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STRENGTHENING MENTAL HEALTH CARE IN THE PENITENTIARY SYSTEM OF UKRAINE: EXPERIENCE FROM MHGAP IMPLEMENTATION (2021–2025)

ЗМІЦНЕННЯ ОХОРОНИ ПСИХІЧНОГО ЗДОРОВ'Я В ПЕНІТЕНЦІАРНІЙ СИСТЕМІ УКРАЇНИ: ДОСВІД ВПРОВАДЖЕННЯ MHGAP (2021–2025)

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People deprived of liberty represent one of the most underserved and clinically vulnerable population groups with regard to mental, neurological and substance use (MNS) conditions worldwide. Evidence consistently demonstrates that the burden of mental disorders in custodial settings substantially exceeds that observed in the general population, reflecting the cumulative effects of social vulnerability, exposure to violence, problematic substance use and the psychosocial environment of detention [1, p. 1310].

International studies highlight elevated rates of depression, psychoses and suicidal behaviour among incarcerated populations, particularly in low- and middle-income countries [2, p. 45]. These patterns underscore the need for structured, system-level responses to mental health needs within custodial environments, beyond reliance on specialist psychiatric services alone.

In Ukraine, these challenges are further shaped by long-standing workforce constraints within the penitentiary health-care system and by the cumulative psychosocial impact of the ongoing full-scale war. Although the total population deprived of liberty has decreased since 2020, mental health needs remain high. Administrative data indicate substantial levels of suicide risk, self-harm and inpatient treatment related to mental and neurological conditions.

Prior to the full-scale war, specialized inpatient psychiatric care within the penitentiary system was centralized in a single psychiatric hospital serving the entire system. As a result of war-related disruption, this centralized facility ceased operations. As of late 2025, specialized psychiatric care is provided through only three psychiatric units located in Vinnytsia, Zhytomyr and Lviv regions. This reduction in specialized capacity has further constrained access to timely psychiatric care and increased reliance on early identification, initial response and referral mechanisms at facility level.

Against this background, the Mental Health Gap Action Programme (mhGAP) was piloted in the penitentiary system of Ukraine between 2021 and 2025 with support from the World Health Organization. The pilot aimed to assess the feasibility, relevance and acceptability of mhGAP as an operational framework for strengthening responses to priority MNS conditions in custodial settings characterized by limited specialist resources.

The pilot focused on strengthening the capacity of both medical and non-medical staff through the development of competencies in assessment, management and follow-up, delivered through mhGAP–Training of Professionals (mhGAP–ToPS) and supported by supervision. Additional components included support for task-sharing approaches at facility level, clarification of roles and referral pathways, and reinforcement of people-centred and rights-based care consistent with WHO QualityRights principles.

Across nine training cycles, 245 staff members from 23 regions participated in the pilot, including medical personnel as well as staff from security, supervision and social–psychological services. This multisectoral composition reflected the operational reality of penitentiary settings, where non-medical staff often serve as frontline actors in early identification of distress and crisis situations.

Analysis of pre- and post-training assessments demonstrated consistent short-term improvements in knowledge across all training cycles, with effect sizes ranging from moderate to very large [3, p. 12]. In selected training cycles, knowledge gains were accompanied by increased self-reported confidence in identifying and responding to priority MNS conditions,

particularly in acute situations such as suicidal behaviour, self-harm, psychosis and epilepsy.

Findings from an anonymous staff survey further indicated that higher confidence levels were more frequently reported among staff who had participated in mhGAP training and among medical personnel. At the same time, a substantial proportion of both medical and non-medical staff reported confidence levels contingent on access to supervision or specialist support. This pattern underscores the importance of embedding supervision mechanisms within task-sharing models to ensure safety, quality of care and ethical practice.

Importantly, the pilot also highlighted persistent system-level constraints that limit the translation of training gains into routine practice. These include shortages and uneven distribution of specialist mental health staff, limited availability of essential psychotropic medicines required for emergency care, fragmented coordination between medical and custodial services, and the absence of systematic supervision structures. These constraints largely fall outside the scope of training-focused interventions alone.

From a clinical and public health perspective, the findings of this pilot underscore the necessity of integrating mental health care within custodial systems as a core component of health service delivery, rather than as an isolated or specialist-only function. Such integration is particularly critical in conflict-affected settings, where existing vulnerabilities are amplified and health systems operate under sustained strain [1, p. 1312].

The experience of the mhGAP pilot suggests that task-sharing approaches can meaningfully support early identification and primary response to MNS conditions in penitentiary settings, provided that roles, limits of responsibility and referral pathways are clearly defined. However, training activities alone do not ensure sustained system-level change.

Further progress is likely to depend on phased institutionalization of mhGAP principles within penitentiary health governance and training systems, establishment of proportionate supervision mechanisms, alignment of essential medicines lists with mhGAP recommendations, and strengthened linkages with community mental health services to support continuity of care.

In conclusion, experience from the pilot implementation of mhGAP in Ukraine suggests that strengthening mental health care in penitentiary settings may be feasible even under conditions of resource constraints and ongoing humanitarian stress. mhGAP may be considered a relevant operational framework for supporting early identification, primary response and appropriate referral for people with priority mental, neurological and substance use conditions, when embedded within a broader, system-oriented approach.

These findings contribute to the evidence base supporting context-adapted implementation of mhGAP in custodial settings and may inform future clinical, policy and practice-oriented discussions.

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