



# THE PATH TO EFFECTIVE PSYCHOLOGICAL SUPPORT FOR SERVICE MEMBERS OF THE ARMED FORCES OF UKRAINE:

An Integrated Perspective on Challenges  
and the Search for Viable Solutions

Report on the Study Results

The study was conducted as part of the project “Strengthening Capacities for the Provision of Complex Rehabilitation Services in Ukraine”, financed from the Lithuanian Fund for Development Cooperation and Humanitarian Aid (including targeted contribution of the Ministry of National Defence of the Republic of Lithuania) and implemented by the Lithuanian Central Project Management Agency (CPMA). The study report reflects the position of its authors and may not coincide with the views of CPMA.

For the main illustration, a photo of the 503rd Separate Marine Battalion was used.  
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# ABBREVIATIONS

<b>BGMT</b>	Basic General Military Training
<b>CSCG</b>	Combat Stress Control Group
<b>OPSRG</b>	Ongoing Psychological Support and Recovery Group
<b>HCF</b>	Healthcare Facility
<b>AFU</b>	Armed Forces of Ukraine
<b>CMU</b>	Cabinet of Ministers of Ukraine
<b>(I)CBT</b>	(Internet) Cognitive Behavioral Therapy
<b>NaUKMA</b>	National University of Kyiv-Mohyla Academy
<b>NHSU</b>	National Health Service of Ukraine
<b>MoH</b>	Ministry of Health of Ukraine
<b>MoD</b>	Ministry of Defense of Ukraine
<b>NGU</b>	National Guard of Ukraine
<b>TC</b>	Training Center of the Armed Forces of Ukraine
<b>MGP</b>	Medical Guarantee Program
<b>PPS</b>	Personnel Psychological Support
<b>PTSD</b>	Post-Traumatic Stress Disorder
<b>CEA</b>	Central Executive Authority
<b>VR</b>	Virtual Reality (VR-based technology)

# Introduction and Problem Statement

Despite the growing attention to mental health issues in the military sphere, the mental health support system for the AFU service members which would ensure timely access to high-quality and appropriate services is still in the process of development and reform. In practice, the provision of assistance often depends on individual commanders, the enthusiasm of particular specialists, or volunteer initiatives. This creates inequality in access to support and also limits its effectiveness. The study ‘The Path to Effective Psychological Support for Service Members of the Armed Forces of Ukraine: An Integrated Perspective on Challenges and the Search for Viable Solutions’, the results of which are presented in this report, aims to systematize existing practices, identify their strengths, and uncover barriers that hinder their development.

**STUDY OBJECTIVE:** A comprehensive examination of the existing mental health support system for AFU service members and its ability to ensure access to quality services. This includes an analysis of current policies and organizational mechanisms, as well as the study of barriers and facilitators

that affect the accessibility, acceptability, adequacy, and effectiveness of mental health services from the perspectives of both providers and recipients.

Despite the absence of a single regulatory document that would align all services within an integrated mental health support system for service members, this study uses the term ‘system’ in a broad analytical sense – as the totality of institutions, policies, and practices in the military, civilian, veteran, and community sectors that provide mental health services for service members.

When defining the **scope of the study**, it was important to examine all existing areas defined in the new AFU Psychological Support Doctrine, such as psychological diagnostics, psychological readiness training, ongoing psychological support, and psychological recovery. However, we chose not to limit ourselves to these alone, therefore we also studied access to outpatient and inpatient psychiatric treatment, psychological assistance during physical and medical rehabilitation, and comprehensive medical-psychological rehabilitation of service members in civilian health-

care facilities, as well as all types of psychological assistance to AFU service members in the social, veteran, and community sectors.

**STUDY SUBJECT:** Facilitators and barriers that affect the availability, acceptability, adequacy, and effectiveness of mental health support services from the perspectives of both providers and recipients.

**Target Audience of the Report:**

The study results are intended for various target audiences involved in the development and functioning of the AFU mental health support system:

**TARGET AUDIENCE OF THE REPORT:**

The study results are intended for various target audiences involved in the development and functioning of the AFU mental health support system:

**Department for the Psychological Support of Operations of the Ministry of Defense of Ukraine and the Main Department of Personnel Psychological Support of the AFU:** to provide strategic leadership in developing the AFU psychological support system and create conditions for coordinated functioning of psychological service units.

**Mental Health Coordination Center of the Cabinet of Ministers of Ukraine and the Ministry of Health of Ukraine:** to develop a unified policy, i.e. coordinate central executive authorities and community sector initiatives, standardize services, create a systemic

framework for integrating military and civilian sectors, support cooperation with international organizations, and raise additional funding.

**Professional experts and mental health service providers** (in the AFU, healthcare system, veteran policy sphere, social sector, as well as in the private and community sectors): to improve access to high-quality service member-oriented services aimed at developing new and improving existing treatment protocols, diagnostic tools, and training program content.

**Donor organizations:** to direct investments into areas with the greatest impact, i.e. staff training, supervision, quality monitoring, scaling up effective models, and infrastructure development.

**Military commanders of all levels:** to build mental health support processes in units, strengthen leadership, and create ‘fast-track pathways’ without any unnecessary bureaucracy.

**Opinion leaders and the media:** to further destigmatize help-seeking and foster positive attitudes toward mental health in society in general and in the AFU in particular.

**Service members and veterans:** to strengthen their own agency in caring for mental health, advocate for positive change, deepen their understanding of how the system functions, and clarify expected outcomes at every stage.

## STUDY TEAM

The study was conducted by the experts from the NaUKMA Mental Health Center in cooperation with experts from the Human Rights Center for Military Personnel and Veterans PRYNCYP and the Ministry of Defense of Ukraine.

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## Study Methodology:

The study consisted of two parts, namely:

1. Desk study, which included a review of already available information from open sources (regulatory acts of the Ministry of Health, Ministry of Defense, Medical Forces Command, Cabinet of Ministers of Ukraine, academic publications, reports, analytical papers, government websites, etc.).
2. Qualitative study through semi-structured in-depth interviews, followed by thematic analysis of the obtained data.

At the final stage, findings from the desk and qualitative stages were synthesized to triangulate data, identify discrepancies, and integrate diverse sources.

To identify the components of the psychological assistance/rehabilitation system, its levels, and theoretically possible patient pathways, we collected and analyzed information from the following sources:

### DESK STUDY STAGE

To identify the components of the psychological assistance/rehabilitation system, its levels, and theoretically possible patient pathways, we collected and analyzed information from the following sources:

- Laws of Ukraine, regulatory acts of the Cabinet of Ministers of Ukraine, Ministry of Defense, Ministry of Health, Ministry for Veterans Affairs, Ministry of Social Policy, General Staff of the AFU (Appendix 1)

- Publications and reports from other assessments and studies (Appendix 2)
- Publicly available data sources (including the NHSU)
- Other documents (letters, project reports, work plans, standards, protocols, analytical papers) when available.

Documents were obtained through requests to stakeholders, as well as searches and reviews of resources publicly available online, including websites of CEAs, NGOs, projects, service providers, etc.

The documentation analysis aimed to study the regulatory foundations of the psychological assistance system, its structure, areas of responsibility of state agencies and service providers, types of services, and categories of citizens entitled to receive them. Special attention was paid to types of assistance/services not fully regulated

by law (for example, projects implemented by NGOs).

The desk study results were used to develop guides for in-depth interviews.

## QUALITATIVE STUDY STAGE

### Format

Semi-structured interviews were held online or by phone by interviewers residing in Ukraine. Interview participants could be permanent residents or temporarily located in different regions of Ukraine under government control.

### Participants and sample

A total of 49 respondents were engaged in the qualitative stage, including service members, military medical personnel, HCF service providers, NGO representatives, and experts (Table 1).



**Table 1:** Socio-Demographic Characteristics of Qualitative Study Respondents.

<b>AFU service members, total</b>	<b>16</b>
Sex:	
Male	13
Female	3
Age:	
18–32 years old	8
33–47 years old	6
48+ years old	2
Rank:	
Enlisted	6
Junior sergeants and starshinas (sergeant majors)	5
Senior sergeants and starshinas (sergeant majors)	2
Junior officers	2
Senior officers	1
<b>Mental health service providers, total</b>	<b>23</b>
Male	15
Female	8

Type of provider:	
Chaplains	2
NGO psychologists	3
Deputy commanders for moral and psychological support of operations	2
Officer-psychologists	2
Combat stress control group officers	2
Ongoing psychological support and recovery group officers	2
Company combat medic	1
Brigade medical service chief	1
Military hospital physician	1
Psychiatric hospital physicians	4
Mental health center physician	1
Physicians of recovery and rehabilitation facilities	2
<b>National-level experts, NGO representatives</b>	<b>10</b>
<b>Total</b>	<b>49</b>

Respondents for the qualitative study were identified by experts from NGO Pryncyp together with the project study team. When forming the sample, we ensured maximum representativeness (age, sex, veteran status, etc.) and diversity of perspectives and experiences in providing or receiving psychological services. Representatives of NGO Pryncyp contacted participants, provided brief information about the study, and obtained consent to share contact details with the interviewers. Before the interviews, all participants received information on the study's purpose, risks and benefits, rights protection measures, the interview process, and personal data management. Potential participants also received a link to the electronic informed consent form. At the start of the interview, the interviewer read the information booklet with the key study information aloud and answered any questions from the respondent. Afterward, verbal informed consent was obtained from respondents regarding their readiness to participate in the study.

The study protocol was approved by the NaUKMA Research Study Ethics Committee (decision of June 9, 2025, protocol No. 8).

#### **Data collection procedure**

Semi-structured online interviews with respondents lasted up to 90 minutes. At the beginning of each interview, brief sociodemographic information about the respondent was collected using a questionnaire.

The interviews were conducted according to thematic guides, with follow-up questions added as needed. Thematic guides were adapted to the context and the respondent's type/experience/expertise in order to ensure the consistency and coherence of the interviews. The interview guides were developed based on the results of desk study and prior piloting.

The interviews were conducted in the respondent's native language by a trained interviewer. The interviewers were recruited from among NaUKMA staff members who had experience in research on psychosocial

support and mental health. The interviews were audio-recorded with the respondent's consent. The interviews were conducted with due regard for the safety, comfort, convenience, dignity, and confidentiality of both the respondent and the interviewer. The audio recordings were stored in NaUKMA's secure cloud storage and were deleted immediately after the completion of the study by the project team.

### **Qualitative data analysis**

Qualitative data were transcribed for further analysis, which took place in two stages. The first stage included a deductive analysis, which involved coding data units in accordance with the framework analysis method using predetermined categories (accessibility, acceptability, appropriateness, subjective effectiveness), and in line with the theoretical Consolidated Framework for Implementation Research (CFIR) (contextual characteristics, organizational structure and processes, provider characteristics, intervention characteristics, as well as barriers and facilitators to implementation). The second stage included an inductive analysis, during which new themes or unexpected findings were identified through coding and categorization, in line with the study's goals and objectives. The data analysis was carried out using software Dedoose version 10.0.35, for which NaUKMA researchers hold an official license.

### **Quality assurance**

The quality of the interviews was ensured in the following ways: First, the interviews were conducted by researchers with experience in applying qualitative study methods. Second, the interview guides were developed through a careful process that included expert consultations, group discussions, and piloting to ensure the relevance, and appropriateness of the guides. Third, the transcription and

analysis processes included group discussions among interviewers and other members of the analytical team, which fostered shared understanding and helped avoid subjectivity and bias. Fourth, we applied a transparent process of analysis. It was supported through triangulation (i.e., comparison with other data sources). Fifth, the report contains a section on the study's limitations to explain its potential shortcomings. Finally, the qualitative study was based on agreed-upon principles of good practice, including transparency, comprehensiveness, reflexivity, adherence to ethical standards, and systematicity.

### **Results validation**

After completing the process of data analysis for both the desk and qualitative stages, the results were presented and discussed with experts from the NGO Pryncyp. The next step toward triangulating the data was the two online workshops lasting 4 hours (9 participants) and 2 hours (5 participants) with the key informants among the main beneficiaries of the study and stakeholders, namely: representatives of the Armed Forces of Ukraine, the Ministry for Veterans Affairs, the Ministry of Health, the Mental Health Coordination Center, and representatives of the civil sector (Veteran Hub, etc.). During the workshop, researchers from NaUKMA presented the results of reviewing the system of mental health support services for service members, as well as the main conclusions and recommendations regarding the stages of ongoing psychological support, psychological recovery, treatment of mental disorders, and psychological assistance as part of rehabilitation. The workshop participants discussed the conclusions and recommendations developed by the study team regarding system improvement, supplemented them, and prioritized them in terms of impact and implementation complexity.

## THEORETICAL APPROACHES TO DATA ANALYSIS AND INTERPRETATION

To design the study, we drew upon some fundamental theoretical models used worldwide in planning, organizing, and evaluating the effectiveness of mental healthcare systems. In particular, these included the WHO pyramid for mental health and psychosocial support (MHPSS)<sup>1</sup>, health system organization strategies such as Task Shifting<sup>2</sup>, and the integrated CFIR<sup>3</sup> (Consolidated Framework for Implementation Research), which helps systematically analyze the implementation of innovations in healthcare.

### The Pyramid for Mental Health and Psychosocial Support (WHO / IASC, 2007):

The pyramid model reflects the hierarchy of levels of mental health and psychosocial support in emergencies and conflicts. It consists of several interconnected levels:

- 1. Basic services and security:** meeting fundamental needs (food, water, shelter, safety), which are prerequisites for mental well-being. Interventions at this level:
  - Humanitarian assistance (food, water, shelter)
  - Safety and protection
  - Access to medical care
  - Creating conditions that minimize additional trauma
- 2. Family and community support:** restoring social connections, informal support networks, and strengthening collective cohesion. Interventions at this level:

- Support groups
- Recreational community-based activities (educational, cultural, sports events)
- Strengthening cohesion, restoring family and social networks

**3. Targeted, non-specialized support:** reducing acute stress, preventing psychological exhaustion, and providing early response to crises. Interventions at this level:

- Psychological first aid
- Crisis counseling
- Brief interventions provided by psychologists without a degree in psychotherapy, social workers or healthcare professionals after basic training
- Support and referral to more specialized services

**4. Specialized services:** treatment of mental disorders (PTSD, depression, anxiety disorders, substance use disorders, psychotic conditions), long-term rehabilitation. Interventions at this level:

- Individual and group psychotherapy
- Psychiatric care
- Comprehensive medical and psychological rehabilitation

### Task shifting

This is a healthcare system organization strategy that involves redistributing tasks from specialists (psychiatrists, psychotherapists, clinical psychologists) to workers who do not have specialized training in mental health but can perform certain functions after appropriate training and

1 - Inter-Agency Standing Committee (IASC), United Nations. Mental Health and Psychosocial Support in Emergency Settings: Guidelines (in Ukrainian). [2010 or year of publication] Geneva: Inter-Agency Standing Committee (IASC). Available at: [https://interagencystandingcommittee.org/sites/default/files/migrated/2017-05/iasc\\_mhpss\\_guidelines\\_ukrainian\\_0.pdf](https://interagencystandingcommittee.org/sites/default/files/migrated/2017-05/iasc_mhpss_guidelines_ukrainian_0.pdf)

2 - World Health Organization; PEPFAR; UNAIDS. Task Shifting: Rational Redistribution of Tasks among Health Workforce Teams. Global Recommendations and Guidelines. Geneva: World Health Organization; 2007. ISBN 978-92-4-159631-2. Available at: [https://iris.who.int/bitstream/handle/10665/43821/9789241596312\\_eng.pdf](https://iris.who.int/bitstream/handle/10665/43821/9789241596312_eng.pdf)

3 - Reardon, C.M., Damschroder, L.J., Ashcraft, L.E. et al. The Consolidated Framework for Implementation Research (CFIR) User Guide: a five-step guide for conducting implementation research using the framework. *Implementation Sci* 20, 39 (2025). <https://doi.org/10.1186/s13012-025-01450-7>

under supervision. This strategy is key in resource-limited contexts, as it allows scaling up basic and focused interventions, reduces the burden on the limited number of specialists, and ensures availability even during humanitarian crises and war.

The goals of the strategy are to:

- Address the shortage of highly qualified mental health professionals
- Expand access to non-specialized types of care
- Ensure timely intervention at the level of a person's immediate environment

Key principles

- 1. Task differentiation:** mental health specialists focus on complex cases, while trained non-specialists deliver basic interventions
- 2. Training and standardization:** non-specialist workers receive short-term, targeted training (e.g., in psychological first aid, screening, crisis counseling)
- 3. Supervision and support:** mandatory oversight and regular consultations by professionals to ensure the quality of care
- 4. System integration:** delegated functions must be embedded into clear care pathways (from basic to specialized levels)

### **CFIR (Consolidated Framework for Implementation Research)**

The theoretical and methodological basis of the qualitative stage of this study is CFIR, an integrated framework aimed at the systematic analysis of factors influencing the implementation and sustainability of innovations in healthcare. CFIR consolidates insights from various theoretical models, provides a unified approach, and allows for consideration of external conditions as well as internal organizational and individual factors. In our study, we adapted the

classification of CFIR's main domains and highlighted a sixth domain – the needs and problems of service users. This aligned with the study goal, namely to examine the subjective experience of using mental health support services from the perspective of AFU service members.

The framework consists of six interconnected domains:

#### **1. Outer Setting**

Includes factors outside the system: external policies, incentives, and regulatory requirements.

#### **2. User needs and problems**

Describes the current state of service members' mental health and their attitudes toward psychological support in general.

#### **3. Inner setting**

Describes the system's internal characteristics – its structure, culture, climate toward innovation, and readiness for change.

#### **4. Intervention characteristics**

Covers the properties of measures and services, including their innovativeness, adaptability to the military context, implementation complexity, acceptability, and evidence base.

#### **5. Characteristics of providers**

Covers personnel's attitudes toward innovations, their knowledge and beliefs, level of self-efficacy, and readiness to change professional practice.

#### **6. Process**

Reflects the dynamics of change implementation: planning, engaging key stakeholders, execution, and further evaluation. Implementation barriers and facilitators

Thus, the CFIR approach ensured a comprehensive study of the mental health support system for AFU service members, allowing for the analysis of contextual, organizational, and individual factors that determine success or barriers in implementing the pro-

posed measures and services. By applying this framework in the study we obtained a structured understanding of the services at each stage of the system and developed conclusions and recommendations.

### Program implementation outcomes<sup>4</sup>

Criterion	Definitions	Application in the study
<b>1. Accessibility</b>	The degree of ease with which a service member can reach psychological assistance. It takes into account physical, geographic, time-related, financial, informational, and administrative accessibility of services.	<ul style="list-style-type: none"> <li>• Does the service member know where to turn for help?</li> <li>• What barriers exist (waiting lists, transportation, time constraints, commander's permission, access control system, etc.)?</li> <li>• How quickly can they receive help?</li> </ul>
<b>2. Appropriateness</b>	The extent to which the services provided correspond to the actual needs of the service member, taking into account their condition, context, and service experience.	<ul style="list-style-type: none"> <li>• Are the services adapted to the needs of the service members?</li> <li>• Do the specialists have experience working with combat stress?</li> <li>• Are relevant methods being used (low-intensity interventions, psychotherapy, medication treatment)?</li> </ul>
<b>3. Acceptability</b>	The degree to which the services are perceived by the service member as ethical, respectful, convenient, and culturally or personally acceptable.	<ul style="list-style-type: none"> <li>• Does the service member trust the specialist?</li> <li>• Do they feel judged or stigmatized?</li> <li>• Are they comfortable discussing their condition?</li> </ul>
<b>4. Effectiveness</b>	The extent to which the services contribute to the improvement of the service member's psychological state, restoration of functioning, reduction of symptoms, or improved adaptation.	<ul style="list-style-type: none"> <li>• Did the help bring relief?</li> <li>• Has the service member started to better cope with emotional strain?</li> <li>• Has the ability to perform tasks been restored?</li> <li>• Did they complete the course of help or discontinue it?</li> </ul>

4 - Proctor E, Silmere H, Raghavan R, Hovmand P, Aarons G, Bunger A, Griffey R, Hensley M. Outcomes for implementation research: conceptual distinctions, measurement challenges, and research agenda. *Adm Policy Ment Health*. 2011 Mar;38(2):65-76. <http://doi:10.1007/s10488-010-0319-7>

## STUDY LIMITATIONS

This study has a number of limitations that should be taken into account when interpreting its results. First, it was based on a desk review and analysis of qualitative interview data, without the use of quantitative data collection or statistical hypothesis testing. Thus, the results primarily reflect respondents' subjective perception of the system's capacity to provide access to quality services.

Second, the participant sample was limited, which does not allow the results to be extrapolated to the entire psychological support system of the AFU. We did not conduct interviews with representatives of the MoD or the General Staff of the AFU. We did not conduct a systematic analysis of quantitative indicators, nor did we study staffing and financial resources of the system. The absence of previous research in these areas did not allow us to form a comparative overview or rely on an existing evidence base.

Third, the study results should be considered in relation to the immediate context of participants. We did not analyze the specifics of working

with service members released from captivity, and did not devote special attention to practices of psychological support for AFU command staff. The system for selecting and training psychological support specialists was studied only partially. We did not assess the level of evidence and effectiveness of specific training programs, psychodiagnostic tools, or methodological guidelines.

Fourth, the study did not include work with classified information, such as official statistics on service effectiveness and the activities of AFU psychological support teams. This limited the ability to produce a comprehensive assessment of the system's effectiveness.

Thus, the presented conclusions should be regarded as a reasoned but incomplete portrait of the functioning of the psychological health support system for the AFU service members. The results obtained highlight the need for further, broader studies using quantitative methods and with access to an expanded empirical base, in order to ensure system development.

# STUDY RESULTS

Presentation of the study results is structured so that first we give a review of the system as a whole. It consists of a description of contextual factors that are relatively constant and affect its functioning at all stages. Next, we identify and describe the needs and mental health status of service members. We present the overall structure of the psychological support system – based on both analysis of regulatory and legal documents, and synthesis of interview data, which reflect respondents' subjective perception of accessibility, effectiveness, acceptability, and appropriateness of services. In addition, we outline the service member's path at each stage of the system, describe the key characteristics of service providers, features inherent to the system as a whole, as well as barriers and


facilitators that affect the implementation of planned measures and the system development. We conclude this section with findings and recommendations at the general system level.

Then, we consider each stage of the mental health support system separately, while maintaining a consistent structure of presentation. For each stage, the following is presented: the goal and objectives according to the regulatory framework; the organizational structure and processes that ensure service delivery; the characteristics of actors who provide services (providers); the description of measures and services at the relevant stage. For each stage, conclusions and recommendations are also given.

# GENERAL PERCEPTIONS OF THE MENTAL HEALTH SUPPORT SYSTEM FOR THE AFU SERVICE MEMBERS


## Context of the System's Functioning

We identified several factors that characterize the context in which the mental health support system for service members operates and which affect practically all measures at all levels of service delivery. The functioning of the psychological support system in the military sector is primarily defined by the **priority of combat readiness over mental healthcare**. This means that treatment or rehabilitation of service members is put on the back burner, while the continuity of combat missions becomes the priority. In these circumstances, the provision of minimal assistance is often determined not by formal procedures but by the discretion of a particular commander, who, in most cases, favors getting the service member back to active duty rather than facilitating their recovery. This practice creates inequalities in access and delays in care. One of the service providers noted:

 "...there is no understanding of how accessibility of care for active-duty service members can be ensured in practice... at the end of the day, it's the commander who decides. If the commander cares about his subordinates, then he himself will... use his own resources to find a way to help, a way to get treatment. Otherwise, that, to my mind, is the main obstacle. Nothing can be done about it." (**Psychiatrist**)


A serious limitation for implementing support measures is the **lack of opportunities for rotation and replacement** of service members. Even when significant mental or physical

health problems are identified, it is often impossible to replace a service member. As one respondent emphasized:

 "He can leave the position in only two cases: either he gets wounded or he leaves in a body bag... because there's simply no one else to replace him." (**Company combat medic**)

This results in service members being stationed on positions with no alternative. An additional factor is the conscious unwillingness of some service members to leave their positions, since the process of exiting and returning is associated with an increased risk of being killed or wounded.

An important factor shaping the conditions of the mental health support system is **military culture, based on rigid hierarchy and subordination**. It determines the style of decision-making about service members and often complicates open communication, which is critically important for the early identification of problems. Service members greatly value being in units where the negative influence of military hierarchy is minimized. One service member described it this way:

 "...in our unit it was like that, there wasn't all this military bureaucracy, you know, those stupid drills, unnecessary line-ups, adherence to some ridiculous rules that just waste time... In general, we lived by our own ordinary, normal human rules." (**Service member, junior officer rank**)

## Generalized Description of the Factors Affecting the Mental State of Service Members

We have identified a range of psychosocial factors and cultural attitudes typical of many service members, which influence both their mental health status and their overall access to psychological support.

Service members experience **loss of control over their own lives** and a lack of opportunities to influence their psycho-emotional state. This leads to feelings of demoralization and helplessness.

“They give you a paper – like, you are going there and that’s it. You know, we’re military people (laughs). How do I put it... I have always said that the army is slavery. Very little depends on you there. Whatever is written in the paper, that’s where you’ll go.”  
(Service member, junior sergeant and starshina rank)

**Chronic fatigue, insufficient sleep, shallow rest, and frequent awakenings** lead to exhaustion and reduce the capacity for recovery.

“Well, you can jump up at any little rustle, any sound... even throw an elbow in your sleep...”  
(Service member, enlisted rank)

Overload, stress, and lack of resources often lead to **heightened aggressiveness and conflicts** among the military. Aggressiveness may have both verbal and physical manifestations..

“I even grabbed people by the throat and could choke them.”  
(Service member, enlisted rank)

**Difficult feelings connected with death and loss** – the theme of death is omnipresent but at the same time hard to discuss, which increases emotional pressure.

“...a captain, at that time, asked me: ‘Are you already 30 years old?’ I say: ‘Not yet.’ And he answered: ‘Don’t hold your breath.’ So we just laughed about it together. And at that point we decided not to raise that subject anymore.”  
(Service member, junior officer rank)

**Adverse living conditions, lack of basic comfort, and high daily expenses** negatively affect recovery and mental well-being of service members.

“A village head literally allocated former stables to us... One load of laundry cost UAH 100... Shower also costs from UAH 50 to UAH 100...”  
(Service member, junior officer rank)

**Lack of time to recognize one’s own emotional needs** – service duties leave little room for service members to reflect on their experiences or process their losses.

“...I had no time for this, to process it, to reflect, to accept this loss somehow. In fact, I still haven’t really worked through that moment.”  
(Service member, enlisted rank)

**Limited contact with loved ones.** Service members often do not have

sufficient contact with their families, which reduces their opportunities to receive emotional support. At the same time, family problems weigh heavily on them.

“...in more than six months of our relationship we saw each other maybe 30 days at most. That also leaves a mark.” **(Servicewoman, junior sergeants and starshinas)**

**Closedness and lack of trust** – many service members conceal their own experiences, don’t want to burden their families, rarely share with comrades, and do not know whom to turn to. Many of them believe they can cope with stress on their own and help themselves better than psychologists can.

“I didn’t tell anyone anything... almost anyone. Maybe just a little bit to my wife... Well, I tried to spare my family from worry.” **(Service member, enlisted rank)**

“...most people, well, even those people you serve next to, they know next to nothing about you...” **(Service member, enlisted rank)**

**Remaining in a state of constant mobilization** allows service members to keep functioning for some time, but once the stress subsides, a sudden deterioration often follows. In the long run, the body’s psychological resources and capacity for self-regulation become depleted.

“...people are now running on adrenaline, those who are at positions... but when the rest period comes... then all those psychological problems will just burst up to the surface.” **(Company combat medic)**

“I just got used to living in this state, when you are constant-

ly working beyond your limits, but you’re working. Because you don’t really have much choice.” **(Servicewoman, junior sergeants and starshinas)**

We also identified unproductive attitudes among service members that prevent them from seeking help.

To relieve stress, service members often use **harmful self-help strategies** such as alcohol, tobacco, drugs, or energy drinks. This worsens symptoms and makes it more difficult to seek professional help.

“There was a period... I could smoke two packs a day.” **(Service member, junior officer rank)**

“Energy drinks... we were guzzling them like water.” **(Service member, enlisted rank)**

**Reluctance to use the formal support system** – service members sometimes avoid official rehabilitation mechanisms in order to maintain their connection with the unit and feel they still belong.

“There were guys who, after being wounded... the doctors gave them a month of leave... But he said he wouldn’t go anywhere... He spent the month in the village with the guys, cooking for them...” **(Company combat medic)**

**Stigmatization of complaints** – in the military community, there is a common attitude that complaints about one’s psychological condition are perceived as shirking service or as something unimportant. This hinders seeking help and creates feelings of guilt.

“...there’s this fear that they’ll say: what, are you’ slacking off now?” **(Service member, enlisted rank)**

**Gender and cultural stereotypes** are widespread in the military environment, which hinders the acceptance of psychological assistance. Such practices may be considered ‘weak’ or ‘unmanly’. There are also biases toward young female psychologists.



“Exercises, for example, the ‘Butterfly’ for relieving stress – simple, basic things... service members don’t really like them, they think it’s silly and a bit ‘girly’, excuse my language.” **(Mental health center specialist)**

## General Overview of the Organizational Structure and Service Delivery Mechanisms

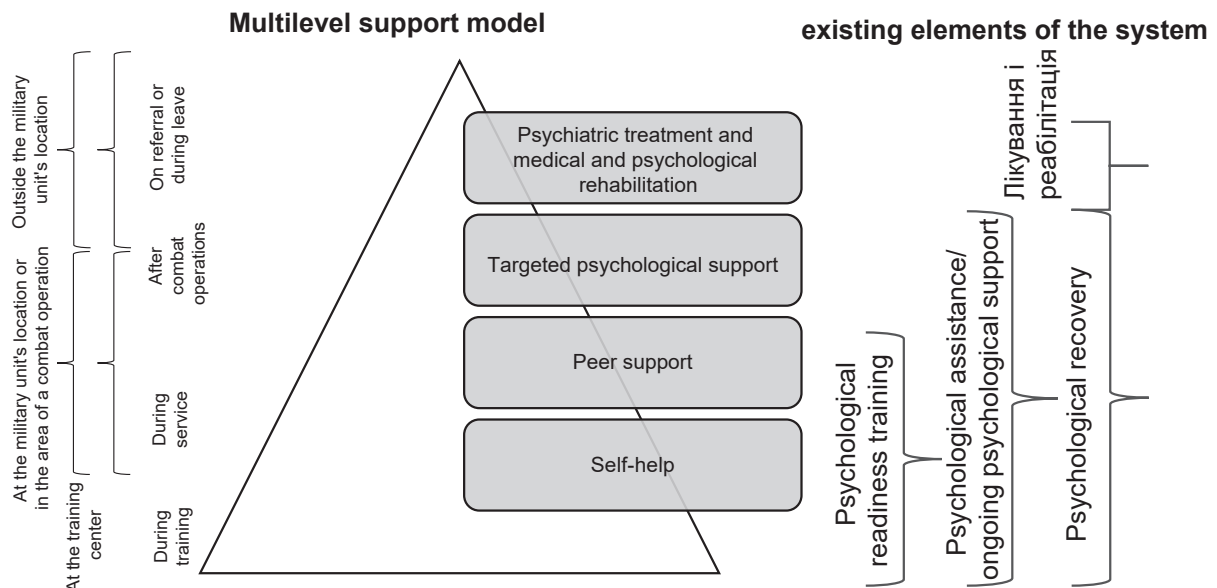
We identified five key components within the mental health support system for service members of the Armed Forces of Ukraine:

- Psychological readiness training (activities aimed at developing psychological resilience and readiness to perform assigned tasks)
- Ongoing psychological support (activities conducted during service and mission execution, aimed at maintaining optimal mental health)
- Psychological recovery (activities carried out during and after task performance, aimed at preventing and overcoming the negative effects of exposure to psychotraumatic factors)

- Treatment of mental disorders in healthcare facilities
- Psychological and psychosocial assistance in other sectors (veteran policy, social policy, and the non-governmental sector).

Formally, these components cover all levels of mental health services defined by the WHO intervention pyramid. The existing system of psychological support for the AFU service members includes measures and services corresponding to each level of the intervention pyramid described in the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings in Emergency Settings – rang-

These components can be schematically represented as follows:



ing from the basic needs and efforts to reduce the impact of stressors to specialized psychiatric treatment services. During BGMT, all service members receive knowledge about the effects of combat stress on the mental state and its manifestations, enhance their psychological readiness for battle, and develop self-help skills for coping with stress. Commanders are responsible for meeting the basic needs of service members (such as food, sleep, and water) as much as possible given the unit's deployment conditions. During ongoing psychological support and at the initial stages of recovery, service members are expected to apply self-help and peer support skills. A military leadership school has been established, along with programs to train 'psychologist assistant' instructors or 'khorunzhyi' (standard bearer) who provide informal peer support<sup>5</sup>. In some units, patronage services are in place to provide, among other forms of support, psychological assistance to families of fallen service members, thereby fostering a culture of care and mutual support. Service members maintain constant contact with their families and friends, who provide both financial and emotional support. Military psychologists conduct psychological support of operations and mental health activities throughout service, in particular during combat operations and the recovery period. These activities include psychological diagnostics, crisis interventions, individual and group counseling, more comprehensive decompression activi-

ties, and recovery programs at the brigade level in psychological assistance centers. When necessary, psychologists may coordinate with the unit's medical service as well as with social, medical, and psychological services and institutions in the civilian sector. All these activities correspond to trauma-focused, non-specialized forms of mental health service delivery. By order of the medical service commander, service members may also be referred for specialized psychiatric treatment and comprehensive medical and psychological rehabilitation in civilian healthcare facilities.

At the same time, access to the above mental health support services remains uneven and is characterized by a number of barriers – organizational, sociocultural, and financial. We will examine these barriers in more detail when describing each stage of the system separately.

#### **Pathway to access mental health support services**

We have also systematized key information regulating access to mental health support services for service members at each stage, in accordance with the available regulatory and legal documents, and presented it in a table. This table serves as a "map" and includes: (1) a list of all stages of mental health support, (2) responsibility assigned to service providers, (3) information from RLAs governing activities at each stage, (4) triggers that activate stage-specific services.

Task of mental health support	Psychological selection	Psychological training	Psychological counseling at the battalion and brigade level
	MoD	MoD	MoD
<b>Positions responsible for service delivery according to RLAs:</b>	TRC officers, Officers of PPS departments	Cycle-based psychological training committee within the TC structure, general military training instructor (psychological training instructor)	Deputy commanders for PPS
<b>Goal of the stage according to RLA - quote:</b>	Determine the alignment of personal characteristics with service requirements and conditions, monitoring of the psycho-emotional state of service members	Develop psychological resilience in service members and readiness for combat, extreme conditions, rapidly changing situations, prolonged psychological stress, and overcoming challenges related to military duties	Maintain optimal mental health of service members during assigned tasks by fostering mental resilience to stressors, psychological readiness for assigned tasks, and preventing negative psychological states
<b>RLA</b>	Order 272	Order 173	Order 349
<b>Service trigger</b>	Mandatory process	Mandatory process	Self-referral, observation-referral by command, or platoon/company combat medic
<b>Timing</b>	During candidate selection, during BGMT	During BGMT	During troop deployment
<b>Service location</b>	TRC, TC or directly in the brigade	At training centers	At the place of service

Psychosocial support from the civilian sector	Additionally: Support provided by chaplains, combat medics, and medical service heads	Peer support from fellow service members and self-help	Brigade-level recovery
MoH, Ministry of Social Policy	MoD	MoD	MoD
Medical and social workers, psychologists, psychotherapists Hotlines, VeteranHUB, CETA, Opora, Free Choice (Vilnyi Vybir), Impulse Organization, etc.	Chaplain, chaplain assistant, combat medic	Peer support, Baza app, etc.	CSCG officers, Brigade-level PCRG officers, psychologists, other relevant personnel
Promote social adaptation (readaptation), provide socio-psychological support and social services, including social support, counseling, mental health promotion, and psychosocial well-being	Support the constitutional right of service members, employees, and their family members to freedom of conscience and religion by meeting their spiritual and religious needs	<ul style="list-style-type: none"> <li>• Restore and maintain mental and physical health of service members</li> <li>• Stabilize, correct, and return to optimal psycho-emotional state and task readiness</li> <li>• Prevent psychogenic losses and psychopathological changes due to combat-related psychological trauma</li> <li>• Support psychosocial adaptation to changed life circumstances</li> </ul>	
"RCMU 1338, MoH Order 2118 Activities of NGOs not regulated"	Law of Ukraine On Military Chaplaincy Service	Orders 174, 349, 378	Orders 174, 378
Self-referral	Self-referral or referral by medic, chaplain	Self-referral by service member, fellow service members initiative	If condition does not improve within 3 days Deputy commander for PPS, based on officer-psychologist's recommendation
During leave, remotely - during service	Throughout the service	Throughout the service	Within 3 days after the event
At civilian HCFs, state-owned, private, NGOs, private service providers	At the place of service	At the place of service	Brigade psychological support points near brigade medical post

Task of mental health support	"Decompression "	Recovery in specialized facilities in the rear area	Recovery in specialized facilities outside the combat zone	Recovery of released POWs
	MoD	MoH, MoD	MoH, MoD	MoH, MoD
<b>Positions responsible for service delivery according to RLAs:</b>	Psychological support officer team for management bodies, CSCG officers, PCRG officers, officer-psychologists, medical service head	HCF staff under qualified specialists' supervision	Facility/Institution personnel	Multidisciplinary team
<b>Goal of the stage according to RLA - quote:</b>	Comprehensive measures conducted after units are withdrawn from operational areas aimed at restoring service members' mental health	<ul style="list-style-type: none"> <li>• Restore and maintain mental and physical health of service members</li> <li>• Stabilize, correct, and return to optimal psycho-emotional state and task readiness</li> <li>• Prevent psychogenic losses and psychopathological changes due to combat-related psychological trauma</li> <li>• Support psychosocial adaptation to changed life circumstances</li> </ul>		Goal: return the individual to professional duties (performing service tasks) and/or social life Goal of post-isolation support: consolidate results of reintegration or post-isolation measures, ensure full post-isolation adaptation, restore physical and mental health of released personnel, and provide necessary assistance to family members
<b>RLA</b>	Orders 174, Decompression Instruction	Order 378	Order 378	RCMU 296 dated 03/15/2024
<b>Service trigger</b>	Mandatory process Everyone must undergo, organized by the commander	If condition does not improve within 3 days Unit commander based on PPS deputy's recommendation, with medical service head's approval	If condition does not improve within 3 days Unit commander based on PPS deputy's recommendation, with medical service head's approval	Release from captivity
<b>Timing</b>	"Duration: 3 to 7 days As a separate measure during rotation or redeployment"	Duration up to 14 days	Duration up to 21 days	After release
<b>Service location</b>	Not specified	HCF in the rear area	HCF outside the combat zone	At specialized institutions/facilities

Treatment in specialized civilian psychiatric HCFs or military hospital departments	Psychological support and psychiatric treatment during care in HCFs (for illness or injury)	Psychological rehabilitation for service members during leave or remotely	Comprehensive medical-psychological rehabilitation
MoH, MoD	MoH, MoD	MinVeterans	MoH
Medical and non-medical staff	Medical and non-medical staff	Psychiatrists, psychotherapists, psychologists from organizations included in the MinVeterans Register	Multidisciplinary team
Treatment of mental disorders	Treatment of injuries/trauma, improvement of psychological state during care	1) "Psychological assistance goals: 1) Preserve and restore mental health, prevent or mitigate development of mental and behavioral disorders in service recipients 2) Overcome difficult life circumstances 3) Promote post-traumatic personal growth"	Restore or compensate for impaired mental functions, personality traits, and relations of service recipients; create conditions for complete recovery from psychological crisis to maintain health, restore combat or work capacity, and psychological and social adaptation mechanisms affecting behavior and quality of life
Medical Guarantee Program (RCMU 1503)	Medical Guarantee Program (RCMU 1503)	RCMU 1338, MoH Order 2118	RCMU 1338, MoH Order 2118
Urgent or self-referral (during service or leave), referral by unit medical service head according to Article 260 of the Service Regulations	Urgent or self-referral (during service or leave)	Self-referral to the service provider or via Diia app	Referral by primary care physician, treating physician, second-level provider, or self-referral
14+ days	Throughout treatment period	At any time remotely or on outpatient basis during leave	14+ days, inpatient
Psychiatric, addiction treatment departments and hospitals, mental health centers	All HCFs providing treatment for injuries, trauma, and illnesses	Organizations listed in the MinVeterans Register	Individual HCFs

## Analysis of Available Publications in Academic Sources

As part of the desk study, we conducted a search for academic publications to assess the evidence base for existing recovery programs and other elements of the system of psychological support of operations within Ukraine's Security and Defense Forces. Publications focusing solely on the psychological state of service members or the psychometric properties of screening tools were excluded from the search.

As a result, we identified 13 publications (Appendix 2). The overwhelming majority was theoretical and methodological in nature and did not present the results of systematic studies. Only two articles reported on the effectiveness of recovery programs. In one study, the evaluation was conducted on a single cohort of 1,090 service

members (without a control group), and the authors concluded that there were positive psychological changes after completing a seven-day program. In another publication, the results were based on a sample of only seven participants.

Thus, the available data indicate a de facto absence of systematic studies assessing the effectiveness of ongoing psychological support and recovery measures. At the same time, most of the identified publications do not contain essential research information, such as descriptions of study protocols and ethical approvals. Reliability of the results remained uncertain due to the lack of reference groups and delayed intervention outcome assessments.

## General Characteristics of Psychological Support Providers in the AFU

**Insufficient staffing.** According to research on personnel provision in the AFU, there is one psychologist per 400-500 service members. By comparison, in the Israeli army, the established standard for military psychologists and social workers is one specialist per 70-90 people<sup>6</sup>. Workload norms for one psychologist providing


ongoing psychological support during mission execution are defined as no more than 400 persons in peacetime and no more than 300 persons during wartime (special period). As of June 24, 2023, the staffing level of officer-psychologists in the AFU was 72%.<sup>7</sup>

6 - The Mental Health of Service Members Is Much Worse Than That of the General Population – ArmyInform


7 - Organization of Psychological Support of Operations in the Defense Forces of Ukraine: History and Experience: A Historical Essay. – Kyiv: Research Center for Humanitarian Problems of the Armed Forces of Ukraine, 2025. – 176 p.

**Mismatch in training** (in most cases, individuals in psychological service positions within the AFU do not have a degree in psychology). In 2023, PPS structures were established, but in practice, this change was largely nominal – the same personnel remained in place. 32% of those in military psychologist positions did not have training in the relevant field<sup>8</sup>. Experts interviewed by the study team mentioned that this percentage might be even lower.

**The exhaustion among the service members and PPS officers** is above the acceptable levels. This results from the duration and intensity of combat operations and the inability to conduct rotations or recovery activities at the required frequency due to personnel shortages<sup>9</sup>. Assistance providers themselves remain under constant stress, working and living in difficult conditions, which leads to emotional burnout. This, in turn, can impair their ability to regulate their own reactions and reduce their professional effectiveness.

 “It was quite a tense situation. Not exactly a conflict, maybe a bit so, but mostly just emotional situation. It was hard for me to overcome myself, to refuse to carry out the order, to argue with someone. Technically, I could have stayed silent, left, and kept sitting there. Well, I just lost my temper a bit.” **(Service member, junior officer rank)**

**The Command factor and overall leadership culture.** From the respondents’ perspective, commanders’ loyalty and basic knowledge in mental health are decisive factors for providing support. Unfortunately, commanders often show negative attitudes or refuse to approve recovery or treatment for service members. This is partly due to a shortage of personnel to carry out the tasks, but to a large extent also indicates a lack of understanding of the importance of psychological support for maintaining mental health, and consequently, combat readiness. It is difficult to convince ‘Soviet-style officers’ of the importance of psychologists, and the absence of loyalty or basic competence from a commander makes any effort ineffective. It should also be noted that due to a heavy workload, commanders themselves are often exhausted and unable to devote attention to mental health support.

 “No matter what we do, it doesn’t work without the commander’s support or if he lacks basic competence in the field of mental health... So, training commanders is the main gap... if the commander cares about this, he gives it attention, and then you find resources and opportunities. If he doesn’t, then nothing gets done.” **(Psychiatrist)**

8 - Ibid., page 79

9 - <https://suspilne.media/kherson/922243-psihologichni-problemi-na-vijni-z-cim-stikautsa-vijskovosluzbovci-z-hersonsini-ta-aku-dopomogu-otrimuut/>

## Barriers and Facilitators to Implementing Changes and Developing the System

### Barriers

**Long and costly training of psychologists** reduces the capacity of state institutions to attract and retain certified specialists. Due to inadequate salaries and limited incentives, they go to the private sector or NGOs, deepening the personnel shortage in the AFU and state institutions.

“There is a lack of psychotherapists, psychologists with psychotherapeutic skills, but for us it’s also a problem – the shortage of qualified psychotherapists, certified and supervised in psychotherapy, for obvious reasons, because it’s a long and expensive path to qualification. Accordingly, these specialists work in projects, in international organizations, in private institutions, or run their own private practice. Anyway, they’re not looking to work for 200 hryvnias an hour, they want more. Right? It could be a thousand or two thousand hryvnias. That is the market rate for such specialists. And the AFU’ package doesn’t cover these things. Higher pay, therefore, corresponds to the level of psychologists’ skills.”  
(Psychiatrist)

**Limited engagement of qualified civilian specialists in the army.** The number of qualified psychologists trained in evidence-based psychological interventions in the civilian sector is insufficient. Low pay and difficult service conditions make military service uncompetitive for civilian psychologists, reducing the personnel reserve for the support system. As a result, high-quality specialized

services, such as psychotherapeutic services, remain largely inaccessible.

“I can’t bring qualified psychologists into my team because of the conditions. Most civilian psychologists won’t agree to either this pay or these living conditions.”  
(Officer of the Combat Stress Control Group)

**Dissatisfaction among the military psychologists with the outcomes of reforms in the psychological service.** Frequent organizational changes, such as the creation and subsequent de facto abolition of ongoing psychological support and recovery groups, personnel redistribution, etc., without a clear long-term logic, create a sense of instability, additional workload, and reduced belief in the effectiveness of changes.

“So, basically, when they canceled – first introduced for a few months, and then canceled – these OPSRG in battalions, ongoing psychological support and recovery groups, nothing changed.”  
(Officer-Psychologist)

**Available continuing education programs for the providers are perceived as formal and low-quality.**

The introduction of short ‘certification’ courses to acquire the status of clinical psychologist/psychotherapist creates risks of reduced service quality. Training is often formal, not accompanied by supervision or adequate practical experience, and it pulls specialists away from their work processes.

“...starting next year, you can’t work without a formal degree in clinical psychology... the solution is to take a course... a three-month course... another three-month course... or six-month... It’s a very crazy thing... a three-month course... is... not enough... it looks like just another... way to make some money.” **(Psychologist at a psychiatric hospital)**

**Insufficient Support for the Implementation of Innovations.** Technological innovations (e.g., eye-tracking, VR) are met with skepticism among both service members and some providers. And the lack of trust reduces the willingness to implement and scale new approaches.

“...it didn’t gain traction in the Armed Forces. Because there’s no trust.” **(Service member, enlisted rank)**

According to experts and service providers, the information platform Pryzma, designed to create digital accounts, conduct individual and group online testing, and monitor changes in psychological state, still has the status of an experimental project and is being implemented semi-legally. At the same time, there is a lack of adequate awareness among military psychologists about the platform’s capabilities.

“As far as I know, there is a pilot project called Pryzma, which attempted to establish a CRM-based system – specifically for managing the processes within the responsibility of an officer in charge of psychological support of operations. But I don’t know how successful it has been or how likely it is to be scaled up within the actual military context and transformed into a truly accessible service, which it definitely isn’t at this point.” **(Expert)**

## Facilitators

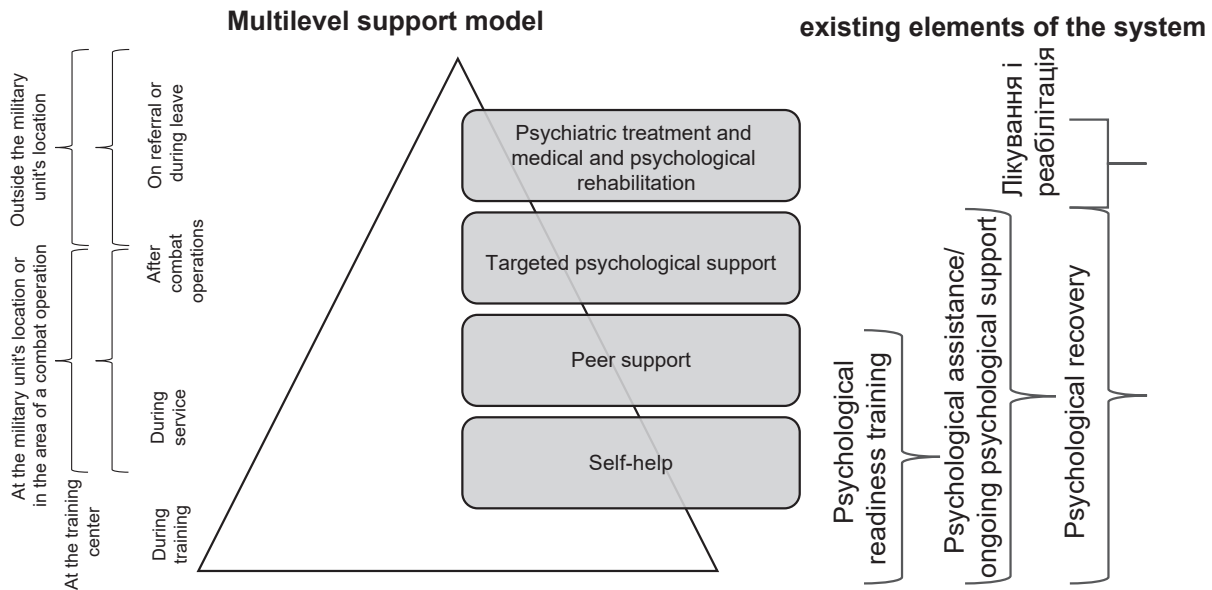
**The market for psychological support services is rapidly developing.** Veteran and civil initiatives are opening their own assistance centers – from safe spaces to multidisciplinary teams. This expands service accessibility, strengthens healthy competition, and raises overall quality standards.

“...the field is really buzzing right now. I mean, new structures, players, organizations keep appearing; veteran organizations, for example... This is good, not bad. It’s good – and then we try to build rapport with them in terms of referring service members who need specialized help, but it’s just a very dynamic process today.” **(Psychiatrist)**

**Horizontal networks** fill gaps in formal interactions and the lack of quality training programs within professional communities. Informal associations, intervision meetings, and regular experience exchanges, both online and in person, accelerate the circulation of effective practices and provide specialists with rapid feedback. Joint case reviews help refine approaches and significantly improve assistance quality. At the same time, support from colleagues and the possibility to ‘vent professionally’ curb burnout. These networks operate alongside formal institutions, filling their gaps and making the support system more resilient.

“Obviously, there’s ongoing training and a large number of very supportive projects... Communities – there are several with specialists. You could say this is an informal level of contact, and in fact, our meetings... they are like intervisions, experience exchanges... horizontal connections – they are probably the most important thing... it’s very important.” **(Psychiatrist)**

## Conclusions and Recommendations Regarding the System as a Whole



The mental health support system for the AFU service members consists of five interconnected stages: psychological readiness training, ongoing psychological support, psychological recovery, treatment of mental disorders, and psychological assistance within rehabilitation and other sectors. Each has conceptually defined tasks and tools, but in practice is characterized by significant gaps between design and implementation; functioning remains uneven and only partially achieves intended goals. Unfortunately, most activities at all stages insufficiently account for real constraints, which we identified earlier:

- 1) The impossibility of quickly addressing the shortage of qualified personnel
- 2) Overload of commanders at all levels
- 3) Persistent stigma regarding mental health problems
- 4) Constant personnel shortage in the AFU and, consequently, prioritization of combat readiness tasks over mental health support tasks

The main barriers of the system remain personnel shortage, the gap between design and implementation, the combination of moral and psychological support tasks in the functional duties of military psychologists, excessive formalization of procedures creating access barriers, stigmatization of mental health problems, and dependence of access to services on commanders' decisions. Despite this, system effectiveness is maintained through informal practices, culturally acceptable activities, and local initiatives suited to frontline realities.

Although formally described in regulatory acts, the system model corresponds to the principles of multi-level support, but in practice they are insufficiently implemented. Experts believe this is caused both by a lack of qualified personnel working as psychologists and by unclear definition of peer support specialist, military psychologist, military medic, and psychiatrist in the psychological support, as well as the tasks for each role, and the lack of sufficient competencies

required for carrying out both specialized and non-specialized psychological support measures. We note that global experience in implementing such approaches involves mandatory training in evidence-based interventions at all levels of care and regular supervision during work. According to the study respondents, this task is practically unfulfilled.

### **Accessibility**

At all stages, accessibility is limited due to a lack of personnel, resources, and excessive formalization of procedures (large amounts of reporting, paperwork, regulatory documents). At the ongoing psychological support stage, this manifests in insufficient numbers of psychologists at the brigade and battalion levels, lack of conditions for confidential conversations, and significant dependence on commanders' attitudes toward psychological support. In psychological recovery, access depends on service members' ability to enter recovery programs at the brigade level, the availability of recovery centers in the rear area, available spaces in such centers, commander's permission, and unit personnel resources, making the service fragmented and uneven. In psychiatric treatment, access is also regulated by commanders and formal routing; there are no clear mechanisms for obtaining outpatient care, and access is limited due to a shortage of qualified psychiatrists, addiction specialists, and psychotherapists.

### **Effectiveness**

Overall system effectiveness is partial. In ongoing psychological support, the most effective measures are informal peer support, short leaves, psychologists' visits to positions, and innovative practices. In contrast, widely used psychological testing is conducted formally and fails to

achieve timely detection, triage, referral, and, consequently, prevention, treatment, and rehabilitation of mental disorders. The effectiveness of psychological recovery programs ranges from positive effects (reduced stress symptoms, improved mood, restored sleep) to formal execution without real benefit due to lack of standardized methods and staff shortages. In psychiatric treatment, stabilization is achieved selectively, often limited to pharmacotherapy, while long-term therapy and reintegration remain insufficiently provided. Choosing treatment inappropriate for the diagnosis, such as hospitalizing service members with neurotic disorders, is not only ineffective but also increases service members' distrust of the system overall.

### **Acceptability**

Support forms based on peer relationships, humor, and positive leadership of commanders are perceived as culturally acceptable at all stages. At the same time, formalism, stigmatizing practices, and authoritarian management styles undermine trust and reduce willingness to seek help. In recovery, service members respond positively to practices adapted to military culture (sports, conversations, routines, creative activities) but reject 'foreign' models. In treatment, acceptability heavily depends on medical staff: a person-centered approach builds trust, whereas formalism and poor conditions repel.

### **Relevance**

In ongoing psychological support, the system meets urgent needs for stress relief and short recovery breaks but does not ensure long-term resilience. In recovery, the key factors are real rest and release from combat duties. However, barriers remain, such as poor conditions in some facilities and lack of program standardization.

Treatment partially meets the needs: short durations and the predominance of pharmacotherapy prevent effective work with trauma and integration, and coordination between civilian and military systems is insufficient.

### Recommendations

To ensure long-term psychological resilience and effective treatment, systemic integration of the stages is needed based on the principles of the WHO multi-level intervention model<sup>10</sup> and task shifting strategies<sup>11</sup>, which allow building an effective mental health support system under limited resources. These guidelines have been actively implemented in the civilian sector of Ukraine since 2014 and rely on a shared consensus among mental health professionals regarding their appropriateness and effectiveness.

Reviewing the organizational structure of each stage of the system for its compliance with the stated guidelines will contribute to improving the coherence of mental health support measures with their goals and objectives and will help to better take into account the actual context of the system's functioning and the resources available for their implementation. In particular, ongoing psychological support is regulated by several orders of the Commander-in-Chief of the Armed Forces of Ukraine (Nos. 174, 349, 378). The conceptual framework and the definitions of system elements (for example, the definition of psychological assistance) in these documents are not aligned with each

other or with other documents (the Doctrine<sup>12</sup>). The orders do not provide a clear division of functions among actors ("Ongoing psychological support is provided by commanders, officer-psychologists, CSCG, OPSRG, and other officials responsible for the psycho-emotional state of subordinates").

Separately, it is necessary to highlight the task of continuing the professionalization of the AFU's psychological service, which primarily involves an adequate level of staffing with qualified personnel with a degree in psychology. On the one hand, during the expert-level study, we observed a broad consensus that without fulfilling this task, it is impossible to build any effective mental health support system. Most experts referred to the availability of the necessary human resources that the psychological service of the AFU can mobilize, namely the large number of psychologist specialists who graduate annually from Ukrainian higher education institutions (HEIs). On the other hand, the need for staffing with qualified psychologists was identified already in 2023 in a previous study<sup>13</sup>, and since that time, as far as we know, no significant progress has been made in resolving staffing issues. It should also be noted that among the graduates majoring in Psychology (053), the overwhelming majority are women, who are not subject to mandatory mobilization. Another limiting factor is the absence of a military department in HEIs and mandatory military training for many psychologists

10 - Inter-Agency Standing Committee (IASC), United Nations. Mental Health and Psychosocial Support in Emergency Settings: Guidelines (in Ukrainian). [2017] Geneva: Inter-Agency Standing Committee (IASC).

11 - World Health Organization; PEPFAR; UNAIDS. Task Shifting: Rational Redistribution of Tasks among Health Workforce Teams. Global Recommendations and Guidelines. Geneva: World Health Organization; 2007.

12 - Doctrine 'Psychological Support of Personnel' approved by the Commander-in-Chief of the Armed Forces of Ukraine on August 21, 2025.

13 - NGO Bezbariarnist, commissioned by 'How Are You?' program, with support from the USAID Public Health System Recovery and Resilience Activity. Audit of system resources for the provision of mental health services. 2023. <https://bbu.org.ua/audit-resursiv-isnujuchoi-sistemi-nadannya-poslug-u-sferi-psiichnogo-zdorov-ya/>

during their studies. The position of military psychologist is an officer's post, and a significant number of mobilized psychologists will not be able to hold these positions, as they are mobilized as enlisted rank. We recommend reviewing the barriers that hinder the implementation of this important task and find an effective way to eliminate them in the medium and long term.

The tasks of professionalizing the psychological service of the AFU should also include delineating the roles of psychological and moral support of operations. Combining disciplinary functions (including official investigations) with the therapeutic functions of a psychologist is mutually contradictory. If a single position combines disciplinary functions, moral support, and psychological support in functional responsibilities, the priorities of command staff usually do not favor psychological support. Moreover, involving officer-psychologists in official investigations undermines trust and confidence in confidentiality on the part of service members. As a result, military personnel avoid seeking help even when they need it and want it. Officer-psychologists also spend their time and energy on administrative activities instead of performing their primary psychological support duties. A possible solution is to separate the functions of moral and psychological support between different positions. Tasks of moral support and related or simply additional administrative assignments should not be assigned to qualified psychologists.

For a long time, the task of improving the quality of training at all stages will remain urgent. Above all, this concerns scaling up training programs in psychosocial and psychotherapeutic interventions with proven effectiveness, which are al-

ready represented in Ukraine and have undergone cultural adaptation. As experience with implementing a multi-level assistance approach worldwide shows, its effective implementation is only possible under conditions of quality training and supervision among both specialized and non-specialized service providers. It is necessary to provide for the allocation of financial resources to scale up effective training programs covering evidence-based interventions that have the greatest real impact and have already been adapted to Ukrainian context. Training in evidence-based psychosocial interventions follows a mentorship model and provides for a rapid transition to delivering practical support to service members under supervision immediately after completing the didactic cycle, which lasts from several days to several weeks.

An important task is to standardize services according to the purpose of the stage, the real needs of service members, cultural norms, and currently available evidence-based interventions at all levels of care, including already widespread telemedicine practices. This applies to both specialized services, such as rehabilitation programs or psychological assistance during medical rehabilitation, and non-specialized psychosocial peer support interventions. Standardized services can be scaled up much faster, in particular through the involvement of professional and organizational resources from the civilian sector and funding within international cooperation frameworks. Special attention should be paid to the accuracy of the triage and referral process to specialized services according to the identified needs. The effectiveness of this process significantly affects the system, which is built on multi-level principles.

When planning the implementation of changes in the psychological support system, it is important to consider two factors that we believe to be crucial: **the commander factor and the level of trust in psychological support** among service members. The influence of commanders' decisions on the mental health of service members and their access to mental health support services is systemic and is palpable at all stages. Unit commanders act as conduits of the system; it is on their decisions that the access to all formal types of support depends. Their role is also decisive in shaping the psychological climate in units, which also significantly affects the quality of informal support. During the study, we observed a high level of distrust of psychological support among service members

at all stages, except for informal peer support. Although we heard claims that the level of stigma and distrust toward psychologists and psychiatrists is gradually decreasing, it will continue to affect the process of service members seeking professional help for a long time. During the study, we saw that the processes of first-time use of specialized services were sometimes unclear to service members. This is compensated for by the persistence of service members themselves in formulating requests for help and active steps to receive it. However, we cannot expect this from all service members, especially those whose level of social functioning is limited due to excessive fatigue and a general loss of belief in the ability to influence their lives during military service.

# SELECTION

The stage of psychological selection was not central in our study, as we understood that the task of selecting candidates could not be fully accomplished in the current situation. But from the perspective of mental health support, this stage is a component of the overall system.

● "...selection still takes place... at the training center... For certain specialty categories, there must be appropriate psychological traits; special forces, snipers must have specific character traits... If it is truly quality training and selection, it should determine how and to what extent a person is fit for the service specifically in this sphere..." **(Expert)**

● "...when people are brought... to the brigades... we accordingly also conduct professional evaluation... we recommend or do not recommend a specific person for service in a particular unit." **(Officer-Psychologist)**

If personal characteristics do not match the profession, one can expect maladaptation of service members due to role mismatch: fear, feelings of incompetence, and guilt. Formally, the stage is multi-step: selection at the Territorial Recruitment Center (TRC), at the training center, and in the military unit. But according to respondents, the selection process functions more as a formality, through which even obviously unsuitable candidates pass, adding extra burden to unit command:


● "...we had people with brain damage. This... is the fault of the TRC and the psychologists working in the rear. And this is a big problem across all brigades, except for those like the 3rd Separate Assault Brigade. They can select suitable people for their brigade." **(Officer of the Ongoing Psychological Support and Recovery Group of the Brigade)**

# TRAINING


The purpose of psychological readiness training is to develop psychological resilience and combat readiness (the ability to perform assigned tasks) in service members. Psychological readiness training is carried out during training sessions, exercises, drills, courses, including the general process of troop combat training. Training activities must be conducted regularly during service. Psychological readiness training methods include verbal (persuasion, suggestion, psychological consultation), practical (exercises and drills), and emotional regulation and willpower (self-management, self-control skills). By levels and content, psychological readiness training is divided into general, specialized, and targeted.

Psychological readiness training in the AFU is conducted according to Instructions<sup>14</sup>, Manual<sup>15</sup>, and Standards.<sup>16</sup>


The stage of basic general military training (BGMT) was analyzed in detail in a study by the Come Back Alive Foundation<sup>17</sup>. Participants in our study also noted that during the course, recruits' motivation systematically decreases. Stress caused by basic everyday difficulties and the low emotional culture of some training center (TC) staff hinder effective learning. Any future changes in the work of TCs must directly consider mental health support tasks: a person under stress is much worse at learning than a person in a calm state.

 “BGMT is the army nobody wants. It’s like – bam – and you are surrounded by a bunch of strangers. And when you stand up for your-

self, many people somehow don’t like it, especially if you are living in tight quarters.” **(Service member, enlisted rank)**

 “At first, it (mental state) worsened during BGMT when I faced a large number of alcoholics, this strange... Sovietness from the instructors. Then, when I faced incompetence, I just started looking forward to when I would get into a brigade.” **(Servicewoman, junior sergeants and starshinas)**

Providers and participants in training essentially describe two tasks of the psychological support at the training stage: (1) Support during the civilian’s adaptation to the army, and (2) Psychological readiness training for professional task performance. In different TCs and later in units, one or both directions may fall out of focus. Most often, it is support for the adaptation to the army. Several respondents noted that they had no psychological readiness training or only formal ‘lectures from a book’ and were forced to prepare for combat on their own.

 “Regarding psychological readiness training, or some psychological stuff to prepare you for the battlefield, everyone just ignores it. At most units. I’m not saying, maybe there are some highly motivated units ... where they seriously work inside the unit on preparing quality soldiers. Yeah, maybe there. In most average units, in most units, no one cares about psychological readiness

14 - Order of the Commander-in-Chief of the Armed Forces of Ukraine No. 173.


15 - Organizing Psychological Readiness Training in the Armed Forces of Ukraine: Training and Methodical Manual/ Edited by Major General V. Klochkov. – K.: Research Center for Humanitarian Problems of the Armed Forces of Ukraine, 2023. – 325 p.

16 - Standards CTI 000Г(В).58А, CTI 101А.26В, CTI 000Г.22Л, CTI 000А.22А, CTI 000Г.22К.(И), CTI 000Г.22Л.02


17 - How do civilians become soldiers? Issues of basic general military training in the Armed Forces of Ukraine (as of 2024). <https://cbacenter.ngo/page/doslidzennia-iak-civilna-liudina-staje-viiskovoju-problematika-bazovoyi-zagalnoviiskovoyi-pidgotovki-v-zbroinix-silax-ukrayini-stanom-na-2024-rik>

training, period. Well, at least where I was. Of course, on paper, in official reports, they say activities are conducted, and that's it.”  
**(Company combat medic)**

A separate third task is to help meet the need for specialized mental health interventions during BGMT (such as urgent adjustment of treatment for an existing mental disorder or crisis interventions after suicidal incidents in the unit during BGMT). Access to specialized assistance at this moment is limited by: (1) TC staff attitudes, who immediately interpret such complaints as malingering and evasion, and (2) Unrefined referral pathways to specialized assistance at this level. Despite isolated examples of quality assistance from instructor-psychologists, general accessibility is low. TC staff must be trained in low-intensity evidence-based interventions (suicide prevention gatekeeping training) and have a clear referral algorithm.


 “I needed a psychiatrist consultation to slightly adjust medication doses, because a different scheme was needed. I couldn't have a meeting with one at all because everyone thought I was slacking, nobody believed I actually needed help. Well, the knowledge of psychology in the army is somewhat lacking. Not for everyone, but for some people.”  
**(Psychologist at a psychiatric hospital)**

There is potential for change, though. Respondents talk about effective, war-adapted practices – from programs aligned with NATO standards and NGO projects to developments by specialized AFU units, effective programs of individual units of the AFU and NGU, which can be replicated. It would be smart to describe the standards of these practices and scale them up.

 “We have a corresponding pre-training program for recruits. It lasts 2 to 4 weeks, depending on the recruits who arrive. And we have our own fairly sizable part of the program. It includes... assessment of the psycho-emotional state of recruits entering the course, and ... during the implementation of the course program, we conduct several sessions, including not only theoretical but also practical ones. For example, ICOVER protocols or other methods of first psychological aid for affective conditions, training outdoors, on the training ground, or somewhere outdoors. We practice all these things.”  
**(Brigade officer-psychologist)**

Respondents also describe effective but uncommon experience using VR technologies, which help perform psychological readiness training tasks for combat readiness.

For professionally oriented training, the heterogeneity of service members' motivation (lower among involuntarily mobilized), varying levels of learning skills, and, accordingly, the pedagogical competence of instructors, remain critical. With the emotional immaturity of some instructors, the expected quality of this module decreases. An additional risk factor is hidden conflicts between instructors with combat experience and those without; this must be considered when implementing changes at the BGMT stage.

 “A person who was caught, called up, is still morally unstable, not ready for this. They are distancing themselves. They begin to work themselves up, thinking that everything's going wrong, and so on. And after joining the army, they are not ready for these or other extreme conditions. I am telling you, there are

three groups of service members for basic general military training. Or even professional. We also teach professional skills. There are three different categories of service members. The first category, these are those who 'received some guidance' or 'paid their way out' or something else. They come, they don't want to learn anything. They don't want to. Later, once they are assigned to their brigade, they'll come and say: 'Nobody taught me.' But they don't want to. They just walk around and loiter, so to speak. They just don't want to. They slack off. The second category of service members includes those who want to. They understand, they want to, they learn. And both instructors and teachers maintain contact with them afterward. The third category of service members are those for whom there is little time for training. That's the thing So they need more time. They don't absorb information as quickly as, for example, the second category of service members. But I wouldn't classify them as those slacking off. They try, they do. But they can't absorb everything as quickly." **(Service member, junior officer rank)**

BGMT cannot fully meet the needs for long-term psychological readiness 'once and for all' – repetition and reinforcement at key service moments are necessary. This will not only update knowledge among those who have completed training but also provide necessary knowledge and skills for the first time to the service members mobilized in 2022, when, according to experts, psychological readiness training was ineffective, e.g., in the form of lectures without practical exercises. Technological solutions for large-scale, convenient training in war conditions (online modules, microlearning, simulations) are relevant.

Finally, the problem with the lack of continuity of psychodiagnostic data clearly emerges. Tests are often done at the BGMT stage, but subsequent levels of the system do not have clear protocols for using these results. Unified data transfer routes, data protection, and feedback mechanisms between TCs and combat units are needed.

# ONGOING PSYCHOLOGICAL SUPPORT

## Description

Ongoing psychological support is a set of measures aimed at maintaining the optimal state of mental health among service members.

Ongoing psychological support objectives:

- Prevention of negative states
- Provision of timely assistance
- Identification of individuals with neuropsychological instability and prevention of their assignment to missions

Ongoing psychological support measures include:

- Psychological assessment
- Training sessions, education, individual and group sessions, and other types of collective training
- Psychoeducation and awareness-raising activities

Ongoing psychological support must be provided by commanders, officer-psychologists, combat stress control groups (CSCG), ongoing psychological support and recovery groups (OPSRG), as well as other officials responsible for the psycho-emotional state of their subordinates. However, in the regulatory framework, the duties and roles among these actors are not clearly delineated (“Ongoing psychological support is provided by commanders, officer-psychologists, CSCG, OPSRG, and other officials responsible for the psycho-emotional state of subordinates”).

Ongoing psychological support measures should be implemented in safe locations that ensure confidentiality.

In the current regulatory framework, self-help and peer support are not classified as ongoing psychological support. However, in terms of objectives (prevention and assistance), self-help and peer support are important ways to achieve them. In addition, from this same perspective, pastoral support from chaplains and psychological services provided by non-governmental organizations can also be considered part of ongoing psychological support.

A separate order of the Commander-in-Chief of the Armed Forces of Ukraine<sup>18</sup> defines the procedure for organizing moral support for the AFU service members. Moral support is not included in the concept of ‘psychological support’ as defined in the corresponding order<sup>19</sup>, in the Regulation on the Psychological Service of the Armed Forces of Ukraine<sup>20</sup>, and in the draft order of the Ministry of Defense<sup>21</sup>. However, according to Order No. 177, moral support is provided by commanders (chiefs) of all levels through the officials of the structural units responsible for personnel psychological support. Accordingly, officer-psychologists are tasked with both psychological and moral support, and the balance between these duties must be determined by the unit commander.

18 - Order of the Commander-in-Chief of the Armed Forces of Ukraine No. 177 dated April 14, 2025.

19 - Order of the Commander-in-Chief of the Armed Forces of Ukraine No. 177 dated April 14, 2025.

20 - Order of the Commander-in-Chief of the Armed Forces of Ukraine No. 317 dated December 4, 2014.


21 - Procedure for providing psychological assistance to service members in the system of the Ministry of Defense of Ukraine, draft Order.

# Characteristics of the Organizational Structure and Mechanisms for Service Provision

The effectiveness of ongoing psychological support primarily depends on how roles, instructions, communication, and the interaction of psychologists with other service providers are organized. One of the most noticeable problems is the conflict of roles assigned to the position of a psychological support officer. The position often combines support functions with disciplinary control, which creates overload and makes the work of the psychologist less focused on providing assistance. As a result, specialists spend time on tasks that do not correspond to therapeutic goals and lose the opportunity to work systematically with service members. We have mentioned this earlier because this problem negatively affects multiple stages of the system simultaneously.

Another frequent obstacle is the inconsistency of professional instructions with actual service conditions. Instructions may exist on paper, but during combat operations and daily excessive workloads, they prove inconvenient or unsuitable for practical use. For example, this applies to instructions regard-

ing screening and mechanisms of referral for assistance. Psychological referral becomes a formality if there is no clear mechanism for continuing assistance (for example, access to rehabilitation or a specialist). There are cases when comrades or commanders notice a problem and initiate a referral – this is a critically important element of the detection system. Service members themselves emphasize the importance of immediate referral in cases of obvious signs of severe stress:

 “I, seeing his condition, referred him to the PPS officer, and (he) referred him to rehabilitation.”  
**(Servicewoman, junior sergeants and starshinas)**

This example demonstrates that when processes function properly, they can prevent problem deterioration. Otherwise, service members’ problems remain unresolved, and they lose faith that they can influence important events in their lives.

# Characteristics of Providers

Ongoing psychological support in the military is provided by various groups of providers: military psychologists, commanders and informal leaders, chaplains, and military medical personnel. Each of these categories plays an important role, but their effectiveness is highly uneven and significantly depends on their level of competence, motivation, and the conditions in which they operate.

Service members often note that the attitude of some commanders toward psychological needs is indifferent. In such cases, soldiers have neither proactive support initiatives nor discussions on topics important to them. This creates a sense of abandonment, especially among younger service members who cannot cope with the workload. As one provider noted:

“My comrades are young, around 20 years old... they were simply discharged because of injuries. Unfortunately, they became addicts because nobody cared about them.” **(Officer of the Ongoing Psychological Support and Recovery Group of the Brigaden)**

Chaplains and informal leaders in units play a special role in peer support. Their informal conversations, advice, or even mere presence often create a safe space that is lacking in the formalized system. In units composed of foreigners, chaplain support is crucial because they remain the only ones able to provide ongoing psychological support measures in their native language.

The lack of professional education and competencies among deputy commanders for PPS is a systemic problem. Often, random individuals without any psychological readiness training are appointed to these positions, making them ineffective in crisis situations. One service member described a similar experience as follows:

“That person had zero competence... Service members wanted to shut him down rather than engage in any kind of conversation.” **(Servicewoman, junior sergeants and starshinas)**

Even psychologists themselves are not always free from biases. Sometimes they inadvertently stigmatize service members with mental health issues, using labels and devaluing complex conditions. This reduces trust and hinders timely help-seeking.

For military psychologists, it remains a difficult task to distinguish simulation from real crisis states. The inability to draw this line creates risks both for the discipline and combat readiness of the unit and for those who genuinely need help.

Alongside these challenges, a notable feature is the high level of intrinsic motivation among many specialists. Moral and patriotic values, a sense of duty and responsibility often become sources of resilience for service providers in difficult circumstances. As one of them explained:

“When it was difficult and hard, I would remind myself why I came here... It helped me sometimes.” **(Company combat medic)**

An important characteristic is also the persistence of some commanders in defending the rights of service members to receive treatment. They can act against administrative or medical pressure to ensure hospitalization and proper care. As one junior officer recalls:

“All because this neurologist also has an unofficial cutoff... We tell them straight up that they should back off, and we will refer as we always have.” **(Service member, junior officer rank)**

Thus, psychological support providers in the army form a heterogeneous group: from professional psychologists to commanders, medics, and chaplains. Their effectiveness is determined by a combination of professional competence, personal motivation, and readiness to take responsibility in crisis moments. Despite a lack of training and risks of stigmatization, key factors remain humanity, persistence, and the ability to create a supportive atmosphere – these traits most often determine whether a service member receives timely and effective assistance.

## Characteristics of Interventions

The measures at the Ongoing Psychological Support stage, according to study participants, encompass a variety of forms of support. They combine both psychological interventions and a broader range of informal practices that arise within combat units.

Assistance from military psychologists, which they themselves consider effective, is practically built around regular visits to units. Even short-term meetings prove useful, as they allow service members to vent, receive attention, and care. However, a critical limitation is still the shortage of qualified personnel: a few officer-psychologists have to take care of thousands of service members, making it impossible to reach all personnel. Psychologists themselves acknowledge that due to lack of time they cannot conduct ongoing psychological support measures of sufficient duration and quality, and service members often do not trust their confidentiality because they are subordinate to commanders. Some structured interventions demonstrate effectiveness, for example group debriefings after crisis events. Advising commanders on organizing rest for soldiers was also noted as effective by the respondents. However, such measures are not always feasible due to the limited availability of psychologists. Additionally, both service members and providers note the formality of psychological testing and lack of transparency in the procedures for inclusion in 'high-attention' groups, which reduces trust in official procedures.

Service members themselves emphasize the value of even brief moments of individual attention:

“Even just that we came, they simply got to talk it out. They saw new people, vented, and felt better.” **(Officer of the Brigade Ongoing Psychological Support and Diagnostics Group)**

Alongside formal measures, there is a whole spectrum of informal assistance. It emerges in the daily life of units and serves as real psychological support capable of reaching all service members. This includes peer support among comrades, informal conversations with chaplains or medics, as well as service member's own self-help strategies: calling family members, sports, humor, caring for animals, or even small household chores.

All of this helps reduce tension and strengthens the sense of control over the situation. One service member emphasizes:

“Probably the pet helped the most... everything seems fine.” **(Servicewoman, senior sergeants and starshinas)**

Service providers also stress the importance of simple informal communication:

“If you see that the guy is not doing well, you just approach and ask: ‘What’s wrong?’ You sit down, have a cigarette with him, and just talk.” **(Company combat medic)**

A key factor in ongoing psychological support is the microclimate within the unit. Warm relationships, mutual assistance, and even dark humor strengthen resilience and reduce the

risk of psychological burnout. At the same time, the group can also act as a barrier limiting access to information or reinforcing undesirable self-coping practices if they become the norm within the unit. Service members recall self-help knowledge and skills they acquired during BGMT and apply them in critical situations. Some psychosocial and psychodiagnostic innovations have been tested and are positively assessed by both service providers and military personnel. For example, these include the use of remote assessment through eye-

tracking or VR technology to reduce stress. An additional resource that service members find on their own is remote counseling by civilian psychologists. However, innovative and effective approaches are unevenly distributed and are not part of the systematic activity of the psychological service. They are implemented thanks to the initiative and qualifications of individual military psychologists or the personal initiative of the service members themselves

## Conclusions and Recommendations

### 1. OPTIMIZE THE STRUCTURE OF THE SYSTEM OF PSYCHOLOGICAL SUPPORT OF OPERATIONS

**Problem:** Ongoing psychological support is regulated by several orders of the General Staff of the Armed Forces of Ukraine (Nos. 174, 349, 378). The conceptual framework and the definitions of system elements (for example, the definition of psychological assistance) in these documents are not aligned with each other or with other documents (the Doctrine<sup>22</sup>). The orders do not clearly allocate functions among the actors.

**Consequences:** Ambiguity in wording and lack of division of responsibilities prevent the implementation of an effective structure of the psychological support of operations.

**Opportunities / Solutions:** Review and update key regulatory and legal acts (taking into account other conclusions below), providing a clear system structure, and define the responsibility of each actor.

### 2. SEPARATE THE ROLES OF PSYCHOLOGICAL AND MORAL SUPPORT OF OPERATIONS AMONG ACTORS

**Problem:** Combining disciplinary functions (including official investigations contrary to existing norms<sup>23</sup>) with the therapeutic functions of a psychologist is mutually contradictory. If a single position combines disciplinary functions, moral support, and psychological support in functional responsibilities, the priorities of command staff usually do not favor psychological support. Moreover, involving officer-psychologists in official investigations undermines trust and confidence in confidentiality on the part of service members.

**Consequences:** Officer-psychologists do not have time to engage in ongoing psychological support. Service members avoid seeking help, even when they have genuine needs for it.

**Opportunities / Solutions:** Separate moral and psychological support functions across different positions.

22 - Doctrine 'Psychological Support of Personnel' approved by the Commander-in-Chief of the Armed Forces of Ukraine on August 21, 2025.

23 - Clause 8.3 of Section II of C-in-C Order No. 349 prohibits involving psychologists in official investigations.

### 3. DELEGATE TASKS FROM PSYCHOLOGISTS TO NON-PROFESSIONALS AND STRENGTHEN NON-SPECIALIZED PSYCHOLOGICAL SUPPORT

**Problem:** The execution of ongoing psychological support tasks is mainly assigned to officer-psychologists, who are in short supply. At the same time, there are other barriers to accessing psychologist's support: lack of confidentiality and anonymity, dispersed units, lack of communication, risks of traveling to combat zones.

**Consequences:** Stage tasks are performed partially or formally (testing), while quality psychological assistance is largely inaccessible.

**Opportunities / Solutions:** Enhance the role of non-specialized psychosocial support by delegating some functions (task shifting) to non-professionals (training in self-help and peer support skills, psychoeducation, brief interventions) provided there are established algorithms, training, and supervision. Scale up non-professional training (without changes to the staffing structure or by introducing appropriate positions) in peer support methods, brief interventions, e.g., TRIM. Delegate part of the ongoing psychological support and recovery tasks to non-professionals.

### 4. SCALE UP EFFECTIVE LEADERSHIP PRACTICES OF COMMANDERS AS THE KEY CONDUITS OF PSYCHOLOGICAL SUPPORT

**Problem:** Commanders have a decisive impact on the psychological climate within the unit and on subordinates' access to support, yet their training remains unsystematic and insufficiently standardized. Managerial maturity among commanders will always vary.

**Consequences:** At best, commanders provide support; at worst, they become a source of additional stress.

**Opportunities / Solutions:** Develop and implement simple standards for several key processes for commanders. Prepare training module materials for commanders and dedicate 5-10% of the total training scope to issues of mental health support. Improve trainer preparation to scale up training.

### 5. DEVELOP UNSTRUCTURED PSYCHOLOGICAL SUPPORT WITHIN UNITS

**Problem:** There are effective practices of mutual support (humor, encouragement, mentoring) and the use of short leave, but their implementation is uneven and depends on the unit's culture.

**Consequences:** In 'healthy' units, these practices enhance resilience; in 'toxic' units, they are virtually absent.

**Opportunities / Solutions:** Systematize and disseminate best practices of commander leadership through the training of formal and informal leaders (instructors, junior commanders, assistant psychologists), making these methods accessible and more uniform.

### 6. IMPROVE SCREENING TOOLS AND REFERRAL ALGORITHMS

**Problem:** Referral of military personnel to specialized support, as well as identification of those in need, work poorly. There are complaints about formalized testing and the absence of modern digital screening tools. Additionally, determining recovery levels in a multi-step model requires a clear and transparent procedure based on objective and valid assessments.

**Consequences:** Service members with real needs get no recovery or treatment, losing trust in the system.

**Opportunities / Solutions:** Introduce validated digital screening tools. Improve standard operating procedures for data collection and use, taking into account the real situation in units.

Digitize data collection and storage. Use ethical protocols. Engage Ukrainian scientific organizations, preferably in cooperation with international scientific and academic partners, to develop a unified, end-to-end diagnostic tool adapted to the Ukrainian context for accurate triage and evaluation of intervention effectiveness.

### 7. CONTINUE REDUCING STIGMA AROUND SPECIALIZED PSYCHOLOGICAL SUPPORT

**Problem:** Service members perceive informal peer support positively, but specialized help (from officer-psychologists and psychiatrists) often provokes fear and stigma. Stigma from providers, psychologists' role conflicts, witnessing negative experiences of fellow service members in psychiatric hospitals, and general distrust of psychological assistance create a combined negative effect.

**Consequences:** Reduced willingness to seek professional help even in crisis situations. During treatment, service members may have negative experiences.

**Opportunities / Solutions:** Advocate for reducing hospitalization without indications and for quality checks of inpatient care, implementing standards for communication with service members. Target stigma-reduction programs at all components of the system through leadership school training programs.

### 8. SCALE UP BRIEF INTERVENTIONS THAT CAN BE DELIVERED BY BOTH PSYCHOLOGISTS AND NON-PROFESSIONALS (CHAPLAINS, COMBAT MEDICS, VOLUNTEERS, INFORMAL TEAM LEADERS)

**Problem:** There are tested and contextually adapted ongoing psychological support and assistance methods in Ukraine, including digital tools (applications Baza, Anima, Pryzma, Training for Assistant Psychologist Instructors with Supervision Component, ICOVER, TRIM, gatekeeper training for suicide prevention, early interventions to reduce substance abuse (AUDIT, motivational counseling), evidence-based trauma-focused counseling programs (CETA, UP+, EMDR). However, they are not included in official methodological recommendations, and their application is limited.

**Consequences:** The potential of existing methods is underutilized.

**Opportunities / Solutions:** Include tested methods in methodological recommendations. Pilot these methods among non-professionals using peer support approach.

# PSYCHOLOGICAL RECOVERY

## Description

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Psychological recovery is a set of measures aimed at preserving, restoring, and correcting the psychophysiological and psychological functions of military personnel affected by psychotraumatic factors.

Unlike ongoing psychological support, which (like any prevention) must cover all service members, recovery must be carried out only with certain service members according to their needs.

Tasks of psychological recovery:

- Selection of personnel in need of recovery
- Decompression
- Assistance during the deployment of troops
- Recovery in specialized facilities

The psychological recovery system is divided into five levels:

1. Self-help and peer support (within three hours after a psychotraumatic event)
2. Recovery at the battalion level (up to three days)
3. Recovery at the brigade level (up to three days)
4. Recovery in specialized facilities in rear areas (7-14 days)
5. Recovery in specialized facilities outside the combat zone (up to 21 days)

Sequential referral is provided for between recovery levels, conditioned on the insufficiency of measures at the previous level. Accordingly, such a system implies that the number of service members requiring recovery decreases at each subsequent level, and quantitative recovery needs can be schematically represented as a pyramid (where the smallest portion of personnel requires the most intensive recovery).

The range of measures included in recovery starting at the brigade level is very broad – from in-depth diagnostics to physical activities and cultural events. In specialized facilities, the range of measures is even wider and includes psychophysiological (physiotherapy) and social (cultural and leisure activities, as well as social adaptation) components.

In this psychological recovery scheme, decompression is not highlighted as a separate level or stage in regulations, but it is noted as a form of primary recovery, mandatory for all service members after performing combat tasks.

## Characteristics of the Organizational Structure and Mechanisms for Assistance Provision

An important part of stepwise recovery is the needs assessment procedure using screenings designed to help identify those who require referral – from brigade-level support to recovery in specialized facilities outside the combat zone. The routing mechanism involves interaction between psychologists, medical services, and commanders. One of the key elements of routing is the availability of clear instructions specifying criteria for triage and referral: from assistance at psychological support points to full rehabilitation in specialized centers. However, in practice, confusion often arises between routes: service members may be referred not to recovery but directly to treatment in psychiatric facilities. This creates an additional barrier and increases stigma, as the path from the unit to a psychiatric hospital appears far more complicated and less acceptable to the service member than temporary recovery in a center.

A separate challenge is the complexity of approval procedures during referral. To receive specialized psychological support, a service member must navigate a multi-level bureaucratic system of reports and permits. This not only slows access to assistance but also makes it less understandable for the service members themselves. The first step in seeking help remains the hardest: for many, recognizing the need for psychological support comes with an internal barrier and a lack of navigation in the system. As one service member described:

“Somehow this barrier, ‘I have to do this’ is hard to overcome in such a case. If someone had told me: ‘Just go, they’ll talk to you, and you’ll understand if you need

it or not’... It’s hard for me to go and say: ‘Yes, I need it.’” **(Service member, enlisted rank)**

During the study, we did not receive any information on the existence of a digital information system for storing data on the psychological state of service members. The development and implementation of such a system are necessary to preserve and transmit data within the multi-step multidisciplinary psychological recovery process. At the same time, experts noted the existence of such a system in the psychological service of the National Guard of Ukraine, which could be adapted to the needs of the AFU.


One of the main challenges of the stage, mentioned by study participants, is the lack of a sufficient number of specialized centers, especially in close proximity to combat zones. At best, service members could go through recovery programs in remote facilities, which complicated logistics and reduced timely assistance. As one provider explained:

“Well, there are no centers located as close as possible to the combat zone. The closest ones are psychological assistance points deployed by the brigade.” **(Officer-Psychologist)**

Despite these challenges, there are resources that could be used to expand the actual capacity of the recovery stage: sanatoriums, tourist facilities, and recreational facilities in rear areas, which remain unused during the war. They could be engaged through agreements, integrating

them into decompression measures and short-term recovery programs at the brigade level. Engaging civilian psychologists could help address the shortage of military psychologists.

In some regions, infrastructure exists for organized recovery. Centers accommodate 30 to 100 service members at a time; programs last two weeks and include daily meetings with psychologists. Stays at these centers are free thanks to government funding, allowing service members to undergo both psychological and medical procedures. One service member said:

 “Firstly, of all, everything was free; secondly, we were given roughly

900 hryvnias per day for our stay... So I underwent all the screenings I wanted.” **(Servicewoman, junior sergeants and starshinas)**

At the same time, practical limitations arise. The number of vouchers and available spots in centers is extremely limited: sometimes only a few spots are allocated for an entire battalion. Conditions do not always meet recovery needs: overcrowded rooms, noise, and heat reduce the effectiveness of rest. An additional risk is the location of some centers – proximity to strategic facilities that are regularly shelled causes stress rather than relief.


## Characteristics of Providers

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The effectiveness of psychological recovery stage, which involves professional mental health support, largely depends on the service providers: officer-psychologists and the staff of recovery centers and healthcare facilities. Their role lies not only in providing assistance but also in launching and sustaining the recovery system itself.


There is certain unevenness in this regard: as with the entire support system, it was noted that some specialists lack the appropriate training, while others demonstrate high professionalism, are able to conduct resource debriefings, psychoeducational sessions, and design individualized recovery plans. An important characteristic is the initiative demonstrated by the officer-psychologists. They are often the ones who look for opportunities to refer service members to recovery

centers, make arrangements with facilities, and create channels for accessing resources. As one of the providers noted:

 “In simple terms, that’s the psychologist’s job. Find a way to reach this recovery facility, arrange the stay, and send the people who need it there.” **(Officer of the Ongoing Psychological Support and Recovery Group of the Brigade)**

The influence of the commander as a service facilitator at this stage is also evident, as we have mentioned earlier.

When it comes to the staff of the recovery centers, service members particularly value specialists who have experience working with the military and are able to communicate effectively with them:


 “Well, specifically with this psychologist... this lady works a lot with soldiers returning from captivity... I think she’s competent.” **(Service member, junior officer rank)**

It is also worth noting the healthcare professionals involved in recovery programs implemented at healthcare facilities. Where the attitude is attentive and friendly, service members report a much greater positive effect from their stay and a higher willingness to engage in the process.

## Characteristics of Interventions

Recovery programs, both at the brigade level and in specialized institutions, are designed to be comprehensive. In addition to psychological assistance, service members undergo medical examinations, massages, physiotherapy, and the opportunity to take part in sports and cultural activities. This creates a sense of care and multidimensional support and is meant to ensure a gradual return of service members to a more stable state after intensive combat operations. However, in practice, implementation faces significant challenges.

First, planned decompression activities rarely take place in full. A lack of rotations, time, and suitable conditions prevents the creation of a safe environment. When units remain in the same operational area for years, they have no formal opportunity to undergo recovery. This leads to cumulative exhaustion and reduced combat effectiveness. Often, decompression is reduced to superficial recreational activities without any psychological processing, after which service members are quickly returned to duty. As providers emphasize:

 “In practice, unfortunately, it doesn’t work, we just don’t have

enough time for unit recovery.” **(Deputy commander for moral and psychological support of operations)**

Second, the content of recovery programs at the brigade level and in specialized facilities is not clearly defined, so there are no unified service standards. Each provider implements their own understanding of what types of activities are effective during psychological recovery. In the desk review part of the study, we analyzed several publications describing the content of recovery programs in inpatient facilities. However, data on the effectiveness of these programs in scientific sources are virtually absent. We found only two publications presenting results of recovery program implementation<sup>24, 25</sup>, but the reliability of those studies remains uncertain (due to the absence of information about study protocols, ethical approval, use of non-randomized observational designs, and a general lack of detailed information about study organization and data collection). As a result, it is impossible to assess the actual effectiveness of recovery programs.

24 - I. I. Prykhodko, Ya. V. Matsehora, M. S. Baida. Psychological Recovery of Ukrainian Service Members After Prolonged Participation in Combat Operations.

25 - Kohut, O. & Vyshnichenko, S. (2023). Results of Testing a Rehabilitation Program for Service Members. Scientific Bulletin of Uzhhorod National University. Psychology Series. 109–115. 10.32782/psy-visnyk/2023.3.22.

## Conclusions and Recommendations

### 1. IMPROVE THE PROFESSIONALIZATION OF THE PSYCHOLOGICAL SERVICE

**Problem:** Only some of psychologist positions are staffed with specialists who have formal psychological training.

**Consequences:** There is a lack of basic professional competencies required to carry out recovery activities. This results in the lack of effective recovery, loss of resources, and trust in the service as a whole.

**Opportunities / Solutions:** Determine the number of psychologists needed based on the optimal workload required to perform recovery activities (mobilization task – select qualified psychologists). Concentrate officer-psychologists with professional training in specialized units at the brigade (or corps) level. In such units, prioritize the training and supervision of nonprofessionals and the provision of specialized support in their functional duties.

### 2. ENSURE FLEXIBILITY IN CHOOSING RECOVERY MEASURES BASED ON AVAILABLE RESOURCES

**Problem:** Planned recovery stages cannot be fully implemented. Decompression rarely takes place due to the lack of rotations. Recovery in the rear zone and outside combat areas does not differ much because of the shortage of centers. RLAs stipulate sequential referral between stages.

**Consequences:** Formally, a multilevel model is in place, but in practice, most of its components do not function. This reduces trust in the system and risks overloading the few active centers. A brigade psychologist has almost no options for recovery measures that can realistically be implemented at the battalion level given limited resources.

**Opportunities / Solutions:** Develop and standardize additional recovery activities that can be implemented under limited staffing and without removing the unit from its operational zone. Provide for the possibility of referral to any level of recovery from any level. This will ensure flexibility in selecting recovery measures based on available personnel and infrastructure resources.

### 3. STANDARDIZE RECOVERY PROGRAMS AND CREATE AN EVIDENCE BASE

**Problem:** Ukraine has no standardized 2-, 3-, 7-, or 14-day recovery programs with proven effectiveness. Fragmented or author-designed approaches are used. Recovery funding is irregular and based on temporary mechanisms (the NHSU rehabilitation package, international funds).

**Consequences:** Recovery quality is inconsistent; effective practices are hard to scale up; there is no evidence base for attracting state or international funding.

**Opportunities / Solutions:** Conduct comparative studies of the effectiveness of programs of varying duration, standardize them, and secure Ministry of Defense funding for their implementation and scaling. Institutionalize partnerships (sanatoriums, NGOs, HCFs) through unified procurement rules (requirements, specifications).

### 4. ESTABLISH EFFECTIVE COOPERATION BETWEEN HEALTHCARE PROFESSIONALS, PSYCHOLOGISTS, AND TRAINED NONPROFESSIONALS

**Problem:** Military general practitioners are not systematically trained under the mhGAP program, and there are no established procedures for

joint case management among medical staff, psychologists, and trained nonprofessionals. There is a lack of teamwork skills in multidisciplinary teams.

**Consequences:** Service members receive fragmented assistance with no continuity, which reduces recovery effectiveness.

**Opportunities / Solutions:** Review job instructions and defined duties for each role according to a task-shifting strategy, including joint case management procedures with screening, case management, triage based on needs, impact monitoring, and case supervision. Conduct joint trainings involving a psychiatrist, medic, psychologist, and trained nonprofessional (psychologist assistant) to improve coordination.

## 5. INTRODUCE INFORMATION SYSTEMS TO ENSURE CONTINUITY OF PSYCHOLOGICAL SUPPORT

**Problem:** There is no unified digital system containing service member's data (diagnostic results, history of interventions, recovery plans, self-help materials).

**Consequences:** Data are scattered, making it difficult to optimize resources and determine the most effective type of recovery.

**Opportunities / Solutions:** Adapt and scale existing digital information systems that integrate psychological and medical data about the service member (psychological status, requests, implemented medical and psychological interventions) from registration through training, service, and demobilization.

## 6. ENHANCE PSYCHOLOGISTS' QUALIFICATIONS IN EVIDENCE-BASED METHODS

**Problem:** The level of training among military psychologists is uneven, particularly regarding evidence-based interventions.

**Consequences:** This lowers the quality and effectiveness of recovery programs and limits the ability to scale best practices.

**Opportunities / Solutions:** Compile a list of priority evidence-based interventions, engage civilian and international organizations in training, and secure funding for professional development.

## 7. PROVIDE PROFESSIONAL TRAINING FOR RECOVERY CENTER STAFF AND ENGAGE VETERANS

**Problem:** Specialists in recovery center programs often lack sufficient qualifications and fail to inspire trust among service members.

**Consequences:** This reduces the effectiveness of programs and may further undermine confidence in the recovery system itself.

**Opportunities / Solutions:** Encourage retraining of veterans and demobilized service members in evidence-based trauma-focused interventions and engage them in recovery programs.

## 8. BUILD A KNOWLEDGE BASE GROUNDED IN RESEARCH DATA

**Problem:** Decisions about recovery programs are made without sufficient information on the effectiveness of particular interventions.

**Consequences:** Uncertain effectiveness of limited resource use undermines trust in the system's effectiveness.

**Opportunities / Solutions:** Identify priority psychological recovery interventions and commission comparative studies, for example: Comparing the effectiveness of online CBT and (I)CBT during recovery; Comparing specialized psychological support programs vs. leave or non-specialized assistance (peer support, family, animal-assisted recovery), etc. Provide training for MoD research institutions on modern research methods (implementation studies, cohort studies, etc.).

# TREATMENT OF MENTAL DISORDERS

## Description

All services provided in state-owned and municipal healthcare facilities as part of the Medical Guarantee Program are theoretically available to service members, according to the concept of a unified medical space<sup>26</sup>. Funding for healthcare services, including mental health services, provided under the State Program of Medical Guarantees for the Population, is carried out by the National Health Service of Ukraine (NHSU) in

accordance with the established Procedure<sup>27</sup>. Financing is provided based on contracts between the NHSU and healthcare facilities for specific medical service packages, for which unified specifications and procurement conditions are established, and which all providers must comply with.

Overall, mental health treatment services are included in the following packages of the Medical Guarantee Program.

Package	Services related to mental health	Number of providers as of July 25, 2025
Primary healthcare	Provision of specific mental health services, including: <ul style="list-style-type: none"> <li>• Screening for mental health disorders, as well as neurological disorders and substance use disorders (SUDs) in patients</li> <li>• Providing emergency (crisis) psychosocial assistance in cases of acute stress reaction or acute crisis</li> <li>• Providing psychosocial assistance to prevent the escalation of psychosocial problems, their progression to chronic forms, or the development of mental and behavioral disorders or other mental health problems</li> <li>• Managing patients with SUDs through <b>pharmacotherapy</b> and psychosocial assistance within the competence of the family doctor, in line with RLAs and the mhGAP program</li> <li>• Implementing preventive measures for groups, families, and individuals at highest risk of difficult life circumstances due to adverse external and/or internal factors</li> </ul>	2582

26 - Military Medical Doctrine of Ukraine, approved by the Resolution of the Cabinet of Ministers of Ukraine, dated October 31, 2018, No. 910.

27 - Resolution of the Cabinet of Ministers of Ukraine dated December 24, 2024, No. 1503 Certain Issues of Implementing the State Program of Medical Guarantees for the Population in 2025.

	<ul style="list-style-type: none"> <li>• Issuing referrals to SUD patients, when necessary, to meet a psychiatrist or addiction specialist for consultation and treatment</li> <li>• Raising awareness, encouraging, and supporting the population in maintaining mental health and well-being</li> </ul>	
<b>Prevention, diagnosis, monitoring, and outpatient treatment</b>	<p>Providing patients with specialized consultative-diagnostic, therapeutic, and preventive medical care and healthcare services in specific areas, including:</p> <p>1.17. Psychiatry – consulting, diagnosing, assessing, and treating patients with mental and behavioral disorders. Includes educating patients and/or their legal representatives to improve their knowledge, awareness, and understanding of the illness, as well as providing recommendations for preventing deterioration in condition.</p> <p>1.40. Psychology – assessment, diagnosis, and treatment of mental disorders associated with conditions affecting the brain, including: (a) Assessing the nature of cognitive, behavioral, and emotional changes caused by acquired or degenerative conditions or brain trauma; (b) Assessing how these changes affect lifestyle; (c) Cognitive testing; (d) Cognitive therapy and ongoing psychosocial support. Includes educating patients to improve their understanding of their condition and providing recommendations to prevent deterioration of mental disorder symptoms.</p>	1113
<b>Inpatient psychiatric care for adults and children</b>	<ul style="list-style-type: none"> <li>• Conducting psychiatric examinations</li> <li>• Performing necessary psychodiagnostic testing</li> <li>• Pharmacotherapy, psychotherapy, psychological interventions, and rehabilitative assistance</li> <li>• 24-hour medical follow-up by a psychiatrist</li> </ul>	118
<b>Psychosocial and psychiatric assistance for adults and children provided by mental health centers and mobile multidisciplinary teams</b>	<ul style="list-style-type: none"> <li>• Providing psychosocial assistance and services related to mental health at the secondary outpatient level, in line with national healthcare standards</li> <li>• Providing outpatient psychiatric care, in particular by multidisciplinary or mobile multidisciplinary teams</li> <li>• Developing and implementing individualized recovery plans</li> </ul>	128

	<ul style="list-style-type: none"> <li>• Assessing the needs of patients with mental and behavioral disorders for social services and supporting their social and vocational reintegration</li> <li>• Providing psychological support to family members of the patient</li> </ul>	
<b>Outpatient rehabilitation care for adults and children</b>	<ul style="list-style-type: none"> <li>• Mental health services are not listed separately in the specifications, but the scope of services includes:</li> <li>• Developing individualized rehabilitation plans and therapy programs by rehabilitation specialists – members of a multidisciplinary rehabilitation team</li> </ul>	513
<b>Inpatient rehabilitation care for adults and children</b>	<ul style="list-style-type: none"> <li>• Additionally, requirements include:</li> <li>• Availability of a psychological assistance office</li> <li>• Availability of a psychologist and/or psychotherapist, and/or clinical psychologist</li> </ul>	368

Service members can access mental health services in the healthcare sector in two ways. The first is by self-referral to facility during leave, under general procedures. The second is through a referral from a military unit doctor following the procedure described in Article 260 of the

Internal Service Regulations of the AFU. However, this article directly regulates only referrals for inpatient examination and treatment – therefore, referrals for outpatient medical services outside the military unit are not standardized.

## Characteristics of the Organizational Structure and Mechanisms for Assistance Provision

The treatment stage for service members is shaped by the intersection of three dimensions: access organization (how and where a person enters care), the quality of initial triage and routing (what should be done for this specific patient right now), and the system’s ability to maintain continuity of therapy (how much and what kind of care the service member actually receives).

**Access and entry threshold.** Urgent psychiatric care often begins too late – at the stage of hospitalization in remote facilities. The distance to specialized facilities and dependence on the chain of approvals raise the threshold for seek-

ing help and delay treatment initiation. In practice, a service member almost never has the option to independently choose a facility and seek care directly; decisions go through the unit and the medical service, which often delays access to help.



“...when it’s already an acute condition and hospitalization, it’s because of care remoteness... by that point, the person is already in severe condition... The main issue is... organizational.”  
**(Psychiatrist)**

● “...you can’t just go to a hospital to see a doctor. You need the head of the medical unit to issue a referral. They either validate the request or don’t.” **(Service member, enlisted rank)**

**Triage and routing.** Initial triage at the brigade level is often inconsistent: clear algorithms, proper training, and supervision are lacking. As a result, psychiatric inpatient hospitals receive patients who could have been treated through outpatient psychiatric care and psychotherapy at their service location. At the same time, sporadic telepsychiatry consultations involving military psychologists and medical service heads have shown high effectiveness allowing some service members to remain in their unit with short-term support and a quick return to duty. However, such a model is still not sufficiently regulated.

● “...telepsychiatry consultation... out of 10 consultations, 8 were not sent to the rear and quickly returned to duty; two were sent earlier because it was necessary. The model is effective, but not yet formally regulated.” **(Psychiatrist)**


**Treatment conditions and duration.** Inpatient psychiatric treatment often takes place in overcrowded wards, with short hospitalization periods (approximately 14 bed-days), and without subsequent follow-up by military healthcare professionals. Such limitations contradict the clinical needs of many service members who genuinely require inpatient care, especially for conditions where pharmacotherapy and psychotherapy require time and continuity. The low NHSU rates barely cover basic accommodation and meals during inpatient care. The cost of the MGP package for treating one inpatient (UAH 13,326.57 per episode, with a 0.751 coefficient for adjustment disorders – a typical diagnosis for referred service members) is disproportionate to the complexity and workload involved. Meanwhile, the mechanism for outpatient psychiatric treatment referrals from military units remains unregulated, effectively limiting patient choice to hospitalization only. However, the most common disorders, such as post-traumatic stress disorder, depression, anxiety disorders, and substance use disorders, primarily require outpatient care.

## Characteristics of Providers

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Providers at the treatment stage operate simultaneously across three dimensions: clinical (diagnosis, pharmacological and psychotherapeutic care), organizational (routing, coordination with military units, compliance with NHSU requirements), and emotional-ethical (addressing trauma, stigma, and the support vs. combat readiness dilemma).

Their daily work takes place under conditions of chronic time and staffing shortages, with a high administrative workload. This limits the time available for quality therapeutic contact, increases the risk of errors, and contributes to staff turnover. Some teams implement self-help programs and external supervision, but systemic support remains insufficient.


 “We have a time limit... to get everything done, you have to pack it all in... your personal life and your own mental health start falling apart.” **(Mental health center specialist)**

The overload is compounded by ethical dilemmas over priorities.

Study participants mentioned cases where providers avoided precise diagnoses and used ‘softened’ terms like ‘adjustment disorders’. Some doctors view psychiatric care requests with suspicion, interpreting them through the lens of ‘malingering’.


A visible issue is uneven qualification levels. Experienced psychiatrists and psychotherapists familiar with the realities of war inspire trust and can build individualized care plans. However, overall, the system faces a market overheating – the best specialists move to private or project-based sectors, while state-owned HCFs remain underpaid and understaffed. A particular shortage of military psychiatrists is evident.

At the same time, many participants emphasized the importance of a human-centered approach in treatment, tailored to the patient’s condition, and gradually restoring trust.

 “It really helped... the doctor was empathetic, visited every day, and you could sign up to talk... I felt better.” **(Service member, enlisted rank)**


## Characteristics of Interventions

For most service members, the 'initial' complaints are the same: sleep disturbances, memory and attention problems, and in some cases consequences of post-concussion syndrome or traumatic brain injuries. In general healthcare facilities, the path to psychological assistance often begins with a somatic cause: injury, exacerbation of illness during service or on leave. To ensure the patient 'does not get lost' between levels of care, 'warm' referrals are used: the team directly contacts specialized professionals and facilities (psychiatry, addiction services) and arranges appointments. This informal, yet effective, pathway between systems is perceived as a sign of attention and care. As described by a provider:

 "...we refer to those who handle this... municipal addiction center, regional... mostly manually, through warm referral." **(Mental health center specialist)**

At this stage, initial psychiatric diagnoses are often 'softened' to avoid recording more severe conditions that could affect service. This delays

the adjustment of the treatment plan and postpones specialized interventions. As clinicians explain:

 "Most often the diagnoses are PTSD or adjustment disorder... while the patient is already... barely holding it together. I mean, really severe PTSD or a post-concussion syndrome." **(Psychologist at a psychiatric hospital)**

A separate challenge is the treatment of addictions. Evidence-based short-term treatment programs that do not require hospitalization and can be implemented at the service location are limited (both in Ukraine and globally). Military facilities generally do not have full pathways for addiction care, and in civilian facilities military patients with addictions face stigma and lack access to treatment. Additionally, co-dependent behavior of family members (for example, passing medications into the ward) complicates care. As a result, interventions are often reduced to disciplinary measures, without a long-term remission plan.

## Conclusions and Recommendations

### 1. REGULATE THE REFERRAL MECHANISM FROM THE MILITARY UNIT TO RECEIVE OUTPATIENT CARE IN THE CIVILIAN SECTOR

**Problem:** There is no clear procedure for referral to outpatient psychiatric care (or any other outpatient care outside the military unit's location). The legal framework<sup>28</sup> defines a mechanism for referral to inpatient treatment in civilian HCFs, but it does not explicitly state whether this mechanism can be applied for outpatient care.

**Consequences:** Treatment begins late or does not start at all, which worsens symptoms and increases therapy duration. At the same time, patients with disorders that do not require hospitalization end up in inpatient care, leading to resource overuse and growing distrust of psychiatry.

**Opportunities / Solutions:** Develop and formalize a standardized referral mechanism for outpatient treatment as part of psychological support (including mental health centers). Develop criteria for hospitalization in cases of primary mental disorders and incorporate them into specifications and/or clinical standards.

### 2. DEVELOP HOSPITALIZATION CRITERIA FOR PSYCHIATRIC INPATIENT CARE (IN MEDICAL-TECHNICAL DOCUMENTS AND MGP REQUIREMENTS)

**Problem:** Referral of service members with mental disorders (or suspected disorders) to inpatient care occurs without objective indications. The specification of the MGP inpatient psychiatric package and clinical standards do not include criteria for hospitalization.

**Consequences:** Patients with severe disorders do not receive proper care, and stigma increases. At the same time, patients with disorders that do not require hospitalization end up in inpatient care, leading to resource overuse and growing distrust of psychiatry.

**Opportunities / Solutions:** Develop hospitalization criteria (and standards for duration) for mental disorders and include them in the MGP specification and/or clinical standards.

### 3. INCREASE TRIAGE ACCURACY AT THE MILITARY UNIT LEVEL AND DURING EVACUATION ROUTES USING TELEMEDICINE

**Problem:** Referral of service members with mental disorders (or suspected disorders) to inpatient care occurs without objective indications. Military doctors lack the qualifications to assess hospitalization indications.

**Consequences:** Patients with severe disorders do not receive proper care, and stigma increases. At the same time, patients with disorders that do not require hospitalization end up in inpatient care, leading to resource overuse and growing distrust of psychiatry.

**Opportunities / Solutions:** Develop an algorithm for interaction between military units and civilian HCFs. Include telemedicine consultations in the algorithm to clarify hospitalization indications.

### 4. EXPAND COLLABORATION BETWEEN CIVILIAN PSYCHIATRY AND MILITARY MEDICINE

**Problem:** There are no clear algorithms for interaction with civilian psychiatry after training military doc-

28 - Article 260 of the Law of Ukraine On the Internal Service Regulations.

tors in mhGAP. Telemedicine tools are not used sufficiently. There are no follow-up algorithms after discharge from psychiatric inpatient care.

**Consequences:** Some service members do not receive specialized psychotherapeutic and psychiatric care in a timely manner and according to standards. The therapeutic effect after hospitalization is quickly lost, and service members don't have support anymore.

**Opportunities / Solutions:** Introduce regular psychiatric consultations for role 1 and role 2 medical unit doctors and brigade psychologists, and formalize the consultation mechanism for more accurate referrals. Engage civilian psychiatrists and psychotherapists in joint remote patient management, consultation, and treatment via telemedicine.

#### 5. EXPAND SERVICE MEMBERS' ACCESS TO REMOTE PSYCHOLOGICAL, PSYCHOTHERAPEUTIC, AND PSYCHIATRIC CARE

**Problem:** The absence of regulations for using online interventions involving military or civilian specialists limits access to trauma-focused care during recovery.

**Consequences:** When outpatient psychiatric care is unavailable, service members don't get timely intervention, increasing the risk of developing mental disorders.

**Opportunities / Solutions:** Develop and implement regulations for remote (online, phone) psychological assistance.

#### 6. DEVELOP THE SKILLS OF CIVILIAN HEALTHCARE PROFESSIONALS IN TRAUMA-FOCUSED COUNSELING AND THE BASICS OF ETHICAL COMMUNICATION WITH MILITARY PATIENTS

**Problem:** Insufficient attention to trauma-focused/oriented approaches and the specifics of military contexts among civilian HCF healthcare professionals.

**Consequences:** Service members do not trust specialists, making it harder to establish a therapeutic alliance and effectively use inpatient care.

**Opportunities / Solutions:** Conduct training (involving military personnel) for healthcare professionals in trauma-focused counseling skills using available resources.

#### 7. ADVOCATE FOR THE INTRODUCTION OF REALISTIC RATES FOR PSYCHIATRIC TREATMENT

**Problem:** The cost of MGP inpatient treatment packages does not match the complexity and workload.

**Consequences:** HCFs are motivated to shorten hospital stay, reducing treatment effectiveness, burnout among healthcare professionals, and a shortage of qualified specialists willing to work for low pay.

**Opportunities / Solutions:** Advocate for changes to the MGP packages.

# PSYCHOLOGICAL ASSISTANCE DURING REHABILITATION

## Description

In addition to specialized medical care, mental health services for service members are available in non-specialized (non-psychiatric/narcological) healthcare facilities (funded by the NHSU), in state-owned or private facilities funded by the Ministry of Veterans, in institutions providing social services (funded by the Ministry of Social Policy and/or local budgets), and in non-governmental organizations. The new Law of Ukraine On Mental Healthcare laid the foundation for an updated structure of the mental health system, but its provisions have not yet been implemented in by-laws and regulations.

In the healthcare sector (excluding primary care and specialized psychiatric/narcological care), psychological assistance is an integral part of medical rehabilitation (following treatment of injuries/trauma). Medical rehabilitation is provided under two NHSU packages: 'Outpatient rehabilitation care for adults and children' and 'Inpatient rehabilitation care for adults and children'. Mental health services are not separately specified in the package, but the scope of care indicates that

provided services must include a rehabilitation plan and be delivered by a multidisciplinary team. The requirements also state that the facility must have (physician) psychologists or psychotherapists.

There are unique examples of facilities that provide specialized rehabilitation specifically for the consequences of psychological trauma and mild traumatic brain injuries (post-concussion syndrome) for the service members (Lisova Poliana). However, such facilities are funded directly by central executive authorities, and their rehabilitation programs remain unique.

Additionally, the Ministry for Veterans Affairs of Ukraine funds the provision of psychological assistance services for veterans and service members. This assistance is provided by state or private organizations or facilities (second level) or by healthcare facilities as part of comprehensive medical-psychological rehabilitation (third level). It is important to note that services funded by the MinVeterans are not defined as 'psychological rehabilitation' in the corresponding CMU resolution.

### STUDY TEAM COMMENT ON THE TERM 'PSYCHOLOGICAL REHABILITATION'

The definition of psychological rehabilitation in the Law of Ukraine On Mental Healthcare: "Psychological rehabilitation is aimed at promoting recovery, improving an individual's functioning and quality of life through a combination of psychological and psychotherapeutic assistance, social skills development activities and social support, and mobilization of community resources." However, in by-laws, 'psychological rehabilitation' is not described as a comprehensive service, and therefore there is no generally accepted understanding of this concept. For example, Cabinet of Ministers Resolution No. 1338 regulates 'psychological assistance', Ministry of Health Order No. 2118 regulates 'psychosocial assistance', but not psychological rehabilitation. Accordingly, in this section, we describe mental health services as defined in the relevant regulatory acts.

## Characteristics of the Organizational Structure and Mechanisms for Assistance Provision

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Study participants emphasized that the greatest systemic barrier in implementing rehabilitation programs is the lack of a definition for the service ‘psychological rehabilitation’. As a rule, the scope and content of psychological assistance included in the ‘medical rehabilitation’ package are also not clearly defined. There are no indications for rehabilitation for patients with primary psychiatric comorbid diagnoses.

“...why can’t we provide the full package within medical rehabilitation?... mental disorders need to be included in the list of rehabilitation diagnoses.” **(Recovery and rehabilitation facility specialist)**

Medical rehabilitation is provided upon referral from the medical service and is formally regulated. However, some units sign memoranda with treatment facilities and seek opportunities to refer service members for psychological recovery. Some providers claim that such memoranda expedite the referral process.

“...at the command level, we have signed memoranda... It’s easier to refer people to us. They already know about the center... hospitalization is coordinated more easily.” **(Recovery and rehabilitation facility specialist)**

Within medical rehabilitation, psychological assistance is limited due to insufficient funding. Some providers noted a gap during facility capacity

assessment, which does not include psychologists in the ‘team capacity’ category, although providers themselves state that psychological assistance may account for up to 30%. This affects the availability of psychological services even when there is a need.

“If I could meet more often, I would use the opportunity... But [the psychologist] was not available... I got as much as I could.” **(Service member, enlisted rank)**


“...medical-psychological assistance... is unavailable. It’s just: ‘Here are 10 sessions for 14 days.’ Everyone is treated the same way.” **(Service member, senior sergeants and starshinas)**

Where facilities have digital solutions, electronic intervention planning systems allow multidisciplinary teams to see each other’s appointments, synchronize psychotherapy with other treatments, code interventions in the e-system, and track implementation – this improves coordination and transparency of the treatment process. At the same time, information transfer between stages remains fragmented: often only the discharge summary or a military medical commission note reaches the next provider without a detailed psychological report and a full list of diagnoses. This complicates the planning of an individualized program and the determination of rehabilitation goals.


## Characteristics of Providers

Psychological support in rehabilitation facilities is provided by clinical psychologists and psychotherapists in close interaction with physical therapy and rehabilitation specialists, physical/occupational therapists, and nursing staff.

Demand for psychological assistance exceeds available resources and team capacity.

 “We need more psychologists... sometimes they just can’t see everyone. They have 6 working hours per day... And psychologists also need to rest” (**Recovery and rehabilitation facility specialist**).

Providers regularly improve their qualifications (certification courses, intervision, learning new methods) to adapt psychological assistance to the needs of service members:


 “In working with service members, 90% is communication... If they trust you, it doesn’t matter which method you use... We are constantly learning.” (**NGO psychologist**)

Some teams maintain high quality of work due to strong service motivation, mutual support, and external partnerships (training, supervision, project-based positions). This reduces burnout risk and increases service stability even with staffing shortages.


Psychologists effectively act as coordinators: help gather documents, explain steps after discharge, maintain remote contact when possible.

Where resources allow, they increase session frequency beyond formal limits to consolidate changes.

Providers familiar with combat conditions or who have served themselves build rapport more quickly and help navigate the system (where to apply, how to schedule appointments, how to combine treatment with unit requirements):


 “The psychologist... also went through the war... I could turn to him anytime... he was like a guide: explaining what is happening and where to turn” (**Service member, junior sergeant and starshina rank**)

The stigmatizing language of providers themselves remains a very sensitive topic for service members. The tone and attitude of personnel have always been an important part of treatment. Depersonalized language (‘ill people’), bans without any explanation, ‘Soviet-style’ rules undermine motivation for therapy. Providers need skills in de-escalation, trauma-informed counseling, and communication standards for everyone interacting with service members:


 “I encountered that Soviet-style approach... they called us ‘ill people’... I said: we are defenders, second, we are patients, not ill people. We have a name and surname to use.” (**Service member, senior sergeants and starshinas**)

## Characteristics of Interventions

Psychological assistance during rehabilitation is built as part of a multi-modal program alongside physical and medical components. Facility capacity and short stays can limit program effectiveness. Often, actual needs are substituted by the formal duration set by a military medical commission note – this leaves no time for full diagnostics or lasting acquisition of self-regulation skills. As one service member describes:


 “They are overcrowded... forced to turn away many people who need their help.” **(Service member, enlisted rank)**

In functioning models, psychological assistance begins with brief psychoeducation and safe contact. Providers explain the nature of symptoms (sleep, anxiety, memories, consequences of traumatic brain injuries), normalize reactions, and plan next steps with the patient.


 “...I explained what was happening to me... set priorities in recovery.” **(Service member, junior sergeant and starshina rank)**

According to experts, these are not ‘lectures’ but short, practical explanations, followed immediately by body-based techniques, breathing exercises, and CBT protocols. It should be noted that workload norms (hours of consultation, number of sessions) and waiting lists force prioritization of the most urgent cases, more group work, and less individual work. This further increases waiting time and leads to insufficient ‘dosing’ of trauma-focused psychotherapeutic interventions.

Initial rehabilitation diagnostics combine standardized military questionnaires with clinical interviews and analysis of combat experience to avoid ‘good scores’ when exhaustion is obvious. As one provider says:

 “You see in front of you an assault soldier serving for 3 years, with a score of 57... that’s not right, we start the interview.” **(Recovery and rehabilitation facility specialist)**

Next, the team works together: psychologists, psychotherapists, general practitioners, and occupational therapists build a unified plan with personalized frequency and combination of interventions. In effective programs, access to a psychologist remains low-threshold (the opportunity to ‘drop in and talk’ by arrangement during the day), and evening and night support is reinforced with on-call coverage because symptoms often intensify at that time:

 “...at night symptoms often exacerbate – the presence of a psychologist is important.” **(Recovery and rehabilitation facility specialist)**

Support is not limited to the office. Facilities add supportive modules (on-site activities, gardening, VR sessions, relaxation practices) and rely on general therapeutic factors – connection with family, short city trips, structured leisure. After discharge, a simple communication channel is maintained (messengers, brief stabilization calls) to catch the person in moments of symptom exacerbation using familiar techniques.

## Conclusions and Recommendations

### 1. DEFINE THE CONCEPT OF PSYCHOLOGICAL REHABILITATION AND DEVELOP OPTIONS FOR INDICATIONS AND SERVICE CONTENT

**Problem:** Psychological rehabilitation is not described in by-laws as a comprehensive service, and therefore there is no universally recognized understanding of this concept.

**Consequences:** It is impossible to measure the effectiveness of programs. For service members, this partially duplicates the recovery program in terms of goals and content. It is impossible to introduce transparent funding mechanisms, which also limits the potential for scaling.

**Opportunities / Solutions:** Define the concept and content of the 'psychological rehabilitation' service, and consider options for indications and service content, including the necessity of having a primary psychiatric diagnosis.

### 2. SCALE SUCCESSFUL MODELS OF PSYCHOLOGICAL AND PSYCHOSOCIAL ASSISTANCE

**Problem:** The number of facilities and organizations providing psychological assistance to service members and their capacity remain very limited. Existing best practices for psychological and psychosocial programs for the military are not being scaled, in part due to their uniqueness and the lack of transparent funding mechanisms.

**Consequences:** Not all service members have access to psychological and psychosocial assistance.

**Opportunities / Solutions:** Identify successful models for further scaling. Standardize their content and implement transparent funding mechanisms.

### 3. DEFINE THE SCOPE AND CONTENT OF PSYCHOLOGICAL ASSISTANCE WITHIN PHYSICAL/MEDICAL REHABILITATION

**Problem:** In some medical rehabilitation centers (providing rehabilitation after injury treatment), psychological assistance is provided at a high level, with a wide range of methods and high patient satisfaction. However, in other centers, access to psychological assistance during medical rehabilitation is limited (not available in all centers or the scope is inadequate). This is partly due to the fact that the specification of the NHSU rehabilitation package does not set clear requirements for psychological assistance, other than that it should be part of the treatment plan.

**Consequences:** Psychological problems and psychiatric comorbidities are not addressed during rehabilitation in some programs, reducing the overall effectiveness of rehabilitation.

**Opportunities / Solutions:** Clearly define the scope and content of psychological assistance in NHSU rehabilitation packages.

### 4. INVOLVE SPECIALISTS WITH PERSONAL COMBAT EXPERIENCE IN PROVIDING PSYCHOLOGICAL ASSISTANCE

**Problem:** Civilian sector specialists providing psychological and psychosocial assistance to service members who lack their own military experience may face challenges in building trust with service members.

**Consequences:** Premature discontinuation of participation in psychological and psychosocial assistance activities or reduced positive impact of these activities due to delayed trust-building in limited time conditions.

**Opportunities / Solutions:** Expand peer support training programs. Increase the number of specialists with personal combat experience, with mandatory selection and systematic training.

# FINAL CONSIDERATIONS

The study showed that the mental health support system for service members of the Armed Forces of Ukraine already has several developments and structural elements, but it remains in the process of formation and improvement. It operates under conditions of constant resource shortages, high-intensity combat, and significant workload on personnel. This creates a situation where even the most effective initiatives may lose their potential due to organizational, staffing, or military culture barriers.

At the same time, the study results indicate the presence of strong facilitators: high motivation among service members to support each other, as well as active expert communities and the civilian sector. These factors provide a foundation for further reforms aimed at integrating military and civilian mental health systems, developing human resources, standardizing services, and scaling successful practices.

Finally, it should be emphasized that the mental health of service members cannot be considered merely as a supportive element of combat readiness. It is a key component of the Armed Forces' operational viability and a guarantee of full integration and social adaptation of veterans after service. Building a resilient mental health support system requires systemic investment, inter-agency coordination, and ongoing dialogue between government bodies, military leadership, civil society, and the service members themselves.

This report contributes to forming a shared vision and roadmap for change. Further steps should be based on an evidence base, systematic monitoring of results, and continuous learning by all involved parties. Only in this way can a comprehensive, accessible, and effective mental healthcare system be created that can respond to the challenges of modern war and ensure long-term well-being for service members and society as a whole.

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prehensively outline the opportunities and limitations of the existing support system.

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This study was made possible through collaboration, mutual trust, and a shared commitment to making the mental health support system for service members more effective, accessible, and resilient.

# Appendices

## APPENDIX 1. List of Regulatory Legal Acts Analyzed as Part of the Desk Study

### LAWS OF UKRAINE

- On the Social and Legal Protection of Service Members and Their Families
- On Social and Legal Protection of Persons Deprived of Personal Liberty as a Result of Armed Aggression against Ukraine and Members of Their Families
- On the Status of War Veterans and Guarantees of Their Social Protection
- On the Rehabilitation of Persons with Disabilities in Ukraine
- On Rehabilitation in Healthcare
- On the Mental Healthcare System in Ukraine
- Procedure for Recovery (Post-Isolation, Reintegration) Measures, Adaptation Measures, Support (Assistance) for Persons Deprived of Liberty Due to Armed Aggression Against Ukraine, After Their Release

Act	Approving authority
<b>ACTS OF THE CABINET OF MINISTERS OF UKRAINE</b>	
<ul style="list-style-type: none"> <li>• Procedure and Conditions for Providing Psychological Assistance to War Veterans, Their Families, and Certain Other Categories of Persons</li> <li>• Procedure for Material, Medical, Psychological, and Social Support Service Members Considering the Needs of Women and Men</li> <li>• Certain Issues of Implementing the State Guarantees Program for Medical Services in 2025</li> </ul>	<ul style="list-style-type: none"> <li>• CMU Resolution No. 1338 of November 29, 2022 (as amended by CMU Resolution No. 307 of March 18, 2024)</li> <li>• CMU Resolution No. 1234 of October 29, 2024</li> <li>• CMU Resolution No. 1503 of December 24, 2024</li> </ul>
<b>ORDERS OF THE MINISTRY OF DEFENSE AND THE COMMANDER-IN-CHIEF OF THE AFU</b>	
<ul style="list-style-type: none"> <li>• Regulation on Psychological Rehabilitation of Armed Forces Service Members and State Special Transport Service Personnel Participating in Anti-Terrorist Operation, Implementation of Measures to Ensure National Security and Defense, Repulsion and Deterrence of Armed Aggression of the Russian Federation in Donetsk and Luhansk Regions, or Performing Official (Combat) Duties in Extreme Conditions</li> <li>• Instruction on Organization of Sanatorium-Resort Treatment, Medical, and Medico-Psychological Rehabilitation in the Armed Forces of Ukraine</li> <li>• Regulation on Psychological Assistance Points in the AFU</li> <li>• Procedure for Providing Psychological Assistance to the AFU Service Members</li> </ul>	<ul style="list-style-type: none"> <li>• MoD Order No. 702 of December 9, 2015 as amended by No. 629 of December 11, 2019</li> <li>• MoD Order No. 591 of November 4, 2016, as amended in 2017, 2018</li> <li>• Order of the Commander-in-Chief of the Armed Forces of Ukraine No. 99 dated 7/28/2020</li> <li>• Order of the Commander-in-Chief of the Armed Forces of Ukraine No. 174 dated 5/2/2024</li> </ul>

<ul style="list-style-type: none"> <li>• Psychological Recovery System for the AFU Service Members</li> <li>• Procedure for Psychological Support for the AFU Service Members</li> <li>• Procedure for Organizing and Conducting Psychological Recovery Activities for the AFU Service Members</li> <li>• Procedure for Organizing Moral Support for the AFU Service Members</li> <li>• Instruction on Organizing Psychological Decompression for the AFU Service Members</li>   <li>• Instruction on Professional-Psychological Selection in the Armed Forces of Ukraine and State Special Transport Service</li> <li>• Instruction on Organizing Psychological Readiness Training in the AFU</li> <li>• Instruction 'Protocols for Providing Psychological Assistance to the AFU Service Members in Combat (Extreme) Conditions'</li> <li>• Instruction on Organizing Psychological Support of Operations for the AFU Personnel</li> </ul>	<ul style="list-style-type: none"> <li>• Approved by the Commander-in-Chief of the Armed Forces of Ukraine on May 7, 2024</li> <li>• Order of the Commander-in-Chief of the Armed Forces of Ukraine No. 349 dated 8/1/2024</li> <li>• Order of the Commander-in-Chief of the Armed Forces of Ukraine No. 378 dated 8/22/2024</li>   <li>• Order of the Commander-in-Chief of the Armed Forces of Ukraine No. 177 dated 4/14/2025</li> <li>• Order of the Commander-in-Chief of the Armed Forces of Ukraine No. 194 dated 4/26/2025</li> <li>• Order of the Commander-in-Chief of the Armed Forces of Ukraine No. 462 dated 12/27/2018</li> <li>• MoD Order No. 272 of September 12, 2022</li>   <li>• Order of the Commander-in-Chief of the Armed Forces of Ukraine No. 173 dated 10/23/2020</li> <li>• Approved by Chief of AFU General Staff, 2021</li>   <li>• Order of the Commander-in-Chief of the Armed Forces of Ukraine No. 305 dated 10/18/2021</li> </ul>
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**ORDERS OF OTHER CEAS:**

<ul style="list-style-type: none"> <li>• Procedure for Providing Psychosocial Assistance and Services Regarding Mental Health, Including Suicide Prevention and the Psychosocial Component of Rehabilitation for Veterans and Other Population Groups</li> <li>• State Standard for Social Services: Social Adaptation of War Veterans and Their Families</li> <li>• On Approving the Registry</li> </ul>	<ul style="list-style-type: none"> <li>• Ministry of Health Order No. 2118 of December 13, 2023 On Organizing the Provision of Psychosocial Assistance to the Population</li>   <li>• Ministry of Social Policy Order No. 175-N of April 11, 2024</li> <li>• Ministry of Veterans Affairs Order No. 330 of December 14, 2023</li> </ul>
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**NATO STANDARDS**

<ul style="list-style-type: none"> <li>• NATO STANDARD AMedP-8.6 FORWARD MENTAL HEALTHCARE, Edition B, Version 1, October 2019</li> </ul>
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## APPENDIX 2. List of Other Publications Analyzed as Part of the Desk Study

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1. I. I. Prykhodko, Ya. V. Matsehora, M. S. Baida. Psychological Recovery of Ukrainian Service Members After Prolonged Participation in Combat Operations. <https://chiz.nangu.edu.ua/article/view/295208>
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3. Rodchenkova, Iryna. (2023). Comprehensive Program of Socio-Psychological Rehabilitation for Service Members Suffering from Combat Stress. Theoretical and Applied Problems of Psychology. 157–172. 10.33216/2219-2654-2023-62-3-2-157-172.
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5. Kolesnichenko, O. S., Matsehora, Ya. V., 2017 DRAFT PROGRAM FOR PSYCHOLOGICAL REHABILITATION OF SERVICE MEMBERS – PARTICIPANTS IN COMBAT OPERATIONS. Psychological and Pedagogical Problems of Professional Education and Patriotic Upbringing of Personnel in the System of the Ministry of Internal Affairs of Ukraine. Kharkiv, 2017
6. Borysova, O. O. (2024). PSYCHO-REHABILITATION OF PARTICIPANTS IN COMBAT OPERATIONS AS SECONDARY-LEVEL PSYCHOLOGICAL ASSISTANCE IN UKRAINE. Scientific Notes. Psychology Series, (1), 9–17. <https://doi.org/10.32782/cusu-psy-2024-1-1>
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8. Matsehora Ya. V. Psychometric Properties of the Methodology “Assessment of Negative Psychological Reactions and States in Service Members” and Experience of Its Use in Short-Term Psychological Recovery / Ya. V. Matsehora, I. I. Prykhodko, O. S. Kolesnichenko, M. S. Baida // Honor and Law. – 2023. – No. 1. – P. 114–124. – Access mode: [http://nbuv.gov.ua/UJRN/Chiz\\_2023\\_1\\_18](http://nbuv.gov.ua/UJRN/Chiz_2023_1_18).
9. SCIENTIFIC PAPER on the topic: IDENTIFICATION OF INDIVIDUALS WITH DEVIANT BEHAVIOR AMONG SERVICE MEMBERS OF A UNIT IN THE COMBAT ZONE.
10. Momot, M. (2024). PSYCHOLOGICAL FACTORS OF SUSCEPTIBILITY TO SUICIDAL BEHAVIOR AMONG SERVICE MEMBERS OF THE ARMED FORCES OF UKRAINE. Scientific Notes. Psychology Series. 55–60. 10.32782/cusu-psy-2024-3-8.
11. Bepalko, A & Lelyuk, M. (2022). Algorithm of psychological support of personnel in the area of military (combat) operations. Visnyk Taras Shevchenko National University of Kyiv. Military-Special Sciences. 9–13. 10.17721/1728-2217.2022.52.9-13.

12. SURHUND, N., & VERBA, H. (2024). FEATURES OF PSYCHOLOGICAL REHABILITATION OF SERVICE MEMBERS AT THE STAGE OF RECOVERY. *Psychology Travelogs*, (3), 47–56. <https://doi.org/10.31891/PT-2024-3-5>
13. Kolesnichenko, O. S., Prykhodko, I. I., Matsehora, Ya. V. *Psychological Rehabilitation of Service Members After Performing Official-Combat Tasks in Combat Conditions: Monograph*. Kharkiv: National Academy of the National Guard of Ukraine, 2021. 75 p.
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15. NGO Bezbariernist, commissioned by 'How Are You?' Program, with support from the USAID Public Health System Recovery and Resilience Activity. *Audit of system resources for the provision of mental health services*. 2023. <https://bbu.org.ua/audit-resursiv-isnujuchoi-sistemi-nadannya-poslug-u-sferi-psihichnogo-zdorov-ya/>
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18. <https://healthsolutions.ngo/library/narkozalezhnist-v-sylakh-oborony-ukrayiny-vyvchayemo-sytuatsiyu/>
19. CBA Initiatives Center (Come Back Alive NGO). *HOW DOES A CIVILIAN BECOME A SOLDIER? Issues of basic general military training in the Armed Forces of Ukraine (as of 2024)*.
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