Fourteenth International
Sakharov Conference

Hidden Wounds of War

Trauma, Healing and Recovery among Ukrainian Veterans

Final report

A roadmap for future veteran mental health services in Ukraine

Organizers

Federation Global Initiative on Psychiatry

ANDREI SAKHAROV RESEARCH CENTER FOR DEMOCRATIC DEVELOPMENT
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Written by Maka Berulava, Brigita Dyburyte, Neringa Galisanskyte, Emilija Pundziute-Gallois and Letizia Santhia, reviewed by Janet Anderson, Janet Gunn, Rob Keukens, Deirdre MacManus and Olha Myshakivska

Final edit, compilation and introduction by Robert van Voren

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Introduction

The idea to organize the “Hidden Wounds of War” conference was born during the Thirteenth International Sakharov Conference in May 2023, which focused on “How to Win a Lasting Peace – Ukraine and the World after the Guns Fall Silent”. The mood was then more optimistic, the territorial gains during the fall of 2022 were still fresh in memory and the hope was that the planned summer counteroffensive would result in much more liberated territory. In other words: it was time to think about life after the war, about recovery.

One of the aspects that came out as the most complex and long-lasting consequence was the psychological recovery of the population. This was not surprising. Ukraine is a country that during the twentieth century went through Soviet occupation with mass-scale repressions, the Holodomor, Nazi occupation and the Holocaust, and subsequently through a re-occupation in 1943-1944 that was referred to as “liberation”, even though for many it was more the opposite. Ukraine is a country where every attempt to stand on its own feet and shake off the yoke of its larger and paternalistic self-proclaimed “brother” was crushed… In such a country the trauma is invariably multi-faceted, and full recovery is bound to take many generations. The current war of destruction, imposed by the same totalitarian neighbor only to suppress Ukraine’s stubborn desire to be part of a free and prosperous Europe and to decide its own future, further deepened these wounds and prolonged the digestion process with yet more generations.

The most poignant issue on the table last year was that of the hundreds of thousands of Ukrainians that already then had front-line experience, a frontline that bore so many similarities with the front line in Northern France during the First World War: a trench war, with close-combat and almost constant and intense shelling. A war of such viciousness is nerve-wrecking for most, and too much to bear for many.

So last year we decided to focus much of our efforts on veteran mental health, and much of our work over the past year has focused on finding ways to contribute constructively to what might very well be the most complex, disturbing, debilitating and long-lasting consequence of the war. This conference is part of this effort.

We now know that this war is not going to end soon, for the very simple reason that the leaders in the Kremlin have no wish to end it. The fact that hundreds of thousands of Russian men have been killed or wounded is of no interest to them. Human life has no value whatsoever, all are dispensable little cogs in the machinery, fully in the Stalinist tradition. Yet while rebuilding the infrastructure of Ukraine will be greatly hampered by the ongoing bombardment with whatever Russia can produce or find in the storages of its equally hideous allies Iran and North Korea, countering the psychological consequences of this war right now is not only possible, but pivotal. Early interventions, proper attention to the psychosocial needs of the defenders, their families and their communities are the most cost-effective and necessary steps that can be taken today. Also, while Russia continues its onslaught and tries to hurt as many Ukrainians as possible.

The “Hidden Wounds of War” conference is part of a much larger and long-lasting investment in the future of Ukraine. At the conference we brought together well over one hundred experts, many of whom are experts by experience. They are people who fought in wars, who are currently fighting in Ukraine, and persons who are helping those who fought and those who are fighting right now. We brought together an enormous multi-national expertise and organized the event in such a way that we made maximum use of this unique occasion. The conference consisted of three separate yet inter-linked events. The first day was a public conference, shedding light on this highly complex yet such an important issue.

The second day invited experts met behind closed doors, to work together on a road map for the future, a road map that will help us understand the needs regarding research, methodology, training and the development of services. Services that are affordable, sustainable, and that help veterans to return to their families and communities and contribute to the rebuilding of the land they so bravely defended. The third day was a training and networking event for the more than sixty Ukrainian participants, which proved to be very useful for both reasons – training and networking – and which we hope to repeat in the future.

The above-mentioned road map, which you have in front of you, is a public document, a reference for all that work in this area. For sure, it will be the workplan for the Veteran Mental Health Center of Excellence that was established in early 2024 at the Taras Shevchenko National University in Kyiv as a knowledge and resource center for the many

governmental and non-governmental organizations in Ukraine that have understood that veteran mental health should be a priority – now, and in the future. But it can also be a resource for all other organizations, and they are welcome to use it in whatever form they would like.

The problem ahead is gigantic, bigger than any crisis Europe has seen since the Second World War. It is also an opportunity, both for Ukraine and Europe, but it can only be so if we work together and collaborate rather than compete. In a post-Soviet environment this different attitude is not an automatic one. (Post-) Soviet life has resulted in a culture of survivalism, and collaboration and sharing are not a standard part of that. However, considering the enormous needs ahead of us, collaboration and sharing are crucial elements in countering the consequences of the war of destruction that Russia has brought upon Ukraine. That is a challenge, but also a great opportunity that we should grab with both hands.

Robert van Voren

Emilija Pundziute-Gallois and Neringa Galisanskyte

Public conference report

The public discussions of the Fourteenth International Sakharov Conference, held on May 21, 2024, in Kaunas, were dedicated to several introductory lectures and debates on the war traumas and different ways of dealing with them, as well as to testimonies from Ukraine and other war experiences. It helped to draw public attention to the scope of the societal damage that the war has been inflicting and will continue to inflict upon the Ukrainian population and to consider possible ways of addressing these issues without delay.

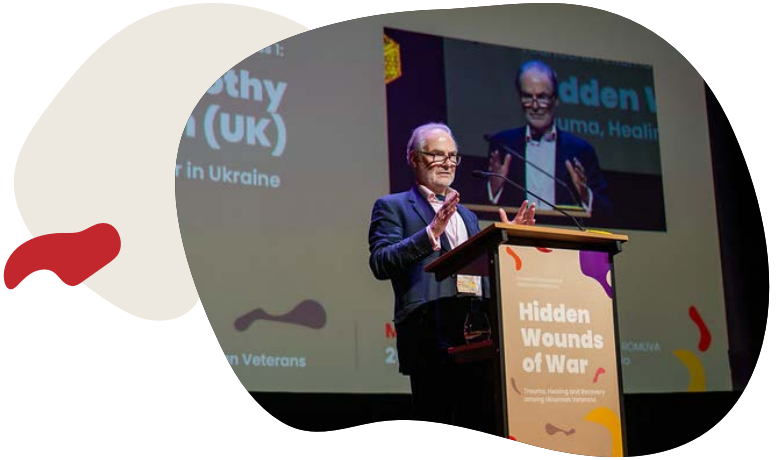
The opening remarks by **Tatiana Yankelevich**, stepdaughter of Andrei Sakharov, paid tribute to the personality of her stepfather, to whom the conference is dedicated. In her words, Sakharov could be "the last remaining common denominator for those who support peace, progress, and human rights". Sakharov was evoked as a person of action, fighting for everyone, advocating truth, based on real facts and on reason. His legacy stands on two pillars: preservation of historical memory and fostering of the democratic society, both of which are undermined in contemporary Russia. But Sakharov is a universal name, and his memory, that of a scientist and a humanist, could still be an example for young minds. Sakharov's thinking can form a solid basis

for today's action: intellectual courage, freedom from selfishness, freedom from prejudice and freedom from fear.

Robert Van Voren introduced the conference's focus on veteran mental health, which is going to be one of the most long-lasting and debilitating consequences of war. At this moment already, there are thousands of Ukrainians with frontline experience, and the war is not about to end. The Russian war in Ukraine is much like the First World War, after which we will live completely different lives. He quoted a British author writing about that First World War who summarized this beautifully in one sentence: *"In a sense the Western Front is a metaphor for the war as a whole: a strip of murdered nature separating the old world from the new."* Replace "Western" with "Eastern", and you have a perfect description of what is transpiring before our eyes.

Therefore, countering psychological consequences of war is pivotal. The Federation Global Initiative on Psychiatry (FGIP) is already engaged in this work, rallying around hundreds of experts of multinational backgrounds. It has recently opened the Center of Excellence for Veteran Mental Health (VMHCE) at the Taras Shevchenko National University in Kyiv.

Timothy Garton Ash started his keynote address "Europe and the war in Ukraine" with the words of a Ukrainian soldier, returning from the front, saying that "Every peaceful day here (in Kyiv, and in Europe) costs a lot of blood on the front." History shows that the decisions we will take these years will be crucial for the future of Europe. Today we must work to help Ukraine to win. Ceasefire established now would not be lasting. **The word of the decade can be the Ukrainian "Volia". It means both freedom and the will to fight for freedom. We too need that Volia, the spirit of the will to help Ukraine.** One of the things we forgot in the West is that



freedom demands a constant struggle. Victory will be achieved, when most Ukrainians, including veterans, feel that Ukraine has won. That is going to be crucial for the psychological wellbeing of the Ukrainians, but also crucial for Europe.

Ukraine's victory is also the best thing that may happen to Russia, Sakharov would have agreed. Illuminated Germans said after the Second World War, that defeat was the best thing that happened to Germany, because their prosperity, democracy and freedom was built on it. For Russia it would be the same.

Finally, among the paths to deal with the aftermaths of war, the most important will be the quest for justice. The war in Ukraine will be the best documented war in history, and we should use this. If we are realistic, it will be very difficult to get the leaders, most responsible for war crimes, to the Hague, but we can look at other possibilities. As Tatyana Yankelevich said, truth is of capital importance: if we cannot have justice, at least we can have truth. This war is also a war against Putin's lies. Getting the facts right will also be a way to deal with the aftermath of war psychologically.

Sir Simon Wessely in his keynote address *"When you have seen one war... you have seen one war"* took a historical perspective on war trauma, shedding light on the unique experiences of different conflicts. After the First World War, for example, there was a relatively small amount of flashbacks (the major elements of the post-

traumatic stress disorder, PTSD) recorded, although the concept of "shell shock" – the damage that the shells have done to bodies, minds, and society – was already developed at that time.

The more recent wars in Iraq or Afghanistan were the wars we did not have to fight, they were "wars of choice", they were carried out by small professional armies. The data shows that around 25% of veterans of these wars suffer from PTSD. These wars were nothing like a war for survival which is being fought now in Ukraine. Therefore, it is very difficult to say, what the consequences will be there. The main lesson from history is that war changes you, but we must not "over-pathologize" those who do not have a real disorder; it will be normal as well to simply have war memories and that is all.

Another lesson to learn is that the consequences of war are born not only by the veterans, but by society. There is, for example, an increase in the percentage of violent offense, committed by war veterans (although not overwhelming). The wounds of war will not be solved by psychologists alone. We will need to rely on sociologists, anthropologists and priests, but also historians, to deal with guilt, anger, and shame, which are all consequences of war.

General Romeo Dallaire, for his keynote address "Mental health and invisible wounds", intervened with his wife and collaborator **Marie-Claude Michaud**. They underlined several important elements that are necessary to deal with the veterans' mental health:

- First, the inter-generational impact of trauma must not be underestimated. The children and families of the war veterans have a difficult burden to manage the trauma of their relatives and may be negatively impacted. Families should get the same attention as the veterans.
- Second, the urgency for psychological wounds must be the same as the urgency for physical ones: they are as dangerous and devastating for personal lives, although difficult to observe from the outside.
- Third, veterans need special protection (especially in courts, in case of crimes), no one must be left behind.
- Fourth, the nature of "hidden" psychological wounds makes it that the veterans will believe that they are alone in their suffering. This is not true. Stigma must be eliminated, and society needs to be encouraged to recognize and openly talk about psychological trauma. The myth that only weak people cannot overcome the impact of war needs to be broken.
- Fifth, peer support and exchanges between veterans themselves is very important. Special structures need to be created for that.

In terms of possible solutions, several examples of helpful institutions can be mentioned: Military family resource centers or transition centers, which provide services for the needs of the military families and the military personnel, offering workshops, supper groups, employment assistance, counselling services, including for the parents of the military and children to provide an adapted response. Above all, however, there is one baseline: love is critical. **It is simple, but it is capital: love them even though they are hurting. Keep in mind that today they suffer war while we watch. "The day when the Russians crossed the border [of Ukraine] was the day NATO should have come in for help. I will always feel guilty that I did not participate beside you."**

What followed next was a panel titled "Living with Trauma: Personal Stories from Survivors," moderated by Prof. **Jana Javakhishvili**. The panel introduced a short documentary by Lesya Kharchenko, updating the audience on the lives of Kyiv Veteran Theater's heroes two years after the invasion. Two of the people from the

theater were present at the discussion – **Andrei Ilchenko** and **Viktoria Samova-Katalichuk** – and shared their first-hand insights on how trauma makes its way into the psychology of the soldiers and how it manifests itself even when one is away from the frontline. Andrei and Viktoria emphasized the necessity for training of active-duty soldiers on how to help each other during and after a traumatic event happens in the field. **Robin Imthorn**, a Dutch marine who served in Afghanistan, shared his personal ways of dealing with trauma. According to him, the hardest part is understanding that you need help and that you are not alone. He recognizes that different methods work for different veterans, but the most important breakthrough happens as soon as one stops denying or feeling shame for one's trauma and scars. Panel was also enriched by the painful recollections of the former UN Peacemaker, polish soldier **Ryszard Chudy**, who witnessed the Rwandan Genocide first-hand. He

says: "Until Rwanda, I would say "show me the enemy, I'll know what to do." Since Rwanda, I say "no more war, never again." Chudy's testimony of the life and work of a peacemaker provided for an eye-opening experience to the entire audience about the role of blame and shame in wars.

The **panel discussion** *"Looking back: what would you do different when developing national models of services for veterans from scratch?"* moderated by **Janet H. Anderson**, focused on experiences from Norway, the Czech Republic, and the United Kingdom.

Oystein Jack Naess underlined that many veterans don't need help: they are resourceful people, they have education, profession, and many have much to go to when they leave military service. They must not be treated as sick but need to be supported through the transitional period. However, some have serious wounds,

which need to be addressed. These two groups should be treated separately.

Lt. Col. Sardar Bahadur pointed out that rehabilitation is not equivalent to curing. The veteran assistance should not aim at curing, but should aim at good health, normal life and work. Work summarizes one's function within a society, looking after one's children is an uplift to one's health. Generally, mental fitness as prevention should be prioritized. This means doing mental exercises in groups or as part of what one is doing in daily life. Mental fitness is about finding a good exercise which one can practice on one's own, for example, mindfulness, learning to cool out, etc. Once it ties into one's normal day, it can be practiced throughout. It is good to encourage soldiers to practice such exercises while they are still serving.

Denisa Dokulilova spoke about guidance by military and civilian psychiatrists and psychologists in general health centers but also special ones, assigned to military units. It is important to first identify the potential problems, and then work with the veterans to help them to be mindful about these problems.

Darren Minshall noted that the recruits are often volunteers from disadvantaged society groups. The majority leave the armed forces well: they train, educate, develop skills and qualifications, and integrate. It is a form of social mobility for many, and for the majority it is a good experience. It is the minority that needs to be worried about.

Among challenges mentioned, were resources, especially the necessary numbers of staff, and access; the necessity to find new effective inroads to overcome stigma. Tailored solutions will need to be found for Ukraine, according to the specificity of this war of national survival and adapted to the cultural specificities. It will be necessary to understand and accept that trauma is wide-ranging, and that much help for the whole of the society is needed. Encouraging help-seeking will be crucial, because the threshold of seeking help is usually high. At the same time, it is important to treat the veterans not as veterans exceptionally, but to allow them to lead normal lives in the society, like everybody else.

Peer support groups have proven to be effective. Veterans often find solutions among themselves. Even the non-professionals can help through listening and recognizing the war wounds. Recognition is important on the societal level. Using new software tools, apps, war games, can be additionally useful, although it will not be a panacea.

Stephanie Houle's lecture *"Moral injury in the aftermath of war and conflict"* addressed the issue of the lasting injury which is left on veterans by the direct and indirect experience of violation of moral beliefs, what is conceived as right or wrong in our societies, and what forms an important part of our individual identities. These moral injuries are the results of bad intelligence, split-second decision making, being emotionally detached in combat, but often come in the aftermath of war as part of grief

over combat losses. Moral injuries are often experienced in the encounters of combatants with children. They cause moral pain, shame, self-condemnation, guilt, disgust, anger, inner conflict and loss in relation to one's identity, loss of sense of meaning, loss of trust in oneself, others, institutions. They often result in depression and suicide.

During the process of healing acceptance and forgiveness are especially important, as well as self-compassion, meaning-making, i.e., reconciling identities, actions, values, flexible consideration of moral rules.

Eric Vermetten in his lecture "From battlefield to brain - why we need to understand the dynamics of PTSD, stress, and trauma?" discussed empirical data on trauma and healing, showing how war affects not only minds,

but also bodies. There are different groups of former soldiers, which need to be treated separately: some have difficulties early on and heal over 2 years, others seem fine at the beginning while their condition deteriorates over time. Among the remedies that can be useful, prof. Vermetten mentioned the 3 MDR techniques, organization of return trips to the field, developing deep links with other people, the loved ones. The use of psychedelic drugs can be beneficial but needs to be controlled.

Rachel Thibeault in her address *"Community-based rehabilitation (CBR) in conflict areas: potential applications in Ukraine"*, explained the benefits of the CBR method. Its objectives are: equalization of opportunities, poverty reduction and social inclusion through the solidarity of communities. It helps to share scarce resources, jointly answer priority needs, and engage leaders to reduce

stigma, provides access to education and life-long learning; it focuses on health, education, livelihood, social life, justice and empowerment. Stakeholders involved range from family through community and to national government. Some countries have made it part of their national health system: it does not replace healthcare but complements it in important ways.

How it works: veterans will get together and define their needs, and then CBR agents will be trained to meet those needs, for example, to assist people in teaching them how to walk again or to improve the rehabilitation potential, to help veterans to return to work or acquire social autonomy. Veterans themselves may be involved in helping others. The core component of CBR is peer support: cultivating the sense of safety, connectedness and hope, sense of self and community. It may also serve the advocacy function: it assists in the fight for the rights of the veterans

The panel *"How to meet the veteran needs in Ukraine when resources are limited?",* moderated by **Rob Keukens**, concentrated on concrete proposals for Ukraine.

Haakon Engen referred to a guide for Operational resilience, which can be drafted as a booklet, easily understood by soldiers. In Ukraine, there is no luxury of filtering the recruits to send only the strongest to the front: everyone, able to fight and survive combat, needs to be taken in. It is important to give them the necessary tools to resist.

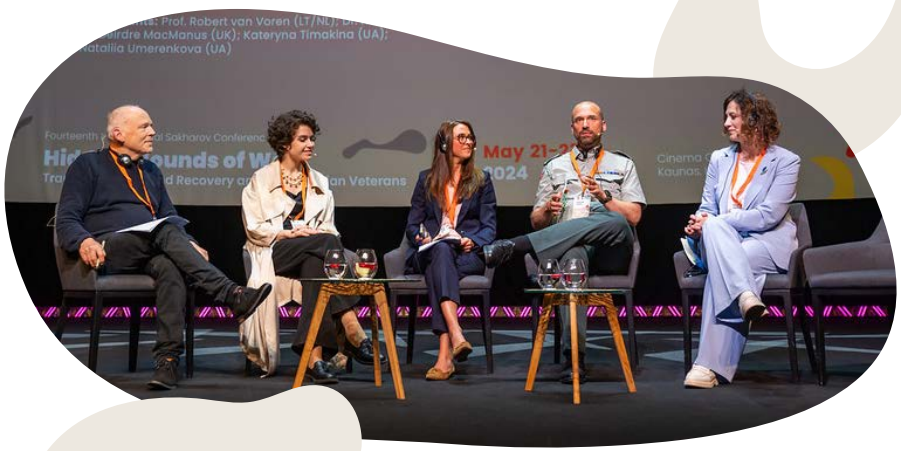
Kateryna Timakina already works with the development of long-term support to veterans and families through multiple NGOs, which provide legal, career path, mental assistance, and carry out studies for future assessment. Innovative approaches are developed: all kinds of start-ups and apps, mobile groups, involving psychologists and lawyers, who can reach out to people, on-line consultations, including of those who are still in the field. The experiences are recorded to make sense of the evolution of the problem.

The war has made the Ukrainian society more sensitive to the needs of their veterans, and they themselves are more open to receive help. The civil society is a crucial actor, and adds its own contribution, sometimes not very streamlined and coordinated, but often providing essential aid to the government in the areas where it struggles.

Nataliia Umerenkova enumerated three major blocks in which work will need to be done: first is health (physical, mental, dental, motoric skills, etc.); second is the social-economic dimension (economic education and training, new qualifications and jobs); third is social and dignity needs of families and communities (such as places of residence, etc.). It will be important to enhance the number of professionals: those who underwent training may in turn provide training to the other providers of services: social services, recruitment officers, police.

Deirdre MacManus stressed the importance of meeting the basic social needs, as they come before the mental needs. In the situation of scarce resources, communities may come to help, through the creation of clubs and gathering spaces.

Among the major challenges for Ukraine is a high number of combatants: around 1 million military and 3 million family members. The war effort already requires many resources, which become scarce for the post-war needs.



Moderator: Deirdre MacManus
Reporter: Letizia Santhia

Report on the Research focus group

This focus group was devoted exclusively to discussing the main questions and challenges related to the research work in this field. Academics, experts in clinical psychology, and practitioners of various organizations, gathered to take part in the debate and share their ideas.

TARGET GROUPS

A significant part of the discussion was devoted to identifying the groups that should be targeted by the research on mental health related to war contexts. In other words, what categories should be considered when collecting data, researching and developing programs?

The primary group is that of the **members of the army**, suffering the traumas caused by the direct involvement at the front. It must be said that there was a consensus over the fact that not only veterans should be supported with specific programs in terms of mental health, but that special attention should also be granted to soldiers still engaged in combat. The two conditions differ significantly and indeed represent two separate subcategories to be targeted independently, taking into consideration several specific factors related to the context in which the patient is placed.

Interestingly, it emerged how the **medical personnel** (especially when it comes to mental health practitioners) is ambiguously perceived among the armed forces: stigmatization of mental health represents a significant obstacle to the proper implementation of useful programs. Therefore, parallel research on how to present the role of medical staff could help to improve the implementation of mental health programs delivered in the army.

On the other hand, while considering specifically the phenomenon of veterans' reintegration into society, there are other actors involved in the process that deserve a particular attention when it comes to social and psychological research. First and foremost, the families and generally speaking the **communities** of supporters, welcoming back returning veterans (or supporting the loved ones at the front) are the most present in the everyday life of the soldiers and play a crucial role in their recovery: it is therefore of the utmost importance that

they act in an informed way and according to specific guidelines to be developed, but it is also fundamental that they never lack the support of specialists and that they can rely on mental care for them too, to cope with the difficulties faced on a daily basis.

Finally, at macro level, the **civil sector** was identified as a possible object of study, considering how impactful is the way society welcomes veteran soldiers: it is crucial to work on the public opinion's perception of the army, and create a specific image of the returning soldiers to avoid phenomena (such as an over-heroization of the army, to mention the most common) that could increase the pressure on the soldiers and consequently hinder a good recovery and trauma overcoming.

Thus, what emerged from the discussion is that working on the specific and directly involved subjects is certainly essential and urgent: however, working exclusively on individuals is a necessary condition for soldiers' mental health, but not sufficient. In fact, this work needs to be combined with broader research on the context in which the subjects are embedded, both at the micro and macro levels, to truly ensure a more comprehensive and fluid recovery.

TOPICS

In this section, we would like to propose several issues that have been brought to attention as deserving of further study. While so far, we discussed the "who" does

the research concern, we now focus on "what" should the VMHCE work on: what are the major issues to be addressed? What are the most pressing issues? What, on the other hand, are the issues to be addressed in the long run?

Once again, it is obvious that the first topic identified is strictly correlated with the treatment of **psychological and psychiatric conditions** of soldiers, their traumas and following disorders related to the lived experience. Specific issues were mentioned, also in relation to space and time factors, in addition to the stage the patient is at.

For instance, it was mentioned the need to structure **specific programs of recovery and rehabilitation**, differentiated according to different factors: the intervention on soldiers serving at the front and the tools needed to treat their mental health are different from those devoted to the soldiers spending their time off between two periods at the front (who, even if they are physically far from the place of combat, will be inevitably impacted by the current situation), since in the first case the time devoted to self-care will inevitably be limited and subject to the urgencies and contingencies of combat. When it comes to veterans, on the other hand, the research should focus on the **consequences of traumatic experiences** and how to build **resilience** among them. This means researching not only PTSD syndrome (post-traumatic stress disorders), but also the impact that physical injuries can have on lifestyle of veterans and therefore on their mental health, not to mention the dysfunctional

behaviors arising in several cases, specifically addictive behaviors and in some cases escalate even into criminal behaviors. Different methods could be applied to support these categories of patients, both in the short and in the long term, eventually considering both group therapy and individual programs.

In other words, in the short term it is important to focus on the most urgent needs, related mainly to acute interventions on soldiers at the front dealing with stress to provide them with immediate tools, while also studying in the medium-long term the conditions of soldiers after deployment to identify the main problematics and elaborate programs to support them through their process of reintegration in society.

However, beside the research to be conducted strictly in the medical field, there are a great deal of questions pertaining to the social sphere. One aspect that is not to be underestimated is **gender-based research**: specifically, it explicitly considers the different involvement in warfare of women and men and in particular the different response to trauma and therapy seen in women compared to men. The design of any programs cannot fail to take this into account to be fully effective.

As it was briefly mentioned in the first section, the **communities** (families, friends, supporters, and more broadly the society welcoming back veterans) ought to be considered as one of the objects of research: in the short term, it is necessary to identify the needs of the

families, understanding what are the traumas they have been through to develop an adequate assistance for mental health. As a matter of fact, two different aspects should be addressed by this research: on the one hand, they must be provided with the right tools and put in the best condition to welcome and support veterans, to make their reintegration smoother; at the same time, also family members need support as individuals addressing their personal needs in terms of mental health facing this challenge. While in the short term these needs should be assessed and the first pilot-projects should be developed consequently, in the medium-long term the plans could be evaluated and eventually implemented on a larger scale.

Another topic that was mentioned, that connects the individual sphere of veterans and the public dimension of social reintegration, is that of the potential contrast between **personal and public perception**, which could cause disorders and psychological fatigue. In fact, while the public opinion may propose a certain image of the valiant soldier, insisting on the idea of strength and virility, the effect on the veterans could be that of feeling great social pressure and eventually feeling ashamed in asking for help. In this sense, the research would be certainly oriented toward a de-stigmatization of mental care but mostly it would focus on how to represent and present to the community the figure of the veteran in an honest and non-dangerous way. On the other hand, it is important also not to incur the opposite risk, namely that of over-pathologizing veterans, which would be counterproductive, to say the least.

It is important to specify that all such research must be carried out with respect for the population and according to culturally appropriate and acceptable methods when it comes to data collection and research, an obstacle that will be explored in more detail in the next section.

METHODS AND MAIN CHALLENGES

When planning the research, it is fundamental to have a clear understanding of who are actors involved in the work, so who is conducting the research, and what are the main challenges that they will have to face with their teams.

Obviously, it is fundamental to evaluate the education and previous training of the people and the **experts** selected to lead the research, to create a team of excellence in the field: those who are in charge of collecting and analyzing data should prove to have the skills and previous experience, specifically in a war context as well as in an **international and multidisciplinary team**. It should be specified that, while the international presence and support is more than desirable, national figures or bodies should be appointed with the leading roles, so to empower the organizations of the country and let them have a sufficient independence, not to mention the fact that the cooperation with local partners and patients would be extremely easier for conationals. In addition to this, there was a broad consensus concerning the crucial role of multidisciplinary teams: not only do the topics

worth studying range from the field of health to that of sociology but having a multidisciplinary team could also enhance a system of interventions at different levels, starting with a primary level of diagnosis going to the planning of further intervention and ultimately leading social reintegration. At this stage, some multidisciplinary teams are already working, and the cooperation is yielding excellent results, which could be an encouragement for wider use of this working method.

In this sense, people with different backgrounds could gather to cooperate, putting their experience and tools to use: of course, this work would go beyond the mere collection and analysis of data, but it would imply a greater engagement and the elaboration of policies and protocols, especially when governmental organizations are involved. This method requires a great effort of coordination and the cooperation among organizations (from NGOs to the medical staff of the army) and pose a significant challenge with respect to capacity building and training of human resources but could lead to impressive outcomes.

Once it is clarified who will conduct the research, it is necessary to suggest different methodologies of research and, once again, the general idea is that of implementing **mixed methods** so to efficiently study the phenomena from different perspectives and in its various facets. In fact, the need to obtain both objective and subjective data has been stressed, and consequently the necessity to implement various methods of data collection - from

administering questionnaires to conducting interviews - clearly emerges: the data collection phase, therefore, will consist of several interviews, conversation and open dialogue that could help to identify the main needs and problems, to later inform a more widespread and organized collection of quantitative data. Special attention should then be paid to setting up longitudinal research that can follow patients over time or for extended periods.

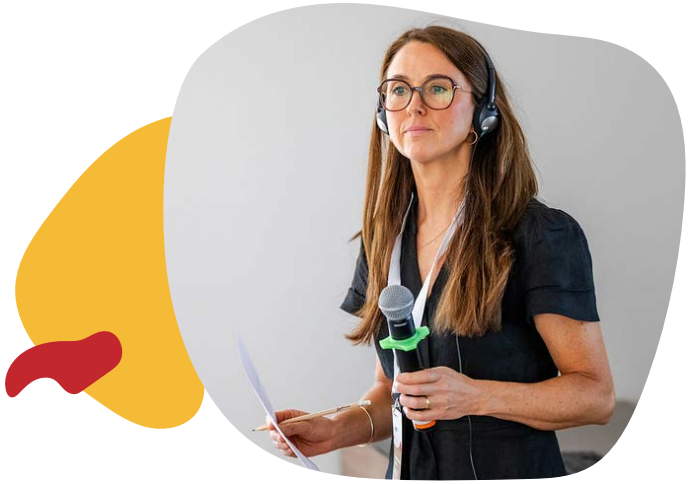
One of the most significant challenges posed by the collection of data is that of outreach of patients: several issues emerge when it comes to the engagement of the subject of research and **how to reach them**. Firstly, it is crucial to consider the cultural differences characterizing internally the country and adapt the methodologies to the actual context: for example, the diversity between urban and rural areas will necessarily require different strategies to promote the research according to the audience involved, possibly identifying partners or place through which people can be reached more easily. One valuable resource, that still should be directed and organized, is represented by the **grassroot organizations and charities**, as well as the church, that are present on the territory (even though with regional differences) and usually maintain a close relationship with the local population, they are trusted by the citizens and are often part of wider networks of associations: their channels of communications with local population and other organizations could be crucial in the phase of data collection. It is more challenging finding a way to

introduce psychological research to the soldiers at the front, fact that would require different means and actors engaged. In any case, it is fundamental to elaborate on the best strategies to engage with people because it is necessary to overcome the stigma around mental health that perpetuates until today.

OBSTACLES

An issue that will deserve particular attention during the planning of data collection phase, and not only, concerns the relation between soldiers (and more generally patients) and professionals of mental health sector. What emerged especially on the side of Ukrainian experts, is the widespread **distrust** toward medical personnel in general, that could hinder dramatically carrying out the research. In fact, not only it becomes essential to provide thorough information and gain the trust of patients, but it is necessary to break down several social barriers: people tend to be rather skeptical and suspicious about providing information, which could lead either to insufficient responses, or to **unreliable results**, as people would rather present and edulcorated and perfect truth rather than honest answers. These traits are accentuated among soldiers, who are particularly skeptical with respect to surveys and anonymous questionnaires and may also influence each other suggesting possible consequences of the results of their surveys (for example, saying that a certain kind of answer will lead certainly to therapy, which is something that many would rather

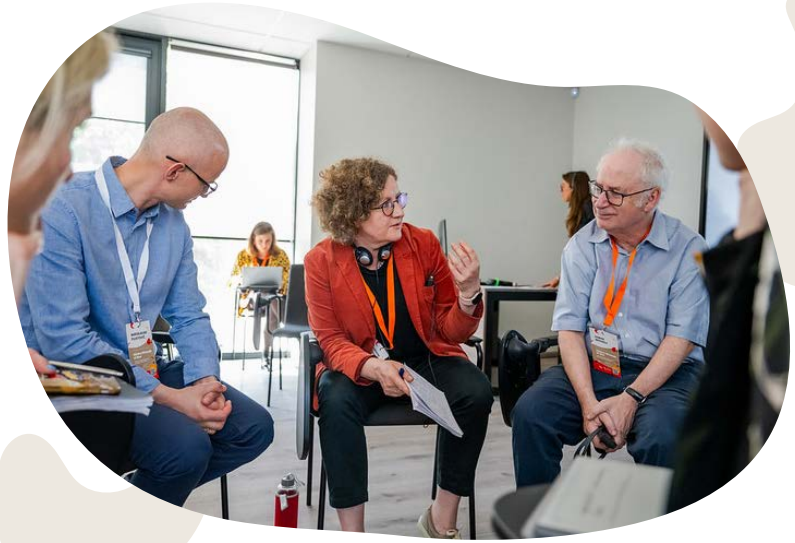
avoid). In other cases, as it often happens with auto-screening surveys, the patient tends to overestimate the symptoms, suggesting an alarming scenario. This is also one of the reasons why questionnaires alone, without being combined with a qualitative approach, would represent a very partial source of information.



One more obstacle to a smooth collection of data and samples is the **motivation of participants**: in the current situation - may it be on the frontline, may it be in their hometown - mental health or long-term studies are not perceived as a priority, so the challenge will be to persuade participants to devote some of their time to such programs. It is crucial, however, that the participation is free and on a voluntary basis, as obviously no one can be forced into a program against their will (also because, among other things, this would produce misleading and biased results).

One last aspect to consider when planning the collection of data is the possible difficulties in finding **representative samples:** for example, it must not be forgotten that only a part of injuries (both physical and psychological) is recorded, therefore relying only on existing database would provide incomplete information; besides, a variety of injuries and conditions ought to be considered, not to leave outside other records. However, the most significant obstacle to a complete and thorough data collection is represented by the fact that, since the war is still ongoing, many soldiers are currently deployed at the front and it is very difficult to have them engaged in a research program; yet, taking in consideration only the soldiers in rehabilitation centers or in the hospital would cover only part of the issues to be studied and, since these placements are temporary, it would turn out rather difficult to keep track of a large number of of people and provide them with an efficient support with **continuity** and consistency.

Finally, the most important and challenging question that needs to be solved beforehand is an agreement on permissions by the ministry of defense, that work according to its own rules (often eventually in opposition to the needs of a research center): working on a cooperation agreement with the government to overcome the possible obstacles is of the utmost importance for a successful completion of the research work. In addition to this question, another issue emerges powerfully and catalyzes attention to itself because of the extreme delicacy inherent in it: namely, the ethical question of how to ensure **confidentiality** and **data protection**, which is also strictly connected to the issue of trust. Possibly, one idea is to rely on institutions and academic structure with good reputation (to gain the trust of participants), but the role of the government might be crucial too. To address this issue, on the one hand it is necessary to work with study participants and develop strategies to gain their trust, explain what the purpose of the research is and how anonymous data will be used and how they would eventually be published in study results. On the other, it is necessary for trust to be well placed and for the positions taken to be consistent with the statements: this requires a reliable data protection system, clear protocols on the storage of digitized data, and most importantly, it implies possible collaboration with government or public facilities.



CONCLUSION

In conclusion, the discussion among experts and academics produced interesting results for setting the work of research center of excellence on mental health in war context. After identifying the main beneficiaries of the research - namely soldiers and veterans, but also civilians and communities – several research subjects were proposed both for short and long-term: among the topics were not only PTSD and other syndromes deriving from the traumatic experiences, but it was also expressed the interest in developing support programs for acute intervention on stress at the front, as well as for communities of supporters. It goes without saying, there are several challenges ahead, first and foremost the eventual cooperation with the ministry of defense and the development of strategies for data protection, but also the difficulties one might face in gaining the trust of study participants.

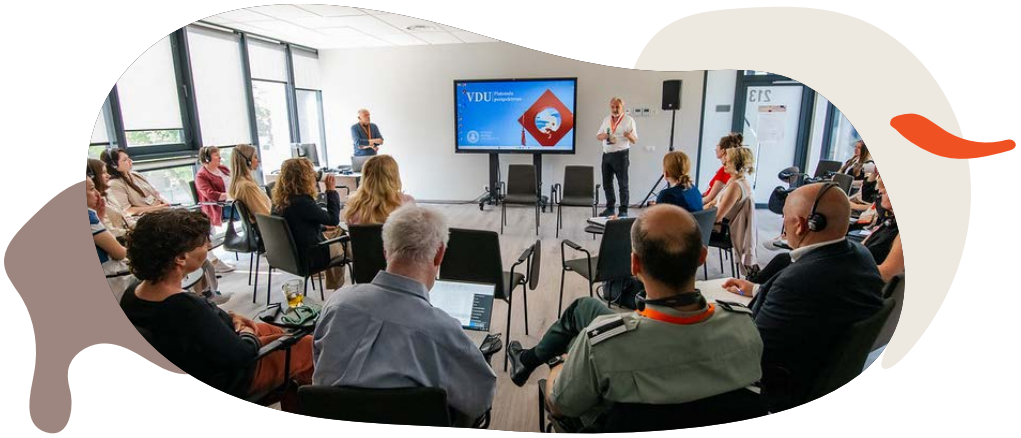
While all these considerations have been discussed, every issue is subject to one element that greatly influences every decision: time. Time is what the research needs, and yet the urgency and the gravity of certain situations require a more immediate action. Time and dedication are what is required to the participant that may fail to commit for this. Time is what is most needed, and yet least available. For this reasons, a precise and detailed planning of the research, the right methodology and an efficient use of the resources and human resources is at the base of any successful research project, especially in the situations hereby considered.

Moderator: Rob Keukens
Reporter: Neringa Galisanskyte

Report on the Methodology focus group

Streamlining Methods That Support Veterans Dealing With Trauma

This focus group very much focused on the future tasks of the newly established Veteran Mental Health Center of Excellence (VMHCE) in Kyiv, which is set to become a pioneering institution dedicated to addressing the unique needs of veterans. However, the outcome of the discussions is valuable to any organization that focuses on this topic.



This collaborative workshop proved highly productive, culminating in the development of a detailed set of guidelines aimed at shaping the Center's methodologies. These guidelines are crucial for ensuring that veterans receive the highest standard of care, even in the face of limited resources, thereby laying a solid foundation for the Center's future operations in assisting Ukrainian veterans' path to mental resilience.

ADAPTING EVIDENCE-BASED METHODS

First, the workshop began with a vibrant discussion on the rights and wrongs of applying existing protocols to Ukrainian veteran treatment. On the one hand, even though each conflict is different, the post-traumatic symptoms are usually the same and the existing methodology is rather well developed to treat them. Not using the available research and standards would be risky considering resources are already limited. On the other hand, in many specific cases that Ukraine must work with, research is scarce, which prompts some to believe that it is up to Ukrainians themselves to develop the methodology which will fit the needs of their patients.

Experts at the workshop were eager to promote evidence-based methods and treatments for post-war mental health care due to their cost effectiveness. Using methods that have become standard is usually a safe bet when resources are limited, which is the case in Ukraine. Moreover, given the sensitive nature of the information to be collected, experts also stressed the use of existent methodology in establishing a secure data system to protect confidentiality. Nevertheless, participants agree that a culture of risk assessment must be developed, where both Ukraine and the Western partners would share their know-how and cultural background to evaluate what existing methods may or may not work based on the context of Ukraine.

Due to the unique nature of the war in Ukraine, mental health specialists, military personnel, and historians agree that the country's system for veteran mental health requires significant adaptations and improvements beyond standard evidence-based methods. Workshop participants highlighted that the war has mobilized individuals with no prior military experience, meaning there are now many soldiers who have not been mentally prepared for combat-related trauma. This conflict also exacerbates transgenerational trauma, which dates to Ukraine's time under the Soviet Union, the Euromaidan protests, the annexation of Crimea, and the ongoing war. Furthermore, the complexity of the situation is heightened by the fact that Ukrainians are fighting an enemy who, until recently, might have been a friend, neighbor, or relative. The trauma is intensified as the battles occur on home soil and the traumatic memories are frequently and easily triggered by familiar surroundings following demobilization. Most existing protocols are designed for veterans who fought abroad and returned home, making them less applicable in this context.

Moreover, over 60,000 women have joined the defense forces of Ukraine, but female veteran mental health is highly under-researched. Given the high levels of time pressure and resource scarcity, it is crucial to assess evidence-based methods on a case-by-case basis, using existing research as a foundation rather than an absolute rule. As one participant concluded, Ukraine should not aim to reinvent the wheel, but rather to improve it.

INVOLVING VETERANS

One of the ways to enhance the system is by involving individuals with lived experience who can share their firsthand insights. Experts agree that collaborating with veteran community organizations and conducting focus groups with veterans and others who have lived through similar experiences would be invaluable in understanding their true mental health needs. However, it is essential to recognize that one veteran's experience cannot fully represent another's, which underscores the importance of incorporating a diverse range of lived experiences. For example, a person with prosthetics will understand the needs of people with prosthetics, and a person who came into war from a completely different, non-military background, will be able to better address the struggles of non-military persons post-combat.

Furthermore, a peer-to-peer network should be established within the VMHCE to create a medium in which veterans can openly discuss their struggles with others who can relate and garner a circle of trust and peer-to-peer support. Understanding that already several successful projects related to veteran communities exist, experts suggested that the VMHCE could play a role of a central hub, identifying and connecting existing initiatives from NGOs and government entities in the field of trauma and social support. Most importantly, however, VMHCE should involve a few people with lived experience into its activities from the very beginning of the development phase to the finish. Sporadic involvement of random persons would not be as useful as strategic integration of several people in every part of the process, experts argue.

Similar arguments were also brought up when discussing whether patients should be involved in the decision-making process related to their treatment plans. Participants agreed that many mental health care providers in Ukraine are following the traditional standard of treatment where the service provider decides on the best treatment for the patient and the patient is expected to accept it. Nevertheless, examples from countries like Norway and the United Kingdom demonstrate that concordance, where patients and mental health specialists collaboratively develop treatment plans, is usually more effective than mere compliance, particularly for non-acute diagnoses. Additionally, workshop participants highlighted the importance of involving the patient's family and support system into the treatment-related decision-making process, especially for long term treatments. Experts

agree that ensuring the family feels safe and informed about potential PTSD triggers is crucial for more effective treatment outcomes.

Moreover, participants emphasized the necessity to include professional orientation courses into the Center's methodology. These courses would be most useful for people who joined the defense effort from previous non-military backgrounds and do not have the same mental resilience or the same preparedness for their successful comeback into society post-demobilization. Professional orientation courses as well as involvement of veterans into the development of the Center would provide them with knowledge on their further choices as well as an additional sense of purpose within the society.

DEVELOPING METHODOLOGY FOR IMMEDIATE RESPONSE

During the workshop, specialists expressed their concern for immediate response to trauma and urged VMHCE to focus on the development of such methodology for Ukraine. Whether it was related to training military personnel's mental resilience and self-assessment during the heat of the symptoms or providing materials to those who are close to military personnel and would be able to ease them out of acute situations, immediate response to trauma is emphasized as crucial. Nevertheless, important is the line between what can and cannot be done during immediate response to trauma. For example, psychiatrists confirm that asking a person to recall a traumatic event within 24 hours of it happening leads to a major increase of PTSD severity level. Therefore, the immediate response methodology preparations must focus on low-risk responses and self-treatment that would assist the person in calming down and pulling out of a stress or trauma induced state.

TRAINING NON-SPECIALISTS

Given the scarce financial and human resources, experts discussed the possibility of training and/or providing materials for people who are not by education or practice psychologists or psychiatrists. The general verdict came down to the line between psychotherapy and psychosocial support. According to experts, psychotherapy and more invasive treatments and interventions should only be provided by psychologists and psychiatrists who have the right qualifications. Meanwhile, people who are not well-informed, even without malicious intentions, may cause more harm

than good when trying to assist someone with PTSD or other combat-related struggles.

Nevertheless, in the face of a huge lack of psychotherapists and the overflow of veterans and war-affected individuals, VMHCE should develop certain methodology related to training non-certified persons to provide psychosocial support to those in need. This should be done carefully - people with no previous experience should not be taught how to treat trauma right away. Instead, with proper training and a high level of supervision, they can and should be trained to listen, build rapport, mitigate their personal biases and provide urgent psychosocial assistance. Another suggestion by experts was to create a network of mid-link specialists who would be trained on specific disorders or symptoms and would be fully qualified to provide such narrow care, as is available in the UK's National Health Service system, for example. Furthermore, task-shifting – redistribution of tasks among highly qualified workers and health workers with less training – can prove useful to make best use of the available human resources in the existent healthcare system.

Regular civilians with proper knowledge and training could provide much needed mental resilience to veterans and the society at large. First, they would reduce the stigma surrounding mental health care, as often veterans do not feel comfortable talking to psychologists or psychiatrists but building a rapport with peers or civilians may be easier. In fact, peers or other people who have a military understanding, may also be highly helpful in getting veterans to talk freely - no terminology barrier means no frustration during conversation. Second, once rapport is built, referring people to a fully qualified specialist would result in veterans gaining further help and treatment for their condition. One way or another, the first step is to connect to another person and simply listen, which is a concept not limited to qualified medical personnel. Experts agree that training provided to both military personnel and civilians would further increase overall mental resilience of the nation.

MAIN TAKEAWAYS AND RECOMMENDATIONS

The workshop provided a vital forum for addressing the specific needs of Ukrainian veterans. Through collaborative discussions, participants helped develop

a comprehensive set of guidelines aimed at tailoring mental health care methodologies to the unique context of Ukraine. These guidelines are essential for ensuring that veterans receive the highest standard of care despite limited resources, setting a strong foundation for the Center's operations. Main recommendations for methodological development include:

1. Adapting evidence-based methods

- Apply existing research and standards as a foundation but assess and modify them based on the specific needs and contexts of Ukrainian veterans.
- Use existing know-how to develop a trustworthy data protection system.
- Assist in developing a culture of risk assessment to evaluate the applicability of existing methods in Ukraine.

2. Involving veterans

- Collaborate with veteran community organizations and conduct focus groups to gather diverse lived experiences.
- Establish a peer-to-peer support network within VMHCE for trust-building and mutual support.
- Play the role of a hub by identifying and connecting existing related initiatives.
- Integrate veterans with lived experience into all stages of the Center's development.

3. Shared decision-making for treatment plans

- Encourage collaborative development of treatment plans between patients and mental health specialists.
- Involve the patient's family and support system in the treatment process to improve outcomes.

4. Professional orientation courses

- Include courses to help veterans from non-military backgrounds reintegrate into society and regain a sense of purpose.

5. Immediate response methodology

- Develop low-risk immediate response strategies for trauma, focusing on self-treatment and de-escalation techniques.

6. Training non-specialists

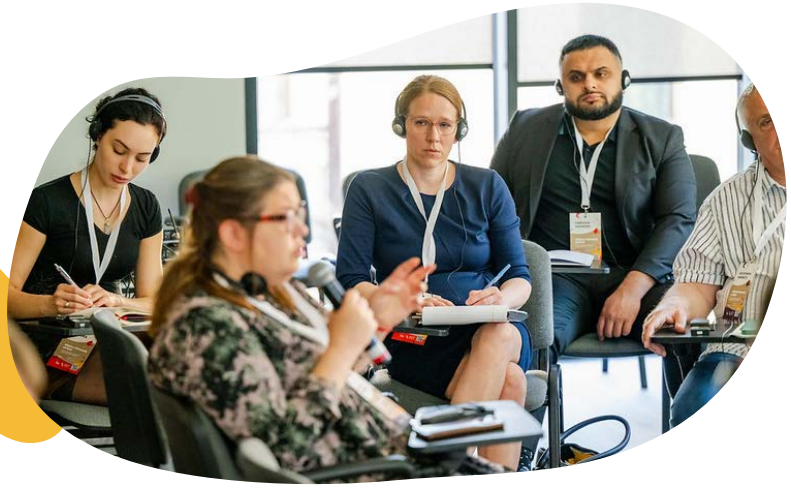
- Train non-certified individuals to provide psychosocial support, focusing on listening, rapport-building, and urgent assistance.
- Prepare mid-link specialists and/or implement a task-shifting approach within the healthcare system to make best use of existing personnel.

Moderator: Janet Anderson
Reporter: Brigita Dyburyte

Report on the Training and Peer Support focus group

During the sessions on training and peer support specialists from various fields including mental health professionals, social workers and military professionals discussed discourses on the ideas of what fields of specialists need training, how these trainings should be implemented and necessary improvements of peer support system in Ukraine.

Discussions were structured and followed four questions regarding training and peer support: **WHO, WHAT, WHEN (& WHERE)** and **HOW?** Such an approach was chosen to clearly outline target audiences as well as develop solutions and discuss continuous implementations methods.



When (& Where) factors were included as the background of the situation is immensely important, thus circumstances of training and peer support must be considered. The participants pointed out the contrasts in situations between a 22-year-old volunteer soldier coming home, a 56-year-old career military member working in the trenches for nearly a decade: both will be 'veterans'. Although both will be mentally affected, their experiences differ, thus a great importance must be placed in separating target audiences and adapting mental health support to each one.

Generally, the sessions focused on unmet urgent needs of veteran mental health, understanding what needs must be met and what issues still exist. A clear structure of the discussion questions allowed to identify beneficial training that could be used by all kinds of organizations with different responsibilities in society to close the existing gaps in the support system.

The morning session devoted certain amount of time to create and discuss a structure and it was made up of participants from a wider variety of backgrounds, when compared to the second session participants. This first group included NGO workers, military personnel, social workers as well as mental health professionals, thus diversifying the discussion and giving it more of a focus group feeling. The afternoon session was comprised of pre-dominantly participants from social and medical worker backgrounds, therefore the discussion and

search for solutions were more concrete and carried out from mostly professionals who are already working in these specific fields (of training and peer support) perspective.

WHO?

The morning group determined that although assisting veterans is immensely important, soldiers who are still on active duty require support and consultations regarding their mental state as well. Participants placed large importance on improving mental health support systems including peer-to-peer for active combatants, as well as providing help for those still on duty, which can help their future recovery as veterans. As one of the participants (working in the medical field) stated: "There is confusion about what peer-to-peer support is. It is support of combatants, veterans, when other military personnel act as role models for others. It is important to understand how we as medical professionals can do referrals". Another group included into the mapping out needs was civilians. The part of the population that is not actively fighting but are affected. People working/ living near the front line, people working in the military but not fighting etc., all experience effects of the front line and would benefit from improvements in mental health support systems. Families of veterans also played a strong role in the discussion, as they spend the most time with veterans, and can be the most affected as well as helpful group for smooth veteran mental recovery.

They experience the outcomes of war equally - they are the caregivers if combatants become wounded in battle (both mentally and physically). Consequentially, this group would benefit from support but most importantly training on ways to spot and assist psychological issues. Lastly, veterans as well as other military members including mental health professionals are a part of the target group as well. As for example, psychologists themselves also need help to process the traumas they must deal with during their work.

The participants during the afternoon placed great importance on the broader society when discussing the target groups. As society needs preparation for the reality of mental issues and their consequences. Also, educating society to break existing stigmas surrounding veteran mental health is a crucial step moving forward. This is necessary not only to encourage veterans to seek help but also to break the stigma of silence, when family members suffer the results of mental issues caused by the war. One of the participants working as a social worker, provided an example - "when wives are experiencing domestic abuse due to their veteran husband's mental issues, in a lot of cases they do not report it. Doubts arise: "who am I to report him? he is a war hero, and I am just a wife." However, due to the family being primary support, they often suffer the consequences of the mental issues of veterans firsthand. Therefore, they should be included as well. This leads to the idea that diversity of the groups affected should be acknowledged (families, wives, families who lost a loved one in combat).

Additionally, adding to the already developed target groups during the previous session, participants outlined elderly veterans, as they need special assistance and support implementation ways. Elderly veterans need other support hubs digital due to their age group. Additionally, mental health assistance as well as reintegration back into the society programs need to be readjusted to disabled veterans. After the war, this specific target group might have grown significantly, therefore the systems must be prepared to assist disabled veterans and consider their needs, mental traumas, mobility and ability to reach assistance hubs.

WHAT?

The discussion here focused on the question of "Are we going to focus on the system, examples or on providing peer-to-peer?". Consequentially peer-to-peer was determined as a priority but improving the mental health support system was also seen as a necessity.

Focus on peer-to-peer was chosen since it works not only with veterans, but also with combatants and families. People with lived experience can become peer-to-peer experts by training in already existing and well-developed programs (for example abroad). However, drawbacks, such as selecting who is suitable for training must be considered. The idea was brough forward, that not every combatant is ready to discuss their issues with commanding officers. Consequentially, outside trained peer-to-peer would be better. Additionally, pressures

being experienced on the front must be considered - not everyone can be peer-to-peer supporters because they themselves need the same support. Here the participants' opinions differed as medical professionals tended not to agree with participants from military backgrounds. They argued that scientifically speaking nobody can provide better peer-to-peer support than combatant to combatant or veteran to veteran due to the lived experience they have. Naturally, there are different types of veterans. But what are we looking at? A good observation about the breakdown of time is that after taking care of their basic needs, combatants have the time to support each other. Although they are not educated or trained to do so, if trained they would have the best capability to help.

Additionally, lack of well-developed methodologies in hospitals was outlined. Peer support occurs in hospitals and day centers among wounded veterans/soldiers; however, they are not professionals. As the demand currently is high for mental health professionals, training them and appointing them to hospitals could improve not only veteran mental health, but also serve as development tool among medical professionals as the notes and experience in dealing with wounded combatants can be shared within the medical community.

The need for a support system for children of veterans was also mentioned. Although the family unit has been determined as a target group previously, the support

and training system often focuses on spouses, however children are equally or even more affected because they are developing. They will be involved in this recovery and renewal of the world, to do that they need to be informed and assisted mentally.

Moreover, an already developed solution that could be more implemented into training peer-to-peer support veterans/combatants and providing mental as well as re-adapting assistance exists. First respondent personnel - primary care, practitioners family doctors, social workers, education sector. Due to online training, these groups are facilitators of the intervention, they act as first respondents and veteran's hub as community of experts.

The second group mainly outlined breaking the societal stigma, improving reintegration programs of veterans into society, training of specialists and utilizing the already existing tools. In their discussions they focused on the complexities related to a return to society and the need to develop readjustment programs, programs to provide mental and social support including peer-to-peer support. It would be necessary to train both professionals and leaders of the combatant groups. Special focus should be on the specific needs of disabled veterans regarding health, housing and employment.

Also, the importance of anti-bullying prevention programs was mentioned. Veterans experience bullying by being called useless. After divorce they are often not

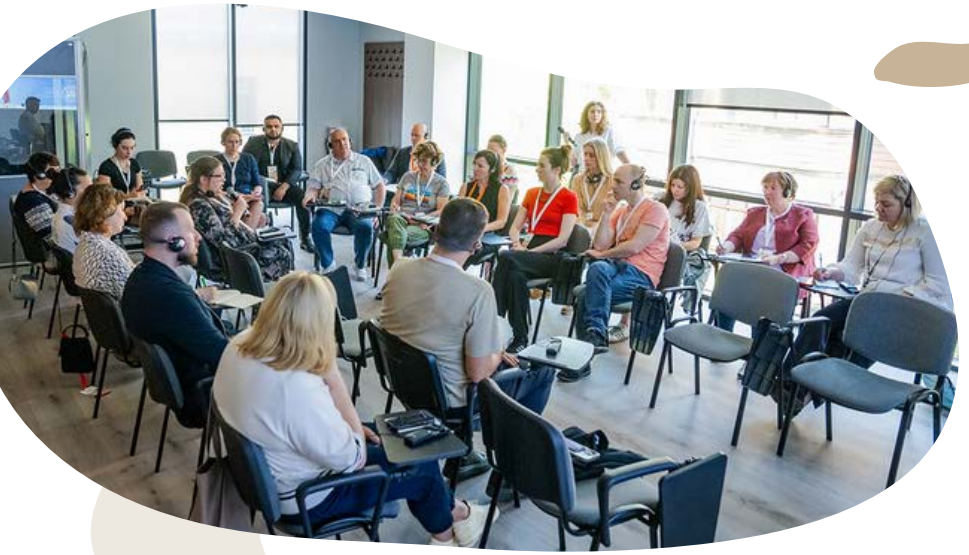
allowed to see their children. Thus, they resort to drug and alcohol abuse. Consequentially, bullying prevention also could assist in dealing with the issue of veteran alcohol and drug abuse.

An important issue is raising awareness of the public towards veteran employment. There is importance in breaking assumptions and stereotypes since employers are cautious that veterans will not make good employees due to their alcoholism or mental issues. This would help with smoother reintegration that could help with improving psychological health. Also, veterans themselves should be motivated to work and reintegrate into society.

In general terms, a problem is the low awareness of where help can be obtained. Many people do not know how and where to find guidance. The creation of one single veteran hub was mentioned, to provide national support. It would help overduplication - when one brigade gets humanitarian aid four times, and another gets none. Some veterans can't go online to get information about the support, so a physical, general hub should be accessible for those people. Also lack of communication about existing tools of mental health or peer-to-peer support was raised as an issue. This gap in communication limits access to the existing tools, thus communication should be improved from the state. This would allow every veteran and their family to have easily accessible information. Although central coordination on national level exists, since Ukraine is a large country,

it is not developed enough so information and existing resources are not accessed by everyone in need.

Finally, the group discussed legislation on accessible services and employment to disabled veterans. It should be mandated by law for businesses to be inclusive of disabled veterans. This is currently very lacking and would help in raising awareness that war requires more needs and inclusion for people with disabilities should be prioritized. Although the UN Convention on the Rights of Persons with Disabilities (CRPD) has been signed and ratified by Ukraine, it has not been completely implemented. However, it can be used as an argument to push for active changes that will benefit the disabled.



WHEN (& WHERE)?

As previously determined, due to different target groups (active combatants, wounded soldiers, retired veterans) the “where” factor matters very much. One size does not fit all. The situation requires adjustment of the approach. Aims differ based on the location and situation - combatants on the front or veterans attempting reintegration into society and for those in hospitals and psychiatric institutions. The action of assistance and peer support must be adapted specifically to these most common situations to reach most productive results.

During the afternoon three main stages were developed when discussing the timing of implementation: before, during and after. Good training given to soldiers before the deployment could act as prevention and such systems could be improved and more widely spread. Similarly, to the previous group, participants also outlined the importance of mental health support during the deployment, this could include the trained designated people who would provide peer-to-peer support in the frontline. Lastly, after the combatants become veterans a coherent hub of services and a well-developed support system would be massively beneficial.

Nevertheless, participants underlined the idea that everything should be developed and implemented now. The needs are urgent and imperative, because there are already people who have returned from the front. Also,

livelihood support is very important at this moment - creating programs dedicated to veteran integration into society.

HOW?

Lastly, possible methods of implementing/improving peer support were discussed. Consequently, specific suggestions were made. First, assistance platforms must be communicated to the people so they can directly benefit from them. It would be good to develop short online courses for families and people interested in veteran mental health support. Every platoon should have a position dedicated to "morale". At least one soldier should be trained to provide qualified peer support, but it should be specifically designated people, not commanding officers and not every soldier since they do not have time or the capacity to act as a psychologist. Also, the location of the training (for peer-to-peer support) must be considered as combatants can't be spared to be sent to specific institution and be distracted from the front.

It would be good to develop supervision of peer-to-peer support in the hospitals. If peer-to-peer is happening in the hospital the specialists must be on the lookout/ supervising because some veterans share toxic coping ways such as alcohol abuse. Thus, the issue is a lack of training and no psychological education background. They understand each other's traumas, but do not know

how to sufficiently help. Consequentially, it is important to have certified training to develop qualifications to carry out proper peer-to-peer support. Not everyone is fit to do so, some people are too traumatized to do so (therefore background check would be beneficial).

Expertise and trainings should be provided by social workers. Social workers could provide trainings for combatants as well as veterans on dealing with emotions and addictions. They could also fill the gap in training veteran/combatant families in rural areas, as currently this group is largely untrained in supporting mental health issues caused by the war.

It would be good to see what expertise and trainings can be provided that have been developed abroad by foreign NGO's. However, it would be important to test developed methodologies. New or improved methodologies can be tested in hospitals, as wounded soldiers are neither active combatants, nor veterans. It is also important to adjust existing systems to war-time conditions.

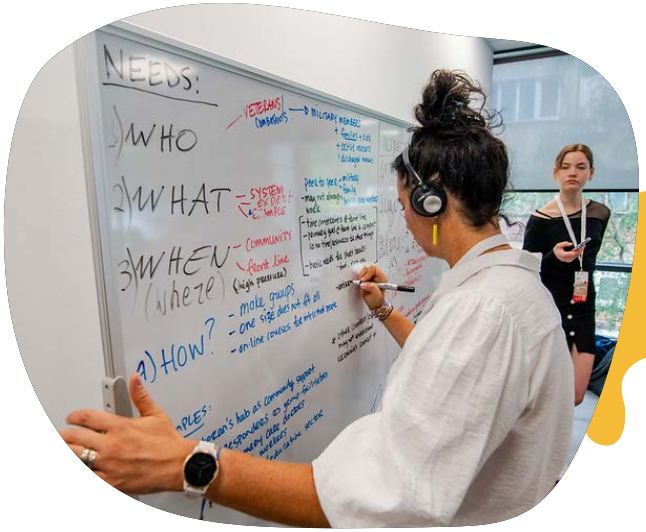
Other issues that were raised were:

1. The creation of a peer-to-peer support team. The picked specific candidates serve the very critical role in peer-to-peer system.
2. Set up veteran hubs. Finding and training a leader from each combatant group. Use already existing sources: courses, frameworks etc. The problem is

lack of coordination or resources to spread it and implement it in the broader sense. Creating a website that would provide coordination of all existing tools.

3. Adjust the programs and support to specific veteran needs (according to their trauma, if they were deployed in the forest, we should not send them back into "hell", we should employ them in environment with less nature, etc.)
4. Animal therapy. Employing veterans to work with horses, for example.
5. Employers match their needs with those of veterans (especially disabled). Companies and the state creating programs and frameworks to help find disabled veterans' employment and live a dignified life.
6. Train HR staff in companies to invite veterans from all regions to work. At the same time, they will form a community with other colleagues, which provides peer-to-peer support as well as reintegration and breaking of the stigma. This applies more to smaller enterprises as larger companies have the resources to do so.
7. Psychoeducation programs of the public. Training the public and schools' principals. Some such programs have existed for some time and have provided positive results.
8. Social project of spreading informative leaflets explaining what words to avoid, how not to trigger etc.

9. Creating a hub for wives and fiancées of veterans, to get support themselves and to be able to provide it to veterans. Also, a hub for families who experienced loss of a loved one should be developed.
10. Communication should be improved from the state so every veteran and their family should have easily accessible information. This also ties in with the necessity of a one, coherent informational hub or creating a website. A HPSS platform although exists it has not been utilized very widely or lacks promotion. But some civil society organizations can fill in these gaps working as a community.
11. The investment of private businesses into providing accessibility to disabled people, by doing so it also helps to raise the stigma.
12. Creation of an interactive map to show what places are not accessible for disabled people.



CONCLUSION

Based on the two sessions, the following summary could be drawn up:

WHO?

- Veterans as people with multiple identities (combatant, wounded soldier, disabled/elderly veteran)
- Broader society
- Families of the veterans (spouses and children as separate groups)

WHAT?

- Division between what the health professionals and military personnel are asking.
- Front line vs. non front line (not only veterans but also hospitals)
- Peer-to-peer beyond the front line (trained veterans in peer-to-peer after returning to society)
- Health, housing, employment, accessibility to disabled veterans.

WHEN (&WHERE)?

- Before, during and after (the war)
- Now

HOW?

- Creation of a single space (support services hub)
- Breaking the stigma through spreading awareness (issue of correct language, correct people implementing the support)
- Improving coordination of existing tools, programs and centers.

Moderator: Janet Gunn
Reporter Maka Berulava

Report on the Integrating Veteran Services focus group

INTRODUCTION

In the conditions of modern Ukraine, the integration of veteran services into existing health and social protection systems is an essential imperative. This report examines the multifaceted approach needed to meet the needs of Ukrainian veterans, their families and communities, with an emphasis on synergies between the military and civilian sectors. As Ukraine overcomes the difficulties associated with armed conflict and military service, the challenges go beyond physical rehabilitation and cover deep needs for psychological and social reintegration. Understanding these issues requires a holistic approach that considers the diverse experiences and unique needs of veterans and their families, especially in post-conflict situations.

Integrating veterans' services involves more than just providing medical care; it requires a comprehensive approach that includes mental health support, community engagement, family education, and effective resource allocation. The purpose of this report, which examines various regional initiatives and international models, is to summarize best practices and offer practical recommendations that can improve the effectiveness of veteran support systems throughout Ukraine. From innovative rehabilitation programs to the joint efforts of government agencies and NGOs, every aspect of this integration is important for building resilience, healing, and building sustainable community support networks.

GENERAL KEY POINTS

Broad Scope of Integration:

Integration efforts must consider veterans and their extended communities, including families and close associates. Many veterans face complex needs, encompassing both physical and mental health issues, and often lack stable housing or employment.

Community and Rehabilitation:

Successful rehabilitation requires integrating veterans into their communities. Community awareness and involvement are crucial for effective integration.

Mental Health Needs:

Some 30-40% of veterans require mental health support. Veterans benefit significantly from peer support and from being listened to. There should be an emphasis on mindfulness, yoga, and outdoor activities, and over-medicalization should be avoided.

Family and Community Support:

It is essential to inform children about the mental scars of war. Schools need to be aware of the challenges faced by children of veterans. It is vital that information on mental health support is provided from the start of service. Drum clubs and similar activities create mindful and focused environments for veterans.

GENERAL RESOURCES AND CHALLENGES

Resources:

- Strong social cohesion due to the war of aggression.
- Civil society with war-time contribution experience.
- Family and community support.
- International assistance and experience.
- Decentralization.

Challenges:

- Over-centralization and lack of local capacity and funds.
- Competition for funds and services.
- Shortage of specialized services.
- Complex needs of veterans, including both physical and mental health issues.
- Military structures focused on ongoing conflicts.
- Displacement and family disruption among Internally Displaced Persons (IDPs).

HEALTH AND SOCIAL SERVICES COLLABORATION

State and Civil Society Roles:

- Determine what services should be state-provided versus community-provided.
- Ensure foreign aid is appropriately qualified and motivated.
- Identify areas where civil society can contribute most effectively.

Strengths of Civil Society Involvement:

- Low cost and flexible.
- Broad impact.
- Community engagement.
- Implementation in context-specific manners.

Consideration for Women Veterans:

- Women veterans may face unique issues such as post-natal depression.
- Mothers and spouses of combatants also need support due to trauma from their husbands' or sons' experiences.

DISCUSSION ON TRAUMA AND SUPPORT SYSTEMS

Military personnel, including medics, many of whom are women, face immense trauma, often counting the lives they save or lose. Combat volunteers also endure significant trauma, witnessing hostilities and facing life-threatening situations. Many soldiers, including those with minimal training, face difficulties adapting to civilian life. Civilians often fail to understand the needs of the military, leading to social isolation and difficult reintegration.

Rehabilitation opportunities are scarce, with some veterans unaware of available support services. Veterans with physical disabilities face significant barriers, such as inaccessible transportation and lack of comprehensive rehabilitation programs or adaptation of their work environment.

As to family and community support, social support units visit families of fallen soldiers, providing necessary supplies and emotional support. Peer support and involvement of social units enhance the credibility and effectiveness of support systems. However, it was noted that the Ministry of Veterans and Ministry of Healthcare in Ukraine need to improve outreach and integrated support for veterans, especially in rural areas. Policies are needed that aim to assist veterans with employment opportunities, including those with physical disabilities.

RECOMMENDATIONS:

Military vs. Civilian Healthcare:

- The integration of military and civilian healthcare remains a challenge.
- Many regions have separate systems for military and civilian health services, leading to gaps in care and follow-up. Ministry of Defence establishments look after serving personnel (but are often keen to get them swiftly back to service at the front line), while veterans are under the care of the Ministry of Health.

Training and Education:

- Ensuring that healthcare providers are trained to understand and relate to veterans is crucial.
- Veterans are adept at detecting insincerity, making specialized training for healthcare workers essential.
- In Canada, training programs have been developed to bridge this gap, emphasizing peer support and cultural competence.

Peer Support:

- Peer support is essential but must be managed carefully to avoid harm.
- Clear boundaries and training for peer supporters are necessary to ensure effective and safe support.

INTEGRATING VETERAN SERVICES: INSIGHTS AND CHALLENGES

Ukrainian psychiatry relies heavily on institutions, with outpatient visits providing a significant capacity for mental health support. Nurses and general practitioners should be trained to identify and direct patients to appropriate mental health services. Clear pathways and guidance for seeking help are necessary. Online resources or dedicated personnel to direct individuals can be beneficial. Better coordination of services and the introduction of digital care can address accessibility issues, especially in remote areas.

Current Issues in the Ukrainian Military can be summarized as follows:

- Prolonged service and exhaustion: Soldiers serving for extended periods (2-5 years) face severe mental health challenges. There is a lack of psychiatric support in conflict areas.

- Command responsibility: Commanders sometimes need to ensure their soldiers receive mental health assistance, but not all are aware of where to seek help.
- Consequences of inadequate support: soldiers without proper mental health support may engage in risky behaviors, leading to fatalities. Substance abuse and gambling are prevalent coping mechanisms.
- Impact on society: The broader society is at risk of increased trauma, suicides, and family problems including domestic violence. Public awareness and understanding of military issues are crucial.

MENTAL HEALTH CARE FOR VETERANS: INSIGHTS AND CHALLENGES

Special attention was paid to the role of women in the military. Currently some 50,000 women serve in the military, including medical personnel, experiencing significant trauma. Wives, girlfriends, and mothers of military personnel also face considerable stress.

Another issue is that soldiers often prefer military hospitals, however in doing so they face challenges. Military psychiatrists are limited in their ability to diagnose and treat due to the need to maintain an effective fighting force. Military psychiatrists may not endorse civilian diagnoses of conditions like depression, causing tension and dissatisfaction among soldiers. Soldiers sometimes simulate mental health issues to avoid frontline duty, leading to skepticism among military psychiatrists.

There is a need for better integration at various levels, including between community and family with state institutions. Mobile teams providing follow-up care post-discharge from hospitals are essential. Integration between NGOs and formal services can enhance care.

Another issue is that veterans often have both physical and mental health issues. New legislation impacts procedures for mobilization and demobilization, with specific implications for mental health care. In addition, there is a shortage of budgetary funding and healthcare professionals, especially psychiatrists, to handle the volume of patients. Bureaucratic hurdles make accessing care difficult, particularly for active-duty soldiers.

Recent legislation lacks clear criteria for mental health-related demobilization, complicating decision-making for doctors. Also, soldiers on the frontline face difficulties in accessing civilian healthcare, often requiring permission from commanders, which may not be timely or forthcoming.

Different approaches are needed for those still serving versus those who have left the military. Integration of state-provided formal services with community and civil society support is crucial. In that sense, NGOs are essential in providing support, particularly in rural areas. Projects involving psychologists and religious organizations aim to rehabilitate veterans and their families.

RECOMMENDATIONS

It is pivotal to improve coordination between military and civilian healthcare systems. There should be clear pathways for soldiers to access civilian mental health services. More mental health professionals, including civilian specialists, should be trained to understand military experiences. The use of mobile teams should be expanded, including telemedicine to reach remote areas.

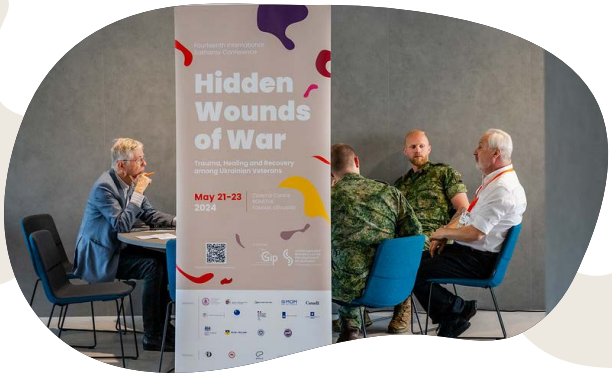
Legislation should be refined to provide clear criteria for mental health-related demobilization. Bureaucratic hurdles should be reduced for active-duty soldiers seeking mental health care.

Structured peer support programs should be developed with clear guidelines and training. Communication between veterans and their families should be enhanced through targeted rehabilitation programs. Also, Public awareness campaigns should be developed to combat stigma and raise awareness about veterans' mental health issues. The public and medical professionals should be educated about the unique needs of veterans and active-duty soldiers. Collaboration between NGOs, military, and civilian healthcare providers should be fostered, and everything should be done to ensure that rural and remote areas are adequately covered by support programs. There is often unhealthy competition between NGOs and local authorities, with a lack of mutual support and understanding. Adequate cooperation

between state and NGO activities are essential to avoid redundancy and ensure effective service delivery. It will also be useful to map these activities so that to know exactly where these centers are located, what support they provide and their contact information.

For veterans, there are various ways to foster integration and rehabilitation at the same time. Programs like swimming lessons with champions and other sports activities can greatly enhance the well-being of veterans, particularly those with physical disabilities. Also, animal-assisted therapy was highlighted. Therapy involving cats, horses, donkeys, dogs, and horticultural therapy can provide emotional support and therapeutic benefits.

It was mentioned that Ukraine may need support in establishing suitable long-term care facilities within communities for veterans with severe mental and/or physical disabilities. Shutting them away in institutions is not a compassionate approach and should be replaced with home visits by professionals, supported housing and similar community-based solutions.



CONCLUSION

In conclusion, both problems and opportunities were identified on the way to the integration of veteran services in Ukraine. The efforts described in this report highlight the resilience and dedication of stakeholders, from government agencies to civil society organizations who strive to meet the diverse needs of veterans and their families. Despite bureaucratic obstacles, lack of funding, and persistent stigma regarding mental health, progress is evident in the establishment of centers for veterans, specialized rehabilitation centers and increased community engagement and peer support initiatives.

Looking to the future, maintaining and expanding these efforts require continued commitment from all sectors of society. The recommendations presented, ranging from legislative reforms to educational campaigns, are not just theoretical, but also practical steps towards creating a more integrated environment that supports veterans. By studying international examples, adapting to local conditions and prioritizing cooperation, Ukraine can develop a comprehensive care plan for veterans that serves as a beacon of hope and healing. Ultimately, the success of these efforts depends on a collective determination to honor the victims of Ukrainian veterans with dignity, respect and continued support throughout their journey of recovery and reintegration into civilian life.

APPENDIXES

CONFERENCE PROGRAM

Romuva Cinema, Laisves av. 54, Kaunas

09.00-10.00	Registration
10.00-10.30	**Opening session** Prof. Juozas Augutis, Rector of Vytautas Magnus University Mr. Zilvinas Tomkus, Deputy Minister of Defense of Lithuania Mr. Masi Nayyem, NGO Pryncyp - Ukraine Ms. Tatiana Yankelevich, Stepdaughter of Andrei Sakharov Prof. Robert van Voren, FGIP/ASRC
10.30-10.55	Keynote address 1: **Europe and the war in Ukraine** **Prof. Timothy Garton Ash (**UK)
10.55-11.20	Keynote address 2: **When you have seen one war...you have seen one war** **Prof. Sir Simon Wessely** (UK)
11.20-11.30	Book announcement **"Waiting for the first light"** Magdalena Paluszkiewicz-Misiaczek and Lesya Kharchenko
11.30-12.00	Coffee break

12.00-13.00	**Panel I: Living with trauma: personal stories from survivors** Moderator: Prof. Jana Javakhishvili (GE) **Kyiv veteran theater two years after the invasion** video by Lesya Kharchenko (UA) Comments by Andrei Ilchenko (UA); Viktoria Samova-Katalichuk (UA) Discussants: Ryszard Chudy (PL); Robin Imthorn (NL)
13.00-14.00	Afternoon break
14.00-14.25	Keynote address 3: **Mental health and invisible wounds General Romeo Dallaire** (CA)
14.25-15.35	**Panel II: Looking back: what would you do different when developing national models of services for veterans from scratch?** Moderator: Janet H. Anderson (UK) Discussants: Oystein Jack Naess (N); Lt. Col. Sardar Bahadur (UK); Dr. Denisa Dokulilova (CZ); Dr. Darren Minshall (UK)
15.35-16.00	Keynote address 4: **Moral injury in the aftermath of war and conflict Dr. Stephanie Houle** (CA)
16.00-16.30	Coffee break

16.30-16.55	Keynote address 5: **From battlefield to brain - why we need to understand the dynamics of PTSD, stress, and trauma? Prof. Eric Vermetten** (NL)
16.55-17.20	Keynote address 6: **Community-based rehabilitation (CBR) in conflict areas: potential applications in Ukraine Rachel Thibeault** (CA)
17.20-18.30	**Panel III: How to meet the veteran needs in Ukraine when resources are limited?** Moderator: Rob Keukens (NL) Discussants: Prof. Robert van Voren (LT/NL); Dr. Haakon Engen (N); Dr. Deirdre MacManus (UK); Kateryna Timakina (UA); Nataliia Umerenkova (UA)
18.30-18.45	Closing
19.00	Reception at Andrei Sakharov Research Center, S. Daukanto st. 27

COMPOSITION OF THE WORKING GROUPS

Research

- Nataliia Barchuk
- Oksana Bryzghunova
- Anne Dastakian
- Denisa Dokulilová
- Haakon Engen
- Miroslav Filistovic
- Fardous Hosseiny
- Stephanie Houle
- Maryna Hrebeniuk
- Ivanna Klivak
- Bohdana Korovaieva
- Goran Mijaljica
- Olha Myshakivska
- Vladislav Oliinik
- Magdalena Paluszkiewicz-Misiaczek
- Antonina Pushko
- Olena Tanasiichuk
- Anna Tarasenko
- Rachel Thibeault
- Oleksii Tolmachov
- Stanislav Tymchyshyn
- Sir Simon Wessely
- Victoria Zielińska

Integrating

- Oksana Alieksieieva
- Dariia Artemchuk
- Maryna Brohma
- Svitlana Cherheiko
- Oksana Chorna
- Larysa Chudakova
- Ryszard Chudy
- Olga Chyrkova
- Vasylyna Danyliv
- Anne Dastakian
- Denisa Dokulilová
- Volodymyr Gabenets
- Alina Gryn
- Nataliia Haluhan
- Nataliia Halytska-Pasichnyk
- Nataliia Havronska
- Laine den Hollander
- Kateryna Hornova
- Fardous Hosseiny
- Robin Imthorn
- Marta Khomchenko
- Emma Khutkovska
- Bohdana Korovaieva
- Volodymyr Kosovskyi
- Olena Kozyr
- Mariia Kulbitska
- Ričardas Lanauskas
- Martynas Marcinkevičius
- Dara Massicot
- Anastasiia Medvid
- Goran Mijaljica
- Darren Minshall
- Oystein Jack Naess
- MaryAnn Notarianni
- Craig Oliphant
- Tetiana Onyshchuk
- Anna Pashkina
- Liudmyla Podzyvalovska
- Olena Protsenko
- Natalya Pryanikova
- Svitlana Prykhodko
- Olena Puhach
- Hanna Revunets
- Anna Rottenecker
- Viktoria Samova-Katalichuk
- Amira Tawashy
- Nataliia Umerenkova
- Joris Voorhoeve
- Victoria Zielińska

Methodology

- Svitlana Berezina
- Oksana Bryzghunova
- Ryszard Chudy
- Vasylyna Danyliv
- Haakon Engen
- Tadeusz Hawrot
- Stephanie Houle
- Kateryna Husak
- Svitlana Kaminska
- Emma Khutkovska
- Olena Kicha
- Sofia Kopach
- Maryna Lukashuk
- Olha Lychko-Parubocha
- Martynas Marcinkevičius
- Dara Massicot
- Hanna Miroshnychenko
- Olesia Morozova
- Oystein Jack Naess
- Daryna Palamarchuk
- Magdalena Paluszkiewicz-Misiaczek
- Arjan Pronk
- Manuela Putz
- Lucie Rehorikova
- Anastasiia Romaniuk
- Viktoria Samova-Katalichuk
- Natalya Shasha
- Hennadii Smirnov
- Olena Tanasiichuk
- Kateryna Timakina
- Oleksii Tolmachov

- Nataliia Umerenkova
- Diana Vakulko
- Renet van der Waals
- Marharyta Voskoboinyk
- Sir Simon Wessely

Training

- Oksana Alieksieieva
- Dariia Artemchuk
- Nataliia Barchuk
- Svitlana Berezina
- Maryna Bohma
- Svitlana Cherheiko
- Oksana Chorna
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- Olga Chyrkova
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- Marharyta Voskoboinyk

NOTES

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