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

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Abstract

Purpose

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

Design/methodology/approach

Series of roundtables (4 roundtables, 62 participants overall), accompanied by interactive brainstorming techniques, were conducted with communities' representatives from the East of Ukraine (Lugansk region, government-controlled area). Participants were provided with the opportunity to discuss mental health services development challenges and create affordable solutions for their communities. Results of discussions were submitted to qualitative analysis and offered to review by participants.

Findings

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

Originality

The paper is original in terms of its topic (connecting decentralisation and community engagement for understanding the challenges of mental health services development) and research strategy (engagement of Ukrainian communities, qualitative analysis of the discussion results and applying the best practices and international recommendations to the local context).

Introduction

Communities are the main actors in the development of community-based mental health services. Just recently, communities in Ukraine received a possibility to become not just recipients of governmental directives, but be fully responsible for their health and social services *(*Oleinikova, 2020*)*. In these circumstances, there is a high risk that needs in mental health services will be less visible and be situated on the last place in the hierarchy of communities' needs. That is especially important in conflict-affected regions. They are more deprived in financial and infrastructural terms and less equipped with modern attitudes towards human rights protection and mental health awareness. At the same time, they have more needs in community-based services precisely because of mentioned above and have one resource not available elsewhere – international and national humanitarian NGOs active in the region.

General Ukrainian context: war, healthcare reform, Mental Health Concept and Action Plan 2020–2023.

Since 2014 Ukraine has entered the phase of both armed conflict and healthcare transformation. Armed conflict, provoked by the aggression of the Russian Federation, resulted in a humanitarian crisis with 3,4 mln of people in need of direct humanitarian assistance (68% - children and women, 38% - elderly), 1.5 mln of IDPs (50% pensioners, 13% children, 4% people with disabilities), 400 000 veterans; 420 km of "contact line" *(*UNHCR, 2022; CARE International, 2021*)*. The conflict is localised mainly in the Donetsk and Luhansk regions (not mentioning the Crimea annexation).

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

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

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

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

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

Decentralisation reform[1] means the transfer of powers and finances from state authorities to local governments, and thus to the community. During this reform, the Ukrainian state executive branch passes on the influence on the local governments and promotes citizens` participation in decision-making. As a result, small communities joined into so-called "combined territorial communities" (further – communities) that become the complete owners of their finances and services. This reform also creates a solid foundation for accelerating healthcare reforms and reforms in the social and education areas *(*Oleinikova, 2020*)*.

Implementation of the decentralisation in Luhansk Oblast (GCA) also have difficult political and economic conditions. It makes it challenging to process reforms, including setting up mental health services in communities.

As of 2022, the area of the region is 26684 km^2. The population is 661 028 people. After the occupation of part of the region and the decentralisation process in the Luhansk region, there are four districts, including 26 combined territorial communities (including 544 settlements). The largest population is concentrated in Severodonetsk, Lysychansk, Rubizhne, in Popasnyansky district.

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

The level of employment and unemployment in the region shows a negative trend. In terms of jobs, the Luhansk region ranks last in the ranking of regions of Ukraine. Analysis of the balance of labour resources of the Luhansk region showed that most of the economically active population is not registered anywhere and does not receive any income officially. These are illegally employed people and migrant workers *(LOA, 2019).*

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

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

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

The recent available mental health data shows that near 40% of the residents of the Donetsk and Lugansk regions had experiences of trauma and trauma-related stress, depression, anxiety, and post-traumatic stress disorder. Up to 5.4% of residents struggle with depression, 8.2% PTSD, 12.7% abuse alcohol *(KIIS, 2018).*

Humanitarian organisations cover some mental health needs. Map of such services is available, launched by the Mental Health and Psychosocial Support Technical Working Group.[2] Those services primarily operate alongside the contact line, and the rest of the region is not covered. 26 out of the 250 health care facilities were damaged, destructed or left in the non-GCT, 30–70% of health workers have been fled conflict-affected areas or been killed *(*Lekhan, Kaluski, et al., 2015). Therefore, the need to develop mental health services in the region is in place.

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

[1] *https://decentralization.gov.ua/about*

[2] *https://www.humanitarianresponse.info/en/operations/ukraine/mental-health-and-psychosocial-support*

Methods

Four roundtables of two-days duration were conducted during September-November 2021 in the Lugansk region (Severodonetsk city). Each roundtable was attended by 2–4 representatives of 4–5 different communities (23 communities in total, GCA[3]). Three communities of GCA and 11 communities of non-GCA were inaccessible. The detailed distribution of attendees is presented in Table 1.

Table 1
Distribution of attendees by communities

	Community	N of participants
1.	Regional level representees	6
2.	Bilovodsk	2
3.	Bilokurakynska	2
4.	Bilolutska	3
5.	Hirska	2
6.	Kolomiychiska	3
7.	Kreminska	3
8.	Lisichansk	3
9.	Milovska	2
10.	Nizhneteplos'ka	1
11.	Novoaidarskaya	4
12.	Novopskovskaya	3
13.	Popasna	3
14.	Rubizhnskaya	3
15.	Svativska	1
16.	Severodonetsk	4
17.	Stanytsia Luhanska	3
18.	Starobilsk	3
19.	Troitska	3
20.	Chmyrivska	1
21.	Shyrokivska	1
22.	Shulginskaya	3
23.	Schastynska	3
	Total	**62**

The distribution of participants by occupation is outlined in Table 2. Social services representatives (24) include community social workers and administrative staff of social services. Healthcare workers include the clinical management of local healthcare facilities and doctors (15). Mental health care – composed of local psychologists and psychiatrists (10). Community administrations are city or village administration workers, like deputy heads of communities, secretaries, etc. (13).

Table 2
Distribution of participants by occupation

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

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

Task 1. Dealing with stigma and negative attitudes towards mental health. Stigma and negative attitudes create a barrier to the development of mental health services (Eaton et al., 2011; Quirke et al., 2021). Several activities were used as the most effective method *(Thornicroft et al., 2018)*: meeting and communicating with a person with lived experience of mental health disorder, watching the record of interview with another person, working in subgroups for the person's needs analysis and the possibility to fulfil these needs in their communities.

Task 2. Capacity-building in terms of modern knowledge of mental health services development, WHO optimal mix of services, instruments for such services development, available in the Ukrainian language[4] (*WHO, 2021b*). Short interactive presentations were used for this task.

Task 3. Motivation and engagement of community members to work on mental health services development. For this task, the activities implemented by other communities, including those supported by the MH4U project, were introduced to the participants.

Task 4. Analysis of challenges and problems in communities that block the development of community-based mental health services. It was accomplished using facilitation techniques (Brainstorming, World Café, Complexity Management techniques) *(*Bens, 2012; Dean et al., 2000; Lindemann et al., 2008).

Task 5. Solutions creation and motivation to their implementation. Based on the revealed problems and challenges, participants were facilitated to develop solutions and make action plans to implement them. The same strategies mentioned above were employed.

Correspondence between tasks and roundtables` elements is presented in Table 3.

Table 3
Corresponds between RT's tasks and elements

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

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

[3] Government-controlled area

[4] www.mh4u.in.ua www.edu.mh4u.in.ua

Results

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

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

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

Under the umbrella of the "**Leadership, coordination and collaboration problems**" cluster falls three related sub-clusters. The first one is about "*Strategic leaderships and coordination*". Community members emphasised that community authorities make many decisions on service development, and most of them have low or no interest in mental health services. Another issue raised by participants is about weak political will and leadership attitudes of community authorities. Most of them are still under pressure of bureaucracy mundane tasks and demonstrate no thinking "outside of the box". Therefore, communities have no strategy for their mental health services development, coordination bodies are absent, and no attempt to make communities` mental health needs assessment was made.

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

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

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

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

CLUSTERS	SUB-CLUSTERS	PROBLEMS AND CHALLENGES
problems	line	Difficult access to services
	COVID-19 impact	Shifting of attention of authorities toward COVID emergencies and away from “non-important topics.”
		Shifting of resources toward COVID response

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

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

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

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

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

Connected with mentioned above awareness problems is a high level of *mental health stigma*. People with mental health conditions face stigma towards themselves, and usually, the more complicated disorders are, the more challenging is stigma and its consequences, like discrimination and even violence. Thus, self-stigma that leads to social isolation creates an additional burden. This situation is expected not just for adults with mental health disorders but also for caregivers of children with developmental disorders and delays.

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

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

All other problems coupled with the impact of COVID – 19 on the communities were and still are devastating in terms of shifting of the attention of the local, regional, and national authorities towards pandemic and away from "non-important topics", like mental health or

social protection of people with mental disorders.

Provided above problems, their classification derived from the communities` representatives structured work and their attempts to list the problems and classify them. It represents their view and position from the inside of the communities. Sure, there are a lot of differences between communities even inside one region – some of them are more reach, some less, some have hospital and psychiatric departments in them, some have nothing except part-time community health workers. Therefore, described problems are not equally distributed among communities and are not a comprehensive description of them, but reveal the most important problems and the most pressure ones.

Ways to deal with barriers, challenges, and problems

After the problem analysis, the ways to deal with revealed problems were created and explored further by participants. In general, all types of decisions fall into one of 7 domains.

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

Increasing the role of communities and local service users in the initiatives of governmental bodies. This was the only type of proposal not related directly to the communities` inside developmental work. Communities are willing to be helpful for the national authorities (relevant Ministries and National Agencies) and want to be heard in terms of needs and proposals. Joint work on the legislation, orders, etc., will better adhere to the local circumstances, conditions, and potential solutions feasible for the communities. Communities' representatives declared readiness to make such input and provide feedback on the documents, orders etc. Formally such procedure exists; it is called "consultancy with a public", and each drafted national document before approval undergo such process. But to be involved, communities must know what to look for, where and when, and because of the diversity of problems, they become easily overwhelmed with it. Therefore, they emphasised the need for organised communication with communities and with services users, via dedicated to this aim separate roundtables, workshops, focus groups, and other formats.

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

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

Embedding the mental health services in the existing services (social, administrative, healthcare etc.). This type of solution was primarily developed by communities where such services and providers exist permanently. The main idea is to equip professionals from the existing services with mental health competencies, support them with supervision and basic regulation, and develop referral pathways for

the patients who need more intensive support or medication. Some communities have centres for social protection, so social workers there can be trained in mental health assessment and providing structured psychological support. If there are some administrative services in the community, like "village council" or "village administration", workers can be provided with mental health knowledge. Community healthcare workers ("feldshers") might be additionally educated in mhGAP provide medication and psychological interventions under the support of family doctors or psychiatrists via telemedicine. Available units of primary healthcare centres will serve perfectly well if family doctors and nurses are trained in mhGAP. In some schools, there are nurses and psychologists. It creates the perfect ground for embedding child and adolescents' mental health support into education.

Mental health advocacy and lobby led by local leaders and service users. These activities, if systemically implemented, can have an impact on mental health awareness of the communities` administrations and lead to decisions in favour of community-based mental health services development. From participants ' perspectives, it is unclear who will conduct these advocacy activities and their target audience. Thus, realising these obstacles, communities declared readiness to be engaged in capacity-building activities in this area.

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

Developing services by combining efforts and budgets of two or more neighbouring communities. This domain of actions appeared due to inter-community communication during these 2-day's events. After getting familiar with the strengths and weaknesses of each other's communities, some groups decided to join efforts and move towards joint services development under mixed budgeting. An example of such a solution might be that one community has premises and social services available, another provides a mobile psychiatric team that regularly visits the community. Another option is the joint establishment of a mental health hub, equally accessible by members of both communities.

Discussion

The article was tried to explore in deep communities' perception of their perspectives in mental health services development in the frame of continuing healthcare, social care and decentralisation reforms in Ukraine.

Community-based mental health services development is a priority and primary instrument for bridging the gap in mental health, as stated in the Comprehensive Mental Health Action Plan *(WHO, 2021c*). All the evidencei suggest that this approach is the most perspective *(*Troup et al., 2021; *Jordan & Kohrt, 2020).* Ukrainian National Mental Health Concept Note support it as a policy vector. It is stated that there will be actions towards "providing accessibility of mental health support in the communities" via "decentralisation and development of the outpatient services" *(CMU, 2017).*

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

An organised set of roundtables with double-aimed methodology – to provide capacity building activities in community-based mental health service delivery and to involve communities in their own needs and problems assessments with following solution creation – proved to be an effective way towards communities' engagement and activation. Vice versa, communities during participation and production results proved to be susceptible to the proposed approach. They demonstrated readiness to fight stigma, collaborate with regional and national authorities, and invest in a better quality of life for people with a mental health condition.

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

Based on the explored problems and solutions, some additional recommendations can be made. For the national authorities, it is essential to proactively involve conflict-affected communities in collaboration during legislation development and implementation of the Action Plan 2021–2023. During such involvement, clear articulate need in participation, not just mental health professionals, but also other community members, family doctors, social workers, administrative staff, and service users. Also, important to combine consultancy and capacity-building approaches. It is also vital to change legislation to open the possibility to task-shifting in providing mental health care by family doctors, social workers, etc. Clear recommendations for the communities about better mental health service development methods must be developed and disseminated. It is recommended to include mental health needs assessment methodology, WHO optimal mix of services model, guidance on the work of working\coordination groups, coordination of service provision and task-shifting approaches.

Conclusions

Ukrainian communities from conflict-affected regions face many challenges towards the development of community-based mental health services. All of them fall into the five clusters: leadership, coordination, and collaboration problems; infrastructure, physical accessibility, and financial problems; mental health and primary healthcare workforce shortage and lack of competencies; low awareness in mental health, available services, and high stigma; war, crises and pandemic-related problems.

Despite the devastating effect of the crises (war and COVID-19), decentralisation reform allowed them to develop their service models. Additional capacity-building activities for such communities are essential to direct their energy and resources into the evidence-based human right based direction: towards increasing their role in the initiatives of governmental bodies; establishing in the better local coordination of services$develo \pm ent; develo\pi ngcreativesolutionsf \text{ or } services$ delivery (community-based hubs for integrated services provision or embedding mental health in the existing structures); mental health advocacy and lobby; increasing capacity in financial management; combining efforts and budgets of neighbouring communities.

There is a lot to be done by joining communities, regions, and national efforts to implement the National mental health vision fully. It is essential not to forget about the potential of communities in this large-scale process, involving them in decision-making, making them a partner, and not just executants of the orders produced by national authorities.

Declarations

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Authors Contributions

Conflicts of Interest

All authors declare no conflict of interest

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Figures

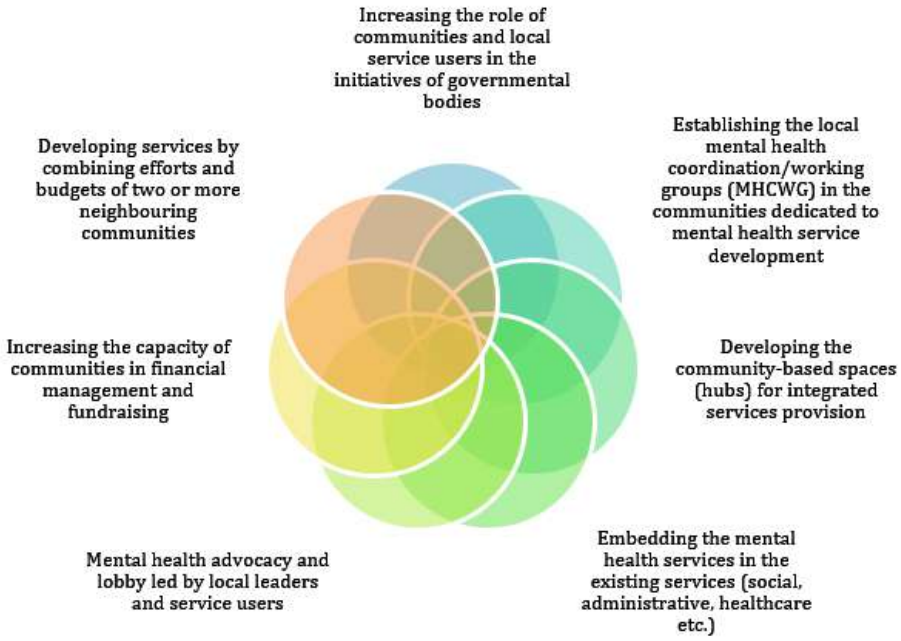

Figure 1

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