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STUDY REPORT

MENTAL HEALTH AMONG THE KEY POPULATIONS

The Needs and Availability of Relevant Services in the Wartime Ukraine

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'Any way we react to this war is absolutely normal. It is only the fact of the war that is not normal in this situation'

Volodymyr Stanchyshyn,
'Wartime Emotional Roller Coaster. Therapist's Reflexions on War'

CONTENTS

ACRONYMS

APH	International charitable foundation 'Alliance for Public Health'
FD	family doctor
HCF	healthcare facility
HIV	human immunodeficiency virus
IDP	internally displaced person/people
KP	key population
LGBT	lesbians, gays, bisexuals, and trans*people
MH	mental health
mhGAP	Mental Health Gap Action Programme
MHPSS	mental health and psychosocial support
MHS	mental health specialists
MSM	men having sex with men
NGO	non-government organization legalized or registered under the legislation of Ukraine
NHSU	National health service of Ukraine
OST	opioid substitution therapy
PAS	psychoactive substances
PHCC	Primary healthcare center
PLWH	people living with HIV
PTSD	post-traumatic stress disorder
PWID	people who inject drugs
SW	sex worker

1. INTRODUCTION

The full-scale invasion of Ukraine started by the russian federation on February 24, 2022 has affected mental health of Ukrainians. According to global estimates of the World Health Organization, in settings that have experienced conflict in the preceding 10 years, one in five people has a mental health disorder ranging from mild depression or anxiety to psychosis, and almost one in ten people has a moderate or severe mental health disorder at any point of time [1]. Applying these estimates to the population of Ukraine suggests that 9.6 million people may have mental health disorders including 3.9 million people with moderate or severe disorders.

Most people are likely to be enduring the stress experiencing anxiety and sadness, hopelessness, sleep problems, being tired and irritable, feeling angry and struggling with symptoms of physical disorders *(such as pain)* [2]. According to available data, at least 50% of the population of Ukraine are going through potentially traumatic experience and will need psychological support of varied intensity [3]. At the same time, about a half (46%) of the people have never visited a psychologist or a therapist, and do not intend to do that in future; another third also have not visited the specialists before but suppose they may if need be. This can be explained by people's perception of a boundary after which the problems are seen as 'sufficient' to seek help – those may include being a POW, losing a loved one because of the war, having mental health problems caused by the war, taking part in active fighting or staying under occupation – and by stereotypes, e.g. ***'psychological aid is only for mentally ill people', 'one can deal with their psychological problems themselves'*** [4].

As a response to the challenges for mental health of Ukrainians, in June 2022, the National Mental Health and Psychosocial Support Program supported by the First Lady of Ukraine was launched. The key partner in implementation of the Program is the Technical Working Group for Mental Health and Psychosocial Support in Ukraine [5] operating since 2015 and led at the national level by the World Health Organization and International Medical Corps. To identify priorities in the field of mental health and psychosocial support (MHPSS), a document titled 'Priority Multisectoral Approaches for Mental Health and Psychosocial Support in Ukraine during and after the War: an Operational Road Map' [2] was created. This document lists MHPSS interventions and services implemented in Ukraine between 2014 and 2022.

These interventions include the national Mental Health Gap Action Programme (mhGAP)[1], operational since 2019 and involving provision of necessary psychological support by family doctors. In 2022, 'Care and Treatment of Adults and Children with Mental Disorders at the Primary Care Level' package was added to the Guaranteed Health Benefit Programme. The package can be contracted by the primary health care facilities where at least 20% of doctors and 10% of nurses have received relevant training with certification. In other words, a person seeing their family doctor can get mental health counseling, and should they need more specialized care, they can be referred to specialist psychological rehabilitation and mental health departments. This innovation is expected to promote reduction of stigma and fears connected with seeking help for one's mental health. According to the Minister of Health of Ukraine, as of March 2023, 20% of family doctors had received the training with 23 392 persons registered in the programme and 19 280 having received the certificates [6]. As of April 2023, according to the National Health Service of Ukraine, the contracts had been closed by 143 service providers *(not including departments of healthcare facilities)* in all regions of Ukraine except Luhansk and Kherson oblasts and the Autonomous Republic of Crimea [7]. It is expected that by the end of 2024, 60% professionals from 1000 healthcare facilities will have completed the training. Besides, according to the MHPSS TWG Referrals map, as of April 2023 mental health services were being provided by 124 non-government organizations (NGOs) or projects [8].

1 *mhGAP – the Mental Health Gap Action Programme aiming at building up professional competency of doctors for providing care to patients with mental, neurological and substance use disorders at general health care facilities.*

The russia's war against Ukraine exacerbates the existing mental health risks for the key populations at risk of human immunodeficiency virus (HIV) – people who inject drugs (PWID), sex workers (SWs), men having sex with men (MSM) and trans*people. On the one hand, HIV increases the likelihood of mental disorders, and on the other hand, poor mental health raises the risk of infection, which attests to the need to integrate HIV and mental health programs [9]. According to studies, mental disorders are more prevalent among people living with HIV (PLWH) and the key populations (KPs) than in general population, and KP members face stigma, discrimination and social marginalization, which together with their vulnerability to HIV and human rights violations leads to increased stress and mental disorders. According to research conducted by the APH in 2022, both KPs and general population experienced decline in mental health *(increased anxiety, sleep problems, emotional exhaustion, a feeling of loss of control over their lives, uncertainty about the future due to the difficult security situation or financial problems, fears of losing access to necessary services)*, and the demand for mental health support services had increased and become a priority [10].

A joint publication by UNAIDS and the World Health Organization [11] emphasizes the importance of dealing with the mental health problems of PLWH and KPs, the role of equal access to the services and universal health coverage in HIV/AIDS response, as well as the need to integrate MHPSS and HIV services. The document also describes possible models of integrated care for varying resources availability. Integration of MHPSS and HIV services is a key priority action of the Global AIDS Strategy 2021-2026 [12], which needs to be considered by strategies of governments and health care partners, social and economic strategies, reconstruction plans and budgets, and in community support activities. According to the Global AIDS Strategy, by 2025, 90% of PLWH and KPs are to be receiving people-centered and context-responsive services to improve their well-being and general health, including mental health.

Considering the above, a study engaging the key populations, HIV-services NGOs and mental health service providers to identify possible ways of engaging KPs in receiving mental health services and provide recommendations on an interaction mechanism for the three parties is relevant. The planned study also promotes meeting the objectives set by the abovementioned Road Map, including: ***'implementing harm reduction services for substance users; build up the capacity of primary care professionals for managing common mental and substance use disorders'***, etc.

2. STUDY METHODOLOGY

2.1. THE GOAL AND THE OBJECTIVES

The main goal of the study is to identify the main ways and mechanisms for engaging PWID, SWs, MSM, and trans*people in receiving mental health services, and to provide recommendations on establishing collaboration between members of the communities, HIV-service NGOs and mental health service providers.

Objectives of the study:

- Identify the existing methods PWID, SWs, MSM and trans*people use to cope with stress or strong anxiety, and assess their awareness of self-help methods;
- Identify the existing and in-demand mental health services for PWID, SWs, MSM and trans*people, in particular those provided by HIV-service NGOs;
- Study how PWID, SWs, MSM and trans*people generally perceive mental health services and whether they are willing to receive them, in particular, from family doctors;
- Identify key barriers and enablers for PWID, SWs, MSM and trans*people seeking mental health services;
- Identify mental health service providers working with general population free of charge and assess their attitude and willingness to provide such services to PWID, SWs, MSM and trans*people;
- Assess the existing capacities of HIV-service NGOs for provision of mental health services for PWID, SWs, MSM and trans*people, including challenges they face, and their attitude and willingness to collaborate with specialist service providers;
- Provide recommendations regarding optimizing the mechanism for cooperation between PWID, SWs, MSM and trans*people, HIV-service NGOs and mental health service providers in order to improve the access of KPs to mental health supports.

2.2. STUDY DESIGN

The study included two components – a desk review and a qualitative study based on in-depth interviews with members of the key populations in five regions of Ukraine.

2.3. TARGET POPULATIONS

There were seven target populations:

- PWID, SWs, MSM, and trans*people
- professionals of HIV-service NGOs providing services to the KPs
- mental health service providers, non-specialist care *(primary care doctors, family doctors)*
- mental health service providers, specialist care *(mental health professionals providing their services for free through projects or programs)*.

TABLE 1. ELIGIBILITY CRITERIA FOR THE TARGET POPULATIONS

№	TARGET POPULATION	ELIGIBILITY CRITERIA
1	PWID	– Having injected drugs in the past 30 days *(as self-declared during recruiting)* – Receiving services from an HIV-service NGO involved in HIV prevention among PWID – Aged at least 18 as of the time of the study – Any gender – Having lived / worked / studied at the location of the study for at least three months – Verbal informed consent to participate in the study
2	SWs	– Having provided paid sex services in the past 12 months *(as self-declared during recruiting)* – Aged at least 18 as of the time of the study – Any gender *(the sample comprises of women only)* – Having lived / worked / studied at the location of the study for at least three months – Verbal informed consent to participate in the study
3	MSM	– Having had at least one anal or oral sex contact with men in the past six months *(as self-declared during recruiting)* – Aged at least 18 as of the time of the study – Having lived / worked / studied at the location of the study for at least three months – Verbal informed consent to participate in the study
4	Trans*people	– People whose gender identity is different from the one registered at birth: trans*women and non-binary people who were male at birth and identified themselves as a woman or a non-binary person during the study, trans*men and non-binary people who were female at birth and identified themselves as a man or a non-binary person during the study *(self-reported, checked by a recruiter during recruiting)* – Aged at least 18 as of the time of the study – Having lived / worked / studied at the location of the study for at least three months – Verbal informed consent to participate in the study

№	TARGET POPULATION	ELIGIBILITY CRITERIA
5	Professionals of HIV-service NGOs providing services to the KPs *(separately for each of them)*	– Aged at least 18 – Any gender – Responsible for counseling and service provision to members of the KPs *(separately for each of them)* – At least two years of experience of working at the NGO with the target population – Experience of provision of mental health services is not mandatory – Referred by the head of the organization to take part in the study – Verbal informed consent to participate in the study
6	Mental health service providers, non-specialist care *(primary care doctors, family doctors)*	– Aged at least 18 – Any gender – Being a general practitioner *(family doctor)* at the time of the study – Any length of work experience – Providing primary care services at healthcare facilities (HCFs) that closed a contract with the National Health Service of Ukraine (NHSU) for 'Care and Treatment of Adults and Children with Mental Disorders at the Primary Care Level' package in 2023, and being referred to the study by the director of the HCF – Experience of provision of mental health services is not mandatory – Verbal informed consent to participate in the study
7	Mental health service providers, specialist care *(mental health professionals providing their services for free through projects or programs)*	– Aged at least 18 – Any gender – Any length of work experience – Having provided one of the following services in 2023 offline or online as per the Map of available services: 7.1 Psychological first aid, 8.1 Individual psychological counseling, 8.1.1 Individual psychological counseling *(short-term)*, 8.2 Basic individual counseling for groups/ families, 10.1 Non-pharmaceutical treatment of mental disorders, 10.2 Pharmaceutical treatment of mental disorders, 10.3 Inpatient psychiatric care, 10.4 Other specialist mental disorder care – Verbal informed consent to participate in the study

The additional criteria used to ensure sample diversity included:

- For PWID, SWs, MSM and trans*people: gender, experience of internal displacement after 24.02.2022, staying under occupation or in the active hostilities area, having mental health problems;
- for professionals of HIV-service NGOs providing services to the KPs: taking part in different HIV prevention projects *(in case there are few NGOs and/or professionals at the location included in the study)*;
- for mental health service providers, specialist care *(mental health professionals providing their services for free through projects or programs)*: providers of online services *(e.g. https://tellme.com.ua/)*, experience of work with the KPs.

Ineligibility criteria for all the target populations:

- refusal to give an informed consent to take part in the study,
- the level of alcohol- or drug-induced intoxication that precludes them from understanding or being able to answer the questions and makes the respondent's behavior dangerous for themselves or the study team,
- psychotic or cognitive disorders affecting understanding or ability to answer the questions.

2.4. SAMPLE AND GEOGRAPHY OF THE STUDY

The total sample was 105 persons in five cities of Ukraine. The cities were selected so as to ensure the diversity under several criteria: HIV epidemiological situation, different capacity of HIV-service network, nature and level of impact caused by war-related factors *(occupation, active hostilities, shelling, migration scale, etc.)*

TABLE 2. NUMBERS OF RESPONDENTS BROKEN DOWN BY POPULATIONS AND REGIONS

№	CITY	PWID	SWs	MSM	TRANS*PEOPLE	HIV-SERVICE NGOs	FAMILY DOCTORS	SPECIALIST SERVICE PROVIDERS
1	Dnipro	3	3	3	3	3	4	
2	Kyiv	3	3	3	3	3	4	
3	Lviv	3	3	3	3	3	4	10
4	Mykolaiv	3	3	3	3	3	4	
5	Kharkiv	3	3	3	3	3	4	
POPULATION TOTAL		**15**	**15**	**15**	**15**	**15**	**20**	**10**
TOTAL		**105**						

Please see the Annex for more detailed information about the characteristics of the participants.

2.5. RECRUITING AND DATA COLLECTION

The study used convenience sampling as a standard method for qualitative studies. Recruiting of every population was designed so as to ensure diversity of respondents based on differing parameters.

Members of the KPs were recruited by NGO workers during service provision. NGO workers contacted their clients, did pre-screening according to eligibility criteria and stratification quotas *(by mental health issues, IDP experience, and gender)*. Whenever the client met the eligibility criteria and consented to an interview, the NGO worker collected their contact data and transferred them to the research team that got in touch with the client to discuss the date and time for the interview. All the potential respondents received NGO services, referrals to other services as required, and printed materials of the APH before or after the recruiting.

NGO professionals, family doctors and providers of specialist services were recruited by the research team directly, using contact data from public sources [7, 8] subject to prior consent from the management of the NGOs and health facilities.

Before the interview began, potential respondents had to complete a screening form to check for eligibility criteria, provide verbal informed consent and complete a sociodemographics form on Qualtrics platform.

The interviews were in Ukrainian or Russian at respondent's discretion, using custom guides for each target population. The interviews were conducted by phone or online *(via Zoom)*. The interviews were recorded with a voice recorder or Zoom functionality for further transcription, coding and analysis of the collected data. The data were collected by five trained interviewers.

The interviews took from 35 to 85 minutes with the average length of 55 minutes.

2.6. DATA ANALYSIS

Qualitative data from the in-depth interviews were transcribed from digital records into Microsoft Word documents. Then, three researchers did data coding and entering into matrices *(Microsoft Excel)*. The researchers conducted a thematic analysis to create a coding system to enable answering research questions [13]. After the coding system was established, 10% of the transcribed interviews were coded by two different researchers, thus implementing double coding and quality control. After the double coding, researchers discussed discrepancies using constant comparative method. All the codes and matrices were discussed and agreed upon with all the members of the team. After that, the rest of the transcription texts were coded; the texts with similar codes were sorted and united into categories that were afterwards grouped into broader general topics containing answers to the questions of the research.

2.7. ETHICAL ISSUES

The study followed the Code of Professional Ethics of Sociologist by the Sociological Association of Ukraine [14] and the Declaration of Helsinki. The study protocol and tools were reviewed by the Integrity Review Board of the Ukrainian Institute on Public Health Policy, Kyiv *(FWA #00015634)*.

All members of the research team had been trained and received certification on protecting the rights of human study participants and research ethics principles, and signed a data use and confidentiality agreement. Interview guides were reviewed by a psychologist of the project who made some recommendations about the wording and asking sensitive questions.

During recruiting and before the interview, all the participants gave a verbal informed consent. All the participants were informed about the goals of the study and the principles of anonymity, confidentiality and voluntary consent, about their right to terminate their participation at any time, and about audiorecording of the interview. Respondents were told that their participation was completely voluntary, and that they could withdraw their consent and stop taking part in the study at any time. Refusal from participation in the study had no effect on participant's access to health care facilities or care. The participants were informed that any information they provided during the study was considered confidential *(no personal identifiers were used)*, and that only aggregated data would be used.

After completing their interview, every participant received a compensation of 500 UAH *(by bank transfer or mobile top up, at respondent's discretion)*.

Participants identified as having psychological problems during screening *(regardless of the fact of further participation in the study)* and those feeling substantial discomfort during the interview were referred to relevant mental health service providers, such as https://help24.org.ua/. No data on the number of the referrals and their outcomes were collected.

Actions to ensure confidentiality were taken at each stage of the study. The interviews were anonymous, and the participants could use any name they chose, no personally identifiable information *(e.g. surname or address)* was collected or saved. For the purpose of data collection and analysis, unique participant identifiers were used consisting of:

- the target population the respondent belonged to: PWID, SWs, MSM, T*P – trans*people, FD – family doctors, NGO – NGO workers, SSP – specialist mental health service providers,
- cities: Kharkiv, Mykolaiv, Kyiv, Lviv, Dnipro *(for all respondents but mental health specialists)*,
- respondent's serial number in their respective population.

Electronic data and other study documents were transferred to ICF 'Alliance for Public Health' which is the owner and custodian of the study materials according to internal procedures and policies.

2.8. STUDY PERIOD

Study data collection took place in July and August 2023.

2.9. STUDY LIMITATIONS

According to the study, willingness of members of the key populations to seek help with regard to their mental health issues to a great extent depends on how much their basic needs are met, whether they have had mental disorders before, and the experience of receiving professional mental health services. However, the study sampling was targeted and convenient. Respondents were selected based on their belonging to a key population, so there could be bias with KP samples including more people with a certain level of income, lack of experience *(or, on the contrary, significant experience)* of seeking help, etc. Thus, general findings may not fully represent the needs of the KPs and their opinions regarding the preferred models of care.

The SSP sample included only psychologists working on the projects providing help to vulnerable populations in Ukraine during the war. Those psychologists that work at social services and privately *(private psychologists in wartime may work as volunteers)* were left out.

The study did not take into account the capacities of the so-called AIDS Centers as the entry point to mental health services, so this access option requires further research.

The study was conducted during the active phase of the war, so its results are valid in this specific context. Planning next steps to improve KPs' access to mental health services *(in particular, in the post-war period)* should be based on continuous monitoring of the situation that is very volatile.

3. STUDY RESULTS

3.1. DESK REVIEW RESULTS

To assess available MHPSS services accessible for KPs in the regions of the study, we submitted requests to the Public Health Center of the Ministry of Health of Ukraine and ICF 'Alliance for Public Health' asking for a list of existing projects and funded service providers. Besides, we searched for and studied publicly available resources, including web sites of potential donors, projects or service providers, activity reports, work plans, minutes of meetings of working groups, etc. The search covered services provided in a targeted manner to KPs *(PWID, SWs, MSM, trans*people)* and other populations vulnerable in terms of mental health *(IDP, military, and veterans)*, as well as general population, because KP members can also belong to these groups and receive corresponding services. Data about state and communal institutions providing MHPSS services were obtained from the open database of the National Health Service of Ukraine.[2] Based on the results of the systemic data search and responses from the organizations, we created a full list of services available to KP members in the studied regions.

TOTAL QUANTITY OF SERVICE PROVIDERS

In the five cities of the study, MHPSS services are provided by 225 organizations *(some of them work in several cities)*, including 198 based in the city proper and 27 that organizations/projects providing services remotely *(such as support hot lines, individual psychological consultations, etc.)*

TABLE 3. TOTAL NUMBER OF MHPSS SERVICE PROVIDERS, BY THE TYPES AND REGIONS (N = 225)

PROVIDER TYPE	REMOTE SERVICE PROVISION	DNIPRO	KYIV	LVIV	MYKOLAIV	KHARKIV	TOTAL
NGO	27	5	4	7	2	6	51
Primary care facility	–	20	45	13	9	26	113
Specialist HCF	–	9	7	7	17	21	61
TOTAL	**27**	**34**	**56**	**27**	**28**	**53**	**225**

Potentially, PWID, SWs, MSM and trans*people can receive help from each of the 225 organizations, as belonging to the communities does not pose a barrier for asking for such services. For example, 85% *(192 of 225)* of the organizations target general public, regardless of whether clients belong to a certain population. Another 5% *(or 12 out of 225)* of the organizations focus on specific populations *(IDP, survivors of gender-based violence, etc.)*, and those KP members that meet their criteria can receive the services they need. The KPs are designated mental health service recipients of 9% *(21/225)* of the providers, and 13 (5.8%) of them are HCFs providing OST services. The rest are 8 *(3.6% of the total)* NGOs that have indicated they provide services to all of the four populations included in our study *(PWID, SWs, MSM, trans*people)* and to individual subpopulations *(such as PLWH, OST patients, or youth)*.

2 *Open data of the NHSU (https://edata.e-health.gov.ua/e-data/open-data). Downloaded on 16.09.2023.*

HEALTHCARE SERVICES FUNDED BY THE NHSU

Regarding the services provided by healthcare facilities, the search included the services provided in 2023 under the following NHSU packages:

- 'Inpatient psychiatry care for adults and children'
- 'Psychiatry care for adults and children provided by mobile multidisciplinary teams'
- 'Opioid substitution treatment of people with mental and behavioral disorders due to use of opioids'
- 'Preparedness and ensuring healthcare provision to people in the areas of active hostilities', which includes basic psychological care
- 'Care and treatment of adults and children with mental disorders at the primary care level'

All these packages include MHPSS services. In particular, specification for 'Preparedness and ensuring healthcare provision to people in the areas of active hostilities' also includes the service 'Providing psychological support to the patient and their relatives'. Altogether, we identified 174 facilities receiving 191 package *(multiple packages per facility are allowed)*. All the services included in the NHSU packages are not focused on the KPs, but all KP members without exception can access them as general public.

TABLE 4. NUMBER OF PROVIDERS OF SERVICES UNDER NHSU PACKAGES

PACKAGE	DNIPRO	KYIV	LVIV	MYKOLAIV	KHARKIV	TOTAL
Care and treatment of adults and children with mental disorders at the primary care level *(% of the total number of primary care providers)*	18 (31%)	45 (29%)	13 (29%)	7 (41%)	25 (44%)	108 (32%)
Preparedness and ensuring healthcare provision to people in the areas of active hostilities	–	–	–	14	20	34
Opioid substitution treatment of people with mental and behavioral disorders due to use of opioids	6	4	3	6	3	22
Inpatient psychiatry care for adults and children	5	4	5	–	2	16
Psychiatry care for adults and children provided by mobile multidisciplinary teams	3	3	4	–	1	11
TOTAL	**32**	**56**	**25**	**27**	**51**	**191**

In all the cities, outpatient and inpatient psychiatric care is available, though it does not target KP members specifically. Majority of the service providers receive funding under the primary care package, which involves providing simplified psychological interventions *(based on mhGAP guidelines)* by a general practitioner and referring to specialist care. There are many facilities like that, from seven in Mykolaiv to 45 in Kyiv, and their share in the total number of HCFs working with 'Primary Care' package is, on the average, not more than a third *(from 29% in Lviv to 44% in Kharkiv)*. Therefore, basic psychological care at primary care facilities is available only for a part of patients.

In one of the cities included in the study, Mykolaiv, there are no HCFs receiving funding under inpatient psychiatry care package *(there is only one HCF working with that package in Mykolaiv oblast – in the town of Pervomaisk)*, which may be explained by reforming and merging of HCFs, and an interruption in funding. Also, in Mykolaiv, unlike other cities, there are no providers of psychiatry care involving mobile multidisciplinary teams. These services are provided according to the Procedure approved by the Ministry of Health of Ukraine [15] based on pilot projects of the World Health Organization. However, there are currently no reports on the coverage and effectiveness of such teams.

NGO SERVICES THAT DO NOT TARGET THE KPs

We have identified 43 NGOs providing 56 individual MHPSS services that do not target the KPs in the selected cities or on the national level. The most available are national level services provided online or via phone *(hot lines)*. Some projects provide individual psychological counseling *(this is mostly done by psychologists)* locally *(two in Kyiv and Dnipro, four in Lviv and Kharkiv each)*, but these projects usually target people affected by the war, women and children. The next level of availability includes a group of psychosocial support services available in every city *(ranging from one provider in Kyiv to four in Dnipro)*, but these services are not clearly defined, and in most cases target IDP.

TABLE 5. QUANTITY OF NGO SERVICES NOT TARGETING KPS, BY TYPE AND TARGET POPULATION (N=56)

TYPE OF SERVICE AND TARGET POPULATION	REMOTE SERVICE PROVISION	DNIPRO	KYIV	LVIV	MYKOLAIV	KHARKIV	TOTAL
TYPE OF SERVICE							
Psychological care	19	2	2	4	–	4	31
Psychosocial support	9	4	1	2	3	2	21
Psychoeducation	3	–	–	–	–	–	3
Psychiatric care	1	–	–	–	–	–	1
TARGET POPULATION							
General population, incl. KPs	22	4	3	5	3	5	42
Other population, incl. KPs	21	3	2	5	3	5	39
IDP, incl. KPs	6	5	–	5	2	5	23
Military/veterans, incl. KPs	1	–	–	–	–	–	1
TOTAL	**32**	**6**	**3**	**6**	**3**	**6**	**56**

NGO SERVICES TARGETING THE KPS

Services specific for the key populations are provided mostly by projects funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria, or by other international donors. We have identified eight NGOs providing 15 services for the KPs on the national or local level. Eleven services are equally accessible for all the KPs, which mostly includes psychosocial support provided by a social worker, or individual counseling by a psychologist, but not within formal interventions or standards. Other four services are related to supporting OST patients, that is why they were accounted for as PWID-specific. Eight services may also be provided to other subpopulations – such as PLWH and young KP members. Two services in Kyiv were identified as those targeting war-affected KP members, including IDP.

TABLE 6. QUANTITY OF NGO SERVICES TARGETING KPS, BY TYPE AND TARGET POPULATION (N=15)

TYPE OF SERVICE AND TARGET POPULATION	REMOTE SERVICE PROVISION	DNIPRO	KYIV	LVIV	MYKOLAIV	KHARKIV	TOTAL
TYPE OF SERVICE							
Psychosocial support	1	1	1	2	1	2	8
Psychological care	2	1	2	–	–	–	5
Psychiatric care	1	–	1	–	–	–	2
TARGET POPULATION							
PWID	4	2	4	2	1	2	15
MSM	4	2	4	–	1	–	11
SWs	4	2	4	–	1	–	11
Trans*people	4	2	4	–	1	–	11
Additional subpopulations *(PLWH, youth)*	4	2	2	–	–	–	8
IDP	–		2	–	–	–	2
TOTAL	**4**	**2**	**4**	**2**	**1**	**2**	**15**

Thus, we have identified 262 services provided by 225 organizations in the cities included in the study or remotely, at the national level. Some of them do not stop at providing only one specific service, providing comprehensive support to their clients *(e.g. psychologist's counseling may be supplemented with a more specialized care provided by a psychiatrist if required)*. In many cases, the services provided by the NGOs are not based on clearly defined interventions or standards, that is why the categorization provided below is tentative, and the groups of services are not fully mutually exclusive.

TABLE 7. TOTAL NUMBER OF AVAILABLE MHPSS SERVICES, BY PROVIDER TYPES AND REGIONS (N = 262)

PROVIDER, TYPE AND NAME OF THE SERVICE	REMOTE SERVICE PROVISION	DNIPRO	KYIV	LVIV	MYKOLAIV	KHARKIV	TOTAL
NGOs that do not target the KPs	32	6	3	6	3	6	56
Psychiatric care	1	–	–	–	–	–	1
Psychiatrist's counseling (hot line)	1	–	–	–	–	–	1
Psychoeducation	3	–	–	–	–	–	3
Psychological care	19	2	2	4	–	4	31
Psychologist's counseling	1	2	2	4	–	4	13
Psychologist's counseling (hot line)	18	–	–	–	–	–	18

PROVIDER, TYPE AND NAME OF THE SERVICE	REMOTE SERVICE PROVISION	DNIPRO	KYIV	LVIV	MYKOLAIV	KHARKIV	TOTAL
Psychosocial help	9	4	1	2	3	2	21
Group sessions		–	1	–	1	–	2
Psychosocial support	5	1	–	2	–	1	9
*Comprehensive services provided by multidisciplinary teams**	4	3	–	–	2	1	10
NGOs targeting the KPs	**4**	**2**	**4**	**2**	**1**	**2**	**15**
Psychiatric care	1	–	1	–	–	–	2
Psychiatrist's counseling	–	–	1	–	–	–	1
Psychiatrist's counseling (hot line)	1	–	–	–	–	–	1
Psychological care	2	1	2	–	–	–	5
Psychologist's counseling	–	1	2	–	–	–	3
Psychologist's counseling (hot line)	2	–	–	–	–	–	2
Psychosocial support	1	1	1	2	1	2	8
Counseling by a social worker	–	1	–	–	–	–	1
OST patient support	–	–	–	2	–	2	4
Counseling by a social worker (online)	1	–	–	–	–	–	1
*Comprehensive services provided by multidisciplinary teams**	–	–	1	–	1	–	2
Health care as a part of an NHSU package	**–**	**32**	**56**	**25**	**27**	**51**	**191**
Care and treatment of adults and children with mental disorders at the primary care level	–	18	45	13	7	25	108
Preparedness and ensuring healthcare provision to people in the areas of active hostilities	–	–	–	–	14	20	34
Inpatient psychiatry care for adults and children	–	5	4	5	–	2	16
Psychiatry care for adults and children provided by mobile multidisciplinary teams	–	3	3	4	–	1	11
Opioid substitution treatment of people with mental and behavioral disorders due to use of opioids	–	6	4	3	6	3	22
TOTAL	**36**	**40**	**63**	**33**	**31**	**59**	**262**

* *These services include provision of psychosocial services to survivors of gender-based violence or hostilities at five integrated comprehensive support centers at PHCCs (Brave&Safe Response and Care Units).*

3.2. IMPACT OF THE FULL-SCALE WAR ON MENTAL HEALTH OF THE KPS

3.2.1. MENTAL HEALTH OF KP MEMBERS BEFORE THE WAR

Most of the interviewed PWID, SWs and MSM, unlike trans*people, reported having had no mental health problems before the full-scale war started. Only some of them had had mental health issues *(mostly depression[3], sleep disorders, anxiety[4], or panic attacks[5])* or a mental disorder diagnosis before February 24, 2022.

> *'I am generally a very cheerful person. I am emotional, yes, but we all are. I could be really negative, but it always passed quickly. That is, before the war, everything was okay.'*
>
> *SW_Kyiv_02*

> *'I used to be anxious. I literally had panic attacks'*
>
> *MSM_Lviv_01*

> *'I felt anxious really often, I had this fear and uncertainty. It was very long ago, back then I would take antidepressant drugs, because I had mental health issues.'*
>
> *MSM_Kyiv_03*

PWID AND SWS

Most PWID and SWs believe these disorders to be caused by excessive alcohol or drug use. For example, some participants from among PWID have experienced depression because of drug use or difficult life circumstances. Interviewed SWs reported excessive alcohol and drug use explaining that by specifics of their work which involves the risk of violence, constant feeling of guilt and shame.

> *'Basically, it is all the same – depression because of drugs. Permanent depression.'*
>
> *PWID_Mykolaiv_03*

3 *Depression is a mood disorder that causes a persistent feeling of sadness and loss of interest to all usually enjoyable activities; you may have trouble doing normal day-to-day activities for at least two weeks.*

4 *Anxiety is an emotional condition when a person anticipates upcoming negative events, feeling apprehension, fear, tension and worry.*

5 *A panic attack is a brief episode of intense fear that triggers severe physical reactions when there is no real danger or apparent cause; you might think you are losing control, losing your mind or even dying. Panic attacks may look very similar to having a heart attack.*

> *'Before the war, I had borderline personality disorder[6] that got more severe as I used drugs.'*
>
> *SW_Kyiv_01*

> *'In this industry, there are drugs and there are girls who use them. Not all of them like it, some just have to do it. It affects their mental condition, they have emergencies with clients which cause panic attacks and all kinds of stress.'*
>
> *SW_Kharkiv_03*

Interviewed family doctors also focused on PWID and SWs reporting that these populations are more susceptible to mental health disorders. And though before the war, KP members comprised a small percentage of the patients, the most 'visible' sign of belonging to the KPs was the fact of substance use. Generally, pre-war experience of family doctors' working with PWID and SWs mostly included making a diagnosis of dependence, managing certain mental conditions and symptoms *(sleep disorders, fear or apathy)*, physical pathologies or related problems *(HIV, viral hepatitis, menstrual disorders, unwanted pregnancy)*.

> *'It seems to me that MSM are the least likely to have some mental disorders. While the patients who use drugs and commercial sex workers are more likely… So, it is not like it is the same for all.'*
>
> *FD_Kyiv_03*

> *'They are the patients we diagnose with substance use disorders. We know that they have co-morbidities – HIV, hepatitis, every woman at our site has it. They do not say they work in sex industry. But surely they have sleep problems and menstruation disorders. Unwanted pregnancies also happen. Sometimes they have fears or, on the contrary, apathy.'*
>
> *FD_Dnipro_04*

Dysphoria[7] and high risk of aggressive behaviors among PWID in withdrawal[8], mood swings among those of them who live with HIV were reported by interviewed NGO workers, and mental health specialists reported having observed substance use disorders among their patients who use drugs: manifestations of withdrawal, sleep disorders and depression.

6 *Borderline personality disorder is a disharmonic condition involving mood swings, impulsive behavior, difficulty forming relationships, as well as inclination to self-harm.*

7 *Dysphoria is form of depressive mood disorder when unhappiness is combined with irritability, anger, gloom and inclination to aggression; it is common in people with epilepsy and is often observed in people who use drugs or have other mental disorders.*

8 *Withdrawal or abstinence syndrome is a diseased condition developing in patients who use drugs after using dependence-causing substances; it is a sign of physical dependence.*

> *'Psychological health of every person using drugs is affected… I saw irritability, emotional and psychological instability… Mood swings.'*
>
> *NGO_Lviv_02*

> *'If we speak about drug-dependent people, they have a lot of problems due to substance use disorders. Depression is widespread, there are cases of post-drug depression. Or persistent insomnia. Or withdrawal syndrome.'*
>
> *SSP_06*

MSM AND TRANS*PEOPLE

Unlike other respondents, almost all the interviewed trans*people reported having some mental disorders *(such as depressive or subdepressive conditions[9])* and persistent psychological discomfort they had felt before the full-scale war.

Mental health practitioners observed depression in members of the community of lesbians, gays, bisexuals and trans*people (LGBT) partly caused by discrimination against this population. Family doctors informed that MSM were rare to seek mental health services, but emphasized that members of this KP avoid reporting about belonging to this community.

> *'It is feeling of mental discomfort, this constant expectation of something bad. I had it before the war too. It is a part of my depression.'*
>
> *T*P_Kyiv_03*

> *'I guess I had attention deficit hyperactivity disorder[10], and possibly something else, but it was ignored when I was a child. Later [came] gender dysphoria, and it all caused… apathy and various kinds of subdepression.'*
>
> *T*P_Lviv_01*

> *'Speaking of LGBT, they really had higher levels of depression before the war, because they are a discriminated community facing specific pressure and specific problems that can trigger these things.'*
>
> *SSP_07*

9 *Subdepressive condition is a light depression that is not a mental pathology and involves low mood, reduced productivity and pessimistic views.*

10 *Attention deficit hyperactivity disorder is a neurobehavioral disorder characterized by inattention, distractibility, hyperactivity and impulsivity; it leads to functional impairments in various areas of one's life.*

3.2.2. CHANGES IN MENTAL HEALTH OF KP MEMBERS AFTER THE FULL-SCALE WAR BEGAN

In the first months of the war, members of all the KPs mostly experienced acute stress[11] with manifestations of varying severity – from confusion, shock, panic attacks that completely disorganized them, to less significant disorders *(anxiety, fear, insomnia, etc.)* that still allowed them to control the situation and make decisions. Severity and manifestations of mental disorders depended on a number of factors, such as intensity of enemy shelling, history of mental disorders, social support and feeling responsibility for one's family, level of substance use, etc.

> *'Since the very beginning, there were fear, confusion and panic. Dead-end. You don't know where to run, what to do; you are helpless. Sometimes I felt insane. Could not sleep in the first two months. I don't even know how to describe it.'*
>
> *SW_Mykolaiv_02*

> *'It was extremely scary in the first days, a lot of chaotic activity trying to learn if the relatives and friends are safe. Of course, it had a terrible impact on the mental health.'*
>
> *T*P_Lviv_03*

> *'For three months, I was confused, and I have dim recollection of those first three or four months. The time passed in panic and confusion. There was no understanding of what was going to happen next.'*
>
> *MSM_Dnipro_03*

The speed of adaptation to the wartime life depended on various circumstances and life situations, but all the interviewed KP members said that later their condition improved *(though some respondents still had mental disorders at the time of the study)*. During the war, some of the respondents from among the KPs developed psychosomatic disorders[12]: they noted deterioration of their physical condition, pain in various parts of the body, heart palpitation, shortness of breath, rapid body mass loss or, on the contrary, rapid weight gaining, acute exacerbation of chronic diseases and so on. Some KP members reported other disorders that become exacerbated with the deterioration of security situation, but in most of the respondents manifestations of acute stress have disappeared.

> *'I lost eight kilos in just two months, and it was abroad. It is a special psychological condition when you cannot influence anything, and inside you there is always… this feeling of being lost and useless.'*
>
> *SW_Mykolaiv_03*

11 *Acute stress is a temporary disorder developing without any other signs of mental disorders as a reaction to an unusual physical or mental stress, usually subsiding in a few hours or days.*

12 *Psychosomatic disorders are disorders of different organs and body systems triggered and exacerbated by mental factors (conflicts, stressful situations, disasters, etc.)*

> *'After the war began, probably in September, I went to a doctor, my diagnosis is Stage 2 hypertension.'*
>
> *MSM_Dnipro_02*

> *'It did affect my health. I started having problems with my heart. It was after one year of the war had passed. Arrhythmia, tachycardia. My nerves began to give because of these explosions, incoming strikes, and all these things.'*
>
> *T*P_Dnipro_02*

Only a few KP members said that the war either had not affected their mental condition or brought some positive changes. One of SWs thanks to support from social workers became an OST program client; after that, her anxiety and panic attacks ceased. A trans*person during the war came to realize their gender identity, found a job and a loved one.

> *'Before the BLAHO foundation helped me to join the program, I was drug-dependent. I had severe anxiety and panic attacks even before the war.'*
>
> *SW_Kharkiv_02*

> *'I had no fear. I lived, the missiles struck. But I cannot say it has somehow affected my health or mental [condition]. I was very calm about it. It was just inconvenient, I had no job. Now, it is very good. I have become myself. I have found a person I love. And a job I love. So far, everything is fine.'*
>
> *T*P_Mykolaiv_03*

> *'This war does not affect me much. My attitude is… I don't care, to be frank. War or no war – it has not affected me really. In terms of moral or physical condition, nothing has changed.'*
>
> *PWID_Kyiv_01*

PWID

Deterioration of mental health of PWID in the first weeks of the war was caused by severe stress, fear for their lives, OST interruptions and problems with access to drugs because of financial hardships and/or stricter police control due to martial law. Problems and life situation of members of this population depended, first of all, on the length and severity of drug dependence, as well as individual specifics, such as one's way of life, employment, being *(or not)* a client of OST program, preparedness to break the law to access drugs, co-morbidities, etc. The interviewed PWID noted a strong connection between their general condition and drug use; some had severe co-morbidities causing feeling of helplessness and very low mood.

> *'I had very severe panic attacks. I was very afraid. And the programs were suspended then, and so there was withdrawal, and all of it together, and this war… And you could not get anything from the pharmacies, it was just terrible. It was scary, and it triggered depression and all the other things. There were explosions and alarms. I was nervous because of this. But now it is sort of okay, and my mental condition is better. More stable. I am calmer now, I do not worry so much anymore. My concerns are about food and many such things, I am always broke. I keep thinking I need to be healthy, and I don't want anything bad to happen. I am very much concerned about my grandma and my husband, and about my parents – all the time.'*
>
> *PWID_Kharkiv_02*

> *'You don't know what's gonna happen tomorrow. Will the pharmacies work? Will the program work? All my acquaintances were afraid. It was this fear of withdrawal. I have some stability now, and it sets me at ease. I keep a dose in store. I am afraid of getting into such a state. There is some certainty at the moment, not much of a certainty, but still. No interruptions in drug supply. And if I can't get my methadone from the program, I can buy street one.'*
>
> *PWID_Mykolaiv_02*

> *I: 'So, the most common effect is that people are looking for drugs and are concerned that the supply is low, there is low access to drugs?'*
>
> *R: 'Of course. Especially now that there are military men everywhere, and the police, there are cameras on every corner, they see everything. It is more serious now.'*
>
> *PWID_Kyiv_01*

Family doctors, mental health specialists and NGO workers also reported that PWID now struggle finding drugs. They believe that dangers of the martial law, displacement, unemployment, and unending price growth restrict access to psychoactive substances, so the PWID tend to more often commit crimes to get money or pawn their personal documents. Because of the limited accessibility of PAS, withdrawal has become common, and there are more patients with alcohol psychosis[13] caused by restrictions of alcohol sales at the beginning of the war – this was reported by both family doctors and mental health specialists. According to them, for PWID, PAS use still prevails over other needs, and the increase in alcohol consumption and prolonged drug use promote development of anxiety and depression with dysphoria, inclination to aggression, and suicidal ideations.

NGO professionals also described worsening of mental condition of PWID. In particular, in some cases social workers observed development of adynamic depression[14], apathy, and escalation of suicidal ideations. They noticed rapid increase of the number of OST patients requiring prescriptions to obtain drugs, which was caused by simultaneous closure of many sites and private facilities in the first days of the war.

13 *Alcoholic psychosis is an acute impairment of brain activity caused by systematic prolonged use of alcohol; it is usually a result of chronic alcoholism or acute alcohol intoxication.*

14 *Adynamic depression is a depressive condition mainly involving energy disorders: loss of motivation, asthenia, sluggishness, idleness, weak emotional response and subjectively weak feeling of low mood.*

'That is what I experienced – drugs were nowhere to be found. At the beginning of the war, everything was closed. Pharmacies were closed. They came to the polyclinic, and they wanted to get their dose no matter what.'

FD_Kyiv_01

'[When the full-scale war began], all the seventy-two private facilities somehow related to OST and serving four thousand patients just packed up and left the city. That is, we got four thousand drug users in withdrawal in the streets. Besides, there was a small upsurge because there was no alcohol… Patients developed acute alcoholic psychosis. But in those two months we observed the trend of reduction of the quantity of people with alcohol problems.'

SSP_01

'All those who were stable and absolutely normal are now hungry and dirty. Some had their homes destroyed, some have no water or power supply. People have become poorer, and so they are angry and disappointed. They are afraid. They look for a better place, they move to a village somewhere. But it is not as convenient as here. They panic and return. But here they get bombed. No stability. They were hysterical before, and now they are even more hysterical. They say they are stretched thin. They now use more of some new drug. And their condition is different from what it was two years ago.'

NGO_Mykolaiv_02

'The users face stress and fear, and start using even more because of that. And the present situation has only made things worse. There is paranoia, and stress. Anxiety, helplessness. I don't even see a desire to do something. Complete idleness, they have given up. People just stop trying. We have some people from Kharkiv oblast – some places had been occupied there. And of course, no one took care of them under occupation. And after de-occupation, they just rush from there, and we help them to get registered with the sites and return to receiving the therapy.'

NGO_Kharkiv_03

'There is fear of drug withdrawal, fear of moving to another region, fear because they don't know what to do, and suicidal thoughts.'

NGO_Lviv_03

SWS

Panic attacks, anxiety and sleep disorders have followed SWs since the beginning of the full-scale invasion, and, talking about their current condition, respondents often mentioned the fear of death, premonition of a loss, and desire to get away from the reality. In some of these women low mood and apathy prevailed, they noted they had lost the desire to communicate and told that people irritated them. In some cases, they spoke about frustration, heavy inner turmoil, and suicidal thoughts.

> *'I have panic attacks, I get stressed when missiles are incoming, when we are being shelled at. I pull myself together, gradually, and it ends after the shelling is over. We breathe out, sit for a while and go on with our living.'*
>
> *SW_Kharkiv_03*

> *'I live on the 10th floor, it's the top floor. I can say I was calm for a year, but after that hit in Uman in late April, I cannot stop reading Internet. Everyday on the lookout. But when the night comes, it is the worst. I even cried out at night, and not just once… I feel like I can't breathe. I took an ECG, my heart is okay.'*
>
> *SW_Kyiv_02*

> *'It just happens that I do not get involved in the things going on around. I also keep thinking that either a missile will kill me, or I will kill myself, because I just can't take it anymore.'*
>
> *SW_Kyiv_01*

Talking about the problems affecting their mental condition, SWs emphasized financial hardship and a drop in the number of their clients. There are inflation, growing food prices, accommodation problems, lack of money to pay for utilities and support their families, yet martial law and curfew have rendered provision of sexual services in pre-war format or amount impossible. This leads to development or exacerbation of depression and anxiety, prompting the women to drink more alcohol or use more drugs. Similar observations regarding deterioration of material situation of SWs during the war because of the loss of regular customers and changes in life circumstances were also voiced by NGO workers.

> *'Depression is even worse for us now, because in addition to accepting who you are you now have to accept that you can die at any moment. That's why a lot of us now are in depression… A lot of girls who cannot accept themselves or work without drugs or alcohol… A lot of them complain about money… An egg costs six hryvnias.'*
>
> *SW_Kyiv_03*

> *'The girls now have less work. They used to have a lot of regulars who escaped in the first days. So their income dropped. And many have kids, and families. The prices have gone up. And all of this affects their psychological state one way or another.'*
>
> *NGO_Kharkiv_02*

According to family doctors, SWs feel ashamed, they hide their source of income, which triggers anxiety, depression and psychosomatic disorders. Some specialists also mentioned domestic violence against these patients. NGO workers also spoke about domestic violence – including its financial and psychological forms – being common for SWs.

> *'Sex workers are a separate topic. Because they usually do not disclose their occupation, they feel ashamed. And because of this, they develop various psychological disorders. Anything from usual anxiety to depression and psychosomatic disorders.'*
>
> *FD_Lviv_01*

> *'During the invasion, I have worked with five survivors of domestic violence, and it was not related to sex services. The women were subjected to psychological and financial abuse. They had mental disorders, panic, and then I referred them to a psychiatrist.'*
>
> *NGO_Mykolaiv_01*

MSM

While in the first weeks of the war MSM experienced anxiety and confusion, they were afraid of mobilization, now they more often notice reduced intensity of social contacts, limited communications and, as a result, feeling cast-off, lonely, sad and miserable.

> *'Anxiety, as I have noticed, sense of insecurity of the future, we don't know when it ends, and there is a fear to be mobilized. Very often, money troubles. And, maybe, more aggression.'*
>
> *MSM_Kyiv_03*

> *'My friends and acquaintances, on the contrary, they have shut themselves off from everybody. Like nobody really needs anybody. That is how people feel, they are depressed.'*
>
> *MSM_Kyiv_01*

MSM respondents reported more frequent alcohol use, feeling insecure about the future, 'fear of living', financial problems, and more aggressive behavior in their environment after the start of the full-scale invasion. At the same time, some of them, on the contrary, mentioned positive changes in their lives, because in the wartime, people's attitude towards them has become somewhat more tolerant.

> *'Uncertainty. I live for today. Enjoying life to the fullest. You wake up in the morning and don't postpone anything until the next day. And I probably don't care so much anymore.'*
>
> *MSM_Dnipro_01*

> *'A lot of people drink, they somehow work in the evening. It is more frequent now, I notice that and I don't really like that.*
>
> *MSM_Kyiv_02*

> *'A lot of my friends have felt it… they say living is easier now, in terms of us being different from the rest. Because now they take it in a different way.'*
>
> *MSM_Lviv_03*

Talking about problems of MSM, mental health professionals, HIV service workers and family doctors mentioned stigma, including self-stigma[15], high levels of psychological and physical violence, relationship problems and low trust in people around them. All of it triggered depression and suicidal ideations in MSM. Noting this population's vulnerability to discrimination and 'closedness' of MSM, NGO professionals have observed a raise in the use of anti-depressant drugs and tranquilizers since the beginning of the full-scale war.

> *'They are very often depressed, because the society and their friends, and family don't accept them. And even some talks about sex minorities cause a lot of negativity. It takes them really long to acknowledge their condition, they believe it is only an exhaustion, or keep looking for some disease in themselves, they don't consider depression a disease.'*
>
> *FD_Lviv_04*

> *'Some of them are subjected to attacks, physical and psychological abuse because of their sexual orientation. And so they are in that cohort that, at least, needs psychological support. Quite often, what they need is a psychiatrist and a pharmaceutical therapy.'*
>
> *SSP_06*

> *'MSM are very often vulnerable… they are discriminated against. That is, MSM are considered a close group, they cannot always openly tell about themselves.'*
>
> *NGO_KY_02*

> *'A lot of MSM have taken to anti-depressant drugs and tranquilizers.'*
>
> *NGO_KY_01*

15 *Self-stigma is feeling shame and expecting discrimination, the fear of actual stigma a person has experienced in the past.*

TRANS*PEOPLE

Current mental condition of trans*people to a great extent depended on personal circumstances *(training or work, income level, availability of social support, etc.)* Some of the respondents said they had adapted to the situation and disengaged from the thoughts about the war, trying to live their lives and solve daily problems. At the same time, some continue struggling with anxiety and depression, even though they have learnt to control their condition. Mental condition of trans*women with male gender marker has been affected by the ban on leaving the country.

> *'It is quieter now, because shells do not explode near the windows making them jar. I got used to what's going on. Sirens do not scare me anymore… Me personally, I feel quite bad, lonely… and apathic.'*
>
> *T*P_Kyiv_02*

> *'Yes, as I am a student, the most pressing problem is that a new academic year is starting soon. And it will be one of the most difficult ones. In the last two months I regularly feel an anxiety I struggle coping with. It goes on day after day. Sometimes it may last for several hours, sometimes it's just twenty minutes.'*
>
> *T*P_Lviv_02*

> *'Many people have become desperate because a lot of transgender women with male gender marker could not leave. For example, when they had no choice, no money for living in Ukraine or other things like that.'*
>
> *T*P_Lviv_01*

In the context of factors worsening the psychological condition of trans*people, they often indicated financial hardships they face in wartime. Some respondents stressed that it was harder to find a job than before the war, and, being deprived of a regular income while facing inflation and other problems caused by the war, they found themselves in a difficult situation. Even for employed ones making ends meet *(paying rent, getting food, keeping pets, etc.)* has become significantly harder. Material problems of trans*people are to a great extent linked to the need to procure hormonal medicines *(that are not freely available on the market anymore)*, pay for medications and visits to doctors required by the transition procedure.

> *'A lion's share of my income, like two thirds of it, I spend on rent and utilities. My parents helped me with money during the whole 2022 and the first half of 2023. The money I got from my mom or other relatives, I spent to cover basic needs, because everything has become very expensive, unaffordable. When the full-scale war began, new problems came because pharmacies stopped selling hormonal medications.'*
>
> *T*P_Lviv_01*

> *'There were problems with medications. After the war began, everybody rushed to pharmacies. My medications were not available, and I had very small stock of those. And it was very difficult before I was able to buy some more. Some people helped me by sending the medications from Germany. I struggled to afford buying the necessary amount of medicines.'*
>
> *T*P_Dnipro_01*

> *'It has become somewhat harder to find a job. I once was interviewed, and it was okay, they were ready to take me. But it was by phone. And then, when I came there… Roughly speaking, I did not meet expectations. There is a boy in the documents, and a girl comes in.'*
>
> *T*P_Mykolaiv_03*

> *'I am unemployed… Before going to psychiatrist, I need to at least get my thyroid gland examined. I cannot afford psychiatrist. Besides, I may also have an allergy. I now need to spend more money to live without severe symptoms.'*
>
> *T*P_Dnipro_03*

GENERAL OPINION OF THE EXPERTS

Family doctors, NGO workers and mental health specialists have observed deterioration of mental condition of all their patients/clients regardless of belonging to a key population, first of all, many more cases of stress, sleep disorders, panic attacks, depression and apathy. And while some family doctors reported the increase in the number of visits of KP patients, sometimes they could only guess that a patient belongs to a key population or learnt about that from a third party. To learn about patient's risky behaviors, trust-based relationship had to be built.

> *'I think [the health] in these key populations has become worse, just like in everyone else. Generally we now see fewer patients with mental disorders. Maybe it's because of migration, some of them have left. But they all fail to ask for psychological support when needed, to be honest. You know, when they have anxiety, anxious conditions, or suspect they have a depression. They ask to be referred to a psychiatrist or determine whether they really have a disorder. We have been seeing more of that recently because of the war.'*
>
> *FD_Kyiv_03*

> *'They don't come like that, they only come for a treatment. They may come with a cold, and then conversation will touch their well-being. They may say they have problems in the family. Like, nowhere to live or they are being expelled from home. They rent an apartment, and so having problems. No permanent accommodation, with calmer life.'*
>
> *FD_Kharkiv_01*

> *'I have such people in my district, they are difficult. They are asocial. That includes alcohol abuse and drug use. They don't say about it. I can guess it by their habitus, by co-morbidities. Or their relatives may tell me. I also sometimes can see that the patient works in sex-industry or is a transgender man. I have a patient who keeps asking referrals to an urologist. And I say: 'You know, I need to know what the problem is, tell me please.' No way. The patient comes to me for help very rarely, only when they have an acute health problem.'*
>
> *FD_Dnipro_04*

According to professionals, war-related insecurity, loss of family members or separation from them, substantial changes in life circumstances, displacement, loss of employment and stable income while needing more money to buy PAS, and reduction of numbers of SW clients have caused development or exacerbation of stress conditions, anxiety, and sometimes aggression. Despite the fact that a lot of patients/clients have eventually adapted to living in the situation of war *(for example, by moving to a safer place, meeting basic needs, using self-help or specialist help)*, KP members are still affected by stress factors and often encounter difficulties, which leads to poor mental condition.

> *'[The condition] changed to worse. People have become more mentally unstable.'*
>
> *NGO_Mykolaiv_ 03*

> *'I now see a lot of couples, where women went abroad and men break bad. Some have stopped the therapy, some have switched to street drugs.'*
>
> *NGO_Mykolaiv_ 02*

> *'A lot of people live under stress during active fighting and now too. Because it's the same. Because every person is vulnerable, and bombing or shelling causes mental disorders. Stress, anxiety, irritability and fear. Fear paralyzes many people, they panic and don't know what to do and how to live further.'*
>
> *NGO_Lviv_03*

> *'Our key populations live in chronic stress. They have no stability. And this is the biggest challenge. When a patient does not know where they are going to live tomorrow, or where to get money for living… As long as these problems persist, patient's mental health… you understand what I mean.'*
>
> *FD_Lviv_01*

Some mental health specialists reported a significant increase in initial presentations of disorders and in the quantity of patients with post-traumatic stress disorder (PTSD)[16] developing due to staying in the area of active hostilities and intense shelling. Service providers quite often mentioned panic attacks, persistent depressive conditions and suicidal ideations[17] caused by the long war, permanent negative news in the media and social media, financial problems and deepening social disadaptation[18]. Respondents believe that such circumstances provoke risky behaviors – such as providing paid sex services, increasing substance use, etc.

> *'We now see more initial presentations… From acute psychosis to depression, to disadaptation, panic attacks and so on…'*
>
> *SSP_02*

> *'It seems to me that more people have depression… I think those who have lost income can also provide sexual services and so on.'*
>
> *FD_Kyiv_04*

> *'It's a depression, but not a regular one, it is related to the news we get from the TV and various Telegram channels.'*
>
> *FD_Kyiv_02*

According to family doctors, common reasons for patients with mental disorders to visit general practitioners are pain, dizziness and other manifestations of physical disorders. While the ultimate cause of the problems are stress-induced disorders, patients seek help only after manifestations of physical signs – such as elevation in arterial pressure, arthritis, etc.

> *'When a physical pathology begins, they come here, and we start talking about psychology. Their problems – hypertension and leg pain.'*
>
> *FD_Dnipro_02*

> *'Some people don't even understand the problem is rooted in psychology, they think it is purely physical. They get some symptoms that look like they are unrelated to a psychological problem, but after we exclude organic damage, we conclude that the problem is caused by stress.'*
>
> *FD_Lviv_03*

16 *Post-traumatic stress disorder is a severe mental condition, a kind of anxiety disorder triggered by a single or repeated traumatic situations.*

17 *Suicidal ideation, suicidal thoughts – thoughts, ideas and considerations regarding committing a suicide; depending on situation, these can be fleeting thoughts or deep, detailed suicide planning.*

18 *Social disadaptation is a person's complete or partial loss of ability to adapt to social conditions.*

Among long-term effects of the war, many of the professionals mentioned deterioration of mental health of IDP. They spoke about aggression, depression, anxiety, sleep problems and psychosomatic disorders. The doctors explained it by changes in cultural environment, uncertainty that is stronger than for local residents, and pressing financial problems.

> *'For example, if you compare Kharkiv oblast and Lviv oblast. They move to Lviv, and they don't feel comfortable. They may be not used to this way of life, even social things, and the issue of language is a particular concern. They take it hard when someone reproves them. And this also causes unwanted consequences.'*
>
> *FD_Lviv_01*

> *"Displaced persons move to temporary accommodation centers, there schizophrenic conditions get aggravated, and they come seeking aid.'*
>
> *SSP_02*

According to experts, psychological condition of all the KPs gets affected when they test positive for HIV, often reacting with despair and panic. When people learn about their status for the first time, they can stay depressed for some period, feeling anxiety and having sleep disorders. When tested HIV-positive, KPa member is more likely to get stigmatized, and NGO workers believe that the fear of stigma and necessity of status disclosure become especially stressful because of poor security situation and high likelihood of having to move inside the country or abroad.

> *'Sometimes I give this envelope with the test results, the client opens it, sees the result and cries out: 'I have AIDS, I will die!' They say they have anxiety and struggle to get some sleep after receiving this information.'*
>
> *NGO_Dnipro_02*

> *'And people with HIV [are affected by the stress] the most. Because they all had to move, for example, abroad. It was difficult for them to get registered and receive the therapy, and disclose the status to more people.'*
>
> *NGO_Kyiv_03*

> *'In this situation you don't know where you will have to run, to move, you are permanently stressed and don't know whether your stock of medicines is enough, will you be able to get some more and not lose them. So that is an elevated stress. People who have to go to their relatives or to another country, they are anxious about disclosing their status. Because very often staying abroad they cannot seek medical aid without help as they don't speak the language.'*
>
> *NGO_Kyiv_02*

3.3. METHODS OF WARTIME SELF-HELP FOR THE KPS

Far from all respondents from among the KPs were able to name some psychological self-help methods[19], yet almost all of them used some methods of self-comforting to cope with their fear during attacks or with anxious thoughts, sadness, and low mood. For all the KPs, a way to calm down was and is spending time with close ones – family, friends, colleagues, and community members. But not all of them could access this kind of support: many of respondents from among SWs had lost family ties because relatives were negative about their work, and MSM who favored seclusion lost their friends because they moved abroad.

> *'There was support from the friends who stayed here and abroad, who left in the very first days. Back then a lot of people from the trans*community evacuated. Later, a lot of others came from Kherson and Kharkiv oblasts. Those who stayed and those who had moved abroad provided support – material and moral.'*
>
> *T*P_Dnipro_02*

> *'My support is my husband. I called him, and he reassured me, we had a good talk, and he supported me. Also, I can call my mom. She also can calm me down.'*
>
> *SW_Kyiv_02*

> *'The problem is that most of my friends are now abroad. Though they are not really my friends anymore.'*
>
> *MSM_Dnipro_02*

> *'The thing that helped me the most is talking to people. This is the main thing – to communicate… The most important thing is not to stay alone.'*
>
> *PWID_Kyiv_01*

19 *Psychological self-help is a self-directed improvement of one's mental health (emotional, psychological and social well-being) through self-reflection, self-care and self-improvement strategies.*

PWID AND SWS

The interviewed PWID and SWs mostly were unable to name particular self-help methods to be used in stressful situations. Some PWID spoke about watching films, breathing exercises, physical exercise, but most of them interpreted the question about self-help in the context of dealing with the dependence, so they said they could not deal with it themselves and required help, e.g. from mutual support groups.

> *'Coping with irritability is simple – breathing exercises, some light physical exercise… And if it is some serious anger, we… I have nothing to advise. You should see a specialist.'*
>
> *PWID_Lviv_02*

> *'The practice shows, you cannot solve this problem alone. Only with the support from other people, not drug-dependent. When you join this community, you just understand that you are not the only one like that, and many other people have the same problems, and they tell about their experience, how they coped with these problems, and the most important part – how they did without using drugs. And you just understand that such a life is possible.'*
>
> *PWID_Kyiv_03*

Respondents from among sex workers focused on daily routine *(cooking, cleaning)*. Some believed that under stress you just need to 'pull yourself together' and not think ***'about bad things'***, they tried to ***'persuade'*** themselves to think about positive things, visited popular Internet resources or watched films, listened to the music, did breathing exercises, sometimes meditated or did sports. Some participants tried taking melatonin to improve their sleep, but found it to be not effective.

> *'You just need to pull yourself together. And not think about bad things. Think about something good. That's the main thing.'*
>
> *SW_Lviv_02*

> *'Jogging works for me. For example, when my kid is playing in the playground, I am jogging. I kept telling me everything was going to be alright. And this way you can pop yourself up.'*
>
> *SW_Mykolaiv_01*

Members of PWID and SW communities mentioned prayers or mantras, going to church as the ways to overcome anxiety and tension, including those caused by wartime dangers.

> *'Sometimes I just feel like reading the Lord's Prayer. I sometimes get comfort from reading a prayer or a mantra.'*
>
> *SW_Mykolaiv_03*

> *'If I am really worried, I just pray and I know it will work out somehow. God always helps me, He never abandons me. Whatever my situation is.'*
>
> *PWID_Kharkiv_02*

These two KPs often used alcohol and/or drugs to cope with the stress. Some PWID told it was unacceptable to ask other community members for help or advice, as this is considered a weakness, which is why they consider using drugs or alcohol the most appropriate way to deal with problems. Speaking of alcohol as a way to overcome the effects of wartime stress, SWs said they went for small doses because alcohol helps dealing with severe anxiety and allows you to take care of children and other family members.

> *I: 'What do you usually do when you feel insecure, when you are worried?'*
> *R: 'I use. [Other PWID], I think, they only use. They don't even try to share their problems with anyone, because drug-dependent people consider calling someone to complain or ask for an advice a weakness. And they have no trust.'*
>
> *PWID_Kyiv_03*

> *'When I felt bad, I went to a store and drank a bottle of vodka right there, or took it home.'*
>
> *PWID_Kyiv_01*

> *'A lot of the girls are drug-dependent. They use a lot of drugs, and that is how they cope with the stress.'*
>
> *SW_Kyiv_03*

> *'Alcohol and drugs – one hundred percent! – they don't comfort and they are not effective. That's what I know from my experience and that's what I see in the girls I work with. Just five minutes pass, and the fear is back.'*
>
> *SW_Mykolaiv_02*

MSM AND TRANS*PEOPLE

Compared with the interviewed PWID and SWs, participants from among MSM and trans*people were the most aware about self-help methods. Among the methods that can be used to cope with anxiety or panic attacks and other manifestations of mental disorders, they mentioned some psychological techniques, breathing exercises, yoga, meditation, sports, and playing or listening to the music. Some of the trans*people preferred to drown themselves into work or studies, focused on household routine or tried to make a daily schedule and follow it. The participants also mentioned positive thinking, believing in the victory, and strengthening national consciousness during war as ways to improve one's psychological condition.

> *'I know some methods against anxiety. I mean breathing and meditation.'*
>
> *MSM_Lviv_01*

> *'Breathing technique, attention shift, sports. Various activities that can distract or comfort us. Listening to the music, too. Playing instruments. Contact with animals… I can go on and on… I always try being positive. It has helped me to become stronger, a more responsible citizen of my state. And a nationally conscious person. This fear does not defeat me. I find comfort in having faith in our ZSU [Armed Forces of Ukraine] and in that Ukraine will really win. I sincerely believe in that.'*
>
> *T*L_Kyiv_01*

> *'These practices involve getting awareness of what is going on around you, feeling the space, taking notice of objects around you, or breathing… You have to wake up in the morning and spend about seven minutes trying to get the feeling of your body, that is to touch hands, ears, head, to feel you are here and not wander with your thoughts elsewhere.'*
>
> *T*P_Lviv_02*

> *'I know that every morning I have to wake up at a certain time, then turn on PC and do certain tasks. And that has a very positive effect on my psychological condition. Because if you follow a schedule, some sequence of necessary actions, it is a great support.'*
>
> *T*P_Lviv_03*

Similar to other key populations, MSM and trans*people have practiced substance use to cope with the stress – both in the past and after the war began. At the same time, the respondents more often had negative opinion about such a way of improving their psychological state, reporting having stopped using the substances since the beginning of the full-scale war.

> *'They sort of seek comfort in alcohol or other things like drugs. I have had a lot of stress, and I tried using alcohol to cope. It was about surviving every single day.'*
>
> *MSM_Lviv_02*

> *'Of course, I can drink alcohol, but after the war started, I stopped drinking.'*
>
> *MSM_Mykolaiv_03*

> *'Talking about dependence in general – neither me nor my acquaintances have experienced it. If we take psychoactive substances – no. Such conditions might be rare [among T*P].'*
>
> *T*P_Kharkiv_01*

> *'Quite a lot of people solve this problem just with chemistry, that is by drinking alcohol or, at best, taking tranquilizers for example. I also use tranquilizers, but not often. I consider drugs an absolute evil.'*
>
> *T*P_Lviv_02*

Taking tranquilizers and antidepressant drugs *(prescribed by doctor)* was most typical for MSM and trans*people; the same goes for group-based or individual psychological help online or taking part in mutual help groups.

> *'I had antidepressant drugs, I took them and that was my therapy.'*
>
> *MSM_Lviv_01*

> *'My acquaintances mostly take antidepressant drugs trying to vary them if a particular medication doesn't work.'*
>
> *T*P_Kyiv_03*

> *'We get supervision sessions with specialists, and we can communicate – individually or all together, with a psychologist. Online.'*
>
> *MSM_Kyiv_03*

> *'I do it online. Lately, going to meetings and events of the LGBT community has been eye-opening. There are people, and you can have a discussion with someone who has similar problems.'*
>
> *T*P_Kyiv_01*

> *'We have a trainer, she has conducted a lot of trainings, she is a psychologist. People from our community meet in Zoom. It actually helps.'*
>
> *T*P_Dnipro_02*

GENERAL OPINION OF THE EXPERTS

Service providers generally did not pay sufficient attention to their patients'/clients' awareness about effective self-help methods to cope with stress or psychological disorders. Speaking about well-known ways KPs use, experts most often mentioned substance use *(alcohol, drugs, tobacco, tranquilizers)*, which is typical not just for people with dependence, but also for those who have never used substances on a regular basis. PWID combine a main drug with other substances, e.g. alcohol. Some mental health professionals mentioned that during the full-scale invasion they observe a spread of uncontrolled benzodiazepine use *(in particular, Gidazepam)* leading to dependence. Family doctors reported uncontrolled use of plant-based tranquilizers and barbiturate-based pharmaceuticals.

> *'They try taking medicines they see advertised or those their friends recommend. Some plant-based medicines, while some switch to alcohol.'*
>
> *FD_Kyiv_03*

> *'Some, as they say, get hooked on barboval or valeriana.'*
>
> *FD_Mykolaiv_03*

> *'Unfortunately, there is still this "wonderful" coping tool – Gidazepam, which is a prescription drug, but people throw a pity party and get it sold to them without a prescription. And they may use it not according to guidelines, and this eventually leads to dependence.'*
>
> *SSP_07*

> *'OST patients start looking for an additional drug. A lot of people drink. OST is not compatible with alcohol or street drugs. Yet they still try to get that street methadone, additional drugs to cope.'*
>
> *NGO_Kharkiv_01*

Some NGO workers believe that clients have poor awareness and just try to restrain the fear shellings and missile attacks cause, facing the risk of development of psychosomatic disorders. Some mental health specialists said that stress-related self-help information is available to the patients thanks to psychoeducation[20] materials in social media *(e.g., on the Facebook page of 'Ty yak?'[21] program)* and availability of brochures and various publications. Some family doctors taught their patients stress-coping techniques.

20 *Psychoeducation is explanation and delivering to people important information about mental health, psychological issues and their consequences for personality.*

21 *'Ty yak?' ('How are you?') is an all-Ukrainian mental health program initiated by the First Lady of Ukraine, Olena Zelenska, in order to create a culture of caring of mental health in the society, raise the awareness and provide tools to help Ukrainians take care of their mental state.*

> *'A lot of people don't know or feel ashamed to react to the shelling, they don't know what to do when their knees shake. They try to restrain these things, and it all stays in the body and manifests later through diseases. A lot of people don't even know about breathing exercises, for example.'*
>
> *NGO_Dnipro_02*

> *'It is very good we have psychoeducation. There is 'Yak ty?' program, and a lot of other sources that keep telling about resources and stabilization exercises. Like, communicate if that's what helps you, go for a walk. And I know that people read books – it is important to disseminate popular self-help literature. People need to understand what's going on with them, what they can do themselves. And when the time comes – they need to get professional help.'*
>
> *SSP_07*

Experts believe that self-help regarding psychological disorders is a very individual thing depending on influence factors, manifestations of the disorder, way of life, awareness of the methods of coping with stress, and ability to help oneself. Some NGO workers believe that their clients have higher chances of coping with stress if their basic needs are met and if they enjoy support from close circle or professionals. To overcome the stress, KP members can use communication with their relatives and partners, but some just assumed that could work because they had never discussed such issues with their patients.

> *'A person must have some survival minimum – food, a roof over their head, and at least some friendly support. If these needs are met, the person can cope.'*
>
> *NGO_Mykolaiv_01*

> *'There are patients supported by friends and relatives. They have it easier. They can shift their attention. The patients who have left or lost their nearest and dearest are stressed all the time. It is also easier to those who have a job, a hobby.'*
>
> *FD_Dnipro_04*

> *'Some people take care of their health. They are fighters, they do something for themselves. And the passive ones are now emotionally drained, they are deprived of home and food. Of course, they don't take care of themselves until we learn about them. A doctor calls us – or a nurse – and asks "Please do something."*
>
> *NGO_Mykolaiv_02*

3.4. KNOWLEDGE, NEEDS, BARRIERS AND ENABLERS OF RECEIVING MENTAL HEALTH SERVICES

3.4.1. KPS' AWARENESS OF MENTAL HEALTH SERVICES

PWID

PWID's awareness of what help psychologists and psychiatrists provide was mostly superficial; only some of them knew about psychological services from personal experience of receiving them at rehabilitation centers. Altogether, few of the respondents knew about the services provided at rehabilitation centers or narcological or psychiatric inpatient facilities.

> *'Psychological care is provided when people come to a psychologist or psychiatrist. They start working with parents and go deeper. But I don't really know much, though I recommend other people to use it.'*
>
> *PWID_Kharkiv_01*

> *'When I feel bad, I have contact data of a psychologist from the rehabilitation facility, I write to her, and she responds.'*
>
> *PWID_Lviv_02*

> *'I haven't been to such places. I have just learnt they exist, the rehabs and those facilities. I just shift for myself, as they say. I haven't tried going anywhere.'*
>
> *PWID_Kyiv_03*

> *'I was really bad, and they hospitalized me for ultra-rapid detoxification. For six or seven days. They bound me, and I had a complete meltdown… They filmed it… I was surprised seeing that. I even have some prejudice [to psychiatrists].'*
>
> *PWID_Kyiv_01*

Some of the interviewed PWID were aware of psychological support provided by NGOs and in the groups of Narcotics Anonymous[22], but most of them had not used that support. Some turned to social workers while being on an OST program.

22 *Narcotics Anonymous is an international non-commercial association of women and men recovering after drug use, who conduct meetings to stop using drugs and help each other start a new life free of mind-altering drugs.*

> *'I go to "Women's Space". They do education, they tell where and what doctor, for example, treats HIV. They invite a psychologist, but unfortunately I did not meet him. Our people don't know about these organizations [NGOs]. There is little information. Our people are not properly informed.'*
>
> *PWID_Dnipro_03*

> *'Some volunteers [say]: "We have psychologists. Go and see them. We have "Parus" organization, come on Wednesday." And I say: "Oh, no, thanks". So far, I have had no problems with psychological state, I can take care of myself.'*
>
> *PWID_Kharkiv_01*

> *'If you don't want a rehab, you should go not to a psychologist, but to these Narcotics Anonymous group meetings.'*
>
> *PWID_Kyiv_03*

> *'With this program, you can go to a social worker and get help. Also, when I needed help with documents, I always received it from social workers.'*
>
> *PWID_Mykolaiv_03*

Regarding online services, PWID either have never heard of them or had only sketchy knowledge. The same is true about receiving mental health services from family doctors.

> *"I have seen it. They sent me a link once. I have online access to all these things. Psychological, too. And free trainings. I was just not interested.'*
>
> *PWID_Kharkiv_01*

> *'Family doctors providing psychological aid? I have not met such family doctors.'*
>
> *PWID_Lviv_02*

> *'I didn't even know [a family doctor] can help with that, or that I could come to her with some psychotherapy issues.'*
>
> *PWID_Kyiv_03*

SWS

Sex workers' awareness of existing services and professionals providing mental health services turned out to be moderate: some have heard about the services provided by some professionals from their acquaintances, some have seen such services only in the movies, and some were aware they could go to a family doctor. Some of the respondents *(including, in particular, those SWs that had psychological issues or mental disorders)* could not say precisely what specialists provide such services and where they could be found.

> *'A friend of mine used to visit a psychologist, and she told me she liked it a lot. They discuss some childhood traumas and she… She sort of feels better when she tells about her problems and gets help. But that's it. That's all I know.'*
>
> *SW_Kyiv_03*

> *'I don't even know. A psychologist… I heard about psychotherapists. I know the word, but I don't precisely know the meaning.'*
>
> *SW_Dnipro_02*

> *'I don't have a person I could visit with this. A doctor, a psychologist. I don't know about them. Where can I find them? You know what I mean?'*
>
> *SW_Lviv_02*

The respondents included SWs who had visited psychologists or psychiatrists and were aware of the functions of each of the specialists, and those who have heard about mental health facilities in their locality. Some participants also mentioned narcologists when answering questions about mental health services they knew of, and told that they had seen information about online-counseling.

> *'There is a clinic on Kulparkivska street, where they treat mental disorders. And that is it, that's all I can say.'*
>
> *SW_Lviv_01*

> *'Psychiatrist is when it is really bad, a person cannot control themselves, or is delirious, or in a severe condition. Or when they have DT, they need a psychiatrist.'*
>
> *SW_Dnipro_ 01*

> *'Narcologists work with alcoholics, roughly saying. Those, who drink heavily, and drug addicts, and those who attempt suicide.'*
>
> *SW_Mykolaiv_01*

> *'I have seen something about online counseling, probably on Instagram. There were ads, like, if you need help you can get it online.'*
>
> *SW_Kharkiv_03*

Despite the experience of receiving prevention services from NGOs, not all the SWs remembered they could get psychological support or mental health services from NGO personnel. Some participants spoke about the help social workers provide to prevent violence or infection prophylaxis, yet they did not link their work to coping with wartime stress.

> *'The girls, social workers, they told me they can provide this kind of help, so I know that if need be I can ask them and they will find my a psychologist.'*
>
> *SW_Kharkiv_03*

> *'I have only met our social workers, our "Virtus", we interact. The girls explain us how we can avoid diseases, how we can defend ourselves, defend ourselves from violence, and how to interact with the police. And now, I don't know what I can add related to the war.'*
>
> *SW_Dnipro_01*

MSM AND TRANS*PEOPLE

Among all the respondents, MSM and trans*people had the best awareness of mental health services and professionals. Almost all of them knew they could go to psychologists from public and non-government organizations or to private specialists and get help regarding mental disorders or psychological problems in individual or group format. Some of the respondents were able to distinguish between the functions of psychologists, psychotherapists and psychiatrists and understood that whenever needed psychologists can refer patients to psychiatrists.

> *'Psychologist, psychotherapist, different psychological groups where you can share, talking not just one-on-one to a psychologist or psychotherapist, but to the whole group and discuss everything and get different opinions.'*
>
> *T*P_Kyiv_01*

> *'A psychologist does psychotherapy, without pharmaceuticals. If they see that serious care is required, they refer you to a psychiatrist… Treatment can be combined, involving both psychotherapist and psychiatrist.'*
>
> *T*P_Mykolaiv_02*

> *'Psychotherapist and psychiatrist mean treatment facilities related to psychiatry. That is a higher level than psychologist work, for more complicated mental disorders.'*
>
> *MSM_Mykolaiv_03*

Many trans*people and some of the MSM also knew about psychological support provided by HIV-service NGOs and community-based organizations, and some called for more publicity of NGO capacities to promote accessing the services from those organizations. A lot of the respondents were also aware they could obtain some online services, but the awareness of family doctors' providing mental health care was lower.

> *'[NGO] programs included psychological support. Something was provided by "Prozhektor", something by "Convictus". There were also other organizations providing a psychologist for IDP.'*
>
> *T*P_Mykolaiv_01*

> *'I have heard that this kind of help was available. I know, they even used to advertise "Insight", and they had psychological support, an online hotline.'*
>
> *T*P_Dnipro_01*

> *'So that more people knew about them [NGOs] and used it more. Because it takes effort to find such an organization yourself.'*
>
> *MSM_Lviv_03*

> *'I have never heard that family doctors can do something about mental conditions. We signed declaration in May, I think, not long ago actually. With a friendly doctor, a good person and a competent professional.'*
>
> *T*P_Kyiv_01*

> *'It all starts with family doctor. He refers you to others according to guidelines, including if you need an examination by a psychiatrist. A family doctor can only give you a referral.'*
>
> *T*P_Mykolaiv_02*

3.4.2. DEMAND FOR MENTAL HEALTH SERVICES AMONG THE KPS

PWID

At the time of the study, none of the interviewed PWID was receiving mental health services; most of them denied having mental issues requiring specialist care and did not intend to seek help. Some of them were interested in narcologist's or psychologist's services, or in attending psychological support groups, but cited being busy or unprepared to receive help.

> *'I don't need a psychologist, that's for sure. I behave normally, and I feel normal. I am not like the rest. I do my best to behave normally because I go to the child every day. I sort of don't need help, but I understand that maybe I do, because I have started injecting again. I don't know yet, I am not ready to go to a doctor, I cannot do it right now.'*
>
> *PWID_Mykolaiv_03*

> *'Even though they propose it, I am busy working, unfortunately. We had a talk about group psychologists, I am even interested in attending a group session with a psychologist. It is an emotional relief anyway. You stop being wrapped up in yourself...'*
>
> *PWID_Dnipro_01*

> *'I probably need psychological help. I don't realize. I always have this desire to drink, it's always in my head – I always want to use, and I hear nothing, I see nothing. I think I need a narcologist, a psychologist, some rehabilitation maybe, something like this if it's available.'*
>
> *PWID_Kyiv_02*

SWS

Despite having only a superficial idea about the essence of psychological help or corresponding services, many of the interviewed SWs said they needed psychological support because of the existing risks of provision of sexual services and war stress-induced disorders. Though a lot of participants consider mental health services accessible and have spoken positively about the help in principle, most of them had not sought it. Only some of them had already received care from a psychologist or a psychiatrist, and additionally *(because of psychosomatic disorders)* – from other medical specialists such as gynecologist or general practitioner.

> *'People dependent on substances, alcohol, drugs, they very often need help... I think that in wartime, everyone needs psychologist.'*
>
> *SW_Kyiv_01*

> *'I usually have panic attacks, stresses when something is happening, when there is shelling. I believe that the sooner the better [it is to seek help].'*
>
> *SW_Kharkiv_03*

> *'We have a psychologist [in our NGO]. And I went to her. And she helped me. Then I went to a specialist who prescribed me more [tranquilizers].'*
>
> *SW_Mykolaiv_02*

> *'I went to the doctor, I thought it was my heart. He made an ECG and told me: "It's not heartache, it's a panic attack." Venereologist-gynecologist. She told me it was psychology-induced and prescribed some medicines. I took the course and recovered my health. Because I also had a menstruation disorder caused by my mental state.'*
>
> *SW_Mykolaiv_01*

MSM

Only a few MSM respondents had the experience of going to professionals in relation to psychological state disorders, and most of them were not planning to obtain mental health services explaining this by having adapted to the wartime life. Only several of them who had had mental disorders before expressed a desire to see a psychologist or a psychiatrist.

> *'I used to take antidepressant drugs – under doctor's control. It was at a psychoneurological dispensary… I probably ought to see a doctor too, but I haven't yet.'*
>
> *MSM_Kyiv_03*

> *'I had a treatment of anxiety, of panic attacks [with a psychiatrist before the war], I took a course of antidepressant medicines… Now I am anxious because the missile strikes become more intensive, I am worried… It goes in waves… for a month, and then it subsides. If my situation got critical, I would probably go to a charitable organization, it is free there, and I cannot afford a private [psychologist].'*
>
> *MSM_Lviv_01*

TRANS*PEOPLE

The key mental health issue trans*people needed help about was support during transition when they encountered bullying, discrimination, risked developing stress reactions, depression, and suicidal intents. It is desirable that transition is supported by services from different providers – a psychologist, a psychiatrist, a family doctor – provided those are community-friendly professionals. Participants also noted specifics of adolescent psychological state connected with gender discomfort; this means adolescents need to have access to long-term psychological aid *(and some of the respondents advised prohibiting transition until the age of majority or even until 25 years)*.

> *'We need qualified professionals, very good ones, and tolerant to trans*community, to help us cope with the situations. When there are issues about the transition, about document change, there is a great need of support and knowledge of how this is done. Family doctors and psychologists are definitely required.'*
>
> *T*P_Dnipro_01*

> *'If we speak about the trans*community, there is always work for a psychologist. It depends on the problem. If there are suicidal thoughts, it should be a psychotherapist. If it's anxiety and intrusive thoughts, psychologist's counseling will help. If a teenager starts saying they feel uncomfortable in their body and have dysphoria, it is advisable to go to a psychologist, but to avoid initiating the transition. Just work with a psychologist. I think that before the age of majority, even before 25, a person can just have doubts about all these things.'*
>
> *T*P_Kyiv_02*

> *'Ideally, it's help of a psychiatrist. We lack trans*people-friendly psychiatrists in Ukraine.'*
>
> *T*P_Lviv_03*

A lot of the respondents had some experience of seeing therapists and psychiatrists because of depression or personality disorders, and psychiatrists – during the transition. During the war, internally displaced trans*people received group psychological support, while some turned to psychologists and psychiatrists to receive pharmaceutical therapy.

> *'When I lived at a shelter, we had a psychologist who did group or individual therapy sessions. The psychologist helped me a lot back then.'*
>
> *T*P_Mykolaiv_01*

> *'In February this year, I came for help and they referred me to a medical psychologist who made a diagnosis of borderline personality disorder and prescribed Lamotrin monotherapy.'*
>
> *T*P_Lviv_01*

> *'When I realized I needed [psychological aid], I decided to go to civil society organizations. Because some people were already receiving psychological aid and… I now use this availability. I am getting counseling from a therapist.'*
>
> *T*P_Kyiv_01*

3.4.3. BARRIERS FOR KPS ACCESSING MENTAL HEALTH SERVICES

BELIEVING HAVING NOT PROBLEMS AND BEING ABLE TO DEAL WITH THEM INDEPENDENTLY

As has already been noted above, KP members encounter a range of psychological problems, but they aren't always prepared to seek professional aid as they believe they are able to deal with their problems themselves, without professionals. At the same time, in every KP there were participants who emphasized the need to timely turn to mental health (MH) specialists, in particular because this topic is being promoted in the communities.

> *'I just thought it would pass, to be honest. But it might not pass, it hasn't passed after a year.'*
>
> *SW_Mykolaiv_03*

> *'I also must have fooled myself thinking I can deal with it without help. It seemed to me I would not have it like other people, with me it would be different. But every person with dependence thinks so, I assure you.'*
>
> *PWID_Kyiv_03*

> *'I always believe that a person can stress themselves out, building the stress from inside. And so they can make the stress go too.'*
>
> *T*P_Dnipro_01*

> *'Never give up trying to improve your mental health, do something for it and see different specialists. Mental health is important, and solving related problems is just as important.'*
>
> *T*P_Lviv_02*

> *'The community needs to be told more about the need to seek help with their mental health.'*
>
> *MSM_Dnipro_03*

According to experts from among family doctors, NGO workers and mental health professionals, people having a mistaken belief that they don't have mental health problems requiring external help prevents them from seeking professional aid. Even when they have mental disorders, KP members usually do not consider them a sign of a disease, try to ignore psychological problems developing or exacerbating under wartime stress factors, try self-medicating or following friends' recommendations, and only severe manifestations force them to seek professional care. When coming to family doctors with physical problems or to NGO workers to get humanitarian aid or prevention products, patients/clients quite often hide having psychological problems and disorders. So the professionals need to build enough trust to identify the need of counseling or treatment.

> *'[They come] only with acute conditions. They just try to ignore anything else and think that's how it should be.'*
>
> *FD_Kyiv_03*

> *'If we speak about PWID, I tell them this, and they answer: "What do I need a psychiatrist for? I am fine! I have drugs. Everything's alright. So it's more of me being proactive than them asking for it. That is, after you have talked to a person several times, they open up. At the beginning, they don't open up and don't tell they need help.'*
>
> *NGO_Kyiv_01*

> *'I think that they quite often are under illusion that they need no help.'*
>
> *SSP_09*

> *'When they have sleep disorders, almost all of them want to be given a sleeping pill, and they don't think it's a problem. And when I tell them they should see a neurologist they reply: "What for? It's just that I can't sleep.'*
>
> *FD_Kharkiv_02*

> *'Some advertising is needed, a social ad. If you notice these symptoms… Maybe not all people understand they already have mental health problems.'*
>
> *FD_Dnipro_04*

LACK OF AWARENESS OF AVAILABLE HELP

For a part of the respondents, the barrier preventing them from accessing mental health care was the lack of knowledge about the contents of the services, specialists or facilities providing such services, as was indicated in the respective section of the report.

> *'Psychotherapist? I don't even know what kind of doctor that is. Is that the one treating nervous system and heart?'*
>
> *MSM_Kyiv_01*

> *'At the beginning of the war, in the very first days, I was thinking about that a bit. But there was no information about where I could find the people that could help, you know, everybody just left and nothing worked. I would probably have gone somewhere for help, but I just did not find where I could go.'*
>
> *SW_Kharkiv_03*

Many family doctors and some NGO workers also believe that KP members do not receive adequate information about mental health services provided by family doctors, new services available at public primary and secondary care facilities or provided by NGOs. Thus, they believe that more awareness raising activities are required to let people know about available services, including through advertisements on TV and online.

> *'I think that most of our people don't know they can get mental health help from their family doctor. They ask about the help unconsciously, just during a conversation.'*
>
> *FD_Kyiv_03*

> *'I have good friends, psychiatrists, and they say that no, [the patients] know nothing. For example, they don't know that basically in every policlinic there is a psychologist's office providing counseling, so yes, they aren't always aware.'*
>
> *FD_Lviv_04*

> *'Not all the people know there are psychologists working at non-government organizations. So far, awareness raising is not yet very good.'*
>
> *FD_Mykolaiv_02*

> *'Maybe we need to promote it more. It should not just be on the Internet, it should be on the billboards, on the posts. People need to see they are welcome, it's okay. There should be more advertising.'*
>
> *SW_Kyiv_02*

STIGMA, PARTICULARLY CONCERNING SEEKING HELP OF MENTAL HEALTH SPECIALISTS

One of the factors preventing people from contacting MH specialists was the stereotypical negative perception of MH services, the fear of contact, of negative reaction of close circle and possible status of a person with serious mental disorders.

> *'That's how our people are raised: there have never been any diseases and no need for psychologists, that is why they are afraid of doctors, even if it is a psychologist, psychotherapist or psychiatrist. It is these stereotypes, it is the only thing that stands in the way.'*
>
> *SW_Kyiv_01*

> *'I grew up in such a family, and that is my view of life. Because no-one from my family goes to a psychologist.'*
>
> *MSM_Lviv_03*

> *'People are afraid of visiting psychiatrists because there is this stereotype that only lunatics do that. And that is discrimination. Second, going to psychiatrist is somehow considered shameful.'*
>
> *T*P_Lviv_03*

Respondents from among SWs had encountered judgment and stigma by medical personnel at public health institutions, and that is why some of them avoided seeking aid for mental disorders. Members of this KP believed that any kind of help for them is difficult to access because of stigma related to the illegal nature of their work, so they feel the need to resolve the problem on a systemic level by legalizing sex work in Ukraine.

> *'Doctors don't like us when they understand what our occupation is. In public institutions they look down on you, and the nurses whisper behind your back.'*
>
> *SW_Kharkiv_02*

> *'If they allowed the girls to work legally, they would not be afraid the police could come and take all you have and put you in jail for no reason. We are okay even with paying taxes if this work becomes legal. I think so long as there is no legalization, no services will be accessible.'*
>
> *SW_Dnipro_01*

> *'Maybe doctors need to be controlled, they should treat us like other people. The girls told about situations when someone found out. The attitude immediately changed for the worse. Otherwise, I believe, our system is not bad.'*
>
> *SW_Kharkiv_03*

Trans*people mentioned stigma and discrimination as barriers for accessing help, including mental health care. They believed that to mitigate those problems International Classification of Disease-11 should be implemented, and information about specifics and needs of the trans*community should be included in curricula of medical and pedagogical schools. They also think there should be more publicity of cases when KPs are denied access to care, including psychological aid.

> *'It would be good to positively cover… LGBT communities. So that people understood that there are different people.'*
>
> *T*P_Dnipro_03*

> *'And the Ministry of Education should include information about the transgender component and how to work with such people in their curricula. First of all, for higher education, for universities. And colleges too, maybe. And not just medical ones, pedagogical too, for teachers.'*
>
> *T*P_Mykolaiv_02*

> *'The professionals need to treat us as humans. Whenever [the community] faces violence or transphobia in some public or private institutions, they should not be silent, they should complain and draw attention to it.'*
>
> *T*P_Kharkiv_01*

Providers also mentioned the fear of stigma as one of the barriers preventing KPs from seeking mental health services. KP members face stigma, discrimination and bullying in their everyday lives, in particular when they come to health institutions, and have an additional risk of stigma related to mental disorders. For KPs from among PLWH this can be a triple stigma *(belonging to a KP – having a mental disorder – being HIV-positive)*.

> *'I think it's the fear of judgment. Distrust in health care. They have some negative experience in terms of the attitude. Even if they are just ill, it is difficult for them to come and access help. They try to treat some ordinary physical diseases themselves, and that is doubly so when we speak about some psychological or mental issues.'*
>
> *FD_Kyiv_03*

HIGH SERVICE COSTS VS. DOUBTS ABOUT THE EFFECT

Generally, all the KPs noted high cost of mental health services. For example, trans*people complained that they lacked resources to obtain services from private mental health professionals, while not having trust in specialists working at public institutions. Low income, regardless of location, is caused by the difficulty in employment because of stigma and discrimination, as well as the need to buy expensive hormonal medications for the transition. Some participants informed about prevalence of bribery in public clinics where the services are supposed to be provided free of charge.

> *'Psychologist, psychotherapist – they are expensive. I don't have the money to afford it.'*
>
> *SW_Kharkiv_01*

> *'Affordability. Like, you ask people in the organization – there is corruption everywhere. Go and pay, and they will help you.'*
>
> *SW_Mykolaiv_01*

> *'I want to get help, but when I am able again to afford going to specialists. Because it helps me. But so far, I get along without it.'*
>
> *T*P_Lviv_03*

> *'Because the guys who use drugs, none of them have the money. It's always about money.'*
>
> *PWID_Kharkiv_02*

Family doctors and NGO workers also considered lack of funds to pay for the services, especially in case of a long-term therapy, as one of the barriers. Besides, NGO workers, as well as other KP members, confirmed cases of extortion of money for the services at hospitals despite the services being free for the patients according to the NHSU package.

> *'If it's a lengthy counseling of a highly-skilled specialist, it is likely to be commercial, and not everyone can afford that.'*
>
> *FD_Mykolaiv_04*

> *'If we take drug addicts, they are always broke. It is difficult to refer them to a psychologist or a psychiatrist.'*
>
> *NGO_Kyiv_01*

> *'Most often, even if the service is free as a part of the NHSU package, they are still told to pay. It must be free, but they charge it anyway. Those who don't know that it's supposed to be free, they give the last of their money.'*
>
> *NGO_Dnipro_03*

INACCESSIBILITY OF FREE SERVICES AND THEIR IRRELEVANCE TO KP REQUESTS

Not all the KPs can access the services provided by NGO psychologists. The main reason is service organizations' being located in big cities, while the people living in small towns remain neglected. The lack of money and the time required to travel to the service organizations make it harder to access the services.

> *'Considering that the trans*community is basically poor, not all of us even have the money to pay the fare. That is why the situation in small towns, some rayon centers or villages is more difficult. But there are people there too.'*
>
> *T*P_Dnipro_02*

Family doctors also mentioned that KPs' access to services is hindered by remoteness of specialist care institutions, especially for people living in rural areas. This problem becomes especially acute when, having spent money for the trip, a patient has to wait in the line, face a closed door or the institution that is shut because it has been ruined or significantly damaged by shelling.

> *'If it is a specialized polyclinic we refer them to, they need to travel there, and there are lines too. And these people usually already struggle. So they are not always ready and not always have the time to go there.'*
>
> *FD_Kyiv_04*

> *'You have to take on a lot of red tape, legal issues, and then go through two or three doors with metal bars, and only then does the patient see the doctor. I really doubt a patient would be willing to go through these trials without support.'*
>
> *FD_Kyiv_01*

> *'The problem is that, for example, there were just two psychiatric clinics in our city. Unfortunately, one of them – the one in our district – has been recently hit by a missile. And now the patients struggle as they have to travel to another bank.'*
>
> *FD_Dnipro_03*

LACK OF TRUST IN THE PROVIDERS AND INFORMATION DISCLOSURE RISKS

The lack of trust in mental health service providers was voiced by those KP members who had personal experience of seeking aid and those who rely on rumors and experience of their friends and acquaintances. For example, members of the MSM community often emphasized the risks of information disclosure by the professionals – a family doctor or another person who knows their friends, neighbors and colleagues. For some, these concerns were also relevant with regard to NGO psychologists, and some said they had less trust in female mental health professionals compared to male ones. An MSM informed that if you got mental disorders caused by traumatic war experience, it is inappropriate to seek aid from specialists who have not been in the areas of active shelling or fighting as they cannot understand the patient. A lot of the interviewed trans*people were discouraged from approaching professionals by the fear of stigma due to their gender identity. Personal negative experience of seeking services and negative feedback of other members of the community prevented their timely seeking aid, forcing them to take care and spend time looking for a friendly professional sensitive to their specific needs.

> *'I have a few friends who really need help. But they don't come for it simply because they have no trust. And the problem is that most of us probably remember our school psychologists.'*
>
> *T*P_Kyiv_03*

> *'I attended group sessions with a psychologist, and it was terrible. Because the psychologist living in Odesa had not seen the war until recently. I think that [for him] working with people who were at the frontline or at least in the area of fighting was a stupid idea.'*
>
> *MSM_Mykolaiv_03*

> *'There is a possibility that this person may, willfully or by accident, tell somebody something about me. He may tell it to a neighbor, for example. But a specialist is unlikely to be acquainted with my neighbors, so I would definitely not go to a family doctor.'*
>
> *MSM_Kharkiv_03*

> *'A skilled professional providing services at an NGO may contact other clients and may be not a very good person, he may let out things he discusses with a client.'*
>
> *MSM_Dnipro_03*

Some of the interviewed family doctors had personally encountered distrust of KP members who were afraid their personal information would be shared with their relatives of acquaintances. Professionals from small towns or villages had seen that their patients were not willing to tell about their specific problems, and so believed that it would be easier for them to receive such services in other towns.

> *'Some may never open up because a family doctor knows their family… they are afraid that other people may learn it.'*
>
> *FD_Dnipro_02*

> *I even doubt that is possible at all, because members of the key populations are afraid of disclosure. For them it is easier… I just know about a situation where people who use drugs go to Kyiv for group programs. Because our community is small, we know each other.*
>
> *FD_KY_03*

3.4.4. FACILITATORS FOR KPS ACCESSING MENTAL HEALTH SERVICES

SEVERE PSYCHOLOGICAL/MENTAL CONDITIONS OR TRAUMAS

All the interviewed KP members noted various mental conditions and life circumstances that demand mandatory seeking professional psychological or psychiatric aid. The main ones were:

- deep and prolonged depression, apathy and indifference to everything rendering a person unable to 'live a normal life', making them stop or limit their social contacts, bringing the feelings of sadness, despair, suicidal thoughts or thoughts about the purpose of life;
- change in usual behavior patterns and external signs, such as 'crazy' gaze;
- loss of control over one's behavior *(the person becomes hysterical, yells, beats his head against a wall)*, erratic actions, losing one's temper against family or friends and harming or abusing them;
- using drugs and alcohol while lacking support from family and friends or being away from them.

> *'For me personally? To go there? If I were lying at home like a cabbage. Like when you don't want to live or eat or do anything. Then I would definitely go. If my home is hit, and that's it. If it is very bad. There are situations when you don't care anymore. You are ready to knock on every door.'*
>
> *SW_Lviv_01*

> *'If I had a grief. If my wife broke with me, I would go at once.'*
>
> *PWID_Kharkiv_01*

> *'When you cannot get rid of fear. Because you are afraid for some time and then it subsides. But if it didn't, I would go, of course.'*
>
> *PWID_Mykolaiv_02*

Talking about the main individual factor encouraging KPs to seek aid, service providers named manifestations of severe disorders. Some of the specialists believe that an important condition for seeking aid is meeting the basic needs, and for PWID, additionally, is a relatively stable condition and avoiding using street drugs while being on OST or, on the contrary, withdrawal.

> *'Usually they come when they see they cannot manage it themselves. When they start having suicidal thoughts…'*
>
> *FD_Lviv_01*

> *'When they are in withdrawal and they cannot get a relief, they try to see a doctor – a narcologist or a psychiatrist.'*
>
> *SSP_06*

> *'The guys on OST mostly avoid using street drugs and have a more social way of life. They try to avoid crime and drugs, so these ones can go to a psychologist.'*
>
> *NGO_Kharkiv_01*

AVAILABILITY OF COMMUNITY-FRIENDLY SERVICE PROVIDERS

Access to friendly professionals was a crucial facilitator for seeking aid for the respondents from among trans*people and MSM. Regardless of the service providers, trans*people emphasized that Ukraine generally lacks community-friendly professionals, explaining that by the Soviet legacy and wartime migration of such specialists. That is why the participants first of all want to see more of qualified and tolerant service providers. Information about mental health specialists that are sensitive to their projects mostly came to them from other community members, friends or, occasionally, from social media or NGOs. Most of these respondents preferred specialists recommended by their acquaintances or those they found through social media.

> *'I went to her [a psychologist] upon recommendation of my close friend.'*
>
> *MSM_Mykolaiv_02*

> *'Psychotherapy, and sometimes maybe a visit to a psychiatrist, because probably some people need treatment with pharmaceuticals. And, considering transgender people, I also included here endocrinologists, because levels of some hormones including testosterone also affect the emotional state. If there was a database of transgender-friendly therapists or psychiatrists, I would probably visit them more, being confident that these people have already worked with the community members or people who work in this field.'*
>
> *T*P_Lviv_02*

> *'Recommendations are important. If some MSM I know recommended a good specialist, I would rather go to them.'*
>
> *MSM_Kyiv_03*

> *'The attitude to trans*people in our health care is still the same it was in the Soviet Union. Very few of the friendly psychiatrists who worked before the war and cooperated with the organizations are left, like one person per city. The same goes for psychologists.'*
>
> *T*P_Dnipro_02*

SUPPORT FROM THE CLOSE CIRCLE AND 'VALUED' PEOPLE

For some KP members, support from the close circle was a factor encouraging them to approach mental health service providers. This close circle could include family and friends as well as social workers of NGOs who motivated them to get the services.

> *'It was not me who learnt [where to go to get help], but my family, from the Internet. And they helped me.'*
>
> *SW_Kyiv_01*

> *'Very often these visits are actually driven by friends, relatives or partners of the people in critical conditions. Because a person in a critical situation may just be unable to seek aid herself.'*
>
> *T*P_Lviv_01*

> *'There are people who understand that before [you do]… they better see the picture. So it is important if there are family and friends near you. And trust me, there are even drug addicts who notice others' problems, go to their families and make them save the person.'*
>
> *PWID_Lviv_03*

> *'For a curator, a social worker I interact with to lead me to the psychologist in his organization.'*
>
> *SW_Mykolaiv_03*

In turn, NGO workers also noted the importance of accompanying some clients to mental health specialists or supporting them in looking for optimal ways to get aid.

> *'If your social worker explains you everything and tells you where to go, it is also good.'*
>
> *NGO_Kyiv_01*

> *'We suggest solutions. You need to go here and there… We try to discuss their specific situations with them and look for solutions. I have taken some people to psychiatrists, they did not ask for referrals or anything. I came there as a social worker accompanying two patients.'*
>
> *NGO_Mykolaiv_02*

> *'I have trust relationship with my clients. If I provide a recommendation, they will have trust in the psychologist or another service provider.'*
>
> *NGO_Dnipro_02*

QUICK ACCESS AND FAST PROVISION OF A SERVICE

Some of the interviewed KP members and service providers were convinced that quick access channels are important for seeking aid. For example, trans*people told they wanted to immediately contact a specialist, without referrals, because they believed this way of receiving aid the shortest and the most efficient. At the primary care level, speed of response can be ensured through urgent examination and/or prompt cooperation with a mental health specialist, while at NGOs – through immediate contact with the psychologist via the social worker.

> *'A person needs to get mental health aid quickly, here and now. Their condition may deteriorate, they may start using substances.'*
>
> *MSM_Mykolaiv_01*

> *'When a patient like that came, they would immediately make an appointment with a doctor, they would go and get examined – no-one gets rejected. After the examination, we provide necessary aid and create an electronic referral. When needed, we get in touch with the secondary care, specialist care, and specialist treatment facilities. And the aid is provided.'*
>
> *FD_Mykolaiv_02*

> *'A person asks you about it. You call the psychologist at once. You give that person a number and immediately they get psychological counseling. So it's a fast response. The person does not have to wait.'*
>
> *NGO_Kyiv_01*

> *'The most acceptable [way] is the one allowing you to avoid all those people who just tell you where to go next. You get straight to the specialist… And they will be able to tell what's happening to you: a serious depression caused by some factors or… you need to take tests.'*
>
> *T*P_Kharkiv_01*

> *'For example, if a person has suicidal thoughts, I think they need to bypass primary stages. The sooner a specialist sees them, the better.'*
>
> *FD_Kyiv_04*

QUALITY SERVICES THAT ARE FREE OR MODERATELY PRICED

KP members and service providers believe that services being free or moderately priced would encourage them to seek professional care. However, free services should also be quality assured, according to some KP members. For example, trans*people who had the experience of receiving free services had found this care failing to meet their specific needs.

> *'I spent long time looking for a certain kind of psychological support, but almost all the free psychological services target the issues that are non-essential for me… and I have not found a psychologist in my city. At the same time, prices of the services of therapists are obviously quite high, and I cannot afford them right now.'*
>
> *T*P_Lviv_01*

> *'This should all be free. Especially now, when we have such a situation.'*
>
> *SW_Mykolaiv_02*

> *'They call. And get counseling. Because they hear the word "free".'*
>
> *NGO_Kyiv_01*

> *'If there is some information about the organization, there is knowledge that the help is provided free of charge, they have trust and come again.'*
>
> *SSP_04*

3.5. PSYCHIATRISTS AND PSYCHOLOGISTS: KPS' PERCEPTION AND SPECIALISTS' PREPAREDNESS TO WORK WITH THEM

Generally, members of each of the KPs preferred a psychologist[23] *(private or NGO-based)*, had the most ambiguous opinions about family doctors as mental health service providers and were rather negative about psychiatrists[24]. The respondents almost never mentioned psychotherapists[25] as a separate kind of specialists and when they did they used the term as a synonym to psychologist. In every KP there were participants who were positive towards all mental health service providers emphasizing the importance of such aid in present situation.

> *'I think the system is developed well in the country. Because you can go wherever you choose and you will get help. I have no complaints. And the benefits of the help are probably the same everywhere.'*
>
> *SW_Kharkiv_03*

> *'Generally, all the specialists in all the fields are very important, and I have a positive attitude towards all of them.'*
>
> *T*P_Lviv_01*

> *'I am totally positive about all of them except religious institutions.'*
>
> *MSM_Mykolaiv_02*

> *'I think it is okay. If people need it, it is okay that this kind of care is provided.'*
>
> *PWID_Mykolaiv_01*

23 *A psychologist is a specialist with a humanitarian degree in 'Psychology' who is not always a doctor. If they have not received special training, they can provide psychological counseling and psychognosis services. Unlike therapy, the counseling is short-term and sometimes one-off. Psychologists provide psychological aid using evidence-based methods and approaches that do not involve prescribing medications.*

24 *A psychiatrist is a doctor specializing in psychiatry that makes diagnosis and treats mental and physical aspects of psychological problems. A psychiatrist is the only specialist who can use pharmaceutical therapy (i.e. prescribe medications and make diagnosis) to treat mental disorders and illnesses.*

25 *A psychotherapist is a psychiatrist or a psychologist who have received additional postgraduate training in psychotherapy and is a specialist in one of the areas they can choose among: psychoanalysis, gestalt, psychodrama, art therapy, client-centered or positive psychotherapy, etc. Psychotherapy involves systemic long-term work with a client and regular sessions. Psychotherapist psychiatrists can prescribe medicines, yet their main therapeutic tool is verbal influence. Psychotherapist psychologists cannot treat their clients with medicines.*

3.5.1. PSYCHIATRISTS

Psychiatric care is provided in outpatient or inpatient mode and mostly involves pharmaceutical therapy; also they mentioned narcological care at OST sites.

> *'First of all, it is a pharmaceutical treatment of various disorders. We treat depression, neurotic disorders, i.e. neurosis, stress, PTSD.'*
>
> *SSP_06*

> *'We have these three offices for nine hundred people each. The personnel are two narcology doctors, four nurses, one social worker and one psychologist.'*
>
> *SSP_01*

Members of all the KPs had the most negative perception of psychiatrists compared with other MH service providers. For example, PWID saw them more of a threat than an opportunity to get aid. SWs were the least predisposed to see a psychiatrist arguing that they were not in a critical condition and had no 'diagnosis', and mentioning negative experience in the past. The interviewed MSM perceived visiting a psychiatrist as automatic hospitalization. Most trans*people were negative about their experience of getting psychiatric services despite occasional cases of seeing a friendly highly-skilled specialist.

> *'To a psychiatrist, I think. I believe if you have a problem, you need to go to one. If you have psychological problems, some mental disorders, you go to a psychiatrist.'*
>
> *PWID_Lviv_01*

> *'Psychiatrists… A lot of people don't see them as doctors, they are seen as the ones who want to put you in a madhouse and… get you registered. That is, they are seen as a threat, not aid.'*
>
> *PWID_Lviv_03*

> *'Probably to a psychiatrist. I have not had a condition yet when I could think I was crazy. Maybe I misunderstand something, but this is what I think.'*
>
> *SW_Dnipro_02*

> *'I have visited a psychiatrist once. When I was getting a job and needed this certificate. And I had this impression: either I am mad or he is. They all seem weird to me: you look at them, and they kind of sit with their head in the clouds.'*
>
> *SW_Kyiv_02*

> *'A psychiatrist is a frightful doctor. When something is wrong, he will lock you down in a hospital, and this is scary.'*
>
> *MSM_Mykolaiv_03*

> *'I was just passing the medical stage of the transition at a mental health hospital. I was getting day-patient treatment, and they insulted me so much, there was a lot of bullying. Some doctors are okay there. But generally they often lack even normal humane attitude.'*
>
> *T*P_Kyiv_01*

> *'In the psychiatric hospital I noticed that the doctors were mostly old-school, no youth. [My impression was] pretty normal. They had good attitude, normal people. But in our psychiatric hospital, there is a woman in charge of our district. And she immediately had this attitude [towards me], she almost kicked me out.'*
>
> *T*P_Mykolaiv_01*

> *'I was prescribed a treatment. I was lucky that I had been given contact data of a friendly specialist who treated me as a transgender man.'*
>
> *T*P_Lviv_02*

Family doctors and mental health specialists noted that the attitude towards psychiatrists and psychiatric care is often negative regardless of the KP a person belongs to; it is based on the public image of psychiatric diagnosis as a stigma and psychiatric care as a restriction, a coercion. Family doctors explained that by bias and stereotypical perception of psychiatric pathology and care: 'Do you think I am some kind of mentally ill?', which makes patients to sometimes reject referral to a psychiatrist. NGO workers also considered KPs' attitude towards psychiatric care mostly negative, explaining that by distrust to health workers in general, by a fear of the 'white robe'.

> *'Sometimes patients do not accept a referral. They prefer having me than going to a specialist understanding that they would demand… some pharmaceutical treatment.'*
>
> *FD_Lviv_01*

> *'People often believe… It does not matter whether they are from the populations we are talking about. They believe that a psychologist means there is something wrong in my head, something bad, and that is why this referral is given. They don't take it well.'*
>
> *SSP_03*

> *'The attitude is mostly negative, and it is not necessary based on their personal experience. It is a stereotypical idea that the one who prescribes medicines makes a diagnosis at once. Let me quote a patient: 'If I go there, they will immediately lock me down.' A person believes there will be coercion at once, and it does not work for them.'*
>
> *SSP_09*

> *'Some are afraid of the doctors, let's call it a fear of a white robe. When you talk to a person in a friendly manner without using medical terms, you get more trust.'*
>
> *NGO_Dnipro_01*

> *'Going to a psychiatrist with your problems puts a stigma on you, and that is another reason people don't. People would rather go to a neurologist rather than to a psychiatrist because of the stigma.'*
>
> *SSP_05*

3.5.2. PSYCHOLOGISTS IN GENERAL, INCLUDING PRIVATE ONES

AVAILABLE SPECIALIST MH SERVICES

The interviewed mental health specialists provide psychological counseling, psychological and psychotherapeutic aid using individual or group mode, at health care institutions, centers, or privately; they also use online-platforms with the support of various social projects. Such platforms include, for example, online-platforms for counseling people from the Eastern and the Southern regions of Ukraine, including occupied territories *(SupportME, Safe-WomenHUB and Brave&Safe)*. In some cases they provide psychological first aid after a patient learns he/she is HIV-positive.

> *'We have psychologists at our center. We implement WHO self-help interventions. We have standing groups. We have psychodrama[26], for example, or a group of family systems therapy.'*
>
> *SSP_10*

> *'For our target groups, we now try using self-help+. The site is SH+. And Problem Management Plus. They are quite good. Because they are based on CBT. We have three online platforms. An online platform for teenagers, then SafeWomenHUB – for women affected by the war. And there is one for all people affected by the war. It is called Brave&Safe.'*
>
> *SSP_3*

26 *Psychodrama is a psychotherapy method developed by Jacob Moreno involving a therapeutic group process using a tool of dramatic improvisation to study the inner world of a person, develop their creative potential and improve their behavior and interactions with other people.*

The interviewed mental health specialists cooperate with other psychotherapists and psychiatrists, and can refer clients to them when needed. They also can refer clients/patients to inpatient treatment at HCFs, to resuscitation wards *(in case of acute life-threatening conditions)*, to specialist institutions *(such as narcological dispensaries)*, or to non-specialist HCFs *(in case of a physical pathology)*.

> *'In one project, it is just online chat, in another – online video or offline counseling. I provide psychological crisis interventions. And then I refer the client further to the same project.'*
>
> *SSP_04*

> *'There are groups for requests for the psychologists in the city, you can write: "I don't work with it, who could take the client?" Talking about the substance users, there is a communal institution "Chernivtsi Oblast Narcological Dispensary". They have two psychology doctors, a psychotherapist and two psychologists. They have enough specialists, and their contact data are available. When we need, we can refer our people to them.'*
>
> *SSP_10*

KPS' OPINION OF SPECIALIST MH SERVICES

Though lacking the experience of going to psychologists, PWID were generally positive about such specialists, having notable more trust in those of them who had the experience of substance use and could better understand the needs of the participants.

> *'If I needed, then I would probably go to a psychologist. For me a psychologist is someone who can help me more than some NGOs or something else. More trust.'*
>
> *PWID_Mykolaiv_01*

> *'It is difficult for me to open up with a usual psychologist who just got some training. Then he is here, sitting, trying to help me. If I see a person like me, with the experience of drug use, it is much easier for me to communicate and to open up.'*
>
> *PWID_Kyiv_02*

> *I: 'That is, you have more trust in psychologists who used to use drugs?'*
> *R: 'Of course, only the ones with the experience. Then I see that this person has been able to achieve something.'*
>
> *PWID_Kyiv_01*

SWs were openly positive about psychologists, including private ones, and willing to use their services if needed. Those favoring private psychologists spoke from their own positive experience of receiving such help, believing also that paid services are of better quality.

> *'I would go to the private psychologists who works with me today. I would rather pay to a psychologist and be sure that they will take care about me and likely help.'*
>
> *SW_Kyiv_01*

MSM respondents also favored psychologist, in particular, private ones, when talking about where they would seek aid regarding their mental health. Their help was perceived positively based on personal experience or opinion of friends or other sources, while emphasizing the importance of going directly to the specialists.

> *'If I found myself in such a situation and decided to seek help, I would go directly to a psychologist. I have not had such situations, so for the first time I would go to a paid one. There you understand that you have paid money and will be listened to. They will be understanding.'*
>
> *MSM_Dnipro_01*

> *'I would just go to a psychologist or, first, to a family doctor to get a referral. It is a normal practice in other countries, but here people still freak out about psychologists.'*
>
> *MSM_Lviv_02*

A lot of the interviewed trans*people had personal positive experience of going to psychologists *(psychotherapists)* or have heard about it from others, mostly in the context of a successful search for a friendly professional.

> *'I got a psychotherapist I can strongly recommend to other people, I have been very lucky with her. Psychology is a very important thing, because a lot of these folks [trans*people] can actually benefit from having a psychologist.'*
>
> *T*P_Lviv_02*

> *'So far I like what I get. And what I got in my teenage years also helped me. Because the psychologist turned out to be very knowledgeable.'*
>
> *T*P_Kyiv_01*

Most of the service providers also said that patients/clients have mixed opinions about mental health services in general and psychologists in particular, depending on their personal circumstances, experience of using different services, etc. Some family doctors said the KPs do not consider psychologists proper specialists. So, in their opinion, patients need to be properly informed to build a positive attitude towards specialist mental health care and encouraged to seek such specialist services.

> *'It depends, it depends. It also depends on whether they can find a common language with the psychologist… There are different psychotherapists whom they can like or dislike, there are different psychiatrists, different centers.'*
>
> *FD_Kyiv_04*

> *'If I say that they need to see a psychologist, I give a referral, and the person learns they can go there… They understand their problems, they understand that they need to work with them, and they are okay about it.'*
>
> *FD_Lviv_03*

> *'If the person does not have a severe disorder then… You just need to explain that this is not a psychiatrist and that they will not be locked down. We could have this talk, and I think they would not refuse.'*
>
> *FD_Kyiv_02*

PREPAREDNESS OF THE SPECIALISTS TO PROVIDE SERVICES TO THE KEY POPULATIONS

The interviewed mental health specialists said they were ready to provide mental health services to KP members within the boundary of their competence. Depending on their specialization and the place of work, the scope of this aid, disorders and types of care, involvement in certain projects aimed at meeting the needs of particular KPs may vary. Several participants voiced concerns about working with PWID and reported the need to have additional knowledge and skills to work with this population. It was also noted that projects supporting PWID are not long-term, which prevents achieving appropriate results.

> *'I have no bias because I have worked with each of these populations.'*
>
> *SSP_09*

> *'PWID – no, because I lack certain knowledge, and I am not sure they could rely on me.'*
>
> *SSP_4*

> *'Our knowledge and skills, and the format of our projects do not let us work effectively with the cases of dependence. Those just need more sessions.'*
>
> *SSP_07*

3.6. FAMILY DOCTOR AS A MENTAL HEALTH SERVICE PROVIDER

3.6.1. AVAILABLE MH SERVICES PROVIDED BY FAMILY DOCTORS

Speaking about mental health services provided at primary healthcare centers, family doctors noted establishing a contact with the patient, identifying signs of mental disorders *(including using psychometric methods)* and making initial diagnosis, evaluating the need of specialist care and, if required, referring to specialists. As early as the initial diagnosis stage, family doctors need to pay a lot of time and attention to build trust-based relationship with the patients to overcome their resistance to admitting their mental health issues.

> *'At this facility we provide initial mental health assessment, and this can be done by any family doctor.'*
>
> *FD_Dnipro_03*

> *'If a person comes to me, first of all, I always try to do a scale-based test to determine whether they have depression. These conversations may take a whole hour. Sometimes a person does not want to admit they have some problems, and the family doctor needs to recognize that. When I don't have time, I refer those patients to psychotherapists.'*
>
> *FD_Kyiv_04*

Family doctors consider counseling patients at the primary care level an important component of aid to clients with mental health problems. Some of the professionals provided the patients with recommendations regarding optimizing their way of life, taught self-help methods, and prescribed plant-based sedatives. In addition to counseling, they could prescribe psychotropic medications *(such as antidepressant drugs, tranquilizers or sedatives)* for patients with neurotic disorders[27].

> *'I see it as my responsibility to advise them something, some exercise, or going to a swimming pool. Proper nutrition, a lot of sleep. Plant-based sedatives. And then we check the dynamics – whether the problem subsides or not.'*
>
> *FD_Kharkiv_02*

> *'We hold motivational interviews. We teach the patients to use breathing relaxation technique and panic attack prevention methods. About one person in two has these problems. I give them programs they can download and use. Those include relaxation and meditation. Sometimes I have to prescribe medicines that family doctors are allowed to prescribe. And for some patients, a conversation is sufficient.'*
>
> *FD_Dnipro_04*

27 *Neurotic disorders (neuroses) are a large group of psychogenic disorders including symptoms of depression, anxiety, compulsion neurosis and physical changes that can be chronic, recurrent (waveform), with the periods of aggravation and relapses.*

> *'It depends on the situation. It may be just counseling. If there is depression, we do an interview and try to model the way of life, changes, etc. Quite often, I prescribe antidepressant medications.'*
>
> *FD_Kyiv_03*

3.6.2. KPS' OPINION OF MH SERVICES PROVIDED BY FAMILY DOCTORS

At the time of the study, none of the interviewed PWID was receiving mental health services. The opinion they had of family doctors as MH service providers was mixed. They were mostly positive about them as medical professionals and considered the experience of visiting them as quite good, but did not believe family doctors to have sufficient qualification to provide mental health services.

A majority of PWID respondents had trust in family doctors, spoke about positive experience of seeing them and reporting that specialists showed interest in their mental state. At the same time, some believed them to be insufficiently qualified to provide psychological care.

> *'I am not sure family doctors can provide psychological aid. If the person is properly skilled and has the experience of working with people as a psychologist, then yes. But the family doctors I see are not qualified at all, that's all I know. Currently, everything starts with a family doctor. Any talk – first you go to a family doctor, then he refers you. That is, they need more training in this area so that they are able to provide first aid and then refer the person elsewhere.'*
>
> *PWID_Dnipro_03*

Opinions of SWs regarding family doctors as providers of mental health services divided. Some believed family doctors were capable of providing the services, seeing their familiarity with the health of the patients as an advantage compared with other medical professionals. Some of the participants expressed distrust regarding the competence of family doctors in this field, focusing on their indifference to patients' problems, and some of the respondents thought the demand to sign a declaration with a family doctor entails risks of confidentiality breach.

> *'To the family doctor, because he knows me the best.'*
>
> *SW_Lviv_02*

> *'I would not go to a family doctor, that's for sure, because they just don't care. They can give you a referral and that is it.'*
>
> *SW_Mykolaiv_01*

> *'I want them not to demand the declaration, my passport, and I want just to be able to come with some problem. I don't even know where I can go. You need to be sure about the person you go to and about the confidentiality. Without any proofs that you are you.'*
>
> *SW_Dnipro_02*

MSM were also mostly positive about family doctors as health professionals, but did not consider them MH service providers. So they deemed discussing mental health issues with them inappropriate.

> *'I have my great personal experience, my family doctor, we get on really well. Psychological support – no, but I trust her completely, this is so. Though we have not discussed mental health with her.'*
>
> *MSM_Kyiv_03*

> *'I think family doctors are rather weak psychologists. I tell this based on my personal experience and the experience of all my friends.'*
>
> *MSM_Lviv_01*

According to a majority of trans*people, family doctors do not have the skills to counsel people with mental disorders, and so can only refer them to specialists. At the same time, some of them were unwilling to see a family doctor even to get a referral to a psychiatrist because they were not sure they would be referred to trans-friendly specialists.

> *'Family doctors should not provide… That is, they are being forced now, forced by the state. But they should not provide professional psychological care, because it is not their field.'*
>
> *T*P_Lviv_03*

> *'You probably can go to your family doctor to get a referral to a psychiatrist. You can come, explain, and he will refer you. But you may get referred to an LGBT-phobic specialist who will, for example, treat something that should not be treated.'*
>
> *T*P_Dnipro_01*

> *'Probably, I would not go [to a family doctor]. Because the GPs, family doctors, they are just intermediaries who send you further. They don't think much and don't try to get involved.'*
>
> *T*P_Kyiv_02*

> *'A family doctor may be ethical, professional and tolerant, with humane attitude, that is, with good intent. But nothing more. I don't know what else a family doctor can do. He can explain that you should care about your health – that is important.'*
>
> *T*P_Mykolaiv_02*

Some mental health professionals share the opinion of the interviewed KP members: patients consider family doctors insufficiently competent in terms of MH services, or believe that they lack time to solve their problems. Mental health professionals mostly believed that there are serious limitations to provision of MH services in primary care settings: lacking competence of family doctors and their lack of experience of working with substance intoxication and withdrawal, their focus on treating physical conditions, significant workload and, correspondingly, lack of time to diagnose mental disorders and properly monitor their treatment, risks of medical errors, etc.

> *'They are mostly unwilling. They explain it by saying the family doctor is overloaded with work and does not have time… things like that. And also a doubt: 'How can she help me?' The only need that a family doctor can effectively meet is the need of a prescription of some sedatives.'*
>
> *SSP_09*

> *'This will not be very competent, because a family doctor cannot provide all the services. To name but a few, detoxification or withdrawal management are just out of question. No family doctor does that. And if we speak about psychotherapy – a family doctor can do that neither.'*
>
> *SSP_05*

> *'They are overloaded. A lot of administrative issues, a lot of documenting to do. And few family doctors have actually got training in mental health.'*
>
> *SSP_03*

> *'Family doctors focus more on physical health. And I know from my own experience, I know some family doctors, they prefer sending the patient straight to a psychiatrist. They don't like dealing with these issues.'*
>
> *SSP_02*

Family doctors themselves reported seeing positive attitude of KP members to primary care due to long experience of communication, awareness of the problems of each individual patient and, as a consequence, trust-based relationship. Some of the respondents believe that PWID are less positive and more distrusting about these services as they have more pressing needs *(first and foremost, regular substance use)*, while MSM are more positive, and though they are a 'closed' group, they are willing to share their problems and receptive to recommendations once trustful communication is established. However, just like the other interviewed populations, family doctors realize that KPs do not consider them key actors of health care and would rather go to specialist institutions, and may distrust family doctors because of fear of confidentiality breach as the doctor also communicates with patient's family members.

> *'Patients who use drugs tend to be wary of everything. Other populations, like most of the general public, accept it… if not gladly, but with understanding. And it also depends on the age. Younger patients are more responsive if you offer them help or refer them to a psychologist or a psychiatrist than senior people.'*
>
> *FD_Kyiv_03*

> *'I think MSM are the most positive. Because… they speak about their problems, issues, of what and how they feel. And it goes better for them.'*
>
> *FD_Lviv_01*

> *'The advantage is that a family doctor already knows this patient and the patient knows the doctor. And will have more trust. Drawbacks? Some people may be unwilling to open up because the family doctor knows their whole family. They are afraid of disclosure.'*
>
> *FD_Dnipro_02*

3.6.3. PREPAREDNESS OF FAMILY DOCTORS TO PROVIDE MH SERVICES TO THE KEY POPULATIONS

A significant part of the interviewed family doctors told they were ready to provide mental health services to KPs, stressing that they must help all patients regardless of their way of life. Some were ready to perform general examination of KP members, identify mental disorders, provide life style counseling, and provide information about self-help methods and specialized NGOs. Some of the family doctors mentioned some KPs they would find difficult to work with because of the fear of aggression or the lack of proper training and experience.

> *'I will provide health care to any person, and I don't care what they do in their free time. If they come for medical assistance, I will provide it. Regardless of the KP in question.'*
>
> *FD_Mykolaiv_04*

> *'If I had to choose a population… Basically, we try not to single anyone out. But drug-dependent people are the ones I would like to work with the least. Because I am afraid of their aggressive behaviors. Because we have had such cases.'*
>
> *FD_Kyiv_03*

> *'Of course, we are not fully prepared to help [trans*people, MSM, SWs]. Sometimes we cannot manage. And we definitely lack time. We had drug addicts, people with alcohol problems, HIV-infected. But we have not had these [trans*people, MSM, SWs]. We had a five-day training course… We have not mastered everything. Some things still need to be learnt.'*
>
> *FD_Mykolaiv_02*

At the same time, though some of the interviewed family doctors have already been trained in accordance with the mhGAP, they admitted lacking knowledge and communication skills to build a proper contact with the patients with mental disorders. They think that one training course is not enough to learn to work with such patients, so there is a demand for continuation of the training, in particular regarding pharmaceutical therapy. Still some of the respondents, referring to the absence of professional training, proper authority or excessive workload, were not prepared to provide any MH services, including for the KPs, and would rather refer the patients with mental disorders to other specialists for further examination and treatment.

> *'We were at the mhGAP courses, about mental health. Of course, a specialist doctor is a specialist doctor. Maybe family doctors lack some more knowledge – that is a minus. Because such a patient may require a personalized approach.'*
>
> *FD_Dnipro_04*

> *'One course is definitely not enough. Not enough to professionally and fully meet the needs of the people. The PHC has launched a pilot project 'Mental Health of OST Patients' at our facility… I try to always keep improving my skills.'*
>
> *FD_Lviv_01*

> *'I still lack some knowledge about prescription of medications. We had it in the course, and answered questions, [yet] I believe we need more training. As we get more practice, we will be having more questions and problems.'*
>
> *FD_Kharkiv_04*

> *'I just cannot spend 15 minutes discussing these things with a patient. I cannot imagine what kind of a superprofessional you need to be for that. Not me. Because antidepressant drugs, they have some side effects, and the titration is very complicated, titration is required.'*
>
> *FD_Mykolaiv_03*

3.7. PROVISION OF MENTAL HEALTH SERVICES BY HIV-SERVICE NGOS

3.7.1. EXISTING MH SERVICES PROVIDED BY NGOS

NGO workers focused on universal nature and importance of non-specialist psychological care *(support)* KPs can receive from social workers. Some of them had been properly trained and provide counseling to their clients with regard to diagnosing viral hepatitis or HIV, some have worked with the clients under supervision of professional psychologists. Also, individual counseling by a psychologist at an NGO office or a healthcare facility *(counseling after an HIV-positive test result)* is common. Within some projects, NGOs maintain hotlines, provide online or offline psychological aid, individually or in a group, as well as peer-to-peer counseling.

> *'We provide psychological counseling and motivate people to seek psychological aid. We, as social counselors, provide psychological support when a person learns about their diagnosis or some difficult life circumstances. Our psychologists provide counseling online and by phone too.'*
>
> *NGO_Kyiv_01*

> *'My project is mostly about working with hospitals. A person does HIV and hepatitis C tests, the result is positive, and before that the person was unaware they had a longtime virus. I come to them and provide initial counseling and psychological first aid. If it is a woman, we refer her to our groups. There is a psychologist for the group, and he can work with the person directly if needed.'*
>
> *NGO_Dnipro_01*

> *'I worked with a psychologist. He accompanied me to an outpatient department. He mostly observed, gave me some advice, and pointed out at what I did good and bad communicating with these people. And I did learn something… And he really showed me my weaknesses.'*
>
> *NGO_Lviv_01*

> *'In the context of mental health, our organization notes the highest demand for peer-to-peer counseling… or with a psychologist, but that's for a referral. And I recommend it to all, I am just totally sure there are no people who don't need a psychologist.'*
>
> *NGO_Kyiv_02*

3.7.2. KPS' OPINION OF MH SERVICES PROVIDED BY NGOS

Several of the interviewed PWID live with HIV and had received prevention services from NGOs, but they mostly had not used mental health services provided by the organizations, though they spoke positively about such an opportunity. Some participants were negative about NGOs as potential MH service providers because of the lack of trust and the belief that NGO workers only pursue the interests of their own or do not have appropriate practical experience to work with PWID.

> *'They [the NGO] have groups which meet every Friday, and a psychologist attends them. I have not been there yet.'*
>
> *PWID_Dnipro_03*

> *'I would go to a non-government organization. People there have a lot of experience. They understand you, and you can tell them everything including things you don't tell a doctor. No-one will judge you or give you dark looks. When you get accompanied, that is the best option. You are supported, and you understand you will not be left alone.'*
>
> *PWID_Mykolaiv_02*

> *I: 'Where would you never seek mental health services from?'*
> *R: 'Probably where they dispense syringes'*
> *I: 'A non-government organization? You don't trust NGOs?'*
> *R: 'No. I don't.'*
>
> *PWID_Kyiv_03*

Most of the interviewed SWs had long time been NGO clients and noted accessibility of their prevention services, knowing about them having a psychologist or an opportunity to get accompanied to a specialist by a social worker. Members of this population generally trust social workers, first of all because social workers observe the anonymity principle in their work, and because the SWs had the access to NGO-provided MH services. At the same time, some of the respondents were critical about the possibility of receiving the services from the organizations, mostly because of the remote location of NGO offices and a long time it takes to visit them, but also because NGO workers lack necessary skills.

> *'Talking about a psychologist at an NGO, I have been working in the city for a long time, and I know my NGOs. I asked other girls, we all use these services, it is convenient and good. And it is a pleasure to know that there is a person at the NGO to whom I can come and ask something, or share something, and get advice. I visited the psychologist at the NGO. And there is a hotline, and this is great. Psychologist, psychotherapist. I prefer going to a non-government organization, they help and refer further, and accompany you to a specialist.'*
>
> *SW_Mykolaiv_03*

> *'You can get tested for HIV, and for hepatitis too. Condoms, as usual. They do not offer psychologist's counseling. Maybe they have one, but they did not offer. If only we had more of them, so that you could go to an NGO in your district instead of dedicating half a day to a visit: travelling there, travelling back.'*
>
> *SW_Dnipro_03*

> *'How can they assess my health? They can't, they are not professionals. For example, they have no experience. They also don't know, maybe I would then actually go and hang myself.'*
>
> *SW_Lviv_01*

Talking about advantages of MH service provision by NGOs, MSM mentioned friendly attitude, providers' awareness of community's problems and getting the services free of charge. At the same time they named the lack of specialists at the NGO the main minus of these services.

> *'The organization understands such people better, because it is their specialization, and I think it is just more comfortable for a person to go to them.'*
>
> *MSM_Lviv_03*

> *'You already know that face and it is easier to go there, especially as this is a friendly specialist who can provide a service of a better quality knowing all the aspects. I mean regarding the LGBT topic. It is a great solution when there is a psychologist at the NGO. Unfortunately, psychologists' working hours at NGOs are very limited, while there are so many people who come to get psychological aid.'*
>
> *MSM_Mykolaiv_03*

> *If we take our organization, we don't have such specialists, and we do not have good means to attract them. Usually we can attract only not very good ones, and few – it just does not work.'*
>
> *MSM_Dnipro_02*

The interviewed trans*people included persons who are activists of community-based organizations, and some had received services from HIV-service NGOs. Generally, all the participants considered going to a psychologist working at an NGO the most accessible way of receiving psychological services, and naming specialists' awareness of trans*community's problems and free nature of the services the main advantages of this modality. At the same time, some of them noted how trans*people are unaware of the organization in general and the possibility of getting psychological services from them in particular, and the absence of such services they are clients of. Depending on their personal experience, trans*people could be very positive about accessibility and quality of psychological aid provided by NGOs or spoke about a low level of professionalism of psychologists in these organizations and their lacking interest in working with the clients. Those participants who had seen NGO psychologists were not always satisfied with the help because instead of expected in-depth, person-oriented interventions they had received 'sociopsychological stress relief'.

> *'I think psychologists in such NGOs are an integral part of the organization. Provided this is a psychologist with a degree and a license to conduct different kinds of psychotherapy and so on. The advantages [of NGOs] are that it is cheap and requires no additional expenses. It works when you just need a diagnosis, or when there are no alternatives. The minuses are that it is hardly effective. That is, we got no help beyond diagnosis.'*
>
> *T*P_Lviv_01*

> *'I would probably choose a group session with a psychologist at an NGO. Why? Probably because it is the most accessible and the simplest option. I have had periods of apathy, depression, and I thought about going to NGOs to get help. But I did not get what I had expected from the psychologists there. It was social stress relief rather than help. They work having their own purposes in mind. They are not trying to help the people who come there. They pursue their goal – conducting their studies.'*
>
> *T*P_Kyiv_02*

> *'I would go to a psychologist and, most probably, the one from an NGO, because I know he knows our kind of people and we will find a common language.'*
>
> *T*P_Mykolaiv_02*

> *'I would say that about 30-40% of our community are not aware of the organizations or about the possibility of getting this service from them. And it's not like they don't know NGOs exist, they rather don't know who they can ask about it.'*
>
> *T*P_Kyiv_03*

According to the interviewed psychologists and NGO workers, free provision of the services and the atmosphere of trust at the organizations contribute to KPs' positive attitude towards psychologists working at the NGOs.

> *'NGO psychologists that work at the organizations… it is more comfortable around them.'*
>
> *NGO_Kyiv_02*

3.7.3. PREPAREDNESS OF NGO WORKERS TO PROVIDE MH SERVICES TO THE KEY POPULATIONS

NGO workers themselves told they were ready to work with the KPs, but they did not identify their particular functions in the context of such help because of the lack of necessary background or advanced training. For example, some of them can ***'only have a talk, support, cheer up and distract from the problems'*** or provide crisis counseling. Most of them when need arises refer their clients to a psychologist.

> *'We can only support them and help them to calm down. What other mental health services can we as social workers provide? I can speak to them as a human… To cheer them up, lift their spirits and distract from the problems.'*
>
> *NGO_Kharkiv_01*

> *'I can counsel as a social worker regarding everything related to the problem until the moment the person is in a crisis condition. I can give a referral, I can accompany them. Surely I am not a psychologist, I cannot…'*
>
> *NGO_Mykolaiv_02*

At the same time, almost all the interviewed NGO workers would like to get trained to help people with mental health disorders.

> *'If they trained us, I would take part. I'd like to learn more about this to be able to help the people.'*
>
> *NGO_Lviv_01*

> *'I could do counseling. What do I need for that? Well, I need at least to take a training course.'*
>
> *NGO_Kyiv_01*

3.8. REMOTE MENTAL HEALTH SERVICES

Both the interviewed KP members and service providers have mixed opinions regarding mental health services provided by phone or online. Altogether, accessibility, free-of-charge basis, anonymity and confidentiality were recognized as the main advantages of remote counseling, which is especially important according to the interviewed specialists, for MSM, trans*people and SWs. NGO workers emphasized certain limitations of online-counseling of PWID who often do not have modern smartphones and/or money to pay for mobile services, as well as low digital literacy in the community.

> *'A meeting via phone… Sometimes it is better because not everyone wants it face to face. First of all, it is free. Second, as far as I have heard, they have professionals, they recruit professionals for the projects.'*
>
> *NGO_Dnipro_02*

> *'Anonymity is of course an advantage of online resources. Especially I believe… Sex-industry even and transgender men.'*
>
> *FD_Dnipro_04*

> *'As the practice shows, when we call them, they do not have the phone anymore, it is pawned.'*
>
> *NGO_Mykolaiv_02*

At the same time, some SWs preferred offline counseling as that allows establishing close contact and empathy. The interviewed PWID considered online format for mental health services provision to be the most convenient because it gave them a sense of being protected and allowed avoiding immediate contact, while in certain cases it is the only option when a person cannot visit a specialist *(for example, because of their physical condition)*. Members of the community voiced the need to improve access to remote counseling and to for information about the services to be more readily available.

> *'I have done it online, but I am a kinesthetic person, I need to look in the eyes and see the emotions, see whether they empathize with me. That is why I do not want online services.'*
>
> *SW_Kyiv_01*

> *I: 'Where would you go first of all if you could?'*
> *R: 'Probably online. Because we don't see each other, and I feel free and relaxed, I feel protected. I won't be looked at with judgment.'*
>
> *PWID_Dnipro_01*

> *'I would not choose online services because I favor live communication. When it is about your mental state, it is of course better to see the person. But when the health does not allow a person to go and visit a psychologist, there needs to be online format to enable access. Show some ads on the news channels. Show it all year round. It is important. Like, you can access the services at this Internet resource. Here is the number you can call for free and get access to a psychologist.'*
>
> *PWID_Kharkiv_01*

3.9. INTERACTION BETWEEN MH SERVICE PROVIDERS

3.9.1. FAMILY DOCTOR – MENTAL HEALTH SPECIALIST

Most family doctors interact with specialist institutions and mental health specialists by referring patients. Occasionally, family doctors encounter patients' unwillingness to receive specialist care and refusal from a referral, so they may separately consult with psychiatrists and accompany the patients with mental disorders.

> *'Those patients of mine whom I have been managing for years, if I refer them to a psychotherapist or a psychiatrist, they trust me and they go there.'*
>
> *FD_Kyiv_04*

> *'Sometimes they come running as they need help of a neurologist, psychiatrist, or psychologist. No, I don't refer them, I usually just get consultations. Because a lot of people are shy and cannot tell about these things to someone else.'*
>
> *FD_Dnipro_01*

Some of the interviewed family doctors worked at primary health care centers that have a psychologist and a psychiatrist among their personnel, so they can refer their patients to these specialists. Usually at the city primary health care centers set up as successors of former polyclinic departments of multidisciplinary hospitals, specialists receive patients in the same *(or adjacent)* building with the general practitioners-family doctors. At some PHCCs, at the time of the study, they had specialized mental health centers which in opinion of family doctors promotes bringing specialist psychological/psychiatric care closer to patients and integration of mental health services at the primary care level.

> *'We now have a psychiatrist in our institution, and we can refer the patient without sending them to a psychoneurological dispensary. And we see that the patients are more willing to see a psychiatrist that is here. It does not unsettle them as much as going to a specialized institution.'*
>
> *FD_Kharkiv_02*

> *'We now have a mental health center at our facility, which is very convenient. There are neurologist, psychotherapist, psychologist and speech therapist.'*
>
> *FD_Lviv_03*

> *'Integrated complex support center. There are psychologists, a lawyer, a manager, and we refer the patients there.'*
>
> *FD_Dnipro_04*

Family doctors of small stand-alone primary care facilities referred their patients to other institutions. They could refer them to a specialist/specialized department of a hospital, psychoneurological dispensary, psychiatric hospital, rehabilitation center, psychological support center, reintegration center, or NGO. Also, some FDs reported that they recommend patients to call 24-hour hotlines for psychological support if needed.

> *'If it concerns specialized care – not psychological but psychiatric – then it is for rehabilitation centers, but those are commercial, private rehabilitation centers. If we are speaking about drug or alcohol dependence, then we refer the patient to a psychiatric hospital, but they are usually quite severe conditions.'*
>
> *FD_Kyiv_02*

> *'We have a psychiatric clinic in the city. There is the oblast psychiatric center, inpatient facility. We cooperate with them, we keep in touch, and we have their contact data. We refer our patients to them too. We have a narcology doctor who also works at the center. And the oblast narcological center. Some of our patients go there. We keep in touch with them.'*
>
> *FD_Dnipro_02*

Family doctors used both passive *(just referring their patients)* and active referring *(contacting the specialist they referred the patient to)*. In this case they wait for a feedback from the patient or the specialist, sometimes noticing they receive none, which prevents them from learning whether the patient has been able to receive the services. But they said they understood that the lack of feedback is often caused by the standards of provision of psychiatric care, i.e. confidentiality of psychiatric diagnosis.

> *'I will give the patient his pathway and he will know where he can go to. I refer patients to a psychotherapist and a psychiatrist. We have a big central hospital and a psychoneurological dispensary where they provide these services.'*
>
> *FD_Lviv_04*

> *'If they need a specialist, I can carefully make arrangement with the specialists, provided the patient agrees, and everything is confidential. Mostly they are our specialists, the ones working at our hospital. [And] at the city and the oblast hospital.'*
>
> *FD_Dnipro_02*

> *'I get no feedback. When the patient goes to a psychiatrist to get counseling, I receive no records, no diagnosis. I, as a doctor, would like to know more about the patient, what his condition is. But the information is not available. That is bad.'*
>
> *FD_Mykolaiv_04*

If after the first referral the patients received psychiatrist's recommendations regarding treatment involving psychotropic medications, family doctors could further manage their therapy, but in most cases did not consider themselves sufficiently competent and had to repeatedly refer the patients to the specialists.

> *'There are some patients with psychiatric diagnosis. And sometimes they come to us first when their condition gets worse. I cannot do anything but refer such a patient to a psychiatrist, because they take some serious medicines. I cannot adjust the treatment, this is not my specialty and not my competence.'*
>
> *FD_Dnipro_03*

Also, family doctors may get consultations on management of the patients with mental disorders with MH specialists by phone. Some of the interviewed family doctors try organizing remote counseling for their patients despite the fact that most psychiatrists provide their services only in person.

> *'We have good communication with our psychiatrist, our narcologist, we keep in touch and call each other. We communicate as colleagues, and if there are problems, we can solve them together.'*
>
> *FD_Kyiv_01*

> *'I sometimes ask psychiatrist to consult me by phone. Though they only provide their services in person. But I manage to arrange it, because you have to help people. This way we resolve a lot of issues.'*
>
> *FD_Dnipro_02*

3.9.2. FAMILY DOCTOR – NGO

Most of the interviewed family doctors had no experience of cooperating with social workers from NGOs: only a few have mentioned such cooperation in the context of patient/client referral between institutions. According to the doctors, this interaction had become less common after the start of the full-scale invasion.

> *'For example, we cooperate with "100% Life" organization, and with their psychologists. When their psychologists or social workers refer patients to me. Or, vice versa, I refer my patients to this organization for cooperation or solving some problems.'*
>
> *FD_Lviv_01*

> *'Yes, we used to work with NGOs. But after the war started, I do not know how it goes, maybe it's our omission. But we used to work with an NGO.'*
>
> *FD_Mykolaiv_02*

Some family doctors mentioned NGO workers in the context of collaboration with mental health specialists or provision of care to the KPs at PHCCs. At the specialized center, there were multidisciplinary teams including social workers who helped with referrals to NGOs. Some of the respondents were aware of the practice of social workers accompanying patients living with HIV to AIDS Centers and PWID to OST sites.

> *'Yes, we keep in touch. I also work at an OST site, we have an organization called 'Synergy of Souls'. There is a case manager working with these patients at our site. Also there is 'Women's Space', they can call there and women workers will come. I would say there are more patients with the experience of domestic violence. Or a husband drinks and beats her, we work with these cases too.'*
>
> *FD_Dnipro_04*

> *'I know that if you refer them to social workers, they can advise where there are NGOs working with such populations. We communicate with social workers, they can give patients recommendations about where they need to go to if they don't want to visit healthcare institutions.'*
>
> *FD_Lviv_04*

Employees of some NGOs interacted with family doctors through joint projects, in particular training sessions dedicated to specifics of work with the KPs. There was also collaboration concerning accompanying clients during examinations, signing declarations to enable client's access to free healthcare or applying for disability benefits.

> *'Our organization is now actively training family doctors. We have groups and conduct training sessions for family doctors.'*
>
> *NGO_Dnipro_02*

> *'We communicate with family doctors… when the person takes lab tests, we track what is going on with the patient and where they should be referred to. Signing declarations to receive services.'*
>
> *NGO_Lviv_03*

At the same time, NGO workers identified a range of challenges in cooperation with family doctors which also affect effective referring the clients and possibilities of further receiving of mental health services. They include: significant distance to PHCCs, long queues to doctor's office, KP members' not having IDs which complicates the process of signing a declaration with a family doctor, and insufficient qualification of family doctors as well as cases of stigmatization of clients from among the key populations.

As the family doctor is currently the key 'entry point' to all specialized medical services, clients need to sign a declaration with a family doctor. And though NGO workers provide clients with recommendations regarding signing a declaration *(or sometimes even accompany them in the process)*, the clients sometimes hesitate to visit a doctor because they are unwilling to travel a long distance or wait in line. In southern and eastern regions of Ukraine interaction with the primary care is hindered by the lack of family doctors who have moved to safer oblasts.

> *'Eighty percent of them answer that they don't have a declaration, and I tell them they must sign a declaration with a family doctor and go get the treatment. A lot of them never see family doctors.'*
>
> *NGO_Kharkiv_01*

> *'I personally cannot get to him for a month already, cannot reach him by the phone too. There is a deficit of them, because many doctors have left. And many of the people living in villages have no family doctor at all.'*
>
> *NGO_Mykolaiv_01*

> *'We do not know whether they have problems with this doctor or not. Often they say there is no family doctor… and we kind of help them with signing a declaration. Or there is a very old doctor and they cannot come to terms with her.'*
>
> *NGO_Kyiv_03*

> *'These doctors are very few. And I really just don't understand why they created family doctors as a tier in the healthcare system. What are you talking about? How can we speak about psychology? Or narcology? Or HIV? They don't know their own responsibilities.'*
>
> *NGO_Kharkiv_02*

3.9.3. MENTAL HEALTH SPECIALIST – NGO

Mental health specialists much more frequently than family doctors reported of cooperation with NGOs, including during the war. Some of them noted strengths of NGO operations in the emergency situations, such as prompt responding, implementing innovative methods, flexibility and engagement of volunteers.

> *'NGOs are generally more responsive. They don't wait until they get funding. They take the issue on immediately, they engage volunteers and use various innovations, online formats. That is, civil society organizations are more flexible and fast-acting. These are their strengths.'*
>
> *SSP_03*

Interaction of mental health specialists with NGOs involves mutual referring of patients/clients and taking part in joint projects; at the same time, the specialists noted that KP members referred by NGOs were better aware of the risks of their life style and had higher confidence in the medical specialists, which is a plus. Mental health specialists referred their patients to NGOs to receive temporary shelter, restore IDs, receive prevention services and financial support. Joint projects included supporting PWID at OST sites, treating depression in tuberculosis patients, and psychological aid to people affected by the war.

> *'Usually, when we speak about this category of clients, they are more responsible and tell you about their risks when they are referred to you by an NGO.'*
>
> *SSP_09*

> *'We do refer them sometimes. We actually make use of some programs, e.g. shelters and legal aid. …because some situations are quite complicated. For example, when they [a T*P] need to restore their passport. Sometimes there is a need of a specialized shelter or financial aid.'*
>
> *SSP_7*

> *'Every six or twelve months we have a new project with non-government organizations. Pre-exposure prophylaxis… everything in this country that has relation to HIV, AIDS, substitution therapy, had to be tested in Kyiv at the OST site at our hospital.'*
>
> *SSP_01*

For NGO workers, referring clients is the preferred format for interaction with other mental health service providers because some organizations do not have psychologists in their team and have to outsource them. In cases of severe mental health disorders, social workers accompany their clients to psychiatric hospitals and ensure provision of psychological support by their psychologist after completion of the treatment. At some organizations, clients can be counseled by NGO's staff psychologist, and if a more specialized care is required, the psychologist refers the client to psychiatric institutions.

> *'We do not refer them anywhere, we have our own psychologist. We send them all to him. If the psychologist sees some other care is required, it is up to him. He provides referrals.'*
>
> *NGO_Kharkiv_01*

> *'There was a disease related to psychosomatics and increased anxiety. And that is why the client was referred to a psychiatrist for pharmaceutical therapy, but then again… He works with the psychologist.'*
>
> *NGO_Dnipro_02*

3.10. SERVICE PROVIDERS AS 'ENTRY POINTS' TO ACCESS MENTAL HEALTH CARE

Despite the study being focused on feasibility and acceptability of different 'entry points', in addition to convenience for a patient/client, the following factors are important:

- availability of several entry points each of which should enable access to highly-specialized, quality and free *(e.g. state-provided)* care meeting the needs of the client and suitable for their mental condition,
- fastest possible provision of care, especially for acute and health-threatening conditions *(suicidal thoughts, effects of violence, overdosing, withdrawal, etc.)*,
- clearly defined patient's pathway and feedback on client's progress at every stage *(in case of referral)*,
- fullest possible scope of mental health services meeting the needs of the client/patient at the point of visit.

> *'Any of these options should work. That is, if I need to see a psychiatrist, then wherever I go, I should eventually see a psychiatrist. There has to be a public doctor to whom they will refer me.'*
>
> *T*P_Mykolaiv_01*

> *'I believe that if they dispense methadone, they need to have a psychologist. There should be all the doctors needed to provide help if someone feels bad.'*
>
> *PWID_Mykolaiv_03*

> *'I think this should exist simultaneously. One person may feel more comfortable talking to a psychologist one-on-one, while another will find it more comfortable and effective to mix with the people in self-help groups of community centers for the key populations, while having the same problem.'*
>
> *FD_Mykolaiv_04*

3.10.1. FAMILY DOCTORS

Screening to identify the needs, determining whether provision of care is possible at the place of visit or there is a need to refer the patient elsewhere is the first and the most important stage of provision of mental health services. According to some of the MH service providers, family doctors are capable of making initial diagnosis, referring patients to specialists, performing basic clinical diagnostic tests and treatment of physical conditions, yet they should not treat the disorders.

> *'The first thing that is needed is a proper, adequate diagnosis.'*
>
> *SSP_07*

> *'[A patient] gets counseling, takes tests, e.g. if I suspect depression, I can give him a questionnaire, look at how many points he scores and thus evaluate his condition.'*
>
> *FD_Kyiv_03*

Despite the doubts KPs and mental health professionals have regarding the competence of family doctors as MH service providers, the respondents mentioned the following advantages of a family doctor as an 'entry point' through which KP members can access such services:

- long-term work with the patient and comprehensive understanding of their health problems,
- possibility of early detection of disorders provided the patient visits the family doctor regularly *('the patient always kept in sight')*,
- quick remote accessibility *(by phone or via mobile apps)*,
- convenience of conducting screening and identifying mental disorder risk factors,
- ability to provide basic health services in case of mental health disorders on the free-of-charge basis, including laboratory and instrumental tests if required,
- providing access *(referring)* to providers of free specialized care *(if required)*,
- ability to diagnose and treat a physical co-morbidity.

> *«[The FDs] play the key part, we see our patients much more often. Even if they go and see psychiatrists, those are not so regular contacts. We communicate more and can see the things the patients themselves do not notice. We can manage some of them and refer the rest.'*
>
> *FD_Lviv_04*

> *'It's a good model. The advantage is that I keep an eye on the patient. I will keep reminding, inviting him to counseling. If the patient agrees to see a psychiatrist or psychologist, they will also not get lost if I give the referral.'*
>
> *FD_Dnipro_04*

> *'A family doctor can be the entry point. He can conduct screening that is identifying the problem. He knows the family and other circumstances. He can suggest elementary services such as psychoeducation, discussion of some potential problems, risks, and motivate the patient. And refer them to a specialist.'*
>
> *SSP_10*

> *'But the family doctors in this regard, like in all other regards, are intermediaries between a patient and some medical specialist. That is, I think a patient can see a family doctor to be referred further to receive a more specialized care.'*
>
> *NGO_Dnipro_01*

Considering treatment of mental health disorder at the primary care level, family doctors identified a number of barriers. Those included problems with ensuring confidentiality, lack of proper training and experience, deficit of resources for diagnosing respective pathologies, excessive workload and lack of time to monitor patient condition. Mental health specialists also emphasized that family doctors are able of providing only 'elementary' services such as counseling regarding risks or motivating their patients to seek specialized care, but did not support the idea of making family doctors treat neurotic mental disorders.

> *'A family doctor can do a lot, but that is when you have not more than a thousand patients. And when you have two thousand, you just don't have the time to cover it all.'*
>
> *FD_Lviv_04*

> *'Because in the conditions I work in I cannot always ensure confidentiality. We must be one-on-one in the office, and no-one must enter by accident. We try to have proper conditions here, but it is not always possible.'*
>
> *FD_Kharkiv_01*

> *'Family doctors should not do mental health. A family doctor can make a diagnosis, check what it's all about, and give way to the specialists who can provide the kind of care the patient needs.'*
>
> *SSP_10*

3.10.2. NGO WORKERS

Most of NGO workers considered their own organizations the best entry point for provision of mental health services to the key populations with further referral and/or accompanying to highly-specialized care providers. The respondents, including family doctors, noted the following points favoring this model:

- more frequent contacts with the KPs, in particular initial and repeated visits,
- social workers having KPs' trust and being accessible which ensures they are approached when a patient needs help,
- skills of motivating clients to receive qualified professional care,
- providing free services for the KPs,
- possibility of involving a psychologist,
- provision of a set of social and psychological services at the NGO according to the needs,
- having enough time for individual and group work with the clients,
- practical experience of effective referring to other specialists and *(if required)* accompanying to them.

> *'Most often we say: "We have an hour of time according to our plan", when we are getting a group together to discuss something. But in reality it takes two or two and a half hours, we don't hurry anyone up, we do not tell them to leave already, everyone can speak up, everyone can talk.'*
>
> *NGO_Dnipro_03*

> *'He should contact a social worker. Seeing his condition, I can determine if he needs a psychologist or a mental health specialist. If I am mistaken, a psychologist still counsels him. If the psychologist sees that the condition is severe, he immediately refers the patient to a psychiatrist. We refer everyone to family doctors; when a person comes and wants to get on OST, I refer them to a family doctor. They go and get a referral. Then they go to a neuropathologist. And we escort the patient throughout the whole process.'*
>
> *NGO_Mykolaiv_02*

> *'Our main objective is probably identifying the problem the person has. And it's not just money, drugs or having something to eat, it is their mental state too. And then – motivational counseling where the person needs to realize that they need to do something, they need to make a decision.'*
>
> *NGO_Kyiv_03*

TALKING ABOUT SHORTCOMINGS OF NGOS AS MENTAL HEALTH SERVICE PROVIDERS, THE RESPONDENTS NAMED THE FOLLOWING:

- lack of resources for early initiation of pharmaceutical therapy, diagnosis and treatment of a physical co-morbidity,
- social workers do not have the qualification to independently determine where they need to refer the patient to,
- insufficient sustainability of the services which is usually limited by project work, and the service stop as soon as the funding ends,
- it is impossible to provide the necessary duration of counseling sessions or number of psychological service provisions.

> *'The advantage is that the client has already come with a problem. That means at least some understanding of the problem. A possible disadvantage is organization's competence in identifying the problem and helping the patient. Because the patient has to go to a healthcare facility either way.'*
>
> *FD_Lviv_02*

> *'It is very convenient. But there is one downside: there can be a pathology requiring doctor's intervention. We check the tests and examine the patient.'*
>
> *FD_Kyiv_02*

> *'I think it is difficult to help a person in just one or two counseling sessions. … it should be a whole set of counseling sessions, up to ten in total.'*
>
> *NGO_Mykolaiv_01*

3.10.3. MENTAL HEALTH SPECIALISTS

Using a psychiatrist as the 'entry point' was the model that received the heaviest criticism from the respondents, mostly family doctors. Despite psychiatrists' ability to prescribe and monitor 'complex' therapies, which is their advantage, participants listed a number of disadvantages. They include the lack of capacity for diagnosis and treatment of related or co-morbidity, KPs are less willing to go straight to mental health specialists, and their services are mostly paid *(especially if the patients do not get a referral from a family doctor)*.

> *'Talking about psychiatrists, the problem that as soon as the patient hears the word "psychiatrist"… A lot of people are very negative, going to a psychiatrist is traditionally seen as something shameful. And the second downside of psychiatrists is that they specialize in severe mental disorders.'*
>
> *FD_Mykolaiv_04*

And though for KPs going to a psychologist as the 'entry point' will have the same downsides as going to a psychiatrist, a visit directly to a specialized care provider is more reasonable in case of a relapse in a patient with a chronic mental disorder *(mental health specialists did not consider themselves an 'entry point' of the system of provision MH services for first-coming patients)*. According to NGO workers, for certain conditions and certain needs *(such as taking part in an OST program, overdosing or other acute conditions, disease recurrence)*, direct approach is the most reasonable as it helps saving time and energy by avoiding all the preliminary stages *(NGO worker – family doctor – psychologist, psychiatrist)*.

> *'First to a psychologist, and then to a psychiatrist. Because if the aid is comprehensive and it includes both psychological and pharmaceutical therapies, if needed, then this is the most effective care.'*
>
> *SSP_02*

> *'If all those referrals could be avoided and the patient could get to the specialist right from the start, it would be the best. Time and energy… Not every person is willing to open up before each medical professional and tell where he would like to go next.'*
>
> *NGO_Kyiv_02*

3.10.4. INTEGRATED SERVICE PROVISION

All the interviewed specialists believed that provision of comprehensive and integrated care to KP members with mental health disorders *(at PHCCs or NGOs)* was relevant. Integration of care at PHCCs would allow ensuring screening of psychological state and initial diagnosis of disorders by primary care doctors with further access to specialized care if required. Comprehensive *(sociopsychological, psychological and psychiatric, medical)* care would enable meeting all the needs of the KPs and could be organized either through a staff psychologist at PHCCs, NGOs or OST sites with further referring to highly-specialized care providers or through different specialists receiving patients in one building.

> *'We have centers at the polyclinics where a family doctor works with the patients. Those are our family doctors under WVI. If the doctor decides a particular patient needs psychological aid, they are given a referral to our centers at PHCCs.'*
>
> *SSP_03*

> *'The approach should be comprehensive. If a doctor suspects a different pathology, they should refer the patient further so that they could get another kind of care.'*
>
> *SSP_05*

> *'Psychologists working at healthcare facilities are qualified, they are capable of helping you. And this thing should be better developed at charitable organizations.'*
>
> *NGO_Kyiv_01*

> *'And why can't it be done at the OST sites? They still come every ten days. Some psychological trainings could be conducted.'*
>
> *NGO_Kyiv_03*

CONCLUSIONS

Participants from among both KPs and mental health service providers reported negative effects of the war on the psychological state and mental health of the people. At the beginning of the war, almost all members of the key populations experienced acute stress reactions, panic attacks and anxiety of varying severity. Manifestations of the disorders and their further dynamics depended on multiple factors – a history of mental disorders in the past, security situation at the place of stay, levels of satisfaction of basic needs, social support, displacement and other individual characteristics. Prolonged consequences of the wartime stress observed in members of all the KPs included anxiety, depression, panic attacks, sleep disorders, psychosomatic disorders, and PTSD.

All the service providers were better aware of specific problems and disorders of the mental health of PWID because this population often seeks services related to substance use. Security situation, material and domestic problems in the time of war indirectly affected the mental state of the PWID – mostly through problems with accessing drugs. That is why, cases of drug withdrawal became more common at the beginning of the full-scale war. Later, PWID mostly suffered from anxiety, prolonged depression with dysphoria and sometimes with apathy, suicidal intent. During withdrawal they encountered mood swings, irritability, inclination to brutal behavior and aggression.

Family doctors and mental health specialists noted that usually they only guess that some of their clients/patients belong to MSM or SWs as members of these communities are reluctant to disclose their way of life. Talking about the problems specific for MSM, the service providers mentioned relationship problems, acceptance by the close circle, pressure of discrimination, bullying and stigma, and high risk of violence, which in their opinion leads to depression, suicidal ideations associated with disruption of important relationships.

Providers were mostly unaware of specific problems and aspects of mental state of SWs in the time of the war. Only some family doctors and NGO workers reported cases of domestic violence in patients' families believing that these women are often affected by guilt, shame and, as a consequence, depressive conditions. The interviewed SWs reported having experienced a significant drop in financial standing because of inflation and reduction of the number of clients, susceptibility to stress, panic attacks, anxiety, deterioration of physical condition, insomnia, low mood and apathy. According to the interviewed SWs, negative wartime factors had led to the spread of drug use and intensification of alcohol use in their community.

The service providers were the least informed about specific problems and changes in mental state of trans*people. Generally, members of this KP had non-specific mental health disorders: under the influence of dangers or household problems they experienced anxiety and brief or prolonged depression episodes. However their main problems were related to the transition – during the war, they faced a double stress because they encountered the lack of vitally important hormonal medicines and problems accessing necessary care.

The methods of self-help KPs most often resorted to were the use of PAS *(alcohol, narcotics, tobacco, and tranquilizers)* and taking self-prescribed sedatives and sleeping pills, tried to get distracted from the anxiety by spending time with family and friends, doing household routine, sometimes using self-regulation techniques and breathing practices, and attended mutual help group meetings.

Speaking about the conditions which make it necessary to seek medical aid, KP members mentioned disorders that completely disorient a person, deprive them of control over their own actions, create a barrier to satisfying basic needs, and threaten the lives of the person or people around them. The respondents mostly described hypothetic behaviors of other people and only occasionally admitted the possibility of having such disorders too. None of the interviewed KP members considered neuroses or stress-induced disorders a valid reason to seek professional aid,

focusing mostly on severe *(psychotic)* mental disorders as the reason to see a doctor. Service providers confirmed that KP members lacked the awareness of the need of seeking aid from mental health specialists.

During the interviews, KP members declared they needed mental health services, yet they also reported rarely seeking specialist aid. KP members mostly ignored the need of receiving professional care expecting to be able to resolve their mental issues themselves and facing barriers that hinder access to the services. In the time of the war, family doctors received almost no requests for mental health services from KP members that they were able to identify as such. Mental health specialists and NGO workers mostly received requests for OST, counseling related to patients' being tested HIV-positive or, sometimes, to PAS overdosing, withdrawal, violence, i.e. problems that were not directly connected to the war. The service providers mentioned no specific requests for help from MSM or trans*people.

According to the desk review, MHPSS services *(both medical and non-medical)* are available for KP members in all the regions included in our study. Specialized services *(medical ones or certain psychological interventions)* are largely accessible, yet the evaluation of sufficiency of the potential coverage is impossible due to absence of standards for the numbers of providers per population size. Basic psychological aid *(diagnosis, psychosocial, behavioral and pharmaceutical interventions, referring to a psychiatrist)* is presently available at PHCCs in all the regions included in our study, which was also confirmed during the in-depth interviews with family doctors. The number of healthcare facilities providing this kind of care is less than a third of all primary care providers according to the NHSU which is probably not sufficient. However, the program for training health workers (mhGAP) goes on and the quantity of such facilities will grow.

General, non-KP-specific psychological aid is available offline in all the regions, but to a different extent: the lowest number of the providers was identified in Mykolaiv. Quite a broad range of the services is provided online or by phone by national-level institutions. All these services are available for the key populations and theoretically cover the most prevalent psychological problems identified in the course of the in-depth interviews. KP-focused MH services are provided by NGOs and are funded by international donors. Since most providers of such services declare that they can work with all populations, the focus of these NGOs is likely to be associated with the specialization of the NGOs rather than provision of highly-specialized care *(such as support in case of gender transition or substance dependence)*.

Most of the interviewees had received services from HIV-service NGOs, and a part of them were aware they could receive psychological support from the organizations. At the same time, free-of-charge services provided by psychologists working at NGOs were available not to all KP members because of the distance, inconvenient working hours or lack of information, especially if the clients were IDP or lived in remote rural areas. On the other hand, virtually none of the respondents had information about the free services *(hotlines, online counseling)* or the services provided by family doctors. All the interviewed KP members lacked the awareness of the opportunity to receive MH services at the primary healthcare level.

The study has identified a number of barriers preventing access of the key populations to mental health services in the time of the war: the idea of having no problems or being able to solve them without support; lack of awareness about opportunities of receiving help; stigma, including that related to seeking aid from MH specialists; high cost of the services while the patients doubt the effect; inaccessibility of free services and their irrelevance to the needs of the key populations; lack of trust in the providers and risks of information disclosure.

The main facilitators for the KPs to seek aid regarding their mental health were stressful life circumstances and severe disorders of mental state *(prolonged apathy, confusion, deep depression or bouts of aggression, suicidal thoughts, inclination to self-harm, uncontrolled substance use)*; availability of community-friendly service providers *(which is especially relevant for MSM and trans*people)*; support from close and 'valued' people; quick access to and speed of provision of the service; moderately priced or free quality services.

Despite insufficient levels of trust in family doctors as MH service providers, KP members told they were interested in receiving mental health aid at the primary healthcare level. However, the study shows that family doctors are not sufficiently trained and lack the experience to provide the services. Some of them are ready only to refer patients to specialists and are wary about working with PWID or people with alcohol dependence fearing their aggression. Interaction between family doctors and mental health specialists mostly works in one direction – from a family doctor to specialists, and primary care doctors often do not receive any feedback or consultative support. Better conditions for cooperation between doctors of primary and secondary care exist at PHCCs established as successors of former polyclinical departments of multidisciplinary hospitals and having psychologists and a psychiatrist among their personnel.

NGO workers were generally quite willing to work with the KPs in the field of mental health, yet they lack basic professional training and a clear understanding of the content of the services they can provide to their clients. Interaction between the NGOs and family doctors mostly comes down to passive referring of the clients to primary healthcare for them to sign declarations. MH specialists had more experience of sustainable cooperation with NGOs under various projects the number of which had even increased during the war. Challenges of interaction between the providers include the lack of sustainability of the projects for service provision to the key populations due to low financial capabilities of the HCFs preventing them from continuing providing innovative services.

According to MH service providers, the optimal model of service provision has to meet several universal requirements: (1) maximum convenience for patients/clients; (2) providing screening of the problem, initial diagnosis of disorders and assessment of possibility of providing care at the place of visit or the necessity of referral; (3) soonest possible initiation of service provision and, in case of a referral, a determined patient'/client's pathway with feedback; (4) priority of the access to care for emergency and life-threatening conditions *(high risk of auto- and heteroaggression, overdosing, withdrawal, severe consequences of violence, etc.)*; (5) provision of the services in the places most frequently visited by patients/clients; (6) the fullest meeting of the needs at the place of initial visit *(minimizing the number of referrals)*.

The most realistic and corresponding to the above requirements currently are two service provision algorithms simultaneous application of which enables scaling up access to MH services for KP members during the war and in the post-war transition period. To those who have trust in and steady access to primary healthcare suggesting the model with the initial visit to a family doctor is appropriate. The advantages of provision of MH services by family doctors include: long-term patient management and seeing a full picture of their health issues, capability of early detection of disorders provided the patient pays regular visits to the FD, availability of quick remote access, convenience of screening and identifying mental health risk factors, capability of providing free basic health services in cases of mental health disorders, capability of referring the patients to providers of free specialized care, capability of diagnosing and treating physical co-morbidities. However, to enable successful operation of this model, it is required to additionally train family doctors, raise the awareness of the target populations about availability of these services, and build up patients' trust to family doctors as MH service providers.

A lot of KP members and NGO workers favor the NGO entry point model, which offers the following advantages: more frequent contacts with the KPs, clients' trust in social workers, accessibility, professionals' motivational skills facilitating clients' seeking aid, free-of-charge services, possibility of engaging a psychologist, provision of a complex of social and psychological services through the NGOs, availability of sufficient time for individual and group work, practical experience of effective referring clients to other specialists and accompanying them to the appointments if required. At the same time, it is important to ensure sustainability of activities of the NGOs with staff or permanently associated psychologists, improve the competence of their social workers with regard to assessing the needs of KP members in MH care, provision of social services and psychological support, and, if required, support in communications with family doctors and MH specialists.

RECOMMENDATIONS

1. Most psychological problems and disorders developing in members of the key populations, particularly during the war, are not specific and are typical for the general population. Considering this, a significant part of the needs in services can be met by the providers working with the general public or the populations KP members may also belong to *(such as IDP or survivors of gender-based violence)*. Such services are widely available in the regions included in our study, though this availability is still insufficient considering the scale of the war-induced problems. The priority measure to improve mental health of KP members through access to MHPSS services is psychoeducation, i.e. raising their awareness about mental health, manifestations of disorders and symptoms that indicate that the person should seek professional care, and about available services.

- The possible means of psychoeducation are media campaigns, posting information in the places that are the most frequented by the key populations, and training professionals working at the specialized NGOs,
- National-level and regional psychoeducational activities can be relayed through NGOs working with the KPs.

2. Considering high levels of development and capacity of HIV-service NGOs in Ukraine, their experience of work with the KPs, low access threshold and the preference the KPs give them, it is rational to support sustainability and scaling up MHPSS service through such organizations. It is important to improve qualification of the specialists that can be involved in provision of psychological aid.

- It is reasonable to ensure that the professional development program covers methods of screening for the most prevalent mental disorders, establishing collaboration for effective referring and, where practical, providing structured transdiagnostic interventions *(CETA, Problem Management+, etc.)*
- The more realistic in the current circumstances is funding MHPSS services provision by HIV-service NGOs by international projects, through additional subgrants or inclusion of these services in other domains *(such as HIV prevention, etc.)* In the latter case, MHPSS services must not be a core component of the package so that minimum qualification requirements in the main project are not set too high.
- Provision of MHPSS services through NGOs should be subjected to thorough monitoring and evaluation, especially at the stage of implementation.

3. The program for training primary healthcare professionals (mhGAP) continues, and the accessibility of mental health services should improve. In addition to raising the awareness of KP members of these services, it is important to also improve their accessibility through more intensive mhGAP training of primary care professionals, possibly including a separate module dedicated to the needs of the KPs.

- Priority in training should be given to the institutions that work with the key populations more often *(because of their location or because of having an OST site, etc.)*,
- Training activities should be coordinated with other stakeholders in this field.

4. Within both models *(providing MHPSS services through NGOs or through family doctors as the 'entry point')*, it is important to implement structured referring which suggests coordinated interaction with other service providers, accompanying whenever required and mandatory feedback on the results of referrals while observing the principles of confidentiality.

- A useful tool for structured referring are developed patient pathways for the most common mental problems.

5. Continued implementation of measures to fight stigma and discrimination at the national, regional and local levels is an effective way of reducing the barriers to accessing mental health services for the key populations.

6. Further study of mental disorders among the KPs, their prevalence and influence on receiving HIV services, accessibility and effectiveness of mental health services is important for quantitative justification of the demand for services and monitoring of development in this domain.

ANNEX

SOCIODEMOGRAPHICS OF THE RESPONDENTS

PARAMETER	PWID (N=15)	SWS (N=15)	MSM (N=15)	TRANS*PEOPLE (N=15)
Gender				
Male	11	–	15	–
Female	4	15	–	–
Trans*person	–	–	–	15
Average age *(min, max)*	37.4 (30–52)	37.2 (20–58)	34.5 (21–69)	31.2 (18–48)
Marital status				
married	5	4	1	2
living separately	1	1	–	1
divorced	3	5	2	5
has never been married	6	5	12	7
Employment				
working full-time	2	5	10	6
working part-time	–	4	1	3
temporary job	6	1	3	2
currently unemployed	7	4	2	4
being supported by another person	–	1	–	–
NGO clients	6	11	6	8

PARAMETER	SWS (N=20)	SSP (N=10)	NGO WORKERS (N=15)
Average age *(min, max)*	44.7 (26–72)	–	40.9 (28–57)
Average work experience *(min, max)*	19.3 (1–32)	11.3 (0.3–23)	5.8 (1–19)

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STUDY REPORT

MENTAL HEALTH AMONG THE KEY POPULATIONS

THE NEEDS AND AVAILABILITY OF RELEVANT SERVICES IN THE WARTIME UKRAINE

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