or harmful.

Now, in the time of war, the outlook for the Ukrainian mental health clinical services and research infrastructure is understandably not the highest priority. However, with appropriate planning and support for mental health research, we know the Ukrainian future is bright. Exciting opportunities exist, which although brought about by these tragic events, might generate important research-based answers for mental health challenges of future wars.

Part 4: Reform of advocacy and legal principles regarding mental health

Mental health regulations in Ukraine are steeped in outdated concepts. These include a deficit focus, limitations on legal capacity, and criminalilisation of mental disorders. These all serve to reinforce stigma and promote the image of those with mental disorders as being second class citizens. Although Ukraine's First Lady and many NGOs, among others, are raising awareness about the prevention of mental health impairments during the war, the likelihood of war-related serious trauma is growing by the day. The effects of such trauma are exacerbated by the mental health workforce being weary, understaffed, and by many health-care workers moving abroad.

For more on **Fogarty International Center research capacity building training grants** see *Ann Glob Health* 2014; **80:** 126–33

The paradigm shift required to create appropriate support for mental health patients, staff, and care providers, as well as advocacy for a state-of-the-art human rights-based approach to mental health, would be challenging under the best of circumstances. With the ongoing war, the challenge is both great and urgent. Legislative change is particularly needed for people whose mental disorders might contribute to their committing crimes. At present, they potentially face an outdated judiciary and care system that is devoid of effective human rights guarantees and full of Soviet-era rudiments. The Commissioners' assessment of the current legal system is grounded in the robust case law of the European Court of Human Rights against Ukraine, and the Concluding Observations on Ukraine by the CRPD Committee. The Commission urges prompt implementation of recommendations of the European Court of Human Rights and the CRPD of the Office of the UN High Commissioner for human rights office.[80] The latter is the state-of-the-art framework for advocacy and legal principles regarding mental health. Eight legal principles were chosen by the Commissioners as the most important for Ukraine at this time.

Non-discrimination based on health status and the need for holistic rehabilitation

Ukrainian mental health legislation relies heavily on the term "suffering from mental disorder", which is derived from the medical model of disability. Professionals in Ukraine should choose language that counters stigma regarding mental illness. Use of alternative terms, such as psycho-social impairment, should be considered. The

Panel 4: **Recommendations for rebuilding mental health research capacity and infrastructure**

- Facilitate post-war repatriation by assisting the Ukrainian scientists, trainees, and students who moved abroad temporarily to maintain their affiliations in Ukraine. Offer international researchers affiliations with Ukrainian universities to enhance research collaborations, mentorship, teaching, and access to datasets.
- Provide targeted funding for training programmes (virtual and in-person) for Ukrainian researchers, designed to support career development and collaborations, especially with international partners. Enable Ukrainian researchers, both junior and senior, to build networks and collaborations, and to receive training and mentorship on contemporary research methods and tools.
- Invite researchers to programmes, within and outside Ukraine, that offer mental health support for people living in conflict zones and people with trauma, to implement and evaluate innovative interventions in Ukraine. Allocate more Ukrainian research funds to mental health, with targeted funding for key topics and research priorities developed by the mental health community (both Ukrainian and international mental health experts) accompanied by a system to provide high quality, rigorous, and constructive feedback to investigators. Applied research and implementation science research should take place across multiple settings (ie, hospital, community, and primary care) and be done by multidisciplinary mental health research teams.
- Study the social and economic effect of deinstitutionalisation.
- Replace equipment damaged during the war and provide access to specialised research facilities by collaborating with international funders, partners, and organisations.
- Provide free access to international scholarly journals for Ukrainian scientists, trainees, and students. Support travel to international conferences, especially for Ukrainian researchers to present their work. The Government must provide subsidies for Ukrainian journals focusing on mental health.
- Waive or subsidise publication fees, membership dues, and conference participation fees for Ukrainian researchers during this key period and immediately after the war.
- Modernise the mental health research and training infrastructure by increasing the capacity for multidisciplinary teams to engage in research across hospital, community, and primary-care settings.
- Establish a specialised, distinct mental health research funding agency in Ukraine, similar to those in Canada, the USA, the UK, and across Europe. For the period of transition to such a system of public funding, the Ukrainian National Research Fund and the Ministry of Education and Science should set aside targeted funds for mental health research.
- Establish goals and milestones for the development of mental health training, research, and services. Charge a specific Ukrainian Government body with monitoring progress in reaching goals, while assuring that effect is maximised, redundancy is eliminated, and policy changes benefit the mental health of all Ukrainians. The government body should support efforts mandated by international mental health research funders to employ harmonised measurement tools, participate in Open Science, ensure modern standards of research ethics, and apply principles of research and academic productivity that emphasise effects, as designated in the Declaration of Research Assessment and the Hong Kong Principles.[78,79]

terminology could be expanded to cover and protect people with intellectual impairments. The Commission reinforces the importance of a shift to a human rights-based model of disability, prioritising the need for holistic rehabilitation (article 26 CRPD).[3] Mental health care must be provided by multidisciplinary teams to ensure holistic diagnosis, individualised support, and rehabilitation, including recovery, to minimise the likelihood of barriers to accesing employment, education, and other aspects of community participation and discrimination.

Independent living in the community and deinstitutionalisation

For at least 5 years, the funding for inpatient psychiatric services in Ukraine has been decreasing under the guise of deinstitutionalisation.[81] However, deinstitutionalisation and the transition to community-based services recommended by the Commission (Article 19 CRPD)[4] requires allocation of resources. A functioning, cohesive, and sustainable treatment and support service in the community, including basic protected housing, employment, peer support, and mobile crisis teams, is a prerequisite. Premature closure of psychiatric institutions before community services have been developed puts people at risk of inadequate care, which can lead to the deterioration of their mental health, increased rates of homelessness, and other negative social outcomes, ultimately compromising their recovery and overall quality of life.

Right to life and right to live in dignity

People with mental disorders, including individuals who have committed crimes, are entitled to good emotional and physical health. The right to life in the Ukrainian mental health-care system is jeopardised by the insufficient physical health care in institutions.[82–84] Equally perilous are the inhumane conditions in institutional settings, as exemplified by the case of Kaganovskyy v Ukraine,[85] where the European Court of Human Rights established that the conditions of the enhanced supervision unit of the Kyiv Psychoneurological Social Care Home had been degrading. The Ombudsman's reports on the prevention of inhuman and degrading treatment[86] are replete with examples of inappropriate material conditions.

Assumption of capacity

In Ukraine people with mental health impairments are often legally incapacitated. This process is frequently done via the substitute decision making mechanism known as guardianship, which fully restricts the right to vote,[87] marry,[88] and control income, and limits the right to have standing in court,[89] conduct any major legal transaction,[90] have custody of a child,[91] and decide whether to keep a pregnancy.[92] Legal capacity, including the right to act on one's own behalf, is a basic human right.[93] People with mental disorders must be assumed to have legal capacity and, to the extent that it is necessary, be assisted in asserting this right.

The Ukrainian concept of capacity is antiquated, as a court may remove the legal capacity of a person. "A physical person may be declared incapacitated by a court if he or she as a result of a chronic, persistent mental disorder, is unable to realise the significance of his/her actions and (or) to control them."[94] The Commission recommends

setting clearly defined, short-term limitations imposed solely in the specific areas where any person does not have capacity or understanding, preserving all other rights and freedoms. The existence of a mental health impairment cannot be the sole reason to justify incapacity, and in particular, full incapacity.[95] Furthermore, various forms of advanced planning and supported decision making mechanisms must replace guardianship.[96]

Right to liberty

A disability shall in no case justify a deprivation of liberty (Article 14 CRPD).[3] The Commission recommends an amendment to Article 14 of the law on psychiatric care to make it consistent with CRPD, which allows involuntary hospitalisation if a person is unable to meet his or her vital needs at the basic level. The practice of placing people in institutions, seemingly voluntarily, and then restricting their right to leave the institution needs to be regulated. Also, placing residents of social care homes in restrictive enhanced supervision units requires legal regulation.[97]

The Commission recommends that involuntary hospitalisation when a person poses danger to themself or others should follow the European Court of Human Rights[98] guidance, including recognition of an enforceable right to an external or alternative psychiatric assessment, guarantees for independence, impartiality and objectivity of medical examinations, and the principle of least restrictive alternative. The Commission commends the decision of the Constitutional Court of Ukraine[99] nullifying the possibility of extrajudicial involuntary hospitalisation of people deprived of legal capacity.

Involuntary psychiatric assessment

Involuntary psychiatric assessment is a form of deprivation of liberty and requires the same set of guarantees that apply to any other involuntary intervention. Courts ordering any involuntary psychiatric assessment must take the guarantees spelled out by the European Court of Human Rights[100] as the baseline. The Commission recommends enshrining these guarantees in Article 509 of the Ukraine Criminal Procedure Code and extending the criminal justice system guarantees to any involuntary expert assessment in administrative and civil cases. The Commission sees the importance of inpatient psychiatric examination in some cases. Increasing the number of state-licensed forensic experts is recommended, which should also reduce the risk of corruption.

Fair trial principles

The European Court of Human Rights has found inadequate arrangements for dealing with patients' complaints, poor access to legal representation, and little or no access to an independent outside body in Ukraine.[101] The European Court of Human Rights admonished Ukraine for its absence of effective legal remedies, with an adequate remedy primarily being one capable of effectively ending violations by ordering an immediate release.[102] The Commission welcomes the mandate of the Ukrainian Ombudsman to make ad hoc visits to institutions, but acknowledges that the Ombudsman mostly focuses on recording information rather than providing accountability.

The Commission welcomes that Ukrainian law guarantees free legal aid and recommends that this guarantee be expanded to the entire duration of hospitalisation, including procedural accommodation (Article 13 CRPD). The establishment of an independent patient's advocate to be called in within 24 h of the start of treatment (this is not the same as the legal representative mentioned above) should be considered.

The Commission urges Ukraine to improve the appeal procedure for people undergoing involuntary hospitalisation per Article 17 of the Law on Psychiatric Care by implementing the pertinent ECtHR judgement.[103] The Commission urges that the right to liberty be given importance and meaning.

Decriminalisation of mental health impairments

Article 18 § 4 of the Law on Psychiatric Care requires a court order for the discharge of a person whose involuntary treatment order has expired.[104] Involuntary treatment in criminal cases has been criticised by the European Court of Human Rights[105] and the 2020 Federation Global Initiative on Psychiatry expert report on Ukraine.[106] Holding people with mental health impairments accountable solely on the basis of their disability runs counter to the contemporary understanding that the person has to be separated from their behaviour and that the behaviour needs to be judged differently if an impairment seems to be present. Accordingly, the perception of a person being dangerous cannot by itself, and particularly not on account of stigmatising concepts of mental health, be a basis for criminalisation.

The Commission recommends a person-centred approach based on human rights, maximising the agency of the individual. The rules discussed and the European Court of Human Rights case law (combined with the inaccessibility of inpatient forensic assessments) criminalise mental health impairments, with an overemphasis on perceived dangerousness and conflation of the person and the problematic behaviour. The Commission recommends that Ukrainian law makes a distinction between risk of some behaviours and the perceived seriousness of the same behaviour. Lastly, the Commission believes that the Ukrainian judiciary will benefit from training on mental health and human rights, with one of the highlights being that people with lasting and severe mental health impairments often have no legitimate penological reasons to remain in the penitentiary system.

Panel 5: **Recommendations for reform of advocacy and legal principles regarding mental health**

- Amend mental health laws to reflect international standards, and to be human rights-based and person-oriented, including the assumption of capacity, prioritising consent, with strict limitations on oversight of limiting liberty, including appeals with requisite legal aid.
- Restrict involuntary interventions to necessary cases with strict time limits, strong multidisciplinary oversight, and effective legal protections.
- Integrate human rights principles into legal disposition, including the harm to self and others, based on multidisciplinary assessments, rehabilitation possibilities based on recovery, with peer support, and decriminalisation of mental health conditions.
- Create avenues of redress for possible challenges in the transitional phase from institutional care to community-based services and avenues.
- Overhaul guardianship based on the assumption of capacity with strict time limits. Introduce advance planning and supported decision making.

Conclusion

Although wartime might not seem to be an optimal time to reform a country's mental health system, especially its legal and regulatory elements, it might in fact be just the right moment for Ukraine. The war is and will continue to affect the entirety of the Ukrainian population, leading to the higher prevalence of mental symptoms and disorders, especially among people most proximal to the carnage, military personnel, veterans, first responders, and individuals with physical and emotional trauma. The high levels of concern given to these victims, especially veterans, provides just the impetus necessary for difficult changes. This leverage can be used to transform the entire mental health system, including reform in advocacy and the legal principles underpinning mental health. The process of transformation should begin with abolishing discrimination based on mental health status and will lead to a focus on wellness and rehabilitation, as well as the right to live with dignity. Application of these principles will result in deinstitutionalisation and creation of the belief that most services can be provided in communities where people with mental disorders will be assumed to have the capacity to make decisions about their daily lives and care and can receive compassionate and person-centered care free from stigma and criminalisation. With these legal and policy changes will come a shift in the mental health care paradigm to one that is human rights-based, with equitable justice for Ukrainians with mental disorders and symptoms (panel 5).

Part 5: Resourcing the future of mental health

Similar to many mental health-care systems inherited from the Soviet era, mental health-care services in Ukraine have been delivered using a predominantly biomedical approach that relied on a specialist, institution-based model of care. The Ukrainian Government's Concept Note (2017)[7] and Action Plan (2021)[107] for mental health set out a very different, more contemporary vision for Ukraine, including legislation that aligns with international human rights, new mental health promotion and prevention programmes, and plan for the reconfigured services designed to meet the needs of users at the local community level.

In 2020, total health expenditure in Ukraine amounted to $270 per capita (about 8% GDP), divided almost equally between government-funded services and private, out-of-pocket spending by households. Mental health accounted for about 2·5% (about $6·75 per capita) of the total health-care expenditure, predominantly through inpatient psychiatric care.[108,109] In April, 2020, the bulk of funding for mental health-care services moved to a contract-based system, as part of health financing reforms.

The NHSU includes four care packages: inpatient psychiatric care, maintenance therapy for opioid use disorders, mobile multidisciplinary team-based mental health-care services, and support and treatment of adults and children with mental disorders in primary health-care settings.[110] In 2022, total recorded NHSU outlays for these service packages amounted to $101 million or $2·67 per capita (close to 2·5% of all NHSU expenditure); in 2023, expenditure increased by 2·7%. Additionally, funding for outpatient care and medicines is available; however, it is not possible to determine the amount allocated to mental health because disease-specific disaggregation is not available. There are also mental health-care services within specialised, state-funded services including the armed forces, the security service, and the penitentiary system. Overall mental health spending by the state is estimated to be at least 2·5–3% of all government health expenditures. There is no funding allocated to prevention and health promotion in the budget.

Beyond the health sector, there are 262 boarding institutions in Ukraine, including 147 neuropsychiatric nursing homes (internats), with 26 000 residents. The average cost of these institutions is $51 per month per person, for an overall annual expenditure of $16 million. Boarding institutions also provide assisted accommodation and medical care for people with special needs. Currently, about 1000 people receive assisted accommodation and medical care, at a cost of $272 per month per person, or $3·3 million annually.

In addition to direct health and social care costs, mental and behavioural health conditions lead to large productivity losses. Applying the standardised method developed to represent national mental health investment,[111] Ukraine's losses due to premature death, absenteeism and presenteeism at work have been estimated to exceed $1 billion per year,[109] which is ten times

the amount spent by the Government on mental health-care services. In addition to these measurable costs, the COVID-19 pandemic and protracted war have resulted in incalculable costs in impaired population mental health and wellbeing, including costs related to bombardment, forced displacement, bereavement, disrupted education, and fear or uncertainty about the future.

Resource implications of transitioning to a comprehensive, community-based mental health-care system

Estimates of resource need for mental health care should be based on the current conditions in Ukraine, not pre-pandemic and pre-war data. WHO estimates that one in five people (22%) living in an area affected by conflict have some form of mental health condition.[112] However, this figure might be an underestimate. For example, a 2022 study[113] found that more than 80% of Ukrainian students had symptoms of depression, anxiety, and sleep disorders. Additionally, the war has forced millions of Ukrainians to become internally displaced, losing their homes and being separated from families and communities. Internally displaced people experience stress and anxiety and sometimes try to cope with these problems by using substances, including alcohol. Combatants must have access to mental health services both while on active duty and after they return to civilian life. This requires careful planning. Data from the Ministry of Defense indicate that anxiety disorders, depression, and substance use disorders are twice as prevalent among participants in combat, when compared with the general population. Unfortunately, with only one psychologist for every 400–500 individuals in the Ukrainian army, adequate care within the current military structures is impractical and new integrated military and civilian resources must be created to provide the requisite services.[114]

Management of severe mental disorders

Based on the Global Burden of Disease (GBD)[115] study estimates for Ukraine in 2021, 350 000 people (almost 1% of the total population) have a severe mental disorder, including non-affective psychosis and bipolar disorder. A major part of governmental mental health spending has been directed towards treatment and care for people living with these severe disorders. This practice is set to continue, but via a service configuration that progressively offers care and support to an increasing number of individuals in need, and at the community level delivered by mobile multidisciplinary teams supported by acute inpatient care and primary health-care services), rather than through hospital-based outpatient and mid-term to long-term inpatient services alone. The overall annual cost of a treatment and care package for a person living with a severe mental disorder in Ukraine is estimated to be about $250,[109] indicating that the total cost of reaching and treating 300 000 people living with severe mental disorders (equivalent to a coverage rate of over 85%) would be close to $75 million per year.

The cost of expanding the community-based service model is expected to be modest. For example, the base tariff for CMHTs serving a catchment of 200 000 people is approximately $30 000 per year. On this basis, the service cost for the whole country would be $10 million (excluding staff training costs and capital expenditure on vehicles and other operational needs). All costs can be offset by a reduced reliance on medium-term and long-term stay inpatient beds. There are currently 80 such beds per 100 000 population (close to 30 000 in total); fewer than half that number would be required in a reconfigured care model, assuming that no more than 10% of people with mental disorders are admitted to such facilities and the average duration of stay is less than half a year. At a cost of $10–13 per inpatient day,[116] $3·5–4·8 million per year could be saved for every 1000 beds no longer needed. In practice, however, such savings would be partly offset by new investment in community-based supported living services and traditional state-funded disability allowances (of approximately $400 per year for former residents who were in institutional care living at home or with family).

Management of common mental disorders

GBD 2021 estimated that 4 million Ukrainians were living with depression and anxiety disorders.[115] Treatment coverage remains low, despite sustained efforts in the past 5 years to roll-out mental health and psychosocial support services and integrate mental health into primary health care.[12] Both the COVID-19 pandemic and the war have markedly increased the prevalence of stress, anxiety, PTSD, and depression.[117] Therefore, scale-up of mental health-care services and associated investments needs to increase rapidly—by at least a factor of three—if treatment coverage is to reach more satisfactory levels. The annual cost of a treatment and care package for these conditions in the Ukrainian context is estimated to vary from less than $10 to more than $100 (depending on severity and course of illness), but averages close to $50 (including secondary care use by a proportion of individuals with moderate-severe symptoms).[109] Thus, the total cost of reaching 1 000 000 people with these conditions—equivalent to 28% coverage—would be about $50 million. The principal vehicle for such increased coverage is primary health care; subject to satisfactory completion of training in WHO's mhGAP intervention programme, non-specialised health-care providers working in primary health-care settings can now be contracted to provide care and support for up to 18 individuals with a mental disorder in a month, many of whom will be people with depression and anxiety.

Mental health promotion and prevention

Beyond the development of responsive, community-based services as well as mental health and psychosocial support for the affected populations, additional investment is needed for mental health promotion and prevention. For example, school-based social and emotional learning programmes might reduce the incidence of anxiety, depression, and suicidal behaviours, as well as improve academic achievement. These interventions represent a cost-effective use of resources, with a cost per capita ranging from $0·10 to $0·15.[118,119] Another example of such interventions is preventive interventions for depression using group-based cognitive behavioural therapy, which will be cost saving over 5-years.[120] Accordingly, a dedicated proportion (ie, 5%) of the total mental health budget should be allocated to mental health promotion and prevention of mental disorders.

Financing for the future of mental health

The April 2020 health-care funding reforms have already had a positive effect on mental health care, with a clear shift from a psychiatric inpatient care-directed system to more community-based and primary health-care-based mental health care. There is also improved financial coverage for essential psychotropic medications. Although these changes are a good start, continuing along this pathway to a comprehensive, community-based mental health-care system will require not only a substantial number of new professionals, especially for initiatives in community-based settings, but also a substantial increase in total government mental health spending. Based on a service reconfiguration analysis (appendix pp 3–4), the Commission estimates that the development of the Ukrainian mental health-care system will require a two-times increase in the outpatient budget, a three-times increase in the budget for mobile teams, and a 16-times increase in the budget for mental health in primary health care, resulting in a $24 million additional annual operating cost. These additional expenditures can be more than offset by a substantial reduction in the number of inpatient care beds. This more efficient allocation of resources will allow for greater service coverage for individuals with mental disorders and families.

Currently, half of all Ukrainian health expenditures are out-of-pocket, with the highest costs incurred on inpatient care and medications. This situation is untenable; families need greater financial protection against the risk of potentially high or impoverishing levels of spending on health-care services and products. The Government should aim to halve current rates of out-of-pocket spending. If both service coverage and financial protection were to be enhanced in this way, overall mental health spending from all sources would be expected to increase by 10% and public mental health spending by 45% (from 3% to 4·5% of total government health expenditure).

Filling the funding gap for mental health-care services and workers could be partly achieved through reallocated or new revenue streams at the domestic level, for example through increased excise taxes on tobacco, alcohol, and other products detrimental to health. Given the enormous fiscal pressures the country faces now and in the foreseeable future (Ukraine's real GDP declined by 29% during the first year of the war),[122] international development assistance will be required and should be requested as an integral element of post-war recovery. The mental health consequences of the war will be protracted and extensive; it is vitally important that a resilient mental health-care system be in place to provide all Ukrainians with the services and support their needs now and in the future. The effects of the systemic changes required can be tracked by reference to a set of key indicators, including the overall allocation of resources to the mental health sector (as a percentage of total health spending), and the relative distribution of resources between inpatient and other services.

Panel 6: **Recommendations for resourcing the future of mental health care in Ukraine**

- Continue to move from institution-based to community-based services, allowing for more efficient allocation and use of mental health resources.
- Increase the amount allocated to mental health care by the Ukrainian Government from 3% to 4·5% of total government health-care spending. Allocate at least 5% of the mental health budget to preventive measures.
- Explore and obtain international donor assistance to support the implementation of the proposed changes in the Ukrainian mental health-care system, during the war and recovery period.

Conclusion

Inadequate financing of the mental health-care system was a problem in Ukraine before the beginning of the COVID-19 pandemic; it has become even more urgent with the outbreak of the war. The growing prevalence of mental disorders has led to a sharp increase in the demand for mental health-care services, which, in the context of the large-scale economic crisis caused by the war, cannot be fully covered either by state funding or by out-of-pocket spending. Development of the Ukrainian mental health-care system, which is essential to meet the growing needs of the population during and after the war, requires efficient use of available resources and reconfiguration of the system of funding for mental health-care services (panel 6). These changes can be made by reallocating budget revenues to increase mental health funding to 4·5% of the total government health-care spending, reducing the number of inpatient care

beds, and attracting assistance from international donors to support reform and adequate funding of the Ukrainian mental health-care system.

Commission conclusion

The *Lancet Psychiatry* Commission on mental health in Ukraine offers recommendations for further development of the Ukrainian mental health-care system that ensure relevant interventions and services can be provided for all population groups, at all stages of life, in health and disease. The envisioned network of services includes: basic psychosocial support and brief psychological interventions provided by non-specialised staff in the community; management of common mental disorders in primary health-care settings; community mental health centres and multidisciplinary teams providing specialised mental health care; acute inpatient care in general hospitals; and residential services and supported accommodation for people with severe mental disorders. The suggested stepped-care approach to service provision requires efficient distribution of resources across the steps, with mental health professionals sharing tasks with non-specialised staff who are given training and supervision, and establishing standardised assessment tools and criteria for referrals to specialist services. This transformation also requires changing the overall approach to care provision to working towards people's recovery, social inclusion, and protection of human rights, as well as shifting from crisis management to risk mitigation and crisis prevention. Gradual transition of people currently living in long-stay psychiatric institutions to residential services in the community needs to be done as soon as these services become available.

To support and sustain the transition to new systems of mental health care, Ukraine will require a skilled and resilient multidisciplinary mental health workforce, which can be developed only with substantial revisions in training curricula and clinical training experiences. Undergraduate medical students must have practical experience with people with mental health conditions starting earlier in their training and spending more time in more diverse settings. For both medical students and psychiatry residents, training should include learning and clinical experiences with colleagues in all the mental health disciplines. Additionally, Ukrainian general and subspecialty psychiatry must align with UEMS guidelines, particularly in terms of duration of training and exposure to broad clinical populations and therapeutic tools, while psychiatrists should also learn to work on and to lead multidisciplinary teams. Evidence-based assessment and treatments should be at the heart of this training. The Action Plan[107] for mental health-care services should support current subspecialty training in forensic, addiction, and child and adolescent psychiatry, with the addition of programmes in old age and consultation-liaison psychiatry. Expanding the workforce of other mental health professionals will be essential for the creation of the essential community-based, collaborative multidisciplinary teams.

Building a capable mental health research effort will require development of research infrastructure, augmented with international support and collaboration. To achieve these goals, re-balancing of mental health research funding will be necessary, so that it is consistent with the prevalence and effects of mental disorders within the entire health-care system. Training of Ukrainian mental health researchers must take priority, to produce clinical and other scientists to support the needs of the population.

There are legal issues that must be addressed to bring Ukraine in line with international standards of human rights and clinical practice. Although issues related to capacity and competence, guardianship, coercive treatment, advocacy, and others might be partly addressed by the shift to community-based care, statutory, regulatory, and policy issues must be addressed promptly.

Finally, financing of Ukrainian mental health-care services is inadequate and inefficient. Not only is the total financial support for mental health care disproportionately low relative to the needs of the population, but also a disproportionate share of financial resources is allocated to large institutional care rather than more efficient, more effective, evidence-based, community health-care services. The problem can be readily addressed by resource needs assessments, financial investments, and the gradual shifting of resources to meet the needs of patients and families in their homes and communities.

The plan for Ukrainian mental health is ambitious, because the mental health needs of Ukraine are vast, but the plan is manageable with the thoughtful transition of services and training to contemporary evidence-based standards of practice, supported by effective research, legal, and financial structures. The Commission is convinced that Ukraine is ready and willing to make the necessary changes to meet the standards and join the community of nations providing compassionate and effective mental health-care services for all their citizens.

Contributors

IP, NS, and BLL led the conceptual framework, invited the Commissioners and coordinated their work, wrote, reviewed, and edited the paper with input from all authors. AL-B, MCD, GAC, DC, and PS conceptualised manuscript. AL-B, MCD, GAC, DC, PS, LL, VV, YY, OP, VK, APSG, SC, OM, PGR, MDH, HYL, LJDP, MK, MPdC, JGS, MLW, LS, RWB, RvV, IF, CM, and SK wrote and reviewed the manuscript. LL, VV, YY, OP, VK, APSG, SC, OM, PGR, MDH, HYL, LJDP, MK, MPdC, JGS, MLW, LS, RWB, RvV, IF, CM, and SK edited the paper.

Declaration of interests

MCD declares support from the Commission for travel expenses to attend research group meetings; she is President of the European Union of Medical Specialists Section of Psychiatry, a European Exam Board member, Secretary of the European Psychiatric Association Section on Women's Mental Health, and a Member of the European Psychiatric Association Publications Committee. NS declares being a member of Executive Board and Secretary for Education and Scientific Publications of the World Psychiatric Association. RWB declares royalties from the LexisNexis textbook of Guardianship in medical

assistance; she was a member of the Osmind Community Advisory Board, and the American Psychiatric Association Executive Committee. HYL received financial support from World Psychiatric Association to attend the World Congress in Vienna; and is the Chair for the Council on Communications (unpaid), Chair for the Board Board of Radius Omaha (unpaid), and the co-Chair for the Medical Student Working Group (unpaid). LJDP has received honoraria from Boehringer-Ingelheim and Viatris; and has a leadership role at the European Psychiatric Association; European College of Neuropsychopharmacology, European Psychiatric Association Board and Education Committee, European College of Neuropsychopharmacology Workshop Committee, and Belgian College of Neuropsychopharmacology and Biological Psychiatry Board. AL-B declares financial support from WHO for attending two Commissioners meetings. BLL is the owner of Bennett L. Leventhal, MD, PC, a personal professional corporation providing clinical, scientific, and business consulting, largely in the health care and mental health field, and is a Board Member and Chair of the Research Committee of the Brain Research Foundation: he has worked in Ukraine on a voluntary basis. SC is a Deputy Chair of the Committee on Bioethics of Scientific Research. AL-B and DC are WHO staff members. The authors alone are responsible for the views expressed in this publication and they do not necessarily represent the decisions, policy, or views of WHO. All other authors declare no competing interests.

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