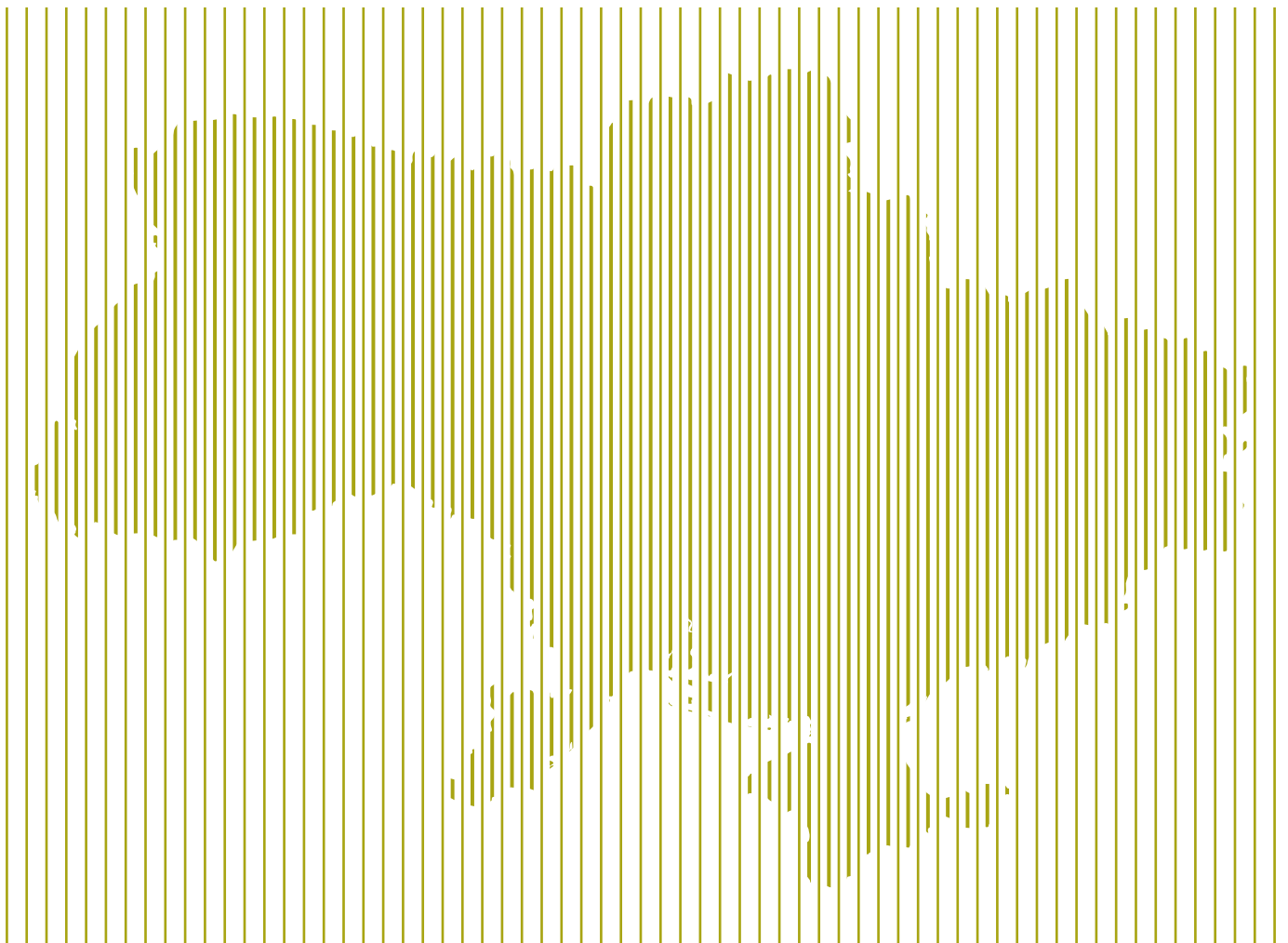# The Mental Health of Internally Displaced People and the General Population in Ukraine

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CONTENTS

SUMMARY

The research's overarching objective is to explore the level of mental health issues and the situation surrounding the provision of mental health care utilization as a result of the conflict in eastern Ukraine. This includes both Internally Displaced People (IDPs) in Ukraine and people who were not affected by war (the general population) in government controlled areas. A mixed methodology was used, consisting of surveys with IDPs (n=1000) and the general population the (n=1000), interviews with professionals in mental health support and representatives of charities and international organisations (n=21).

A key finding from the survey is that 20.2% of IDPs and 12.2.% of the general population have moderately severe or severe anxiety. The overall prevalence of depression was 25% of IDPs and 14% of the general population. Furthermore, 16% of IDPs and 8% of the general population are both severely anxious and depressed. Within these figures the mental health of women is more affected by displacement in respect to anxiety than men. Despite these very high figures only 1.2 % of IDPs and 0.3 % of the general population self-reported mental health issues when asked if their day-to-day activities are limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months. In terms of more general health problems 18.5% of IDPs have issues in mobility, 7.4% significant problems with vision, 6.1% with hearing and 15% - other impairment which limited their day-today activities.

Only 4.9% of respondents have approached professional health care providers in regards to their anxiety, stress or insomnia in the last three years, 3.6% have had consultations on personal and family relations, 2.4% regarding development of personal skills. **Only 21.7% of IDPs and 9.5% of the general population who have clinically significant anxiety and depression have tried to obtain mental health support.** Most of those who receive professional psychological help, did so only once. Women sought psychological help slightly more often than men and most IDPs and the general population were satisfied with the help they received. Interviewees noted that it is not just mental health support, especially the establishing free psychological services, but also the provision of suitable accommodation and access to pensions and other social benefits. Ways to improve the situation in relation to mental health support are not only in establishing free psychological services but also in providing accommodation and access to pensions.

The most common tactics amongst IDPs and the general population in dealing with long-term anxiety and stress are talking with friends (63.7%), music/films (45%), walking/hiking (35.3%). Alcohol and smoking are popular ways to deal with stress for only 16.7% of informants, while addressing psychologists among the least used practices with only 2.8% of informants approaching them. The professionals who were interviewed noted numerous barriers stopping more people from seeking help. These included, the prevalence of 'old' structures such as the Soviet legacy of treating mental health issues with inpatient care, the lack of measures to prevent mental health issues, the poor organisation of patients support system, a lack of specialists and affordable and qualitative programs for professional training and obsolete or inaccurate protocols. Experts stressed that among the population there is little recognition of the importance of mental health, and coping tactics in most cases do not include addressing to health care professionals, due to the prejudice and stigma that surrounds seeking such help.

The key recommendations are:

1) Create stronger links between institutional support and that of the private sector – with the inclusion of family doctors into the mental health provision sphere

2) Introduce a licensing system for those undertaking psychological provision and bring together professionals and communities to develop innovative approaches in mental health care

3) Improve the accessibility of services – especially for IDPs

4) Ensure that gender and age specific approaches to supporting mental health are developed and well publicised – the State to lead a cultural shift on reducing stigma around mental health issues

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INTRODUCTION

According to the World Bank (2017) about 30% of people in Ukraine will experience a mental disorder in their lifetime and that suicide is the most common cause of death associated with mental disorders and alcohol use. According to WHO, as of 2016, Ukraine has the 14th highest suicide rate in the world. Mental health disorders also impact upon physical health, as severe depression is linked to ischaemic heart disease; and post-traumatic stress disorder has been linked to increased mortality from heart disease, tumours, intentional and accidental injuries. The protracted conflict in eastern Ukraine led to the forced displacement of over 1.5 million people and has also impacted on many more people in both the zones of government control and non-government control.

In response NGOs and international organizations mobilised to try and diagnose and treat the country's increasing mental health-related issues, in particular among those affected by the hostilities, in particular ATO veterans and IDPs. However, while one third of IDPs experience various forms of mental health issues, only 26% of this figure have sought professional help (Roberts et al 2017). This is partly due to the lack of capacity in Ukraine's health system as, while there are many psychiatrists in Ukraine, there are not enough psychologists, psychotherapists and social workers. Furthermore, General Practitioners are not trained to provide mental health consultations and treatment. The mental health care system in Ukraine has been undergoing reforms in recent years, mainly in regard to legislation, the legal status of people who get treatment, budgeting as well as the reorganization of approaches to the provision of psychiatric care by specialized institutions with the adoption of the Concept of Mental Health Development in Ukraine 2030.

The current reforms, combined with the impact of the protracted conflict, require a deeper understanding of the situation in regard to the population's mental health. If, for example, the state health care system recognises only some mental and behavioural disorders, then most of people with issues such as anxiety and depression often do not recognise it as a mental health condition and, therefore, do not seek professional help. Furthermore, if a condition is excluded then there will be no statistics on it. Therefore, this study addresses this gap by exploring the level of mental health issues and the situation surrounding the provision of mental health care utilization by IDPs in Ukraine (experimental group) and the general population (control group) in government controlled areas.

METHODOLOGY

The research comprises of quantitative and qualitative research including interviews, a survey and desk research. Some hypotheses were made during the qualitative study of social consequences of population displacement in Ukraine (Kuznetsova et al 2018) which looks at the everyday experiences of IDPs and also at state, NGO and international organisation responses and included over 100 interviews and 2 focus-groups with IDPs and 25 experts' interviews.

In 2017-2018 **key informant interviews** were conducted with practitioners working in the sphere of mental health of IDPs including psychologists, psychiatrists, representatives of NGOs, volunteers and experts of international organisations (n=21). The respondents were involved in working with different groups of people who were affected by social and political crisis in Ukraine of 2013-2014, including the events at Maidan, the annexation of the Crimean Peninsula by Russia and the beginning of hostilities in certain parts of Donetsk and Luhansk regions. The interviews discussed the professional experiences of respondents, the situation with preventive measures regarding mental health of country's population in general and IDPs in particular, measures implemented for mental health support by different stakeholders, and cultural attitudes towards mental health among the population.

The **Survey** was designed by the research team and conducted by SocioInform in August-September 2018. The sample included 1000 IDPs and 1000 people not affected by the conflict aged 18 and over who reside on government control territories in 24 oblasts. The sample of IDPs (age, gender, region) was calculated based on statistics of the Ministry of Social Policy on 2018, the sample of the general population based on standard age, gender and region ratios in the 24

oblasts of Ukraine. The questionnaire included the PHQ-9 for depression, GAD-7 for anxiety and Adults Hope Scale (self-administrated). Overall mental health well-being was accessed via Warwick-Edinburgh scale. The experience of receiving professional mental health and people's tactics of reaction on stress were discussed as well. The survey questionnaire was developed in English and then adapted via translation and pilot interviews into Ukrainian and Russian to ensure validity and appropriateness within the Ukrainian context. The questionnaires were administrated in Ukrainian or Russian. Considering private character of some of the questions, the survey used a self-administrated technique when after the introduction about the purpose of the research, guaranties of anonymity and terms of participation, respondents were asked to answer a questionnaire by themselves (Bowling 2005). Then trained enumerator asked a respondent if explanations of some of the questions is needed and checked if any questions were left. Having a high response rate the standard deviation was 0.61.

Desk research included the analysis of recent studies on mental health of IDPs conducted by International Alert (Roberts et al 2017), the World Bank group report on 'Mental Health in Transition', the Concept of Mental Health Development in Ukraine 2030, HelpAge and UNHCR reports, available public health statistics, publications in mass-media and academic sources.

FUNDING

RESULTS

PART 1. RESULTS OF THE IDP AND GENERAL POPULATION SURVEY

General Anxiety Diagnosis

20.2% of IDPs and 12.2% of non-IDPs have moderately severe or severe anxiety which is clinically significant (Fig. 1).

The data showed significantly higher anxiety scores[1] in displaced individuals when compared with the general population **6.4 vs 5.1** (absolute scores, mean). Furthermore, there was a significant interaction between status and gender with a significantly larger impact of being displaced on women in comparison to men. GAD7 was 6.8 for displaced women compared with 5.1 for men, and among non-displaced 5.4 for women and 4.9 for men (Fig. 2). No significant effect of age was discovered.
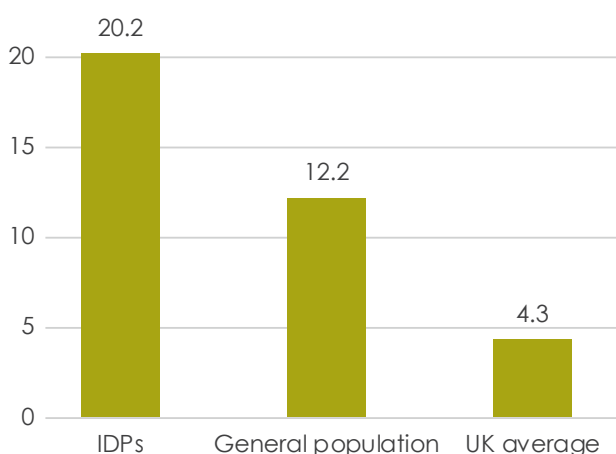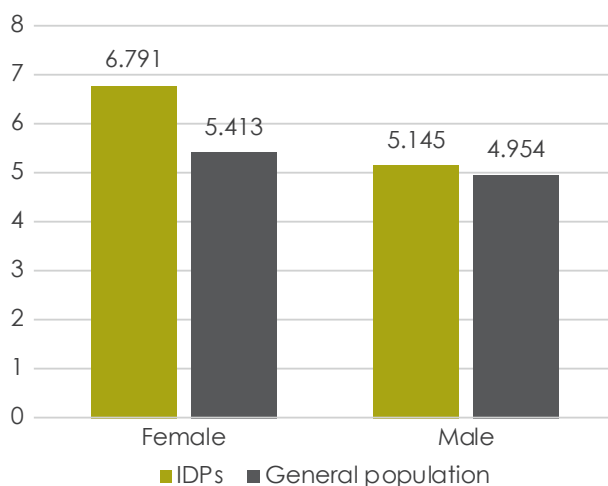

Figure 2. GAD 7 for IDPs and the general population, women and men (absolute scores)

Depression[2]

It was revealed that one forth of IDPs have clinically significant (< 10 score) depression while among general population 14% have same level of depression (Figure 3).
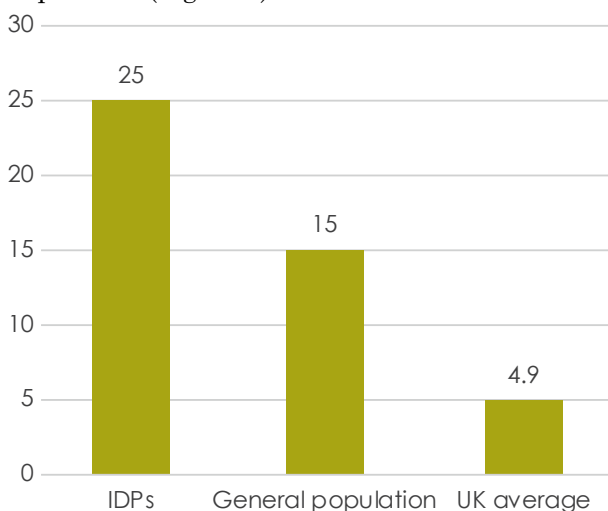

Figure 1. Moderately severe or severe anxiety among IDPs and non-displaced population

Figure 3. Clinically significant depression among IDPs and non-IDPs (%)

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1 GAD-7 (General Anxiety Disorder-7) was used as a screening tool to find out symptoms of anxiety disorders. We used a typical scale to evaluate the severity of an anxiety: 5-9 – mild (required to be monitored), 10-14, moderate (possible clinically significant conditions), >15 Severe Active (treatment probably warranted). The UK average data see Löwe et al 2008.

2 The Patient Health Questionnaire PHQ-9 was used for a depression screening which scores each of the criteria as 0 (not at all) to 3 (nearly everyday). Scores of 5, 10, 15, and 20 represent cutpoints fpr mild, moderate, moderately severe and severe depression, respectively. The UK average data on depression see Kocalevent et al 2013. Depression is higher in the displaced cohort **6.7** vs **5.4** (absolute scores).

16% of IDPs and 8% of non-IDPs are both severely anxious and depressed.

Self-reported limitations in health.

Respondents were asked if their day-to-day activities are limited because of a health problem or a disability which has lasted or expected to last at least 12 months. 6.7% mentioned that they activities 'limited a lot', 20.1% – 'limited a little' (Fig. 4).
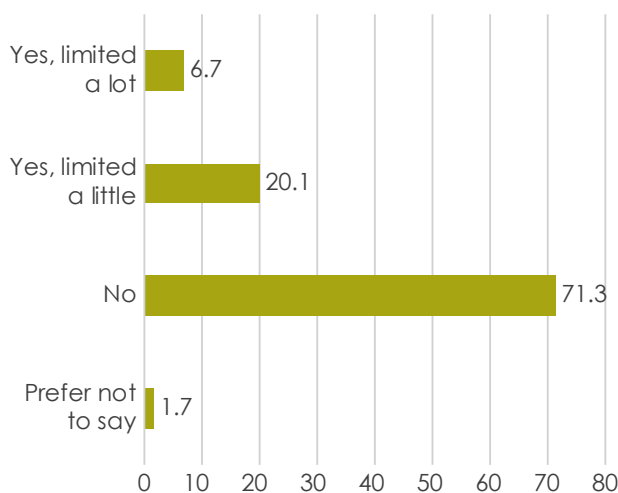

Figure 4. 'Are your day-to-day activities limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months?' (%)

Despite the high level of anxiety and depression among both IDPs and non-IDPs only 1.2% of IDPs and 0.3% of non-IDPs self-reported mental health issues. This demonstrates that in Ukraine people are not aware of mental health issues and 'normalise' their conditions as a 'bad mood', 'blues', this, in turn, stops them from seeking professional help. The situation is exacerbated by other health issues. For example, about half of IDPs self-reported difficulties with mobility comparing with 7.5% among non-IDPs which can be explained by the fact that in their sample there are more elderly people. Blindness and poor vision was self-reported by 7.4% of IDPs and 6.9 of non- IDPs and hearing loss by 6.1% of IDPs and 2.2. of non-IDPs. Struggling with mobility can be a significant barrier to seeking mental health support as it makes it difficult to travel to appointments or too much time is taken up seeking treatment for other issues.

The level of hope

There is a significant difference in levels of hope between IDPs and the general population where there is higher level of hope (Fig. 5)[3]. There is also a significant difference in hope between age groups with hope reducing as people get older – people 65 years old and older have a hope 39.2 (absolute score) while representatives of age groups young and middle age people between 47.7 and 47.2. No significant difference by gender were found.
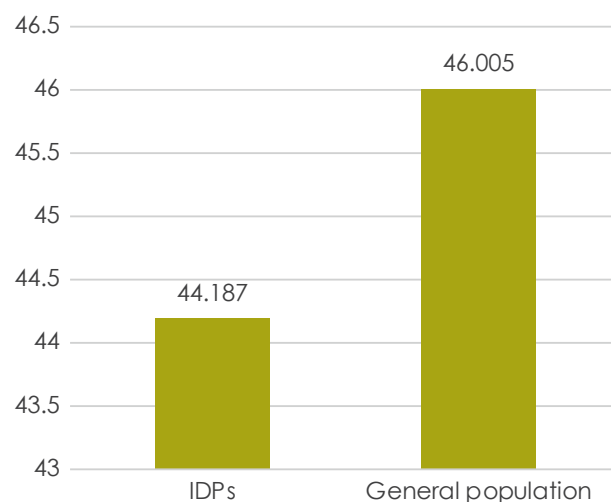

Figure 5. The level of hope among IDPs and the general population (mean, absolute score)

Following the approach which underlines the measurement of hope, some groups would have lower measurable hope as a result of their environment. The environment for IDPs, many of whom who have experienced traumatic experiences in a past, where they suffer from the lack of adequate and affordable accommodation, lower access to good jobs etc meant that they have lower abilities to create goals (uncertainty) and pathways to accomplish these goals. This, in turn, leads to higher levels of anxiety and depression.

Seeking professional help

The research revealed that during the last 3 years about one tenth of respondents (both IDPs and non-IDPs approached professionals regarding stress, or other psychological issues, or for guidance (Fig. 6). 3.8% mentioned that they wanted but did not approach professionals.

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3 The Adult Hope scale was used (Snyder et al 1991) which is a 12-item measure of a respondent's level of hope. In particular the scale is divided into two subscales that comprise Snyder's cognitive model of hope: (1) Agency (i.e., goal-directed energy) and (2) Pathways (i.e., planning to accomplish goals). Each item is answered using an 8-point Likert-type scale ranging from Definitely False to Definitely True.
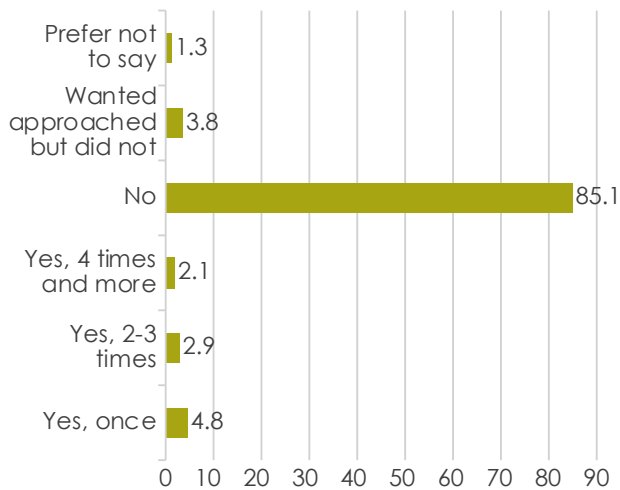
Figure 6. 'Have you approached professionals regarding stress or other psychological issues or for a guidance in the last 3 years?' (%)

The most common reasons for seeking professional help were anxiety, stress and insomnia (4.9% from the total number of respondents). Many people had consultations regarding personal and family relations (3.6%), development of personal skills as communication, creativity, memory (2.4%), professional relations and career (1.3%) (see Fig. 7).
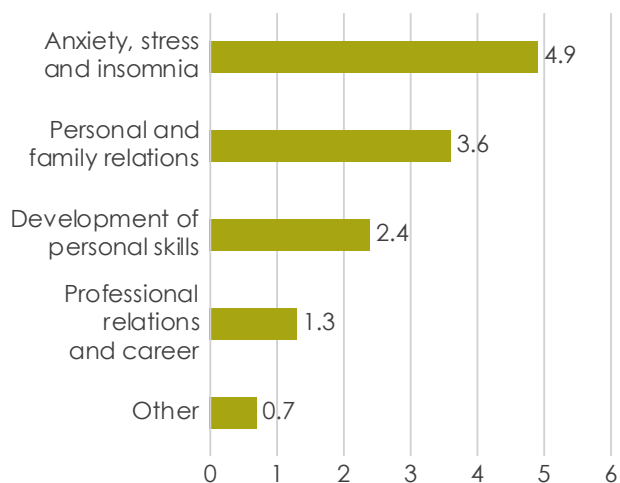

Figure 7. 'What was it focus on?' (%)

Displacement was a key factor in seeking psychological help as the percentage of the general population who sought it in the last 3 years is lower. During the last 3 years, 6,9% of IDPs received psychological help once, 4.5% - 2-3 times, 3.7% - 4 times and more, while among the general population 2.5% received psychological help once, 1.5% 2-3 times, 0.6% - 4 times and more. Respondents from both IDPs and the general population groups mentioned that they wanted to received psychological help but did not (4.3% and 3.1%).

Most of those who received **professional psychological help** did it only **once**, which is not sufficient for clinically significant treatment.

Women received psychological help slightly more often than men – 5.9% had it once versus 3.5% of men, 2-3 times 3.6% versus 2.2%, 4 times and more 2.9% versus 1.1%.

Most of the IDPs received psychological support 3-4 years ago, despite the fact that in case of PTSD or other mental health condition there is a need for a follow up.

The most of respondents who utilised psychological services, **were satisfied** (40.8% satisfied and 19.5 very satisfied), while 12.5% expressed opinion that there were quite not satisfied, and 6.3%. 17.2% mentioned that they are 'neither satisfied nor satisfied'.

Urban/rural impact on seeking professional help. There was no correlation between the place of living and whether a person addressed or not for professional help. 11.2% of respondents who reside in regional centres have not addressed professional psychological help, while 14.1% informants from other cities/towns and 9.4% of those who live in countryside.

The professional support of those who have anxiety and depression. Among those who suffer from anxiety and depression **21.7%** of IDPs vs **9.5%** non IDPs received mental health support. This can be explained by bigger share of those who have mental health issues among IDPs and some services offered to IDPs. The level of satisfaction with a treatment among IDPs are 47% while among non-IDPs is 59%.

Psychiatric services

More IDPs have received psychiatric services than non-IDPs (3.6% versus 1.08%). Two thirds of the respondents who received treatment went to state clinics (66.7%), 20.5% to private clinics and 12.96 preferred not to say. The opinions about received services were divided – about half of the respondents were satisfied, while 24% stated that they 'neither satisfied not satisfied', and a slightly more than a quarter were not satisfied.

Mental health support for internally displaced people

Most of the IDPs who took part in a survey moved to government controlled areas in 2014 and 2015 (70.16% and 21.67%). 4.35% of IDPs were displaced in 2016, 1.81% - in 2017, 1.61% - in 2016 (0.4 – preferred not to answer).

About a quarter of IDPs confirmed that they were offered professional help to deal with mental health issues after leaving the occupied territories (Fig. 8).
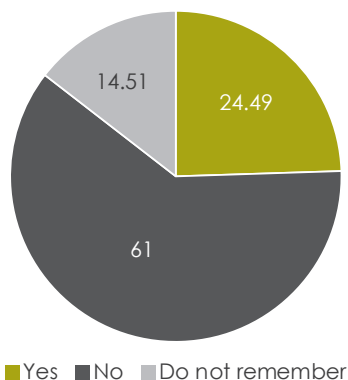

Figure 8. 'When you have just left temporarily occupied territories were you offered professional help to deal with mental health issues?' (%)

However, only 10% of respondents received professional help despite the fact that about a quarter were offered mental health support (Fig. 9). This can be explained by the fact that some of those who did not want to address professional help, did not have clinically significant mental health conditions which require special support, from one side, from the other side, it can result from a lack of understanding of the importance of professional mental help support. The increasing of informational campaign about mental health support which is available for IDPs could increase the number of those who received professional help.
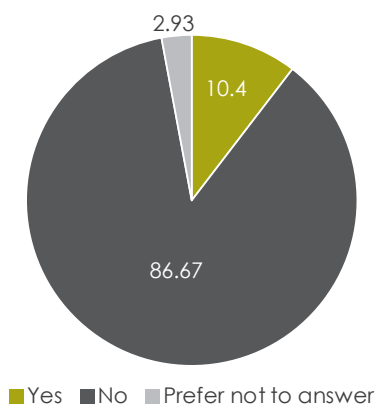

Figure 9. 'Have you received any professional help after you moved from occupied territories as a result of stress or any other mental health condition?' (%)

The most common reason to address professional help was anxiety (61.16%), coping with a loss (27.18). About one fifth of respondents mentioned insomnia (Fig. 10).
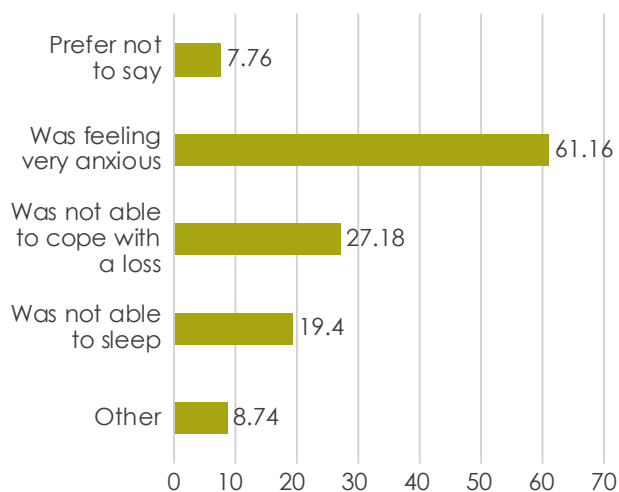
Figure 10. 'Can you share what was a reason to receive a professional help as a result of stress or any other mental health condition after you moved from temporarily occupied territories'? (%, multiply number of answers were possible)

The majority of IDPs who received professional help regarding their mental health conditions after displacement, had individual consultations 86.1%, while 14.9% had group consultations.

For half of those who received professional help regarding mental health issues after forced displacement, it was one time experience. One third of them had 2-3 consultations, and 12.74% - 4 times and more (Figure 11).
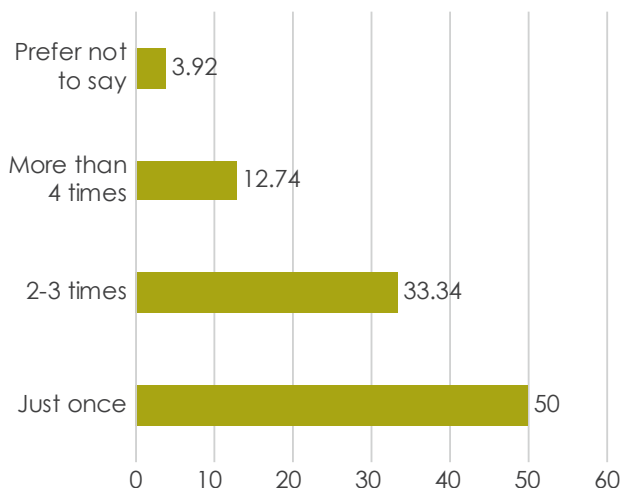
Figure 11. The frequency of receiving professional support with regards mental health conditions after forced displacement (%, among those who received help)

The majority of IDPs who received professional psychological help after displacement found it very useful (25%) or useful (50%), while over one

fifth of them stated that it was not helpful (22%) or not helpful at all (3%).

Over 95% of IDPs who received psychological help did not have to pay for it.

The level of satisfaction of a public health care in Ukraine

One third of the respondents approached medical help in state medical centres or clinics 1-2 times in the last 12 months, 13,5% - 3-5 times and 12.9% - more than 5 times (Fig. 12)
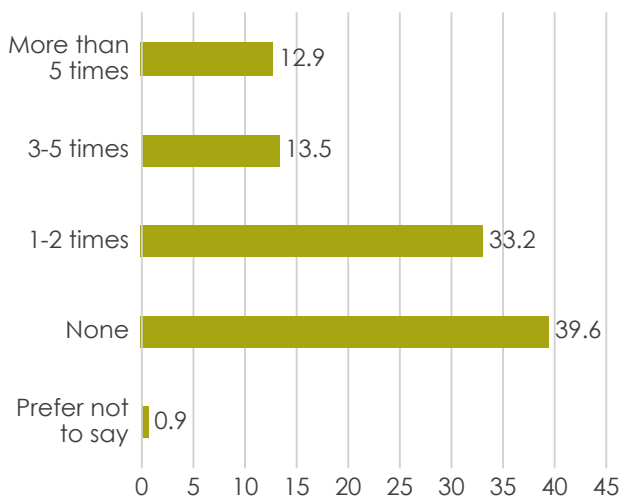

Figure 12. 'How often have you approached medical help in state medical centres or clinics in the last 12 months'? (%)

Patients who approached state health care institutions were asked if they are satisfied or dissatisfied with the state health care in Ukraine. There were more dissatisfied then satisfied patients. Only 2.4% reported that they were 'very satisfied', one tenth – 'satisfied', one fifth 'neither satisfied nor satisfied', 15.3% - 'quite not satisfied' and one tenth – 'not satisfied' (Fig. 13). There were no relations between the frequency of approaching medical help and the level of satisfaction by the state health care.

Respondents' suggestions on what can be done to improve the situation with provision of mental health support for IDPs?

The majority of respondents answered an open-ended question about what could be done to improve the provision of mental health support for IDPs (74.2%). The main response was that the provision of affordable, adequate accommodation, and the general improvement of living conditions, 16.67% of respondents, would
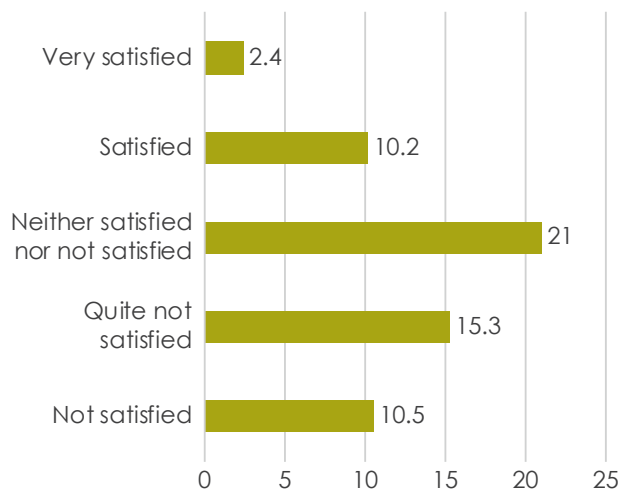

Figure 13. 'How satisfied or dissatisfied would you say you are with the state health care in Ukraine?' (%)

positively impact on mental health. As one of the respondents stressed, 'Living in a hostel especially two families in one room, the parents and children's mental health suffer, we were not prepared to that because used to live in our houses only with our family'. 15.48% stressed the necessity to develop accessible psychological support for IDPs, at low or no cost. Furthermore, there not only needs to be the establishment of such support but also they need to be widely advertised, alongside a societal change in perceptions around mental health. For example, one respondent said that there is the need to 'establish centres for support in all districts and explain to people (the general population) that this help is required not only for 'mentally ill' people'. Some respondents called for the regular monitoring of the mental health of IDPs, with some calling for this to be compulsory. Perhaps surprisingly, only 13.29% stated that their mental health will not be improved while the conflict is still continuing. Some people consider that providing more job opportunities could improve mental health (3.3%). Furthermore, respondents mentioned that improving the currently negative attitudes towards IDPs, providing access to pensions and voting rights is paramount. In short to improve the mental health of IDPs there is the need to 'establish conditions for normal life, provide voting rights, do not treat us as the dregs of society'.

Many people mentioned that for mental health support they would like to be able to have a right for a free access to a health farm (sanatorium). The improvement of health care access and free medication ,and increasing the quality of

medical services in general, is also seen as key. It is interesting to note that many IDPs stated that support for more informal practices would also be beneficial as it was noted that self-support groups and collective ways/spaces of coping with stress as community centres, church etc. were also important. They asked that, for example, the following would be useful

• 'organise more events for IDPs, different interesting meetings to enable people to go away from loneliness and isolation from the society';

• 'to organise picnics and fishing for IDPs, free cinemas';

• 'create a centre where not only a psychologist and psychiatrist but also where conditions just to relax'

Crucially, the precarious conditions of many IDPs, their lack of resources, and the necessity of coping with everyday issues are the principal barriers to applying for mental health support.

Coping with mental health issues

Among the most common tactics within IDPs and non IDPs to deal with long-term anxiety and stress are talking with friends (63.7%), music/films (45%), walking/hiking (35.3%). Alcohol and smoking are popular ways to deal with stress for 16.7% of informants, while addressing psychologists is amongst the least used practices with only 2.8% of informants approaching them,

higher only than the number who engage with healers (1.2%) (Fig. 14).
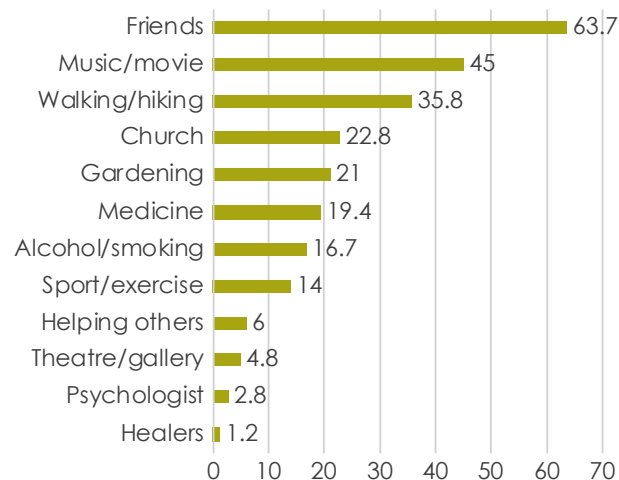
Figure 14. 'What do you usually do when you feel stressed or anxious for a long time?' (%, more the one answer)

There are some gender differences on the ways to cope with stress, firstly, it relates addressing to church – this is popular among one third of women but only 13.7 of men. Taking self-prescribed medicine is prevalent for women as well - 24.7% of them mentioned that they use medicines when feel stress or anxiety compared to 13.2% of men, while alcohol and smoking is more popular among men (27%) then among women (7.9%). Sport and exercise were named more often by men than women (17.8% against 11%) (Fig 15).

Tactics to cope with stress and anxiety depend on age as well. For example, the popularity of church going grows from 6.5% among 18-24 years
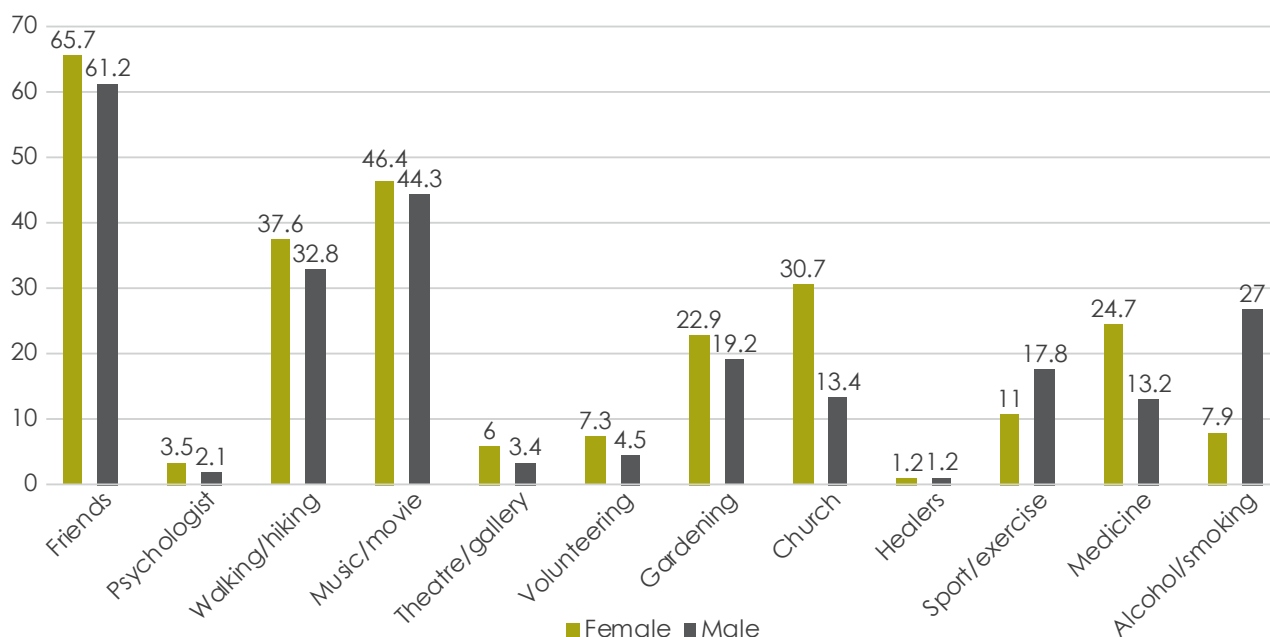
Figure 15. 'What do you usually do when you feel stressed or anxious for a long time?' (%, more the one answer, female and male)

old to 26.4% among elderly people. Gardening as an escape is considered more with an age as well – from 7.8% among young people while it is 26.8% among those who are in age category 45-54. The popularity of sport and exercise decreases with an age as 32.7% of people under 24 years old use this tactic compared to 4.7% among elderly people. Conversely, medication increases significantly with age (Table 1).

|	18-24	25-34	35-44	45-54	55-64	65+
Friends	77.8	70.8	68.3	67.7	51.3	52.3
Psychologist	1.3	2.3	3.2	1.6	4.0	2.8
Walking /hiking	39.9	40.1	38.4	31.1	28.7	32.3
Music /movie	65.4	56.7	48.6	44.7	35.9	32.7
Theatre /gallery	5.2	6.0	7.0	3.9	4.2	3.0
Volunteering	4.6	4.9	10.5	5.8	5.1	4.7
Gardening	7.8	16.9	15.9	26.8	21.7	25.2
Church	6.5	18.9	21.9	21.8	24.9	26.4
Healers	1.3	0.9	1.9	0.4	1.1	1.4
Sport /exercise	32.7	25.2	18.7	12.5	5.7	4.7
Medicine	4.6	9.7	12.7	13.2	17.9	36.7
Alcohol /smoking	17.0	17.8	18.1	22.6	14.1	11.6

Table 1. 'What do you usually do when you feel stressed or anxious for a long time?' (%, more the one answer)

Despite of a high level of mental health issues revealed among the population surveyed, the majority of respondents, including IDPs, think that they do enough to support their mental health (Fig. 16). This could be explained by cultural factors as many people still do not tend to link insomnia or anxiety to mental health conditions. The notion of 'mental health', as revealed in which interviews with IDPs and experts, is very blurred in public perception and has a great deal of stigma attached, thus at an individual level people do not want to link their health problems to it.
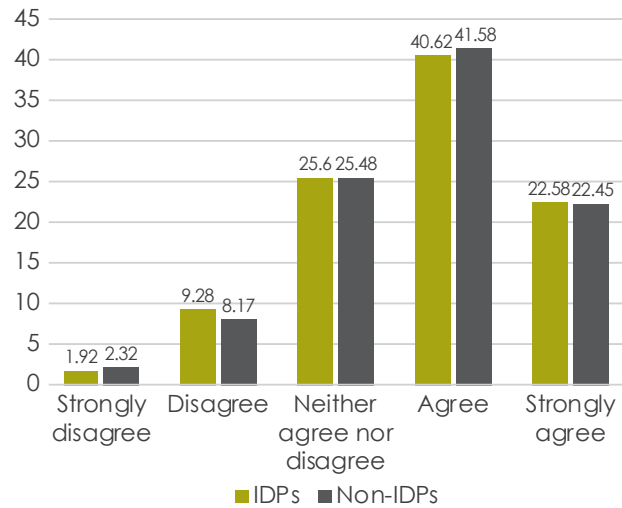

Figure 16. 'Indicate what you think: I do enough to support my mental health' (%)

PART 2.

RESULTS OF THE QUALITATIVE INTERVIEWS WITH EXPERTS ON THE SITUATION WITH MENTAL HEALTH IN UKRAINE

Factors of change

The majority of respondents note that issues of mental health in Ukraine became a significantly more popular topic of discussion after the social turmoil caused by a series of traumatic events, namely the events at Maidan in 2014, the beginning of the hybrid war, the Russian Federation's annexation of Crimean peninsula, the occupation of parts of Donetsk and Luhansk regions, and the associated death and injury and the forced displacement of over 1.5 million people from the region. The events of 2013-2014 can thus be seen as a borderline, after which a rethinking of mental health at all levels, from state policies to the practices of ordinary citizens, took place.

In general, even at Maidan, before the war, there was psychological assistance to Maidan victims – we had such family circles, mutual support groups. This is what started to reduce the level of distrust in psychologists and form an understanding that mental health was important. People suddenly realized that they were different before a traumatic event had happened to them; they understood that something was happening – Maidan, war, displacement, or that they were witnessing some events. They understand that they are not what they used to be but they don't understand what is happening to them (…). (R.1, psychologist, Caritas)

As a matter of fact, many things appeared after Maidan. Basically, Maidan was a trigger for many things, be it public or social sector, or health care. One example is the creation of Crisis Psychological Service, which was organized by specialists, mainly psychologists and psychiatrists, to provide psychological support to the participants of protest and offering them assistance. It has now become Association of Specialists on Overcoming the Consequences of Psycho-traumatic Events, which has a wide network across Ukraine and works in the East of the country, providing psychosocial assistance to local population, IDPs and military personnel. (R.16, psychiatrist)

The structural dimension of problems

Experts discussed that the largest problem around mental health support in Ukraine is the legacy of previous approaches and structure which placed a strong emphasis on psychiatric care and inpatient care as the main method of treatment. This means the resources are mis-allocated as expensive in patient care is not needed by many and, perhaps more importantly, people are afraid to engage with the system for fear of becoming institutionalized.

According to respondents state institutions were too slow to respond to the extreme conditions posed by the of socio-political crisis and war; they were unprepared for the new mode of works and did not have neither the knowledge nor the experience needed. However, these problems go beyond mental health as it concerns the overall systemic problems of state health care provision.

What does not contribute to mental health improvement? The bad organization of the system and insufficient level of specialist training, the level of health care in general – it does not help enhance mental health

awareness and its cultivation at a proper level. (R.16, psychiatrist)

Respondents also stressed the structural problems occurring in the interactions between different ministries, and the problematic redistribution of functions within state health care bodies, such as the irrational use of staff, work overloads, the poor organization of patient support systems and issues around the creation of appropriate medical records.

With regard to veterans, it is the turf of Ministry of Social Policy. They have information on where to go to get the assistance. This is something that state bodies lack when there is no interaction between ministries, between structures. There is no support and follow-up as if the clients had no official records. (R.13, psychologist, NGO)

The state 'lagging behind' in providing solutions in the mental health sphere is the reason for the rapid growth of civil sector in filling the gaps between state activities. However, this provision is often done not in a professional way with public sector representatives generally aware of the danger of amateur intervention in such issues and thus quite often they face a moral dilemma – the choice between provision of insufficiently qualified assistance or the unavailability of and assistance at all. This awareness of the constraints creates the demand for more active state response and intervention.

And of course, if we had state level reforms, that would be wonderful. We cannot be engaged in provision of specialized services, and they will not hire doctors, they will not make diagnoses, they will not hire psychiatrists as you need actual mandate and right for that. NGOs are not engaged in this, and there is nowhere to refer this to. There are no ambulances, no psychiatric examinations are taking place in the buffer zone. (R.9, Crimea SOS)

In the context of the intensification, and diversification, of mental health services provided by various organizations, questions were raised about management of such activities and the creation of appropriate legislative frameworks. This is another area where we see the state running behind the processes that are already taking place in society. On the one hand, this creates situations of disorderly activities of various organizations, and on the other hand, forms new practices of collective pressure on state structures to provide victims with comprehensive social support as psychological help alone will not be completely effective amid other problems that are unresolved (such as lack of housing or unemployment).

That is why there are services on the market that are unprofessional, manipulative and existing only for money making and building service system in such a way that a client becomes dependent on the specialist. This is not how it should be. Such activity must be licensed. The only question is how it should be licensed and who should make a decision about it. This person must not be engaged in corruption. It is a complex process, it needs management. It is necessary but nobody knows how it will happen. (R.13, psychologist, NGO)

Case management is a very effective response to work with IDPs who have many social problems together with mental health issues, however, it is not became a common practice in Ukraine yet.

Besides this, as an expert I understood that psychological help alone was not enough because people needed to solve a series of problems. And then we implemented case management method, that is comprehensive social support already ... There is a multidisciplinary team working with it. (R.1, psychologist, Caritas)

It must also be noted that the state response to these problems is partly driven by the level of public demand for such services, despite the scale of the issue in Ukraine demand, due to a number of social, cultural and economic reasons, still remains low.

In general, in our mentality we have no habit of seeking professional help when there are some problems and, respectively, these things are closely connected – a collective stereotype inside the state and the way a state functions. If people do not articulate the need for psychological assistance, the state does not see this sphere as a priority. We must perhaps start from the fact that people should change their mindset and admit that they need help

and that they can get help from a specialist. At the same time, a person will not be called sick, crazy etc. When this becomes a standard, the state will be able to respond in some way and start working to ensure that there is some kind of response. (R.9, Crimea SOS)

Professional environment

The increase in the demand for psychological services has raised a whole range of questions around the professional environment of psychologists and psychiatrists in Ukraine. In the context of this study, we examined the problem from inside the professional environment. The following are the key points raised by respondents.

Education and certification

Specialists noted several issues relating to quality of Ukraine's psychological education, for example, when state education they emphasized that it is too general and lacks specialization. Graduates thus have a general knowledge which is not converted into a specific patient / client work methodology.

All in all, I think that you are know that our psychologists graduate with a degree in "General Psychology". Our high education does not offer any specialization. At the moment, the only program, at least to my knowledge, that combines general psychology with in-depth study of CBT is offered at the Ukrainian Catholic University. But on the whole, all universities only teach general psychology, so when students graduate, they have only a general idea about psychology, counselling and its stages, which is not a method at all. (R.1, psychologist, Caritas)

In the context of the rapidly growing demand for psychological services there is, understandably, a lack of specialists. A number of international organizations responded to the conflict in Ukraine by providing workshops and training sessions for professional psychologists and public sector workers without a relevant education. Our informants confirmed the possibility of upgrading skills within such programs, both free of charge and/or for a below market cost. However, without appropriate structures, and oversight, this sudden expansion in

psychological training led to a supply of services of varying quality. The glut of graduates of short-term courses on psychological assistance has the potential to cause genuine harm as the average person cannot determine the value of their training. This is exacerbated by the lack of post completion oversight, or a functioning regulatory body

Firstly, you need relevant qualification, education, speciality you work in. But we have a problem in Ukraine that people submit false information or attend seminars, training sessions and courses only on paper. They are awarded with a certificate as a result but in reality they may have never been no that workshop or stayed there for two hours only just to get the certificate, and nothing else. (R.15, private psychologist)

The multitude of courses, adopting a wide range of approaches, as well as informal psychology education without any form of certification, has ensured a plurality of approaches that clients find difficult to navigate. This, in turn, means that there are issues around the suitability of the treatment provided, especially in regards to treating trauma.

Respondents also discussed how some of the methods now used have no academic basis but became popular because of myths and beliefs of the people using them and the growing commercialisation of mental health support.

Even among psychiatrists, there is no uniformity as to different types of treatment. Some say that electro convulsive therapy is normal, others say "coding" for drug and alcohol addicts is normal; there are those who use reflex therapy, acupuncture, manual therapy, osteopathy or else. (…) Some use massage caps which employ pneumatic pressing (…) in therapy of children with intellectual disabilities, they wear the caps that squeeze their heads and they say it cures them. We have many similar techniques that you cannot even call shamanism – it is something from the Middle Ages. (R 17, psychiatrist)

A further barrier is the financial accessibility of training as specialists are obliged to pay for professional knowledge. The fee is partly covered by international foundations, but there is still a

need for a significant financial contributions into one's own professional growth.

Quality of services

Interviewees highlighted numerous problems around the quality of service provision including;

- The lack of professional education in the sphere of mental health and the expensive professional training required for mental health specialists;

- The 'blurring' of the profession due to the influx of people who received certificates for completing short-term courses or training sessions;

- Obsolete protocols;

- The non-compliance with certain standards and ethical norms by certain psychologists;

- The insufficient use of evidence-based medicine.

That is because we had specialists with very different background, who used methods they knew. We did not have a single approach, we had WHO recommendations that clearly say: at this stage you should use stroke, after that you should talk, this you should not touch upon, only talk about this. (R.1, psychologist, Caritas)

Psychologists made mistakes. They, for example, worked with trauma, and they did it in such a way that the patient was traumatized again instead of getting help. You should understand and such things should also be taught. If we have little time, we cannot do such things. (R.15, private psychologist)

Another significant reason for the poor quality of psychological services was the 'blurring' of the profession due to the influx of non-profession people who provide treatment on the basis of completing short-term courses or training sessions.

These problems pertain both to state organizations and NGOs when NGOs can offer their services without being professionals in the field. (R.13, psychologist, NGO)

According to experts the unprofessional promotion of psychological knowledge, caused by the increased social demand for relevant information, has had significant negative impacts. The increased discussion of psychological topics, coupled with misuse of professional terminology by people without relevant education, spread simplistic visions of complex problems and has resulted in the misleading use of certain terms. For example, the term PTSD has erroneously been used to label large groups of people affected by the conflict latter, resulting in it turning into a stigma.

Science, especially the science of psychology, in Ukraine is not so developed and, unfortunately, there is no tradition of research. What I know about world studies, the way I was taught, is that everything was considered the notorious PTSD. There was a period in history when every mental disorder was called schizophrenia. With us, during the war everything was called PTSD. You heard it on TV, from ministers who said that most people has PTSD. That was not true as it is a specific disorder with its diagnostic criteria, it's not just, "I saw the war which means I have PTSD." People did not quite understand it, they heard the term, began to use it and somehow such a myth appeared. Thank God, we have already passed this stage and we do not call all disorders PTSD. (R.1, psychologist, Caritas)

The issue of professional burnout

The traumatic nature of the work, especially in the first years of the war, and the often extremely difficult working conditions, has led to high levels of professional burnout. Often the work was exhausting, due to the issue's scale, and the appropriate tools and support were normally not available. Given the number of people requiring treatment there was not the capacity for professionals to have supervision or 'someone to turn to', it was difficult to maintain appropriate boundaries with patients given the often ad hoc nature of the treatment and there was often little professional reward. The latter was due to the fact that patients would often not be able to have a full course of sessions, due to demand or people moving to different regions, which meant that problems were often not fully explored and the benefits of the work was not visible to the professional. The exhausting nature, of the often unpaid, of the work, coupled with a lack of reward/appreciation, led to the

burnout and traumatisation of many people providing psychological services.

I meet so many people with a severe emotional burnout, who come from different spheres – from service providers who help IDPS to IDPs themselves. All the consequences of prolonged chronic stress become apparent. And if in 2014-2015 people managed to hang in there somehow – there were many breakdowns, many severe situations that were, however, associated with acute trauma, then in 2016-2017 it is rather a depressive state, bordering on nervous exhaustion. (R.12, a psychologist, a psychotherapist, Humanitarian Human Rights Organization employee)

Well, I've lost my health and I could not walk for two years. I paid a very high price. And I saw my family and my little child suffer as I was lying in my bed and could not get up. I realized that I would never be able to stand on my feet because nobody could cure me. Well, I do not want to experience it again. I want to do my job for a decent salary and spend my time there when I want it, I can and I have been asked to. That's what I do. I mean something that does not bother me. I have my own resources. This awareness comes with time. I have done a lot for my country doing what I did, a lot during all those years. (R.15, private psychologist)

The cultural difficulties in providing treatment

Another problem that has emerged in the professional environment, in the context of the social and political upheaval is the 'ideologization' of services provision. This can be traced from patients as well as between professionals themselves. Specialists who provided services without classifying people according to their political affiliations, and language preferences, were often forced to outline their own position and explain any supporting material (for instance why it is in a particular language). The high level of societal distrust, and the practice of 'searching for enemies', meant that there was a high level of distrust of the 'neutral' psychologist.

We worked with people regardless of their belonging to one camp or the other camp. That is, we do not have the right to classify

people. I mean, a psychologist, is apolitical unambiguously, like a doctor. So many started, for example, asking why we were speaking either Russian or Ukrainian to them. We distributed a lot of booklets so that they could at least read, at least look through, and we left our telephone numbers for them to call us. There were also questions, such as, "why is there only information in Russian, we want to have it in Ukrainian language, we love Ukraine", and vice versa, "why is information in Ukrainian only, we want it in Russian", "who are you, and which side are you on, what if you collect this information, and then you pass it somewhere and we will have problems." This fear was present in the minds of people there because there is no stability, nothing is clear, their eyes were full of fear, yes, crazy fear, especially if people lost their loved ones because of the events. It was really very difficult". (R.6, psychologist, work at the state institution, used to volunteer in the zone of military conflict)

Target audience and recipients of services

Respondents noted that there are numerous cultural issues around mental health in Ukraine which impacts on why people do/don't seek treatment, how they understand the treatment that they are given and how they are perceived in society for addressing their mental health issues. This includes;

1) The fear of stigmatization through diagnosis

…While it is possible to bring somebody to a psychologist, psychiatrists or drug therapists are the ones that people fear like the plague. When they do come to seek help, it means they have reached their limit. It is already a branding iron, a stigma, and even if the psychiatrist says that it is not a mental disorder but the result of fatigue or trauma after some shocking event, a visit to this doctor becomes a stamp as you were seeking help of a psychiatrist, which means that something is wrong with you and people can expect anything from you. And very often inadequate behaviour, which is absolutely not conditioned by mental pathology, in everyday psychology is explained by craziness. Why did he do that? – Oh, he's just crazy. – Well, it is

clear now. (R.3, psychologist, lecturer at high education institution)

2) The general culture of education around well-being within society, which sees mental health as a secondary thing and psychological problems as weakness

Well, because they also perceive psychologists as, let's say, punishment, they do not want to admit existence of some personal problems, admit their weakness, or psychological impotence. That is because there is no culture. (R.6, psychologist, works at the state institution, used to volunteer in the zone of military conflict)

3) The prevalence of self-treatment practices in physical and mental health in the Ukrainian society

Many of us use unproven methods of treatment, homeopathic remedies, psychotherapy of unknown origin, some medication that the representative of this or that foreign or Ukrainian pharmaceutical company has recommended. People can also go to shamans, whisperers, and fortune-tellers. (R. 16, psychiatrist)

There is a lot of information on the Internet, and people are busy doing self-diagnostics, er... practically as in Jerome K. Jerome's story, when they diagnosed all kinds of diseases, except for maternal fever, probably)) yes ...something like that. Well, there are many fears concerning mental illnesses, the fear of going crazy and fears of disclosure, that someone will say something to someone somewhere, and it will become known somehow. (R.11, private psychologist)

4) Solving psychological problems in the family, without seeking external help from people or institutions

It seems to me, this topic is only becoming popular, although there are many psychotherapists and people who normally understand what the mental health is, but the culture of going to psychologist or therapist, or seek help from a person who is not your friend, companion, mother or someone else, is

practically absent. (R.3, professional working with victims of GBV)

5) A lack of understanding of the need for long-term work with a specialist, the desire for a quick effect, elimination of symptoms as if treated by medications

You will not seek help because you do not trust anyone. The first visit does not help or helps for a short period of time, and the person loses faith that it is possible at all. Sometimes such psychotherapeutic work may take some time, not necessarily a couple of years, but it is very difficult to predict the result in this work, it is so not obvious, sometimes the changes are invisible, but get accumulated – all this generates such distrust. "I visited a specialist several times, and it did not help me, so it does not work at all." (R.13, psychologist, NGO)

6) The lack of availability of high-quality psychological and psychiatric services, for vulnerable groups in particular, and the high cost of such treatment

I think, it is possible to speak about the financial part, because a visit to psychotherapist costs approximately 500-600 UAH – such is the average price. Even if a person realizes that they have a problem or difficulty they want to work on, they understand that one session will not be enough and the expenses, even 2 sessions per week, multiplied by 4, mean half of their monthly salary, for example. And this is also a difficult question. This is a matter of priorities. And mental health is not a priority. Top priorities include food, walking, and a million different reasons that are more important. (R.3, Professional working with victims of GBV)

Therefore, too often people reject the idea of contacting a specialist for as long as possible for cost reasons until reaching a moment of crisis.

RECOMMENDATIONS

Based on the survey results, and the suggestions of experts on improving mental health care, we suggest a number of recommendations which aim to increase the awareness, and understanding, of mental health problems in Ukraine and to improve the quality and accessibility of mental health care services;

1) Create stronger links between institutional support and that of the private sector – with the inclusion of family doctors into the mental health provision sphere

2) Introduce a licensing system for those undertaking psychological provision and bring together professionals and communities to develop innovative approaches in mental health care

3) Improve the accessibility of services – especially for IDPs

4) Ensure that gender and age specific approaches to supporting mental health are developed and well publicised – the State to lead a cultural shift on reducing stigma around mental health issues

Combined these should inform the Concept of Mental health development in Ukraine 2030, especially the components of the reforms on the 'development and implementation of mental disorders prevention programs', the 'elimination of barriers in access to rehabilitation and social services for persons with mental and intellectual disorders', and 'strengthening the role of the public sector in mental health'. Overall, it will contribute to the Concept's goal on the 'reduction of direct and indirect losses of the national economy dues to total or partial disablement of persons with mental disorders'.

1) Create stronger links between institutional support and that of the non-commercial and non-governmental sector – with the inclusion of family doctors into the mental health provision sphere

Almost all experts stress the necessity of developing systemic and integrated approaches to mental health provision in Ukraine. The latter can be achieved through creation of a new system of mental health utilization, bringing together psychiatrists, psychotherapists and psychologists representing both public and private sectors, with the involvement of all stakeholders (public, patients, NGOs, professional community, institutions of psychological and psychiatric education and advanced training, international organizations, etc.).

Crucial is the creation of a system with more structured state institutions and a flexible private sector. The latter, due to its ability to adapt quickly to new trends and its purpose of providing a rapid response to emergency events, constantly searches for new methods and tools, and provides the basis for building communication both within the professional environment and with the general population. In co-operation with NGOs such a sector would enable a culture of continued learning and finding ways to talk about complex topics with different audiences, etc.

It is also necessary for there to be closer relationship between the private sector and the state provided social service provision. This would enable an integrated approach to working with different categories of people to develop, especially in relation to those in a difficult life situations, the support of whom should be the within the sphere of social service institutions in parallel with psychological support. In short the providing of institutional services, such as better housing etc, combined with psychological support, is the only way to address the country's mental health crisis.

Family doctors can become an important link in this system, and their professional knowledge should be expanded to include mental health diagnosis and support. As a result, they will be able to evaluate patients' mental conditions, including anxiety and depression, and refer them to a specialist at district, regional medical facility or community centre if needed. In this way, it is possible to overcome the problem of 'periphery' – territorial accessibility of psychological and psychiatric care. There are numerous international standards, such as those included in our survey, that can easily be utilised, at little cost, to transform the mental health provision provided by family doctors.

2) Introduce a licensing system for those undertaking psychological provision and bring together professionals and communities to develop innovative approaches in mental health care

An important component of change should be the licensing of psychological care services. This is a manifestation of the desire for certain standardization in the provision of services, the need for greater communication within the professional community to coordinate vision and actions, the spreading awareness of the need for protocols, and keeping to the principles of evidence-based medicine. An important point is changing the approach to the remuneration of public sector professionals; otherwise we have a situation where high-quality specialists do not work for crisis services, as private practice is financially more attractive for them. Experts believe that a strong hierarchy, and a long non-transparent process of decision-making, often eliminates innovators from the possibility of influencing the course of reforms. The additional point is passiveness of the community itself, its segmentation (especially in the field of private practice), as well as the generally low level of knowledge of foreign languages for expanding cultural and professional exchanges. Accordingly, it can be considered as one of the directions for further work on transformation of the professional environment and the principles of interaction in it.

3) Improve the accessibility of mental health services – especially for IDPs

Ukraine's mental health system lack transparency is not clear for the clients,

which makes the procedure for seeking overly complicated. There needs to be the creation of simple and clear 'points of entry' into the system of psychological help, a focus on the observance of consumer rights in mental health and making access as comfortable as possible (to minimize the client's fears concerning stigmatization, incorrect rhetoric towards the patient, violation of privacy, etc.). The accessibility of mental health should be considered in financial, territorial and qualitative aspects;

Financial accessibility can be formed through the introduction of a common system of health insurance, which would provide compensation of the expenses for both physical and mental health.

Accessibility of high-quality services and overcoming the phenomenon of 'periphery' is possible by including appropriately trained family doctors who can determine the need for referral to a relevant psychological assistance specialist (this could be done by a mobile phone style application).

An additional component of this system should be hotlines, which by virtue of their organization give a person a comfortable indirect and anonymous way of communication with a specialist and can mitigate critical states (for example, suicides), or guide the client toward further actions. In addition to 'hotlines', an information database of local specialists or institutions should be created, which a person who needs such services can freely use. The drop-in mental health support centres can be created for group and individual therapy and informal community meetings and events.

Considering the high proportion of IDPs having clinically significant levels of anxiety and depression (20.2% and 25% retrospectively), it should be ensured that they can receive mental health services for free and in the district where they now live. The situation when only one fifth of those who have extremely serious conditions received professional help, which in most cases was limited by the one visit, cannot be allowed to continue.

4) Ensure that gender and age specific approaches to supporting mental health are developed and well publicised – the

State to lead a cultural shift on reducing stigma around mental health issues

As recent years in post-Maidan Ukraine have shown the positive promotion of mental health is of great importance. An increase in the demand for psychological services in the event of social upheavals has generated a demand for relevant information, which the people are trying to find in different ways. The ways in which people do this depends on their age, gender and financial status, thus its promotion such be achieved in respect to this. For many the **Internet** is the most convenient source of information, and the State should take advantage of this. It can be used to promote a more positive image of seeking help for mental health problems, signpost help and support and provide some basic diagnostic tools. **Online courses**, aimed at developing general mental health culture of an ordinary person with an important emphasis and motivation to go to a specialist in case of anxiety concerning one's own health, can also be very helpful. Numerous specialists have their own profiles, and provide information on their own qualifications, specializations and contact details. However, there needs to be a regulatory framework which can guarantee the validity of this information. For people who do not have computers and Internet access, **booklets** with basic information about convenient and accessible "entry points" to mental health system remain relevant.

The State has a key role to play in the de-stigmatization of mental health issues in the country. There needs to be a cultural change through which mental health problems can be much more easily discussed and that people are encouraged to seek assistance at a much earlier point than commonly happens currently. This could be achieved through programmes such as national a 'Mental Health Awareness Week', social media campaigns and discussions on high profile television programmes. The use of media/sports personalities to lead such campaigns has proved very successful in other countries. Preventative approaches, such as promoting Mindfulness, help to reduce stigma and can provide an early intervention to the stresses of everyday life before they turn into mental health issues. It should be a national priority to target men who are at risk of suicide as Ukraine has the seventh highest suicide rate in the work for men compared to the 81st highest for women.

This is an extremely complicated issues but as the report shows young men tend to turn to sport and exercise to relieve stress more than women – therefore, fitness centres could be effective places for informational campaigns and the provision of details of how to obtain help in a crisis situation.

The analysis of the coping tactics used by IDPs suggests to **develop gender and age sensitive approaches** based on the already popular ways which are used by people to cope with stress and anxiety. For example, the survey revealed the important role of church in coping tactics for many of elderly women, therefore work could be conducted in churches and religious organisations, where people could receive information people about mental health support and training and support sessions could be held there as well. Fitness centres could be effective places for informational campaigns for young people.

As the research showed, elderly people in most cases do not use music/movies, sport and exercise in their copying tactics. Partly, it can be explained by the high price of these activities but partly because of their cultural peculiarities. However, these approaches can be effective and developed even with limited resources. For example, there could be organised cinema clubs in cultural centres or in churches, where elderly people could not only watch something but socialise as well. Fitness centres should be advised to make discounts for those who are retired and make some special programs for the elderly. Walking and hiking are amongst the most popular ways of coping with stress and anxiety both for women and men of different ages. This is important to keep in mind while developing mental health support. Communal urban gardening can be an effective way for copying with stress especially for those who cannot have dacha especially for elderly IDPs left their gardens behind. It is important to continue informational campaigns on Gender Based violence and increase awareness of it among different social groups. Art galleries, libraries, museums and theatres play an important role in community programs for supporting mental health for different age and gender social groups across Europe. It will be beneficial to establish cooperation with cultural and arts institutions for initiating public discussions about mental health and informing about such common conditions as anxiety and depression.

RESEARCH LIMITATIONS

The research has several limitations which can affect the conclusions and recommendations. Firstly, the focus on assessment was limited to depression, anxiety, hope and coping tactics. Secondly, it regards only the mental health of only adults. Thirdly, because visiting the so-called 'grey zones' are against UK FCO advice the research was not conducted there although via secondary data and interviews with practitioners we fully understand that mental health is very much affected there, and the access to health care and psychological support in these regions is very limited. Fourthly, understanding the role of alcohol in mental health disorders and as one of the common cause of death, however, in this assessment we were not able to explore this issue in detail which will require a separate study. Fifthly, because the most of IDPs moved to government controlled areas in 2014, it is impossible to conduct a retrospective analysis to ascertain the percentage of those who had clinically significant mental health conditions prior to their displacement.

This assessment focused on an evaluation of the mental health of the general population and IDPs, and practitioners' opinions on the organisation of mental health support. However, it was outside the project's scope to explore the financial and decentralisation aspects and it did not have a specific focus on public health aspects either. The analysis of these aspects can be found in the aforementioned 2017 World Bank report.

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ABOUT THE AUTHORS

Dr Irina Kuznetsova works in the School of Geography Earth and Environmental Sciences. Her research currently focuses on issues around forced displacement as a result of the current conflict in Ukraine. Her research expertise includes migration, health, and critical urbanism. Recently Dr Kuznetsova had a research on everyday experiences of Central Asian migrants in Russia (with Dr Round) and also on social justice in health care access. She also leads a project on mental health of refugees in urban areas in Kigali and Lagos, and co-investigator in Horizon2020 project on the impact of migration on rural communities.

Prof Oksana Mikheieva is a chief of Department of Sociology, Lviv Catholic University, Ukraine. Prof Mikheieva conducted several studies regarding IDPs and former militants including the current AHRC project 'Ukraine's hidden tragedy: understanding the outcomes of population displacement from the country's war-torn regions', and also "Homo militants": in-depth qualitative semi- structured interviews with pro-Russian rebels, Ukrainian military officers and experts» (supported by the British Council Ukraine and "Ukrainian peacekeeping school", PI), The European social policy and models of social partnership, 2011-13 the Jean Monnet Program" (one of the authors of syllabus and textbook) among others. In 2015 she was Eugene and Daymel Shklar Research Fellow at Ukrainian Research Institute, Harvard University.

Dr Jonathan Catling is a Chartered Psychologist, a Counsellor and Cognitive Behaviour Therapy practitioner. He has research interests in the field of resilience and the delivery of talking based therapies through new (mobile based) technologies. Dr Catling works in the School of Psychology at the University of Birmingham.

Dr John Round works at the School of Geography, Earth and Environmental Sciences at the University of Birmingham. He has worked extensively on how marginalised households develop coping tactics in response to socio-economic marginalisation in Russia and Ukraine. His most recent project, in collaboration with Dr Irina Kuznetsova and funded by the Open Society, examined the human rights abuses that Central Asian migrants face on a daily basis in Russia. This includes the barriers that they face when trying to access health care and the tactics they employ to find alternative health interventions and is framed through the use of the Necropolitics concept to critically evaluate the role of the state in these processes. His research is qualitatively based and draws upon the theories of everyday life developed by Lefebvre and de Certeau. Dr Round is also co-investigator in a project on mental health or refugees in urban areas in Kigali and Lagos, and in Horizon2020 project on the impact of migration on rural communities.

Dr Svitlana Babenko is Associate Professor (Docent) at Social Structures and Social Relations Department, Head of MA program Gender Studies, Faculty, of Sociology Taras Shevchenko National University of Kyiv, Kyiv, Ukraine. Her recent project included 'Ideological and Political Cleavages in Ukraine' by FAFO Institute for Labour and Social Research, Oslo (position: participant, 2014), 'Comparing Demographic Trends and Labor Market Fluctuations in Ukraine and Slovenia during the period 2000-2014' (position: Analyst 2013-14), The World Bank Report 2013 'Jobs' (Position: team member for the case-study on Ukraine 2012-13), Health in Time of Transition (EU FP7-Health – HITT) (Position: team member, analyst 2010-12).