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THE MENTAL HEALTH GAP IN UKRAINE'S COMMUNITIES

Assessing Mental Health and Psychosocial Support Service Delivery in Dnipropetrovsk Oblast

Slobozhanska, Samarivska,
Pidhorodnianska, Lyubymivska Hromadas

OBJECTIVES, BACKGROUND AND CONTEXT

This report presents the findings of a gap analysis of Mental Health and Psychosocial Support (MHPSS) services in four prioritized communities of Dnipropetrovsk Oblast—Slobozhanska, Samarivska, Pidhorodnianska, and Lyubymivska. According to international estimates, 20–40% of the population may require MHPSS support, corresponding to approximately 21,200–42,500 individuals across these communities, with a total population of ~ 106,136 people.

The analysis aimed to generate an evidence base on the accessibility, quality, and coordination of MHPSS services at the community level. It sought to systematically analyze the availability of services across all levels of the IASC intervention pyramid, assess coverage relative to estimated population needs, identify underserved population groups and the structural drivers of their exclusion, evaluate the institutional and human resource capacity of local providers, and examine the functionality, coordination, and accountability of referral mechanisms.

The study was conducted by World Vision Ukraine Crisis Response in partnership with “Safe Way Pivden.”

EXECUTIVE SUMMARY

1. MHPSS service availability is structurally imbalanced across the assessed communities. While basic psychosocial support (IASC Level 1) is present in all four hromadas and primarily delivered by state and municipal providers (46% of KIIs), these services remain fragmented and limited in scope. Higher level interventions are largely absent: Level 3 services (e.g. SH+, PM+) are missing in 67%of communities, and Level 4 services (psychiatry and psychotherapy) are unavailable in 3 out of 4 hromadas, with most specialized care concentrated in Dnipro city. As a result, service coverage remains well below estimated population needs (20–40%), particularly in rural and hard to reach areas where entire settlements function as service "white spots".

2. Access to services remains limited and uneven. Across KIIs, 81% of respondents rated overall MHPSS accessibility as average or below, reflecting not only service gaps but also structural barriers such as weak rural outreach, transport constraints, and financial limitations. Internally displaced persons, veterans and their families, families of the deceased, older persons, children and adolescents, and persons with disabilities face the highest levels of exclusion. These gaps are driven not only by limited service availability, but by misalignment between service design and population needs, weak outreach and identification systems, and limited provider competencies. For example, 44% of FGDs reported that specialists lack capacity to work with persons with disabilities, while services for veterans and bereaved families lack tailored protocols and trained staff.

3. Workforce constraints are systemic and directly affect service quality and accessibility. The system is characterised by insufficient staffing (85% of KIIs), low workforce stability (58% reporting low or very low retention), and high workload (38% reporting high caseloads, 4% excessive). Burnout is identified by over 50% of KIIs as a key issue, while structured supervision is largely absent. Technical capacity is also limited, with less than 20% of providers familiar with advanced interventions such as SH+ and PM+, and weak inclusive competencies across the system.

4. Coordination and referral mechanisms are fragmented and lack accountability. Only 31% of respondents reported formal referral SOPs, often only partially functional, while 31% rely on informal personal networks, and 15% report a complete absence of coordination pathways. Additionally, 46% of KIIs reported referrals without systematic follow up, and only 12% indicated functioning case management or coordination mechanisms. These gaps create "closed loops," unclear responsibility, and a high risk of clients being lost between services.

5. The system remains highly dependent on external funding and lacks sustainability. Most Level 2–4 services are provided by INGOs and local charity funds, often through short term projects. Limited integration into public systems and budgets creates significant sustainability risks, as service availability and workforce capacity decline when external funding ends, leaving already underserved communities with only basic support.

PURPOSE AND METHODOLOGY

The study used a mixed-method design: desk review of secondary data; primary collection though 26 (KIIs) key informant interviews with local MHPSS specialists and government structures; 9 (FGDs) focus group discussions with community representatives; facility mapping via questionnaire on service availability, providers, formats and referral functionality. Triangulation across data sources confirmed that over 85% of core findings were consistent and convergent. Service mapping was conducted through structured questionnaires rather than direct site visits; therefore, findings reflect respondents' perceptions and experiences. Data were cross verified between key informant interviews (KIIs) and focus group discussions (FGDs) to enhance reliability.

"Providing a permanent psychologist – is what we need most. We have not a single staff psychologist in the social service."

– Social Work Specialist, Lyubymivska Hromada (KII)

COVERAGE AND GAP ANALYSIS

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Community	Administrative Centre	Population	Characteristics	Est. MHPSS need (20–40%)	Estimated actual coverage
Slobozhanska Hromada	Slobozhanske (urban-type settlement)	14,661	Peri-urban, proximity to Dnipro city	~2,930–5,860	Partial – Level 1. Levels 3–4 absent.
Samarivska Hromada	Samar (city)	69,855	Largest; security restrictions on group activities	~13,970–27,940	Critically low – basic services only.
Pidhorodnianska Hromada	Pidhorodnie (city)	19,138	Urban type, relatively accessible services	~3,830–7,660	Moderate – Levels 1–2. Levels 3–4 minimal.
Lyubymivska Hromada	Lyubymivka (village)	2,482	Rural; 46% of KIIs, lowest service coverage	~500–990	Low, significant geographic inequality.
TOTAL		**~106,136**		**~21,230-42,450**	

"Increasing the number of psychologists – that is the top priority. The people are here, the need is there, but there are no specialists."

— Head of Social Protection Department, Pidhorodnianska Hromada (KII)

MHPSS service provision across the assessed communities is characterized by significant structural imbalances in coverage, depth, and accessibility. IAC MHPSS pyramid Level 1 services—psychoeducation, basic psychosocial support, and humanitarian linked assistance—are available in all four hromadas, primarily delivered through state and municipal providers, which represent 46% of KIIs. These services are generally stable but limited in scope and capacity, operating mostly offline and with constrained by available resources.

Beyond Level 1, service provision declines sharply. NGOs—while representing a smaller share of actors in the system—function as the primary providers of Levels 2–4 services, including community based support, group interventions, and specialized care. Key providers include Red Cross, FHI 360, Rokada, Right to Protection, Berehynia, and the "VONA" Hub, alongside international partners such as UNICEF, Médecins du Monde, ACTED, PUI, and TAPS Ukraine. These services are typically delivered through mixed modalities (offline, online, mobile) and remain largely project dependent, creating instability in coverage.

Despite this multi actor presence, higher level services are limited. Level 3 interventions (e.g. SH+ and PM+) are absent in 67% of assessed communities, and Level 4 services (psychiatry, psychotherapy) are unavailable in 3 of the 4 hromadas. Where such services exist, they are concentrated at oblast level, particularly in Dnipro, including specialized facilities such as the Titan Centre for rehabilitation of veterans and their families. As a result, individuals with moderate to severe mental health needs face restricted pathways to care and are often required to travel, access fee based private services, or discontinue seeking support.

Geographic disparities further compound access challenges. Several settlements operate as effective service "white spots", including peripheral rural areas in Slobozhanska hromada, uncovered locations such as Mykolaivka and Hubynivka in Samarivska hromada, and hard to reach settlements such as Vasylivka, Berezanivka, and Dmytrivka in Lyubymivska hromada. Although mobile psychosocial teams provide some outreach to remote communities and IDP sites, coverage remains irregular and insufficient to meet demand.

Service provision is further shaped by the composition of providers. Local self government bodies (23% of KIIs) mainly fulfil coordination roles but lack a formal MHPSS mandate. Religious organizations (8%) and informal networks, including volunteers and community leaders, provide trusted entry points for basic support (Level 1), particularly in rural contexts. Private providers (8%) deliver Level 3–4 services but operate on a fee based model, limiting accessibility for the majority of the population.

Overall, the system remains centralized, unevenly distributed, and highly dependent on external funding. While there is an ongoing policy shift towards a community based MHPSS model, implementation remains limited. At present, most quality and specialized services are concentrated at oblast level and delivered through short term NGO programming, while community level systems continue to rely predominantly on basic interventions. As a result, service coverage remains significantly below estimated needs (20–40% of the population), and access is constrained by geography, cost, availability of qualified staff, and the instability of project based service delivery.

"Lack of information, stereotypes, no money, poor connectivity, unreliable transport."— FGD participant, Pidhorodnianska Hromada, 26.03.2026

– Barriers Matrix exercise

UNDERSERVED GROUPS AND ACCESS BARRIERS

The assessment identifies multiple, overlapping barriers that restrict access to MHPSS services and disproportionately affect specific population groups. Across communities, access is constrained by a combination of shortage of qualified specialists, weak rural outreach, limited transport options, and financial barriers, alongside lower awareness of available services and low utilization of online support (only 12% reported actual use despite 65% awareness). Social and cultural factors further limit access, including persistent stigma and misconceptions about MHPSS—particularly among men, veterans, and older people, where psychological support is often associated exclusively with psychiatric treatment. These barriers are most pronounced in rural and hard to reach settlements, several of which were identified as effectively uncovered, reinforcing geographic inequities in access to care.

The impact of these constraints is most visible among specific population groups:

- Internally displaced persons (IDPs) experience displacement related trauma and social isolation, yet services remain poorly adapted to mobile populations, with no systematic identification or outreach mechanisms in place.

- Veterans and their families face post traumatic stress, reintegration challenges, and family strain, but there are no specialized protocols in most communities, and providers often lack training in combat related mental health support.

- Families of the deceased require tailored grief and bereavement support; however, dedicated programmes are largely absent, while existing specialists are already overburdened.

- Older persons (60+) face isolation and limited mobility, yet services are predominantly facility based and lack mobile outreach components, effectively excluding those unable to travel.

- Children and adolescents experience anxiety, behavioral issues, and exposure to stressors, but school based psychological services remain overstretched, with limited access to specialized interventions.

- Persons with disabilities face the most severe exclusion, with the system failing at multiple levels. This includes both capacity gaps—44% of FGDs reported that specialists "do not know how to work" with persons with disabilities—and structural barriers, such as physical inaccessibility of facilities and a lack of inclusive service design.

Overall, these findings demonstrate that exclusion from MHPSS services is driven not only by insufficient supply, but by misalignment between service design and population needs, weak outreach and identification mechanisms, and systemic capacity gaps.

SYSTEM CAPACITY, COORDINATION STRUCTURES AND REFERRAL PATHWAYS

Human resources represent one of the most critical bottlenecks in the MHPSS system. Overall, 85% of KIIs assessed the availability of qualified specialists as insufficient. In several communities, this translates into the absence of even one staff psychologist within social services, despite an existing legal framework for such positions.

The workforce challenge extends beyond sheer numbers to issues of distribution, retention, training, and institutional ownership. The system constitution reflects this imbalance: 46% of service provision is delivered by state/municipal actors, while NGOs—though fewer—carry the bulk of Level 2–4 services. NGO programmes often provide more competitive salaries, drawing skilled staff away from public institutions. However, this creates structural instability, as services frequently diminish or disappear when short term project funding ends, leaving communities without sustained capacity.

Workload and workforce wellbeing data further illustrate the strain on available personnel. 38% of KIIs reported high caseloads (20–40 clients per week), and 4% reported excessive caseloads exceeding 40 clients per week. At the same time, 58% of KIIs assessed staff stability as low or very low, reflecting high turnover and limited retention. Burnout is widely recognized as a system level issue, with more than 50% of KIIs identifying it as a key concern. Despite this, structured supervision mechanisms are largely absent, and qualitative findings indicate that many practitioners are unfamiliar with standard practices such as case supervision or team support meetings.

Capacity gaps are also evident in technical competencies. While basic awareness of Psychological First Aid (PFA) is relatively widespread, fewer than 20% of providers are familiar with structured evidence based interventions such as Self Help Plus (SH+) and Problem Management Plus (PM+). Inclusive service capacity remains particularly weak: 44% of FGDs) reported that specialists “do not know how to work” with persons with disabilities, while only 33% assessed competencies as intermediate, highlighting significant limitations in service inclusiveness.

These workforce constraints directly affect system accessibility and performance. 81% of KIIs rated overall MHPSS accessibility as “average” or below, reflecting the combined influence of staffing shortages and limited service capacity. While formal structures exist, their functionality is uneven. Only 31% of respondents reported formally approved and up to date referral SOPs, while an equal share (31%) rely on ad hoc referrals through personal contacts. A further 15% reported complete absence of coordination pathways, 4% indicated that existing systems are outdated or non functional, and 19% either do not know referral procedures or refer clients independently. In addition, only 12% of respondents reported the existence of a fully functioning “single window” coordination mechanism.

These structural gaps translate into fragmented and unreliable referral practices. 46% of KIIs reported referrals without systematic follow up, largely due to the absence of feedback protocols and clearly designated responsible actors. At the same time, only 12% of respondents reported functioning case management mechanisms, leaving individuals with complex needs to navigate services independently. As a result, referral pathways are frequently informal, inconsistent, and dependent on personal networks, creating "closed loops," unclear accountability, and a high risk of clients being lost between services.

Without sustained investment in workforce development, supervision systems, and institutional ownership, the system will continue to struggle to ensure consistent, coordinated, and accountable care across all levels of service delivery.

"Opening a Centre for Social Services for Families, Children and Youth – would resolve many coordination problems."

— Administrative Services Center Specialist, Lyubymivska Hromada (KII)

RECOMMENDATIONS

Immediate priorities (0 to 3 months)

- Provide practical training in Psychological First Aid for social workers, school psychologists, volunteers in all four communities.
- Expand training in structured low-intensity interventions such as SH+ and PM+, particularly where Level 3 services are currently absent.
- Establish regular supervision for MHPSS personnel to reduce burnout, improve case handling, and strengthen quality of care.
- Develop and approve simple, multi-sector referral protocols in each community so that providers know where and how to refer clients and how to follow up.

Medium-term priorities (3 to 9 months)

- Establish community-based support groups for internally displaced people, veterans and their families, women, parents, and other groups identified as having high unmet needs.
- Expand mobile or outreach-based MHPSS services for rural settlements and hard-to-reach areas that currently have little or no regular specialist presence.
- Invest in awareness and information campaigns that explain what MHPSS services are, who they are for, and how people can access them confidentially and safely.
- Support community actors to reduce stigma around help-seeking, especially among men, veterans, older adults, and other groups less likely to use available services.

Longer-term priorities (9 to 18 months)

- Create and fund permanent psychologist positions within community-level social services and other relevant public institutions.
- Introduce local regulations, financing lines, or administrative decisions that formalize MHPSS responsibilities and reduce dependence on project-based delivery.
- Establish a case management approach for people with complex needs so that responsibility for follow-up and continuity of care is clearly assigned.
- Develop a unified system for tracking service coverage and referrals while protecting confidentiality and data security.

“We refer to a specific contact person with whom we have personal connections. If that person leaves — the pathway will collapse.

— Social Worker, Slobozhanska Hromada (KII)

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