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HIDDEN BURDENS OF CONFLICT

Issues of mental health
and access to services
among internally
displaced persons
in Ukraine

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Abbreviations

GAD-7	Generalised Anxiety Disorder Assessment
GIP-Tbilisi	Global Initiative on Psychiatry – Tbilisi
IDP	Internally displaced person
KIIS	Kiev International Institute of Sociology
NGO	Non-governmental organisation
OR	Odds ratio
PCL-5	PTSD Checklist for DSM-5
PHQ-9	Patient Health Questionnaire
PTSD	Post-traumatic stress disorder
WHODAS 2.0	World Health Organization Disability Assessment Schedule 2.0

Key findings

- This study provides the first nationally representative data on the mental health status of adult internally displaced persons (IDPs) in Ukraine.
- The study highlights that there is a high burden of key mental disorders including post-traumatic stress disorder (PTSD), depression and anxiety among IDPs in Ukraine, particularly women. In addition, a high number of people have two or three of these conditions simultaneously. High levels of co-morbidity between PTSD, anxiety and depression were also observed.
- Mental disorders have a strong effect on relations with family members, and reduce a person's ability to work and undertake normal daily tasks such as walking.
- There is a high treatment gap for mental disorders among IDPs – almost three quarters of respondents in this study who required mental healthcare did not receive it.
- The costs of mental healthcare services and medicines are high and this is the principal reason why people do not seek care.
- IDPs should be considered as one of the target groups for mental healthcare provision by relevant agencies such as the Ministry of Health, the Ministry of Social Policy and local authorities.
- Our findings support the need for a scaled-up, comprehensive and trauma-informed approach to the provision of mental healthcare for conflict-affected populations.



A man searches through donated clothes at a transit centre in Dnipropetrovsk, 2015.
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Executive summary

Reliable epidemiological data on the burden of mental disorders, key risk factors and access to health services is crucial in helping to design appropriate trauma-informed mental health and psychosocial support responses for the at least 1.6 million internally displaced persons (IDPs) in Ukraine. The aim of this study was to collect scientifically rigorous evidence on the mental health and psychosocial support needs of IDPs in Ukraine in order to help inform relevant policies and programmes. A cross-sectional survey was conducted throughout Ukraine from March to May 2016 involving 2,203 IDPs aged 18 years and over. Descriptive and multivariate regression analyses were used.

This study found a prevalence of post-traumatic stress disorder (PTSD) of 32% (22% men, 36% women), while the prevalence of depression was 22% (16% men, 25% women) and the prevalence of anxiety was 17% (13% men, 20% women). High levels of co-morbidity between PTSD, anxiety and depression were also observed. It was found that mental disorders have a strong effect on relations with family members, and reduce a person's ability to work and undertake normal daily tasks such as walking. This

study also reveals that the main factors significantly associated with mental disorders include female sex, older age, cumulative trauma exposure, recent displacement and a 'bad' household economic situation. A large treatment gap was also observed – 74% of respondents who required mental healthcare over the past 12 months did not receive it.

This study recommends that IDPs be considered as one of the target groups for mental healthcare provision by the relevant agencies in Ukraine. The findings support the need for a scaled-up, comprehensive and trauma-informed approach to the provision of mental healthcare for IDPs in the country.

1. Introduction

It is well known that conflict-affected populations are frequently exposed to traumatic events and war-related socio-economic stressors, which increases their risk of acquiring mental disorders.¹ Common mental disorders among conflict-affected populations such as PTSD, depression and anxiety can cause substantial suffering and may reduce a person's ability to function fully, which affects not only themselves but also their families and communities. Therefore, large-scale psychosocial interventions and community mobilisation are required to relieve individual suffering and enable processes of development and societal reconstruction. Evidence from other conflict-affected settings strongly supports the need for a scaled-up and comprehensive approach – involving, for example, trauma-informed policies – that will guide the mental health system and its services,² in order to address the mental health needs of conflict-affected populations.

There are at least 1.6 million IDPs in Ukraine as a result of the armed conflict in the country – over 95% of whom have fled the fighting in eastern Ukraine. IDPs in Ukraine have experienced multiple types of trauma such as forced displacement, bombardment, being caught in the fighting, injury and assault. They are living in a combination of private accommodation (e.g. with relatives, friends and other host families, or in rented apartments), or in collective settlements (temporary settlements such as camps, former hotels, hospitals, schools and other government buildings). Unemployment is high and access to social support services, including health, appears limited. As a result, the socio-economic stressors for mental health are extremely high.

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- 1 See: World Health Organization (WHO) and United Nations High Commissioner for Refugees (UNHCR), *Assessing mental health and psychosocial needs and resources: Toolkit for humanitarian settings*, Geneva: WHO, 2012; Z. Steel, T. Chey, D. Silove, C. Marnane, R.A. Bryant and M. van Ommeren, *Association of torture and other potentially traumatic events with mental health outcomes among populations exposed to mass conflict and displacement: A systematic review and meta-analysis*, *JAMA*, 302(5), 2009, pp.537–549; K.E. Miller and A. Rasmussen, *War exposure, daily stressors, and mental health in conflict and post-conflict settings: Bridging the divide between trauma-focused and psychosocial frameworks*, *Social Science and Medicine*, 70(2010), 2009, pp.7–16
 - 2 Inter-Agency Standing Committee (IASC), *IASC guidelines on mental health and psychosocial support in emergency settings*, Geneva: IASC, 2007; WHO, *Guidelines for the management of conditions specifically related to stress*, Geneva: WHO, 2013

Reliable epidemiological data on the burden of mental disorders, key risk factors and access to health services are crucial in helping to design appropriate trauma-informed mental health and psychosocial support responses. However, such data are lacking in Ukraine for its conflict-affected populations.

The aim of the study was to collect scientifically rigorous evidence on the mental health and psychosocial support needs of IDPs in Ukraine in order to help inform relevant policies and programmes. The specific objectives were to: (i) measure the prevalence of mental health disorders including PTSD, depression and anxiety; (ii) examine the characteristics associated with mental disorders; (iii) examine access to and utilisation of health and psychosocial support services; and (iv) draft evidence-based recommendations aimed at relevant governmental and professional bodies in Ukraine.



Mothers with children receive hygiene kits in Kramatorsk, Donetsk, 2015. UNICEF Ukraine/P. Zmey (Creative Commons BY 2.0)

2. Research methodology

This study was designed and led by staff from GIP-Tbilisi, International Alert and the London School of Hygiene and Tropical Medicine. The Kiev International Institute of Sociology (KIIS) led the data collection.

A cross-sectional survey was conducted among IDPs aged 18 years and over, from March to May 2016. An IDP was considered as someone who has been forced to flee his/her home because of fighting and who was living away from his/her home at the time of the study.³ People who were deemed as being under the influence of alcohol or drugs and those with severe intellectual or mental impairment were excluded.

The survey was nationally representative of IDPs in Ukraine and took place in the following cities and regions: Kyiv, Volyn, Zakarpattia, Ivano-Frankivsk, Lviv, Rivne, Ternopil, Khmelnytskyi, Chernivtsi, Zhytomyr, Sumy, Chernihiv, Vinnytsia, Kirovohrad, Poltava, Cherkasy, Odessa, Kherson, Dnipropetrovsk, Zaporizhia, Kharkiv, Donbass, Donetsk and Luhansk.

3 United Nations (UN), *Guiding principles on internal displacement*, New York: UN, 2004

Time-location sampling was chosen as the probabilistic method.⁴ This sampling technique is increasingly used for dispersed forcibly displaced persons and other hard-to-reach groups, including in Ukraine, and involves contacting IDPs in places of gathering – for example, hostels for IDPs, state services, volunteer organisations and non-governmental organisations (NGOs), places where humanitarian aid is distributed, etc. The sampling framework consists of time-location units that represent the potential spectrum of places, days and times where and when the target group can be accessed. For this survey, 33% of the respondents were recruited from collective centres, 31% from NGOs working with IDPs and 6% from state institutions. Another 24% were contacted with the help of another person (informant) and 6% were recruited by other means (e.g. churches or using the door-to-door survey method). In total, 121 unique locations were used for recruiting IDPs (not counting the private dwellings and working places of the respondents approached with the help of informants).

The questionnaire aimed to collect data on the demographic and socio-economic characteristics of the respondents, their access to health services and exposure to traumatic events (using the Life Events Checklist for DSM-5 measure), as well as on the methods used to screen respondents for mental disorders. These measures were the PTSD Checklist for DSM-5 (PCL-5) for PTSD (recall period of one month prior),⁵ the Patient Health Questionnaire (PHQ-9) for depression (recall period of two weeks prior)⁶ and the Generalised Anxiety Disorder Assessment (GAD-7) for anxiety (recall period of two weeks prior).⁷ These instruments screen people for disorders rather than provide a clinical diagnosis. Functioning was also measured using the World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0), which consists of 12 items spanning six activity domains for functional

4 H. Fisher Raymond, T. Ick, M. Grasso, J. Vaudrey and W. McFarland, *Resource Guide: Time location sampling (TLS)*, San Francisco: San Francisco Department of Public Health, HIV Epidemiology Section, Behavioral Surveillance Unit, 2007

5 C.A. Blevins, F.W. Weathers, M.T. Davis, T.K. Witte and J.L. Domino, The posttraumatic stress disorder checklist for DSM-5 (PCL-5): Development and initial psychometric evaluation, *Journal of Traumatic Stress*, 28(6), 2015, pp.489–498

6 K. Kroenke, R.L. Spitzer and J.B. Williams, The PHQ-9: Validity of a brief depression severity measure, *Journal of General Internal Medicine*, 16(9), 2001, pp.606–613

7 R.L. Spitzer, K. Kroenke, J.B. Williams and B. Löwe, A brief measure for assessing generalized anxiety disorder: The GAD-7, *Archives of Internal Medicine*, 166(10), 2006, pp.1092–1097

disability (cognition, mobility, self-care, getting along, life activities and participation), with a recall period of 30 days prior.⁸ The instruments listed have been used and validated in a wide range of cultural and linguistic settings, including in conflict-affected settings.

The survey questionnaire was developed in English and then underwent a thorough adaptation and translation process into Ukrainian and Russian based on best practice procedures to help ensure reliability, validity and appropriateness regarding the study population. The questionnaires were administered in either Ukrainian or Russian by trained KIIS enumerators through face-to-face interviews in a place agreed with the respondent. Before the questionnaire was started, the aim of the survey and terms of participation were explained to each respondent. In addition, the respondent received an information sheet and a consent form, and then gave either written or verbal consent. Ethical approval was granted by the KIIS Institutional Review Board.

Descriptive and multivariate regression analyses (using a stepwise approach) were conducted. The cut-off points used for screening were those recommended by the instruments used: for PTSD, the PCL-5 score had to be >33 ; for at least moderate depression, the PHQ-9 score had to be ≥ 10 ; and for at least moderate anxiety, the GAD-7 score had to be ≥ 10 . All data were weighted to reflect the true geographic distribution of IDPs in the different cities and regions of Ukraine. Statistical significance was assumed at $p < 0.05$. Statistical analysis was performed using Stata 14.

8 T.B. Üstün, N. Kostanjsek, S. Chatterji and J. Rehm, *Measuring health and disability: Manual for WHODAS 2.0*, Geneva: WHO, 2010

3. Findings

A total of 2,203 questionnaires were completed. The overall response rate was 89%. In terms of where the interviews took place, 58% were conducted in regional cities, 40% in other cities and towns, and 2% in villages.

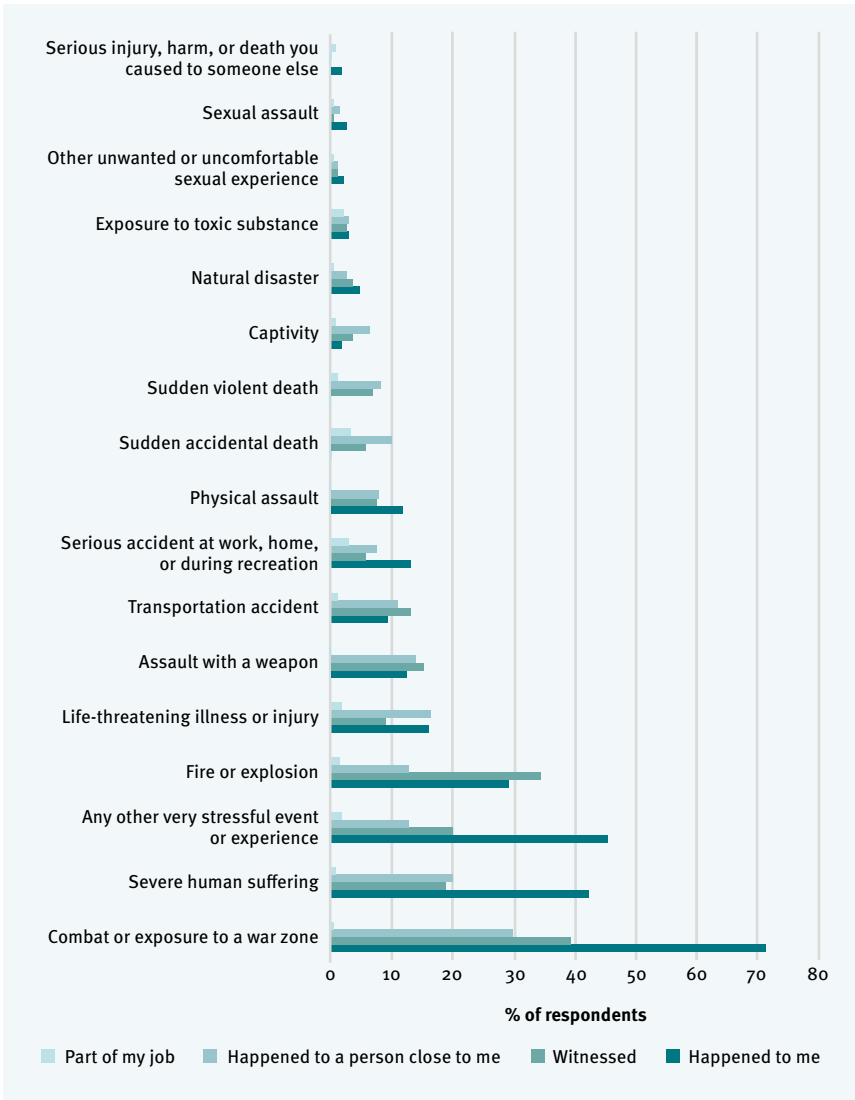
The demographic characteristics of the respondents are summarised in Table 1. Over two thirds of the respondents were women (68%). The sex ratio in the study conforms to other sources such as statistics from the State Employment Service and results of other surveys conducted among IDPs in Ukraine. Approximately 22% of the respondents were aged 60 years and over. The majority of the respondents rated their household economic situation as 'bad' or 'very bad' (59%). Only 22% of respondents were in regular paid work. The average length of displacement was found to be 18 months.

High levels of exposure to violent and traumatic events were observed among the study population (see Figure 1). The most cited traumatic events were: exposure to combat/war zone, severe human suffering, fire/explosion, life-threatening illness/injury, assault with a weapon and other very stressful events or experiences.

Table 1: Demographic characteristics of the respondents (N=2,203)

		N	(%)
Sex	Male	704	(32.0)
	Female	1,499	(68.0)
Age	18–30	480	(21.8)
	31–44	711	(32.3)
	45–59	522	(23.7)
	60–74	356	(16.2)
	75 and over	134	(6.0)
Education level	Incomplete secondary or less	114	(5.2)
	Secondary education/technical equivalent	528	(24.0)
	Secondary technical education/incomplete higher education	767	(34.9)
	Higher education	790	(35.9)
Work status	Regular paid work	489	(22.4)
	Irregular paid work	216	(9.9)
	Self-employed	61	(2.8)
	Unemployed/seeking work	391	(17.9)
	Housewife	81	(3.7)
	Maternity leave	157	(7.2)
	Retired due to old age or invalidity	631	(28.9)
	Other	159	(7.3)
Household economic situation	Very good	15	(0.7)
	Good	95	(4.5)
	Average	755	(35.7)
	Bad	989	(46.8)
	Very bad	261	(12.3)
Displacement	Average length (months) of displacement (min, max)	18	(1.26)

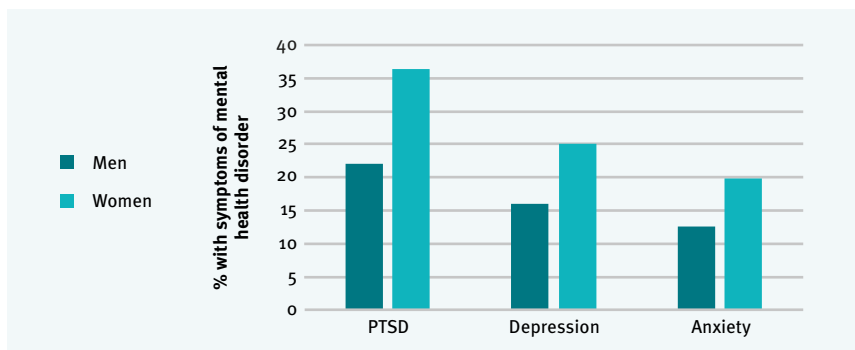
Figure 1: Rates of exposure to violent and traumatic events (N=2,203, multiple responses allowed)



3.1 Prevalence of mental disorders

The rates of mental disorders among IDPs were high, particularly among women (see Figure 2). The prevalence of PTSD was 32% (22% in men, 36% in women), the prevalence of depression was 22% (16% in men, 25% in women) and the prevalence of anxiety was 18% (13% in men, 20% in women).

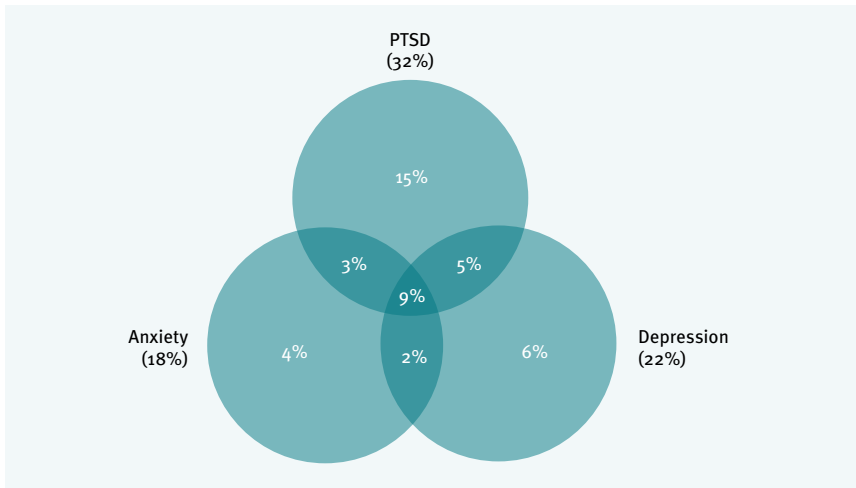
Figure 2: Prevalence of mental disorders among respondents, by sex (N=2,203)



A considerable overlap was also observed between the different disorders (see Figure 3). Of the total sample, 5% had both PTSD and depression, 2% had depression and anxiety, and 3% had anxiety and PTSD. In addition, 9% of all respondents had symptoms of all three disorders. When limited to respondents with at least one disorder, this equates to 43% having more than one disorder and 21% having all three disorders.

Mental disorders were also strongly associated with functional disability. Those with mental disorders had significantly higher WHODAS-2 functioning disability scores (i.e. poorer functioning). Respondents with PTSD symptoms had a mean functional disability score of 25.84 compared to a score of 8.43 among those without PTSD symptoms. Those with depression had a mean score of 32.62 compared to 7.60 among those without depression. Those with anxiety had a mean score of 36.52 compared to 8.67 among those without anxiety.

Figure 3: Proportion of respondents with symptoms of one or more mental disorder (N=2,203)



The factors associated with mental disorders (determined using multivariate regression analyses) are summarised in Table 2. A strong association was observed between female sex and mental disorders. For example, women were twice (odds ratio, OR: 2.01) as likely than men to have PTSD symptoms after adjusting the model for other significant factors. A significant association was also observed between older age, and PTSD and depression. A poor household economic situation was significantly associated with all three disorders. Higher cumulative trauma exposure was only significantly associated with PTSD (>4 events = OR: 1.46). Recent displacement (0–12 months) was also associated with PTSD (OR: 1.51) when compared with the reference category of 19–26 months. A separate regression model showed that having symptoms of other mental disorders was strongly associated with PTSD, depression and anxiety after adjusting for other factors (see Table 2, Model 2).

Table 2: Results of multivariate regression analysis examining factors associated with PTSD, depression and anxiety

Factors	PTSD ^a	Depression ^b	Anxiety ^c
	OR	OR	OR
Model 1 ^d			
Sex			
Male	Ref.	Ref.	Ref.
Female	2.01	1.72	1.76
Age			
18–30	Ref.	Ref.	Ref.
31–44	1.25	1.21	0.96
45–59	1.87	2.13	1.49
60–74	2.15	2.35	1.68
75 and over	2.14	2.82	1.63
Household economic situation			
Very good/good/average	Ref.	Ref.	Ref.
Bad	1.74	2.39	1.67
Very bad	3.71	6.68	3.87
Cumulative trauma exposure – events experienced			
0	Ref.	Ref.	Ref.
1	0.83	0.78	1.04
2–3	0.63	0.60	0.78
>4	1.41	1.15	1.49
Cumulative trauma exposure – events witnessed			
0	Ref.	Ref.	Ref.
1	0.93	0.87	0.76
2–3	1.16	1.28	1.15
>4	1.46	1.23	1.19
Displacement time			
19–26 months	Ref.	Ref.	Ref.
13–18 months	1.19	0.88	0.93
0–12 months	1.51	1.33	1.29

Factors	PTSD ^a	Depression ^b	Anxiety ^c
	OR	OR	OR
Model 2 ^e			
No PTSD	Ref.	Ref.	Ref.
PTSD ^a	N/A	8.21	5.04
No depression	Ref.	Ref.	Ref.
Depression ^b	8.10	N/A	17.13
No anxiety ^c	Ref.	Ref.	Ref.
Anxiety	4.79	17.20	N/A

Notes: Data in bold are statistically significant at $p < 0.05$. Ref. = reference category;

^a PTSD = PCL-5 scores: > 33 ; ^b depression = PHQ-9 scores ≥ 10 ; ^c anxiety = GAD-7 scores: ≥ 10 ;

^d Model 1 – all variables included in multivariate regression model; ^e Model 2 – all variables in Model 1 plus the other two mental health outcomes. Results are in ORs showing the probability of a factor being associated with the mental health outcome. For example, an OR of 2.01 signifies that women were twice as likely as the reference category of men to have symptoms of PTSD.

3.2 Healthcare utilisation and associated costs

Respondents were asked whether they had experienced any kind of mental health or emotional problems over the past 12 months. In total, 703 respondents had experienced mental health problems and were screened positive for PTSD, depression or anxiety.

Of these 703 respondents, 180 had sought care. The sources of services and support utilised by these respondents are outlined in Table 3. The most common types of services/support were: neurologist at a polyclinic (N=84), pharmacy (N=82), psychologists visiting communities (N=74), therapist/neurologist at a general hospital (N=73), NGO/volunteer mental health/psychosocial centre (N=72) and family or district doctor/paramedic (N=67). The most common care type was medication (N=228), psychosocial support (defined as ‘any type of local or outside support that aims to protect or promote psychosocial wellbeing and/or prevent or treat mental disorders’) (N=216) and counselling (N=139).

The average cost of treatment was 1,179 Ukrainian hryvnia (UAH) (approximately USD 46) and the maximum was UAH 67,000 (USD 2,616). The average cost for medicines was UAH 2,479 (USD 97) and the maximum was UAH 70,000 (USD 2,733).

Table 3: Types of external services/support for respondents who self-reported problems, had a mental disorder and sought care (N=180, multiple answers allowed)

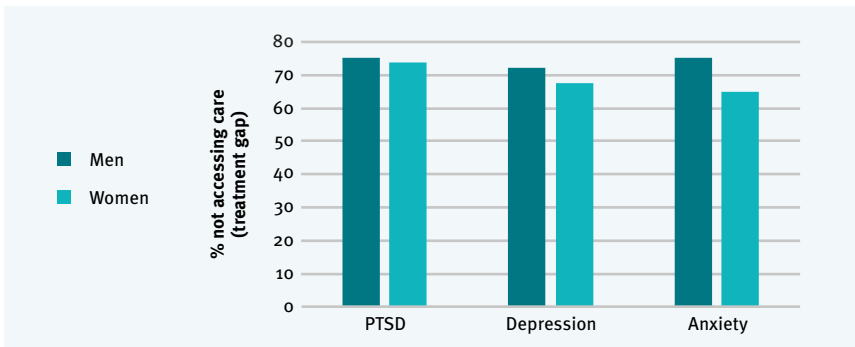
Type of services/ support	Care type						Total N
	Medication		Psychosocial support		Counselling/ psychotherapy		
	N	(%)	N	(%)	N	(%)	
Neurologist at a polyclinic	41	(23.6)	17	(9.8)	26	(14.9)	84
Pharmacy	82	(47.1)	-	-	-	-	82
Psychologists visiting communities	-	-	48	(27.6)	26	(14.9)	74
Therapist/neurologist at a general hospital	37	(21.3)	12	(6.9)	24	(13.8)	73
NGO/volunteer mental health/psychosocial centre	-	-	44	(25.3)	28	(16.1)	72
Family or district doctor/paramedic	36	(20.7)	17	(9.8)	14	(8.0)	67
Private mental health specialist	13	(7.5)	16	(9.2)	12	(6.9)	41
Church	-	-	41	-	-	-	41
Psychiatric dispensary	4	(2.3)	6	(3.4)	5	(2.9)	15
Emergency care	9	(5.2)	2	(1.1)	1	(0.6)	12
Home visits by social workers			9	(5.2)	1	(0.6)	10
Psychiatric hospital	2	(1.1)	2	(1.1)	2	(1.1)	6
Alternative/traditional health provider	4	(2.3)	2	(1.1)	-	-	6
Total	228		216		139		

Notes: % denominator is N=180 (respondents who self-reported mental health and emotional problems and with symptoms of PTSD [PCL-5 score ≥ 33], depression [PHQ-9 score ≥ 10] or anxiety [GAD-7 score ≥ 10] and who sought care)

3.3 Treatment gap

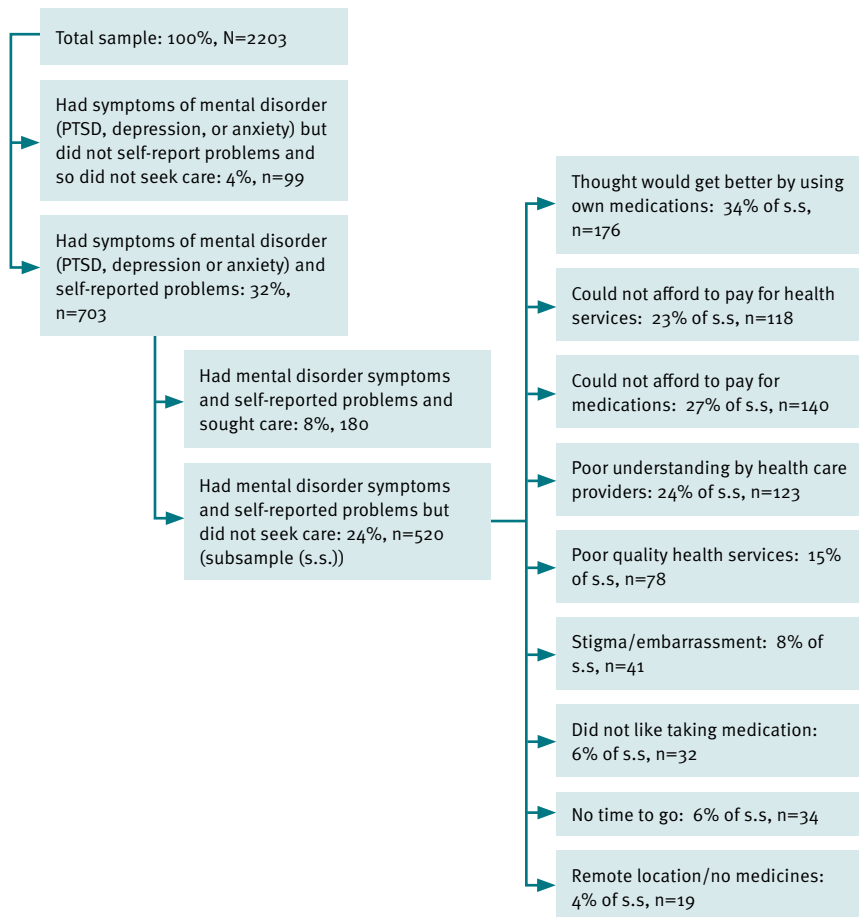
We also analysed the treatment gap for mental disorders among IDPs (i.e. those requiring treatment for a mental disorder who did not receive the care they needed). Of the 703 respondents who reported having a mental health or emotional problem over the past 12 months and who screened positive for PTSD, depression or anxiety, 520 did not seek care (data were missing for the remaining three respondents). This equates to an overall treatment gap of 74%: specifically, 74% for PTSD, 71% for depression and 70% for anxiety. The only statistically significant difference between men and women in the treatment gap for the three different disorders was for anxiety, with the treatment gap higher for men (75%) than for women (65%) (see Figure 4). Notably, the treatment gap was high even for more severe levels of disorders, at 57% for severe depression (PHQ-9 score ≥ 20) and 60% for severe anxiety (GAD-7 score ≥ 15).

Figure 4: Proportion of respondents reporting mental health problems in the past 12 months who had mental disorders but did not access care, by disorder and sex (N=703)



These 520 respondents provided a number of reasons for not seeking care, the most common of which were: thought they would get better by taking their own medication (N=176), could not afford to pay for health services (N=118) or medications (N=140), poor understanding by healthcare providers (N=123), poor quality of services (N=78) and stigma/embarrassment (N=41). Further details are provided in Figure 5.

Figure 5: Reasons why respondents with mental health problems did not seek healthcare (multiple answers allowed)





A woman in a house damaged in a shelling attack in Kuibyshevsky, Donetsk, 2016.
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4. Conclusion

This study provides the first nationally representative data on the mental health status of adult IDPs in Ukraine. It reveals that there is a high burden of mental disorders among IDPs in Ukraine, particularly PTSD, which is especially high among women. In addition, high levels of co-morbidity between PTSD, anxiety and depression were also observed. These mental disorders severely impact people's functioning abilities.

This study found that the key factors significantly associated with mental disorders include female sex, older age, cumulative trauma exposure, recent displacement and a 'bad' household economic situation. The study also discloses that around three quarters of people who required mental healthcare did not receive it. The main reasons for not seeking care were not being aware of the need for care, using self-medication, the high costs of treatment and medicines, and poor quality of existing care. A scaled-up, comprehensive and trauma-informed approach for the provision of mental healthcare for IDPs in Ukraine is urgently needed.

5. Recommendations

Below are recommendations for governmental and professional bodies in Ukraine regarding IDPs:

- IDPs should be considered as one of the target groups for mental healthcare provision by relevant agencies such as the Ministry of Health, the Ministry of Social Policy, the Ministry of Temporary Occupied Territories and IDPs, and local authorities.
- Scaled-up, comprehensive and trauma-informed responses are needed for the provision of adequate mental healthcare for IDPs. Services should be based on a biopsychosocial model; unify social, economic and healthcare efforts; and be gender-sensitive.
- Both the demand and supply sides of mental healthcare services should be taken into consideration. By raising awareness of their own conditions, IDPs should request and address more services, thus preventing further complications and disabilities. On the other hand, contemporary services should be comprehensive and designed and implemented to effectively meet the mental health and psychosocial needs of IDPs.
- Health and social service providers should be trained in managing common mental disorders such as PTSD, depression and anxiety, and also cases with co-morbidity. Up-to-date guidelines for effective care of such conditions should be developed and recommended for use.
- Capacity-building activities should prioritise health and social care staff who are most needed by traumatised individuals, namely neurologists at polyclinics and general hospitals, family and district doctors, as well as mental health specialists visiting communities and mental health/volunteer/psychosocial centres and teams.
- General information about the consequences of traumatic exposure and experiences should be developed and disseminated with the aim of

educating populations on the signs and conditions of mental ill health, self-care, effects of self-medication and stigma.

- Trauma-informed and trauma-specific services should be gradually mainstreamed into the system of general mental health and social care systems to ensure access to healthcare and continuity of support to individuals, families and communities.
- Both care services and medicines for mental health disorders should be more accessible for IDPs. The strong negative influence of poverty on mental health outcomes and access to services should be recognised and addressed through employment and income-generating activities.
- Monitoring and evaluation studies should be conducted to understand the ongoing needs of IDPs and effectiveness of mental health and psychosocial responses.
- The strategy of mental healthcare for IDPs should be part of Ukraine's overall strategies and policies.

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