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Advance Psychiatry and Mental Health Across the World

Policy brief

WPA Expert Committee on the Ukrainian Mental Health Crisis

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Executive Summary

A major policy shift and the onset of the COVID-19 pandemic at the beginning of April 2020 have propelled mental health provision in the Ukraine into a humanitarian crisis. The reduction of funds for in-patient treatment before completing the preparation of community-based mental health care services ensuring the shift of staff to such services resulted in dismissal of personnel and premature discharges of patients putting their life in danger. On top of this came the problems of coping with mental health care in the face of the COIVD pandemic which hit Ukraine at almost the same time.

Patients and their families are in despair, the first fatalities after discharge were reported within six weeks of the start of the crisis. The policy planning for community-based mental health services was on a good trajectory, however not in harmony with the allocation of resources, resulting in the discharges and lay-offs.

A draft National Action Plan on Mental Health exists, developed by a working group of the Ministry of Health, however its details have yet to be fully disclosed and vetting by national psychiatrists has yet to be undertaken. The WPA Expert Committee examined an early version of the document. It wishes to support the idea of reform of institutional-based mental health care and a well-planned transition to a new system of care. It recommends that the latest version of this document be used as a basis for discussions between the Ministry and the psychiatric profession, as well as other stakeholders, retaining elements that have been well developed.

The WPA Expert Committee recommends to

1. Implement the draft National Mental Health Action Plan, fine tuned by an inter-Ministerial working group that includes representatives of other relevant Ministries e.g. the Ministries of Social Policy and Education, as well as, professional mental health related associations and consumer representatives:
2. Finance a twin-track approach: a) adequate resources for in-patient care (possibly with an increase of funding during the actual shift to community care) while b) developing community-based mental health care services:
3. Initiate a regular consultation process between the Ministry and the professional psychiatric associations;
4. Set up train-the-trainer programs for multi-disciplinary approach in community-based mental health-services to support the de-institutionalization process;
5. Utilize international standards on mental health (UNODC, the Convention on the Rights of People with Disabilities-CRPD) as well as recommendations to Ukraine (CRPD, CESCR, CPT, ECtHR)[1] to obtain funding.

[1] CRPD Concluding Observations, CRPD/C/UKR/CO/1 (2015); CESCR Concluding Observations E/C.12/UKR/CO/7 (2020); also various judgements of the European Court of Human Rights, e.g., *Kucheruk v. Ukraine; Anatoliy Rudenko v. Ukraine; Gorshkov v. Ukraine*.

I. Introduction

On May 6, 2020, the Ukrainian Psychiatric Association (UPA) approached the World Psychiatric Association (WPA) with a request for assistance in the management of the crisis due to the disharmonious application of new rules of financing mental health care and COVID- related problems. As a result, many psychiatric services in the country have reported serious levels of under-financing leading to the rapid and unplanned discharge of patients, dismissal of large numbers of personnel, and the closure of departments. At about the same time, the Association of Neurologists, Psychiatrists and Narcologists of Ukraine approached the WPA with a similar request.

The WPA decided to respond positively to the request from both Ukrainian psychiatric associations and commissioned the formation of an International Expert Committee to develop, in collaboration with the Ukrainian Psychiatric Association and the Association of (Neurologists, Psychiatrists and Narcologists of Ukraine, advice on (1) a response to the current emergency situation and (2) the design and implementation of the National Mental Health Plan. The Expert Committee was established in collaboration with the international foundation Federation Global Initiative on Psychiatry. The task of the Expert Committee was to analyze the situation in Ukraine following the implementation of the second phase of the health reform plan, and to advise the professional associations in their discussions with the administrative authorities on how to deal with the situation. The following policy brief is the result of the work of the Expert Committee, which worked throughout the period between its formation and the publication of this report on a voluntary basis. The International Expert Committee members included persons who are well aware of the situation in Ukraine as well as experts who developed appropriate plans for mental health care in their countries and elsewhere. Their competences are highlighted at the end of this document.

In the course of its work, the International Expert Committee had direct communication with the Ukrainian Ministry of Health on several occasions. However, the role of the committee is to assist the WPA in providing support to its two member societies, providing them with suggestions and tools to respond favorably to the incumbent Minister's expressed desire to reestablish communication with the psychiatric profession and to find mutually agreeable way out of the current crisis.

This policy brief provides the above-mentioned tools and suggestions, and also includes a brief analysis of the current crisis and its origins, as well as some case studies as to how mental health reform plans were developed in countries that have a similar socio-political background and the accompanying challenges of a post-totalitarian society. The committee is well aware of the added complexities that Ukraine currently faces because of the ongoing military conflict and its geographical span compared to the two case studies, Georgia and Lithuania. However, these experiences may offer suggestions for a resolution of the crisis and a path to the future. In addition, the role of professional psychiatric societies is explained and illustrated with an example from the United Kingdom.

The Expert Committee has also consulted other international partners, both governmental and non-governmental, and heard their views on the current situation, with the express wish not to add yet another voice to the already existing spectrum of views and visions, but rather to make sure that the policy brief confirms and strengthens the unitary message that most of the external advisors have voiced.

It is also important to note that the Expert Committee believes that the current crisis should be used as an opportunity to remodel the current financing structure into one that allows the old mental health care system to continue to function while community-based services are being developed. The question is not whether reform is needed or not, the main issues are the form, the speed and the sequence of changes that are needed to ensure better access to quality mental health services in the country.

II. Analysis of the origins of the current crisis

The fact that Ukraine has still not been able to develop a modern mental health care system that is based on a combination of inpatient and outpatient care in line with current international standards is the result of a complex combination of factors.

Static factors include

- the lack of priority and disinterest in mental health care has in most post-Soviet countries,
- the lack of collaboration between various stakeholders and interest groups
- and the omnipresent "second economy" that is partially caused by a chronic and severe underfunding of those working in the mental health field.

However, there are also a number of ***dynamic factors*** that need to be taken into account: The war that had started in 2014 by the occupation of Crimea and invasion in the eastern regions of the country significantly impacted the mental health care system in Ukraine. While virtually every organization in Ukraine had expressed their concern about the impact of the war, the issues with combat veterans, their families, the impact of their traumatic experiences on their mental health and the mental status of the society as a whole, very little has been done systematically and sustainably minimize the damage and impact.

Secondly, adequate leadership and governance – particularly an ability to unite the field – in the mental health has not so far been sufficiently developed. There is an urgent need to build support teams (e.g. task force, advisory committees, etc.) for specific tasks that require specialized expertise. The common practice around the world is to bring the best available experts and people with knowledge and skills to contribute to the task.

The World Health Organization (WHO) in their Mental Health Action Plan 2013-2020 (World Health Organization, 2013) underlined that mental health services in local community settings are by far more beneficial for the population in need (especially in emergency settings) than centralized mental health system of large psychiatric hospitals, typically located in big cities. Despite some positive developments such as the initial roll-out of WHO's mhGAP training for non-specialists the Ukrainian government's

plans to improve the mental health service by decentralizing the system were not supported by an adequate strategy to develop community-based mental health services, build capacities and competent workforce among primary health care practitioners, and to implement an accreditation and certification system for mental health professionals. As a result, the implementation of the second phase of the Health Reform Plan, in which financing of specialized health care services was restructured, was bound to fail, as in fact happened.

III. The scope of the current crisis in figures

On April 1, 2020, the health care reform at the secondary and tertiary levels were initiated in Ukraine. The changes resulted in severe budgetary cuts for most of the state hospitals and health care services.

In order to study the emerging difficulties in mental health care service delivery, the Ukrainian Psychiatric Association (UPA) conducted a survey. During the period of 8-16 April 2020 directors of the mental health care services were interviewed online. Representatives of 53 mental health services from 21 regions of Ukraine have responded. No information was retrieved from four regions (Lugansk, Poltava, Sumy, and Chernivtsy). The results were communicated by the Ukrainian Psychiatric association in a letter to President Zelensky and other officials on April 23, 2020.

The results indicate that funding for psychiatric hospitals by the National Health Service of Ukraine for the period from April 1 to December 31, 2020, was on average halved in comparison to the corresponding period of 2019. The hospitals with more beds for long-term treatment faced even more challenges.

The financial problems threaten to lead to the reduction of 3,164 FTE staff. A total of 2,485 mental health care specialists will lose their jobs, among them 197 doctors; 661 nurses; 1,237 nurse assistants and 390 other specialists, including psychologists and social workers. In addition, 785 workers were cut from full-time to part-time employment, including 169 doctors, 188 nurses, 309 nurse assistants, and 119 other specialists.[2]

Starting April 1, 2020, the Ministry of Health introduced a new package-based model instead of a financing system based on reimbursement per bed/day. The packages for "Psychiatric Care for Adults and Children" were not only allotted to psychiatric institutions but also to narcological services and general hospitals. in total 194 institutions received these packages, including only 54 psychiatric hospitals.

The desk review of the official documents conducted by UPA did not reveal any particular order or plan regarding the allocation and distribution of health care funding

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[2] According to the official data of the Ministry of Health, at the beginning of 2019, in Ukraine, there were 58 psychiatric hospitals and 24 narcological inpatient facilities (22 narcological dispensaries with a hospital and 2 narcological hospitals) with total 26,915 psychiatric and 3,372 narcological beds. The average stay at the psychiatric hospitals was 48,7 days, in the narcological clinic 123 days. The prevalence of the mental and behavioural disorders in Ukraine was 3,478 per 100,000 people (in total 1,468,452 patients) including 522,960 patients (1,238 per 100,000 people) with mental health problems due to alcohol and substance use.

among institutions. The survey also revealed that general hospitals that were allotted a budget for mental health care provision, were not prepared for introducing such services and did not have psychiatric departments to serve the patients.

IV. The Role of Professional Psychiatric Associations

Reforming a mental health service requires the involvement of all relevant professional bodies. Any restructuring of services demands extra investment in time, energy and emotion of all stakeholders, including psychiatrists. Psychiatric associations have a unique role to play. For example, they are able to communicate rapidly with their members. They can collect any necessary data and they can consult their members at a very early stage on proposed developments. They can point out potential difficulties. The result of this is that changes can be discussed and then implemented much more easily. It is also much simpler for the Ministry of Health and any other government agency to communicate with the elected leader of the psychiatric association who can speak on behalf of its members. Only through constant and meaningful involvement of all those concerned can a reform process be implemented successfully and all problems, and other obstacles dealt with.

The WPA Expert Committee was surprised to learn that, under the aegis of the Ministry of Health, a draft National Mental Health Action Plan was developed and discussed at various stakeholder meetings since 2017. The committee believes that involving the country's psychiatric associations as a matter of priority will help to resolve underlying tensions and allow the psychiatrists to demonstrate their commitment to the positive changes needed. Measures should be taken to rebuild trust and collaboration between the Ministry and the psychiatric profession represented by both psychiatric associations. They, together with representatives of all other stakeholders, should be constantly involved in the reform process.

The WPA Expert Committee did have access to an undated version of the draft National Mental Health Action Plan. The WPA Expert Committee would recommend that the latest version of this document be used as a basis for discussions between the Ministry, the psychiatric profession and all other stakeholders that should be part of the development process. The WPA Expert Committee recommends to go forward and to make use of work already done and retain those elements that have been properly developed.

Example: the British Royal College of Psychiatrists

The British Royal College of Psychiatrists is the professional and educational body for psychiatrists in the UK. It works to secure the best outcomes for people with mental illness, learning difficulties and developmental disorders by promoting excellent mental health services, training psychiatrists setting standards and being the voice of psychiatry.

The British Royal College of Psychiatrists is constantly involved in drafting and commenting on government policy relating to mental health. It is inconceivable that the Government would produce mental health policy without first consulting the College. The College can speak for the psychiatric profession and it works closely with all relevant UK wide government agencies in what is a mutually productive and effective relationship. Whether it is creating new mental health legislation or commenting on mental health policies the College will always be involved in the process. A recent example is the preparation of all mental health COVID advice for psychiatrists and patients, subsequently approved by the relevant Government agencies and now widely available.

V. Advocacy opportunities

The Human Rights Council of the United Nations appoints human rights experts in their independent capacity on certain human rights issues, including health and disabilities.[3] In addition to providing a thematic study to the Human Rights Council in Geneva and the UN General Assembly in New York, they visit countries and provide public reports on their findings. Ukraine is among the countries that have issued open invitations to special procedure holders, so they could be alerted to the situation and provide international accountability.

Ukraine has signed up to a number of human rights treaties of the United Nations. The country's implementation is regularly (roughly every six years) reviewed by a group of independent experts. The assessment is also based on input from civil society: associations are counted among those who can provide written input ahead of the assessment.[4]

The Council of Europe's independent experts of the Committee for the Prevention of Torture visited Ukraine very recently (2019), providing a lot of pertinent recommendations. A follow-up could be suggested to the Secretariat.

VI. Towards a state-of-the-art care model

Mental health is a public health issue.

Evidence shows a close relation between social stressors and mental health status. People with lower education, income, or occupational class are exposed to factors that affect their mental health. The exact working mechanisms remain unclear but might be related to daily stress related to these living circumstances. Therefore, reducing mental health related suffering is not limited to 'fixing the brain', but also includes **strategies to reduce social inequalities**. (REF)

[3] Special Rapporteur on the highest attainable standard of mental and physical health; Special Rapporteur on the rights of persons with disabilities.

[4] (1) Child Rights Committee in late September: will compile the discussion points for the government, which will be public within October. In its last assessment the Committee was alarmed about juvenile suicide rates (CRC/C/UKR/CO/3-4). (2) Disability Rights Committee to hold a discussion with the government in the first half of 2021; input ahead of that discussion is possible. (3) As recently as March, the Committee on Economic, Social & Cultural Rights (CESCR) assessed the situation in Ukraine, with critical assessments of the mental health situation (E/C.12/UKR/CO/7).

This requires a **cross-domain approach** and a joint strategy of the Ministry of Health, Education and the Ministry of Social Affairs, at a minimum. It should include, among others, the alleviation of child poverty, social-protection across the life-course, supportive programs for caretakers of people with mental health and other disabilities, combating domestic violence, and a proactive alcohol and drug policy. These are also obligations under the Covenant on Economic, Social and Cultural Rights as well as the Convention of Rights for Persons with a Disabilities (CRPD).

Regional diversity requires local solutions.

Due to regional diversity, national plans should be supplemented with decentralised local implementation strategies (applied to the population of a specific geographical **catchment area**, smaller than oblasts, but potentially of the size of raions) for social and psychiatric services. The financing structure for these services should incorporate incentives for care in society above care in institutions (hospitals). It should clearly define the local responsibility for system change and empower this legal entity -- a local public health agency -- with resources and accountability for the regional morbidity. This is not self-evident, since the financing of institutions can more easily be contained than financing regional care networks and needs in institutions are limited to a relatively small number of individuals and restricted life domains. Challenges in society are more comprehensive. The population prevalence of mental health problems can outnumber the care prevalence up to fourfold. Therefore, different strategies to prioritize care are needed in ambulatory health care.

Each local public health agency and local care teams should be allocated a **budget** with which they are integrally responsible for a catchment area.[5] To manage the humanitarian crisis in Ukraine, mental health strategies should increase the available degrees of freedom and include options beyond those provided within the mental health silo. To manage the humanitarian crisis in Ukraine mental health, solutions should be more creative than those provided within the mental health silo. Ideally, the available budget integrates mental health and welfare resources. Joint partnerships between communities (including churches, general practitioners, and local entrepreneurs…) and services, should be explored to supplement local resources. This comprehensive integration of assets, allows leverage and flexibility for creative solutions for patients and caretakers.

Fair and adequate funding

Applying WHO indicators to the Ukraine, health resources could be 1000 USD PPP (10% GDP) and for mental health 100 USD PPP (1% GDP -- net 46 USD per capita). According to the World Bank the Ukraine health expenditures is 7% GDP (2017 data), of which more than 50% is paid by citizens 'out of the pocket'. The public health budget for care is 3.2% BNP or 320 USD PPP (net 120 USD) for health and 32 USD PPP (net 12 USD) for mental health.[6] Which is, for instance, <10% of the Dutch mental health budget, while

[5] With a team we have in mind a community mental health team, preferably a FACT team which combines the community mental health and assertive outreach functionality. Criteria and manuals are available on https://ccaf.nl/fact-facts/english/.

[6] Data on GDP were computed using tradingeconomics.com and checked with the World Bank (pro person 2020 GDP of 10.310 US$ PPP or 3.881 in net US$) (https://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS?locations=UA). No data could be retrieved for the health/mental health breakdown and the clinical/ambulatory care breakdown within mental health (Global Health Observatory data repository at the WHO).

the number of citizens receiving care is comparable (4-6%). Shifting resources requires a national plan involving all domains of society. **Investments in mental health result in a 4-fold return on investment.**[7] But realising these gains involves more than mental health alone. It includes somatic health and other resources in society, both professionally as well as non-professional.

Mental health is a public health issue.

Evidence shows a close relation between social stressors and mental health status. People with lower education, income, or occupational class are exposed to factors that affect their mental health. Additional circumstances such as war and conflict, or the COVID-19 pandemic, affect whole populations. Trauma and adverse childhood experiences differently affect persons. The exact working mechanisms remain unclear but might be related to the daily stress that is caused by these circumstances. Therefore, reducing mental health related suffering is not limited to 'fixing the brain', but also includes **strategies to reduce personal and social inequalities**.[8]

This sets an agenda for parallel multi-domain care (in contrast to serial care that traditionally starts with cure-based symptom reduction and only later engages in participation and personal recovery). The CRPD explicitly states that persons with disabilities (including persons with mental impairments) should never be excluded from human rights and even more, that it is the duty of the government to enable as full participation as possible. Mental health care is not limited to care but comprises all life domains.

Develop a community system that is up to the challenges

De-hospitalisation should be preceded by a period of development of ambulatory resources and practices. Care innovations are not realised by reading a manual. Professionals, patients, family members, stakeholders and society as a whole, should gain confidence that this innovative care system covers the needs of the community. To change the financial incentives from hospital to community-based systems is a necessary step to start ambulatory care networks and get acquainted with and master the innovative practices that are required in this field.

An additional challenge is that moving from a hospital-based system to an ambulatory system, often dilutes resources for severely ill patients. The population prevalence of mental health problems is high and so a system that accesses the whole population has to prioritize care resources. Systems that are not managed or follow a market type dynamic, lead to cherry picking. This is the reason why allocation resources for care should never be attributed unconditionally to services or care professionals. Professionals tend then to create a service that is most relevant to them (e.g. a first onset psychosis services, an anxiety clinic or a therapeutic community for borderline personality disorders) but is not regionally comprehensive.

Understanding the role of hospital and community

While a hospital-based care-system seems to prioritize subjects with the most severe vulnerability, in fact, it is an unethical system that largely neglects most people with

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[7] See https://doi.org/10.1016/S2215-0366(16)30024-4

[8] Social determinants and mental health. WHO 2014 (ISBN 978 92 4 150680 9)

extensive care needs. Also, hospitalization is often not a good solution for those admitted. Most often hospitalization does not reduce suicide, societal danger, and does not improve treatment opportunities or functional outcomes. The same assessment also applies to board and care homes that are relocated in society, but customers remain segregated from society and lack autonomy and social participation warranted by the CRPD. [9]

Small scale implementation opens opportunities
Optimal solutions are planned in smaller catchment areas, e.g. of 15.000 inhabitants, ideally suited to activate local resources and develop a public health strategy. For catchment areas of 15.000 inhabitants the average mental health population prevalence is 24% (3600), the need for care is 6% (900) and the prevalence of severe mental illness is 1.5% (225). The actual local prevalence differs greatly. The allocated budget should be related to the epidemiologically defined prevalence (a better indicator than historical care prevalence) and includes corrections for age distribution, social economic status, migration and urbanicity).

Budget corrections have to be made whenever the regional mental health system also has to take care for other disabled people because there are, for example, no separate addiction services, no separate nursing home system, and no separate mentally handicapped system.

Develop a comprehensive transition that unlocks additional resources
The WPA Expert Committee strongly supports the decision of the Minister to provide **emergency financing** in order to mitigate the deficits caused by the new financing structure that was introduced on April 1, 2020, and would suggest that also 2021 is considered a transition year, allowing sufficient time to conclude the draft National Mental Health Action Plan and a related financing structure that allows (and stimulates) the development of community mental health care services and gradually reduces hospital beds when community care services are available to take things over.

Special attention should be paid to the development of e- and m-health to increase the self-help potential and resilience of vulnerable people and help reduce costs and meet the currently unmet needs of the population. Equally, while recognizing that education does not fall under the authority of the Ministry of Health, the development of adequate training programs of mental health professionals should be an absolute priority, as well as measures to curb the risk of a brain drain of those who have received such education.

Finally, regional network-based service planning should include non-professional resources and foster empowering solutions for neighbourhoods, family and peers. A strong user movement can develop user-run services (for work and sheltered living) that are sustainable and at low costs (e.g. using a club model).

[9] THORNICROFT, G. & TANSELLA, M. 2013. The balanced care model for global mental health. Psychological Medicine, 43, 849-63.

VII. Concluding Recommendations

The WPA Expert Committee encourages both Ukrainian psychiatric associations to use this policy brief as a basis for future discussions with the Ministry of Health.

1. Restore trust and collaboration with all stakeholders

It is clear to the WPA Expert Committee that the second phase of the health reform plan was not properly prepared and implemented at a time when the Ukraine was engulfed by the COVID-19 pandemic. The combination of both factors led to a deep crisis that could and should have been avoided.

However, in broader terms the crisis is the result of a total collapse of trust between the Ministry of Health and the psychiatric profession. This trust needs to be restored, which will require an effort on both sides. Only when a stakeholder platform is established that is based on respect and willingness to work together to the benefit of the mental health sector can such a complex, intensive and protracted process of deinstitutionalization and establishment of community-based mental health services be accomplished.

Transparent and clear communication with all institutions and institutions affected by the changes is crucial.

A client-NGO should be established to enable the participation of clients and their peers in the transformation process.

2. Policy development

The Ministry of Health has to lead and own the process. Expert advice and input from all stakeholders, including the psychiatric profession and patients as experts in their own right, is paramount.

A clear policy framework is of the essence. The draft national Mental Health **Action Plan** should be utilized as a basis for future consultations with a view to supporting implementation and commitment by all stakeholders.

Oversight has to be established close to the decision-making level of the Ministry of Health to respond quickly, effectively and pro-actively to emergencies that will be part of the process of de-institutionalization.

3. Financing

A **financing mechanism** should be put in place that allows the continuation of in-patient care while community services are being developed (twin-track approach). A gradual reduction/phasing-out of beds would result in a step-by-step transfer of finances to these newly established services.

Additional financial and human resource investment during the first period of deinstitutionalization will likely be needed, sufficient budget should be allocated for such purposes.[10]

4. Training and upscaling

Specialist **multidisciplinary teams** should be set up to form the backbone of community based mental health care services. These teams need to be properly trained and resourced before the process of de-institutionalization is rolled out nationally.

Phasing in of modern technology, e.g. e-health and m-health applications; facilitate easily accessible mental health websites for the general public maintained by clients and professionals; e-learning materials in the context of sustainable training programs should be considered.

Potential brain-drain as a result of dismissals should be prevented by using temporary Pro Capita Pro Annum financing model both for general primary care and for mental health care at the primary level.

5. Human rights

International guidelines and obligations, also human rights commitments, need to be adhered to.

Independent advocacy for each client/patient should be established to ensure that their interests are meaningfully represented by someone who is impartial to both the institution and the person's circle, yet fully committed to their well-being and the upholding of their right to liberty at all times.

6. Concluding recommendation

Finally, the WPA Expert Committee suggests to both Ukrainian member associations to keep the WPA informed and request specific follow-up advise when necessary. Such requests will be looked upon favorably.

[10] Utilize international standards on mental health (UNODC, CRPD) as well as recommendations to Ukraine (CRPD, CESCR, CPT, ECtHR) to obtain funding.

Example: Mental Health Reform in Georgia

Since the country achieved independence in 1991, Georgia has undergone considerable changes to the organization of the mental health care systems. In 1995, Georgia adopted a mental health care program (as a part of a new general healthcare program) according which people with mental disorders receive free of charge services and treatment both at hospitals and in outpatient clinics. In 2007 a new progressive and rights-based Law on Psychiatric Care entered into force. The Law instituted some new practices, such as making a court decision for any involuntary hospitalization obligatory. In 2009, Georgian experts analyzed the law's implementation and several further modifications were introduced. In 2013-2014 the process continued and some further changes were made, particularly related to procedures on forensic psychiatric treatment.

To address the problems and challenges in mental health care in a systemic way, the Parliament of Georgia adopted in 2013 the "State Concept on Mental Health Care" as the main mental health policy document for the country. It defines the state policy on mental health issues and represents a joint vision of the Government of Georgia and civil society for the development of this sphere over the next 10 years. The major goal of the policy paper is to assist all stakeholders to contribute and achieve maximum results in the development and proper functioning of the mental health care system in accordance with their needs, capabilities, and interests. One of the essential elements in the process of mental health care reform has been the strong voice of the non-governmental sector. Professional associations, civil society, user groups, and family member organizations created a strong alliance that is essential for the development of a rights-based, humane and comprehensive mental health care.

To meet the goals identified in the State Concept the Ministry of Labor, Health and Social Affairs (MoLHSA) initiated a process of drafting a National Strategy and Action Plan (NAP) for 2015-2020, which was adopted in December 2014. During the process well-known international experts e.g. Prof. B. Saraceno, Prof. G. Thornicroft and Prof. J.M.C. de Almeida visited Tbilisi at the invitation of the MoLHSA, and presented their comments and recommendations for improving the NAP. To achieve the main indicators, the State mental health budget has been significantly increased since 2006. Along with increased financing, the state program for mental health care incorporated a new standard for community-based outpatient services, community-based mobile team services, and mental health crisis intervention services. The methodology for financing community-based mental health outpatient service was changed and defined according to the number of residents in each respective catchment area. As a result, funding for outpatient clinics increased 2,5 times and more. For community mobile services, crisis intervention, and assertive community teams the increase was even 10 times and more. The introduced changes resulted in improved indicators in the strategic document and action plan for 2015-2020. The document specified that by 2020 the ratio between the community and institutional services in Georgia should become 50/50%. The ratio for outpatient and community services changed in 2017 from 25/75% to 42/58%.

Currently, a group of local and international experts are working on the further development of the mental health care system and the 2020-2025 strategic plan. The main focus is to improve intensive and inpatient care. It is planned to re-allocate inpatient beds from mono-profile psychiatric hospitals towards multifunctional community-based mental health centers and general hospitals and to gradually introduce alternative mental health services of medium and high intensity e.g. residential care homes and family type homes, as well as crisis and assertive community services.

Example: Mental health Reform in Lithuania

After the Soviet collapse, Lithuania inherited a highly centralized and inefficient system of psychiatric care. In 1997 the government decided to dismantle the big psychoneurological dispensaries located in mental hospitals in all major cities. Consequently, psychiatrists were sent to set up multidisciplinary psychiatric teams, which were installed at the primary care level (usually in polyclinics). Gradually also the number of beds in 10 major psychiatric hospitals were reduced by 35-45 %. However, many long-term treatment patients with severe mental illness were transferred from hospitals to psychoneurological internats (social care homes).

Since 1997, outpatient MHC has expanded across all geographic regions of Lithuania and is now provided in 114 primary MHC centers. This care is specialized and provided by multidisciplinary teams, that consists from psychiatrist, medical psychologist, psychiatric nurse, social worker and other MHC specialists.

In 2013 the Lithuanian government adopted a new reform plan, under which EU Structural funds were used to improve services: 5 crisis units in psychiatric and general hospitals were renovated, and some acute wards and 27 new day care centers opened at primary mental health care (making in total 40 day care centers specialized in psychiatry). Still important service gaps remain, especially for people with severe mental illness, as a result of which they are often referred directly to psychiatric hospitals.

In 1995, social rehabilitation for persons with severe mental illness was established in mental hospital and in 2001 the first community-based center for psychosocial rehabilitation was established in Vilnius. Vocational rehabilitation services and job support models for out-patients with disability due to psychosis have been developed, and now provide services for about 250 patients yearly. Since 2016, the national sick fund has reimbursed the cost of psychosocial rehabilitation services (hospital and outpatient), but, compared to inpatient cost coverage, it is less than 5%.

Financing of MHC services.
Since 2012 the National Healthcare insurance fund introduced Diagnosis-Related Groups (DRG) payment model for hospital services, including psychiatric hospitals (in conjunction with ICD-10-AM). This model accounts for comorbid diagnoses, and reimbursement for services is provided on the leading diagnosis group cost calculation. Coding the leading diagnosis and comorbid conditions results in case mix definition by diagnosis related groups. However within each diagnostic group there are 2 subgroups: A and B. Group A consists from all diagnoses of the concrete ICD subchapter and other comorbid conditions that have greater negative impact on functioning and bigger direct costs for treatment during hospitalization (e.g. paranoid schizophrenia with somatic complications, such as diabetes mellitus or metabolic syndrome is covered approx. 2000 Eur per case). In contrast, group B diagnoses have less negative impact on functioning, nor on direct costs during the hospital treatment (e.g. paranoid schizophrenia without somatic complications, such as diabetes, metabolic syndrome, glaucoma or psoriasis is covered approx. 1600 Eur per case). This system encounters only for hospitalized patients cost coverage (including psychosocial rehabilitation), and is not providing day care or primary care cost coverage (these are covered in separate arrangements).

Primary care is covered by pro capita annual payment for all citizens living in the catchment area (6.8 Eur/inhabitant per year, completely ignoring the number of consultations or specific care provided for individuals with SMI or other high needs groups). This allows some flexibility in terms of hiring specialists in accordance with local needs, but it also is in general very limited in comparison with psychiatric hospitals cost coverage by DRG. Case management, crisis intervention or assertive community treatment teams are not covered from medical insurance.

Appendix 1

Overview of the mental health care system in Ukraine

In 2019, 1,847,113 Ukrainian citizens (approximately 4.5% of the population) received mental health care. A total of 1,499,239 patients were served in outpatient services, 308,735 patients were treated in psychiatric hospitals, and 39,139 in day hospitals.[11]

I. Funding

The main funding for mental health care is coming from the state health care program. In 2019, other sources of mental health care included municipal and provincial budgets. There are additional funds available at the Ministry of Health, the Ministry of Social Policy, the Ministry of Education, the Ministry of Defense, the Ministry of the Interior, the Ministry of Justice, the Security Service, and the railway department. However, the total spending on mental health care has never been analyzed.

Mental health care funding		
	2019	2020
Health care budget	3.55 billion. USD	4.2 billion USD
Mental health care budget	-	-
Model of hospital reimbursement	Bed/day based	Case based (280 USD)
Funding for outpatient services	The budget covered costs for consultations, diagnosis, treatment, rehabilitation, and medications.	2 USD/per visit No budget for medications
Funding for day hospitals	The directors decide themselves how to spend money from the general hospital funds	Stopped functioning

In 2020 a new model of financing has been introduced (case-based instead of bed day based). There are other state programs, which fully cover methadone replacement therapy, compulsory treatment and all expenses for forensic psychiatric evaluation, and health care programs for children with autism spectrum disorders, including the budget for medications.

II. Mental health staffing

a. Inpatient services:

Psychiatrists:	1,286
Psychiatric nurses:	8,937
Psychologists:	262
Social workers:	76
Professional therapists (doctor-psychotherapist):	23

[11] Data of the Ministry of Health of Ukraine, 01.01.2020. The population of Ukraine without Crimea and Sevastopol is 41,902,416 persons.

b. Outpatient/ambulatory and community services

Psychiatrists:	1,183
Nurses:	2,156
Psychologists:	32
Social workers:	47
Others (psychologists):	177

c. Day hospitals

Psychiatrists (adult and child and adolescent):	74
Nurses:	166
Psychologists (doctor -psychologist)	6
Social workers:	5
Others (psychologists)	8

	No. of facilities	**No. of beds/ patients**	**Duration of hospitalization/ treatment**	**Funding**
Psychiatric hospitals (without narcological departments)	56	26915	48,7days	1) 280USD/per case 2)The state program subsidies the compulsory treatment and forensic psychiatric examination. 3) For children with autism spectrum disorders, the state provides medical support and medications. 5) The regional and municipal budget covers the hospital utility expenses
Psychiatric department in General hospitals	-	-	-	There are no sufficient data regarding the funding options of the psychiatric department in General hospitals. The directors of the clinics can decide, how much spend for the psychiatric units. Usually, they use residual funds. Since the 1st April of 2020 there are two available packages: 1) case-based 280 USD for inpatient treatment and 2) 2 USD/per visit for the outpatient patient.
Outpatient services: 1) District psychiatrists in general hospitals 2) Psychiatric dispensaries 3) Psychiatric outpatient department in general hospitals and psychiatric hospitals.	-	-	-	2USD/per visit No budget for medications
Day hospitals in the psychiatric outpatient department in general hospitals, psychiatric dispensaries, or in psychiatric hospitals.				Since April 2020 the service has stopped functioning as it was left out of the mental health care reforms.
Mobile team				Only one mobile team in Ukraine

Appendix 2

International accountability

1. United Nations

1.1. Special Procedures

The Human Rights Council of the United Nations appoints human rights experts in their independent capacity on certain human rights issues, including health and disabilities. In addition to providing a thematic study to the Human Rights Council in Geneva and the UN General Assembly in New York, they visit countries and provide public reports on their findings. Ukraine is among the countries that have issued open invitations to special procedure holders. Among the roughly two dozen mandates, the following appear helpful to the mental health provision crisis in Ukraine:

a. Special Rapporteur on the highest attainable standard of mental and physical health;
b. Special Rapporteur on the rights of persons with disabilities
c. Independent Expert on the effects of foreign debt and other related international financial obligations of States on the full enjoyment of human rights, particularly economic, social and cultural rights (A/HRC/40/57/Add.1). The Expert visited Ukraine in May 2018 and reported to the Human Rights Council in March 2019; a follow-up on budgetary issues could be possible.
d. Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, who visited Ukraine in June 2018 and provided a report to the UN Human Rights Council in March 2019 (HRC/40/59/Add.3). A follow-up could also be suggested.

1.2. Treaty Bodies

Ukraine has signed up to a number of human rights treaties of the United Nations. The country's implementation is regularly (roughly every six years) reviewed by a group of independent experts. The assessment is also based on input from civil society: associations are counted among those who can provide written input ahead of the assessment.
Upcoming assessments are:

a. Child Rights Committee in late September: will compile the discussion points for the government, which will be public within October. In its last assessment the Committee was alarmed about juvenile suicide rates (CRC/C/UKR/CO/3-4).
b. Disability Rights Committee to hold a discussion with the government in the first half of 2021; input ahead of that discussion is possible.
c. As recently as March, the Committee on Economic, Social & Cultural Rights (CESCR) assessed the situation in Ukraine, with critical assessments of the mental health situation (E/C.12/UKR/CO/7).

2. Council of Europe

The independent experts of the Committee for the Prevention of Torture of the Council of Europe visited Ukraine very recently (2019), providing a lot of pertinent recommendations. A follow-up could be suggested to the Secretariat.

Members of the Expert Committee

Chairperson:

Professor Eka Chkonia MD, Ph.D. is President of the Society of Georgian Psychiatrists, Clinical Director of Tbilisi Mental Health Center, Professor of Psychiatry at Tbilisi State Medical University. Her research areas focus on the organization of mental health care. Her clinical interest involves the treatment and management of severe mental disorders and suicide prevention.

Secretary:

Professor Robert van Voren is Chief Executive of the international foundation Human Rights in Mental Health-Federation Global Initiative on Psychiatry (FGIP), Professor at Vytautas Magnus University in Kaunas (Lithuania) and Director of the Andrei Sakharov Research Center.

Committee members:

Prof. Philippe Delespaul is a Belgian clinical psychologist and professor of Innovations in Mental Health Care at the Maastricht University (Department of Psychiatry) and the Mondriaan mental health trust. He advises local, regional, national and international service users, clinicians and policy stakeholders in mental health service innovation. https://orcid.org/0000-0001-7420-0898

Professor Arunas Germanavicius is director of Republican Vilnius psychiatric hospital and professor of psychiatry at Faculty of Medicine, Vilnius university (Lithuania). His research areas focus on the development and evaluation of community-based services for people with severe mental illness, psychosocial rehabilitation, social psychiatry, public mental health, suicide prevention, human rights and stigma due to mental disorders. https://orcid.org/0000-0002-1226-1449

Mr. Rob Keukens is a mental health consultant to GGZ-Ecademy and the Federation Global Initiative on Psychiatry and a lecturer in mental health nursing in the Netherlands and internationally

Professor Igor Koutsenok , MD, MS, a Professor of Psychiatry at the University of California San Diego, Director of the Center for Criminality and Addiction Research, Training and Application, Director of the International PEPFAR Addiction Technology Transfer Center – Ukraine, and Former Chief of the Prevention, Treatment and Rehabilitation at the United Nations Office on Drugs and Crime in Vienna. He is also a Vice-President of the International Consortium of Universities on Drug Demand Reduction.

Dr. Marianne Schulze, LL.M., is an independent legal consultant and human rights expert based in Vienna, Austria. The implementation of the Convention on the Rights of Persons with Disabilities (CRPD) in mental health settings is a focus of her work. She is a board member of the Federation Global Initiative on Psychiatry.

Professor Norbert Skokauskas MD PhD is Professor of Child and Adolescent Psychiatry and Chair for Research at the Centre for Child and Adolescent Mental Health and Child Protection, IPH, Norwegian University of Science and Technology. Dr. Norbert Skokauskas is the Chair of the World Psychiatric Association, Child and Adolescent Psychiatry section and the Editor of the "World Child and Adolescent Psychiatry".