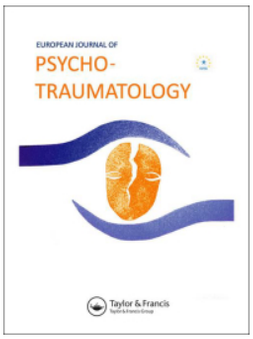

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Implementing scalable face-to-face and digital interventions among forcibly displaced persons from Ukraine in Europe: protocol of The U-RISE Project

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STUDY PROTOCOL

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Implementing scalable face-to-face and digital interventions among forcibly displaced persons from Ukraine in Europe: protocol of The U-RISE Project

Karl J. Weinreich [a], Iryna Frankova [a,b], Natalie Maksymets[a], Corrado Barbui [d], Vitalii Klymchuk [c], Trudy Mooren [b], Emilia Olechno[a], Marianna Purgato [d], Marit Sijbrandij [a], Anke B. Witteveen [a] and Els van der Ven [a,b]

[a]Department of Clinical, Neuro- and Developmental Psychology, World Health Organization Collaborating Center for Research and Dissemination of Psychological Interventions, Amsterdam Public Health Research Institute, Vrije Universiteit Amsterdam, Amsterdam, the Netherlands; [b]ARQ National Psychotrauma Centre / Centrum 45, Oegstgeest, the Netherlands; [c]Department of Social Sciences, University of Luxembourg, Esch-sur-Alzette, Luxembourg; [d]WHO Collaborating Centre for Research and Training in Mental Health and Service Evaluation Department of Neurosciences, Biomedicine and Movement Sciences, University of Verona, Verona, Italy

ABSTRACT

Background: The full-scale Russian invasion of Ukraine on 24 February 2022 has led to millions of forcibly displaced persons (FDPs) within Ukraine and other European countries. Due to war-related exposure and displacement adversities, this group is at significant risk of developing depression, anxiety, post-traumatic stress disorder, and other mental health problems. Systemic barriers, including insufficiently equipped mental health systems and language barriers, prevent FDPs from receiving adequate mental health and psychosocial support (MHPSS). Scalable interventions delivered in person by non-specialist helpers, or digitally, provide opportunities to scale up the MHPSS response.

Objectives: This paper aims to provide an overview of the 'Ukraine's displaced people in the EU: Reach out, Implement, Scale-up and Evaluate interventions promoting mental wellbeing' (U-RISE) project. U-RISE aims to improve the mental wellbeing of FDPs from Ukraine by establishing a network of Ukrainian mental health professionals, building sustainable capacity for provision and supporting implementation of scalable face-to-face and digital mental health interventions adapted to the specific needs of this population.

Method: We build capacity for and implement scalable face-to-face interventions, including Problem Management Plus, Self Help Plus, and Multi-family Approach, for FDPs from Ukraine in Poland, Slovakia and Romania. Digital interventions, including the Doing What Matters in Times of Stress digital guide and a Telegram-based chatbot 'Friend' using principles of Psychological First Aid, are being implemented in Europe and Ukraine. To monitor the population's mental wellbeing and impact of the interventions, qualitative needs assessments among mental health providers and FDPs, and quantitative assessments pre- and post-intervention are collected.

Conclusion: We provide a framework for the rapid implementation of face-to-face and digital interventions in countries that need to scale up their MHPSS in response to humanitarian or complex emergency crises.

Implementando intervenciones digitales y cara a cara escalables en personas forzosamente desplazadas de Ucrania en Europa: protocolo del Proyecto U-Rise

Antecedentes: La invasión rusa a gran escala en Ucrania el 24 de febrero de 2022 ha provocado que millones de personas se vean obligadas a desplazarse (FDPs en su sigla en inglés) dentro de Ucrania y hacia otros países europeos. Debido a la exposición relacionada con la guerra y las adversidades del desplazamiento, este grupo corre un riesgo significativo de desarrollar depresión, ansiedad, trastorno de estrés postraumático y otros problemas de salud mental. Las barreras sistémicas, incluidos los sistemas de salud mental insuficientemente equipados y las barreras lingüísticas, impiden que las FDP reciban un apoyo psicosocial y de salud mental adecuado (MHPSS en su sigla en inglés). Las intervenciones escalables realizadas en persona por interventores no especializados, o de forma digital, brindan oportunidades para ampliar la respuesta de MHPSS.

Objetivo: Este artículo tiene como objetivo proporcionar una visión general del proyecto 'Personas desplazadas de Ucrania en la UE: alcanzar, implementar, escalar y evaluar intervenciones que promueven el bienestar mental' (U-RISE en su sigla en inglés). U-RISE pretende mejorar el bienestar mental de las personas desplazadas de Ucrania mediante el

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Forcibly displaced persons; mental health and psychosocial support; scalable interventions; task-shifting; Ukraine

PALABRAS CLAVE
Intervenciones escalables; apoyo en salud mental y psicosocial; personas desplazadas forzosamente; cambio de tareas; Ucrania

KEY MESSAGES

- Scalable interventions delivered in person by non-specialists, or digitally, have the potential to scale up the mental health and psychosocial support in response to the mass displacement caused by the war in Ukraine.
- U-RISE aims to improve the mental wellbeing of forcibly displaced persons from Ukraine in Europe by building sustainable capacity and implementing multiple task-shifting programmes. These programmes include Self-Help Plus, Problem Management Plus and Multifamily Approach, as well as digital formats, including Doing What Matters in Times of Stress digital guide and a chatbot based on principles of Psychological First Aid.
- U-RISE provides a framework for the rapid implementation of scalable in-person and digital

CONTACT Els van der Ven e.m.a.vander.ven@vu.nl Vrije Universiteit Amsterdam, van der Boechorstraat 7, 1081BT Amsterdam, the Netherlands

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establecimiento de una red de profesionales de la salud mental ucranianos, y crear una capacidad sostenible para la prestación y el apoyo a la implementación de intervenciones de salud mental escalables presenciales y digitales.
Método: Desarrollamos capacidad e implementamos intervenciones presenciales escalables, que incluyen Gestión de problemas plus, Autoayuda plus y Enfoque multifamiliar, para las FDPs de Ucrania en Polonia, Eslovaquia y Rumania. Se están implementando intervenciones digitales, que incluyen la guía digital Haciendo lo Que Importa en Tiempos de Estrés y un chatbot de Telegram 'Friend', que utiliza principios de Primeros auxilios psicológicos, en Europa y Ucrania. Para monitorear el bienestar mental de la población y el impacto de las intervenciones, se recopilan evaluaciones cualitativas de las necesidades entre los proveedores de salud mental y las FDP, y evaluaciones cuantitativas antes y después de la intervención.
Conclusión: Proporcionamos un marco de trabajo para la implementación rápida de intervenciones presenciales y digitales en países que necesitan ampliar su MHPSS en respuesta a crisis humanitarias o de emergencia complejas.

interventions underpinned by qualitative and quantitative research assessing the needs of various stakeholder groups and psychological outcomes pre- and post-intervention.

Abbreviations: DWM: Doing What Matters in Times of Stress; **ENACT:** Enhancing Assessment of Common Therapeutic Factors; **EQUIP:** Developed Ensuring Quality In Psychological Support Materials; **FDPs:** Forcibly Displaced Persons; **MFA:** Multi-Family Approach; **MHPSS:** Mental Health and Psychosocial Support; **NGO:** Non-Governmental Organisations; **PFA:** Psychological First Aid; **PM+:** Problem Management Plus; **PTSD:** Post-Traumatic Stress Disorder; **SH+:** Self-Help Plus; **ToH:** Training of Helpers; **ToT:** Training of Trainers; **UNHCR:** United Nations High Commissioner for Refugees; **U-RISE:** Ukraine's Displaced People in the **EU:** Reach Out, Implement, Scale-up and Evaluate Interventions Promoting Mental Wellbeing; **WHO:** World Health Organization

1. Introduction

On 24 February 2022, the Russian Federation invaded Ukraine, escalating the armed conflict that had been sweltering since Russia's annexation of Crimea eight years earlier, thereby initiating one of the largest humanitarian crises in Europe since World War II (Loft & Brien, 2023; United Nations High Commissioner for Refugees [UNHCR], 2024a). Since the invasion, more than three million individuals have been internally displaced, and almost 6 million individuals have been displaced into the European Union, the majority of whom are women and children (UN Women, 2023; UNHCR, 2024a). Besides stressors experienced during forced migration like violence, death, or other traumatic events, forcibly displaced persons (FDPs) from Ukraine face additional post-migration difficulties. These include loss of social status, cultural shock, language barriers, uncertainty related to temporary protection status, and reduced access to health care and psychosocial services (Frankova et al., 2024; UN Women, 2023).

These stressors occur in addition to other post-displacement stressors including the ongoing war, worries for the safety of loved ones back home due to growing documentation of war crimes, and fears concerning the potential use of nuclear weapons or damage to nuclear reactors (Independent International Commission of Inquiry on Ukraine, 2023; Morganstein et al., 2023; Porter & Haslam, 2005; UN Women, 2023). Furthermore, due to pan-Ukrainian mobilisation and conscription of the male population aged 25–60, men of fighting age are unable to leave Ukraine, resulting in women, children, and elderly, who are at higher risk of mental health problems related to forced displacement, being overrepresented among FDPs from Ukraine (Jain et al., 2022; Li et al., 2016). Due to the measures taken to allow Ukrainians to move freely within the European Union, FDPs from Ukraine represent a highly mobile population that is hard to reach through conventional channels of mental health and psychosocial support (MHPSS).

Studies indicate that forced displacement has exacerbated pre-existing mental health problems among various groups of the Ukrainian population (Bai et al., 2022; Martsenkovskyi et al., 2022). In a cross-sectional survey among individuals who were internally displaced by the hostilities since 2014, prior to the current escalation, 22% reported symptoms of depression, 18% of anxiety, and 32% of post-traumatic stress disorder (PTSD; Roberts et al., 2017). Approximately 6 months after the Russian invasion, 25.9% of people still residing in Ukraine met self-reported criteria for PTSD (Karatzias et al., 2023). An online survey using quota sampling also reported high rates of psychological distress (52.7%), symptoms of anxiety (54.1%), and of depression (46.8%; Xu et al., 2023). These mental health problems are compounded by negative coping strategies (i.e. substance abuse) due to war exposure and are likely to increase in prevalence and severity as the war continues (Hyland et al., 2023; Karatzias et al., 2023).

2. Mental health services for FDPs from Ukraine in Europe

Currently, Slovakia hosts approximately 127,000, Romania 172,000, and Poland 980,000 FDPs from Ukraine, making their health services important first

points of contact for MHPSS (Eurostat, n.d.). Before the full-scale Russian invasion, mental health systems in these countries were already suffering from pre-existing challenges including high rates of unmet care needs, low availability of medical staff, underdiagnosis, stigma around mental health issues, and overreliance on inpatient services (Dlouhy, 2014; Winkler et al., 2017), which were only beginning to be addressed following the COVID-19 pandemic (Directorate-General for Health and Food Safety, 2023; Zadka & Olajossy, 2021). In most countries bordering Ukraine, such as Slovakia, Romania, and Poland, public mental health systems were overall lacking and local MHPSS services were consequently insufficiently equipped to meet the demand of individuals requiring timely mental health support (Organisation for Economic Co-operation and Development, 2023b, 2023c, 2023a; UNHCR, 2024b).

To reduce MHPSS service gaps, the World Health Organization (WHO) launched the Mental Health Gap Action Plan (WHO, 2008). Following the framework derived from this plan (WHO, 2016), the WHO developed several scalable MHPSS programmes that are applicable to broad population groups, transdiagnostic, and suitable for task-sharing. Task-sharing refers to the principle of delegating tasks originally performed by highly-trained specialists to less specialised workers, who receive additional training (van Ginneken et al., 2021). This allows for MHPSS interventions to be carried out by trained primary care workers, paraprofessionals or peer helpers under clinical supervision. Task-sharing may tackle issues like lack of qualified staff, waiting lists, and language barriers (Frankova et al., 2023). It is ideally implemented in stepped or collaborative care settings, where individuals with more severe mental health problems are referred to specialised services. In addition, guided and unguided digital psychological interventions have been developed to ensure delivery to a broad population through scalability, ease of access, and fast distribution (Cuijpers, 2023). Digital interventions can efficiently provide MHPSS to large groups of individuals and benefit from a lower barrier of entry for those who are hard to reach by face-to-face services because of stigma, residing in frontline zones, or high geographical mobility (Bear et al., 2024; Schueller et al., 2019).

3. The U-RISE Project

The present project protocol describes the 'Ukraine's displaced people in the EU: Reach out, Implement, Scale-up and Evaluate interventions promoting mental wellbeing' (U-RISE) project, which was developed following a call by the European Union EU4Health Programme in May 2022 to contribute to establishing an adequate MHPSS response and addressing the mental health needs of FDPs from Ukraine in bordering EU countries, specifically Poland, Romania and Slovakia (Figure 1). To this end, the U-RISE project has four main aims (Figure 2). First, U-RISE aims to mobilise and reinforce a European network of Ukrainian- and Russian-speaking mental health professionals. Difficulties in finding psychological support with sufficient cultural knowledge and language skills remain a challenge for displaced Ukrainians. Establishing such a network can help form a platform for sharing MHPSS resources and knowledge, connecting MHPSS providers with clients, and recruiting mental health professionals as trainers for scalable interventions. Second, U-RISE engages in capacity building by training mental health professionals to train peer helpers, thereby enabling non-governmental organisations (NGOs) to scale up MHPSS responses in the countries of implementation. In most Western European countries, MHPSS is provided by government-funded health systems. In countries bordering Ukraine, the MHPSS response is largely organised by humanitarian NGOs established through the interagency standing committee framework and coordinated via local technical working groups (Inter-Agency Standing Committee, 2007). Third, U-RISE aims to implement best practice face-to-face and digital interventions tailored to the needs of Ukrainian FDPs. Fourth, U-RISE aims to develop a roadmap of available specialised mental health services in Poland, Romania and Slovakia. This roadmap aims to inform MHPSS providers with an overview of available specialised support for Ukrainian FDPs, accelerate referral pathways, and enhance the efficiency of delivering care.

U-RISE is coordinated by Vrije Universiteit Amsterdam in collaboration with other academic institutions (University of Verona; University of Luxemburg), implementing NGOs (International Medical Corps Croatia (Poland); TENENET (Slovakia), Phoneo (Romania), ARQ National Psychotrauma Centre (Netherlands)), and guidance from WHO. A steering group composed of Ukrainian and European independent experts, and international partners such as the United Nations High Commissioner for Refugees (UNHCR), WHO Europe and WHO regional offices in Poland, Romania, and Slovakia, was established to provide external advice on the implementation, transferability, stakeholder needs and sustainability of U-RISE.

4. Ethical considerations

To safeguard ethical standards during implementation and evaluation, ethics approval for the study components was gathered from the Medical Ethics Review Committee of Amsterdam University Medical Centers (2023.0924), the Scientific and Ethical Review Board of

Figure 1. U-RISE implementation sites.

the Faculty of Behavioural and Movement Sciences of Vrije Universiteit Amsterdam (VCWE-2023-133) and the Institutional Review Board of the University of Verona (12a/2023). To ensure the prioritisation of participant safety and well-being, referral pathways for participants in need of more intensive mental

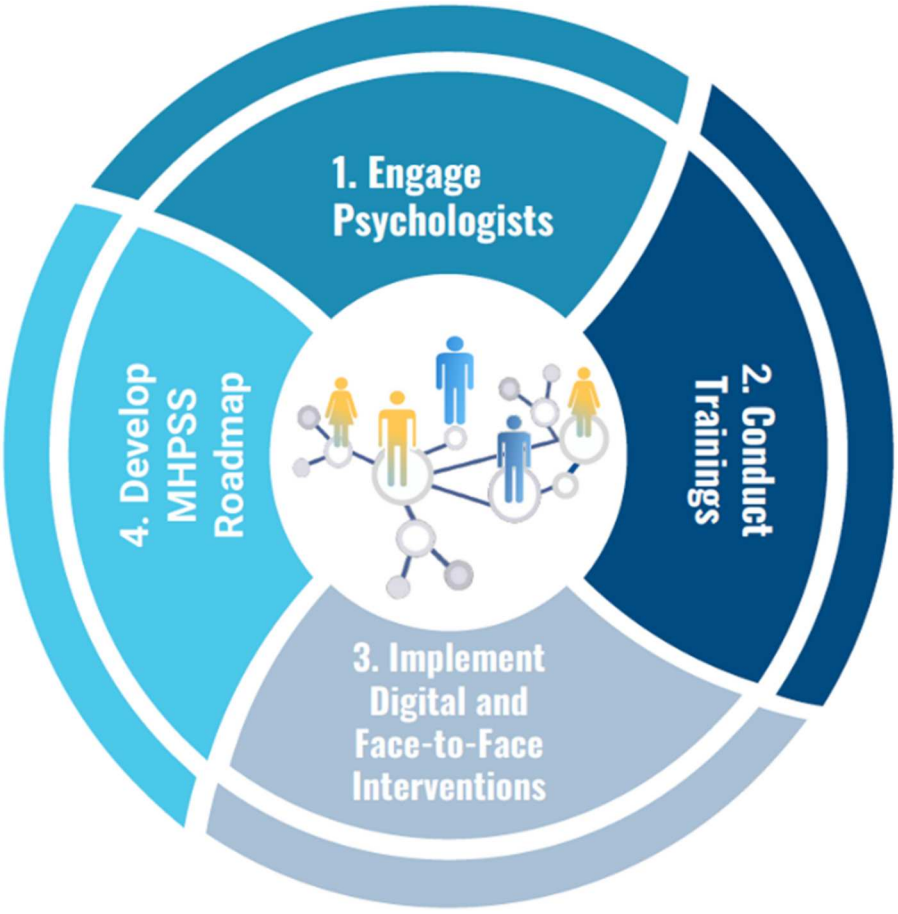

Figure 2. U-RISE objectives overview.

health care were established in each implementation country prior to implementation. We used the Ensuring QUality In Psychological support materials (EQUIP; Marshall et al., 2010) to assess the skills of non-professional peer helpers and provided supervision to avoid beneficiaries would be exposed to unhelpful or potentially harmful behaviour. To ensure ethical treatment of participants, best practice principles were conveyed during trainings, and interventions were offered to all participants regardless of research participation.

5. Face to face interventions

The implementation of face-to-face interventions is carried out by the NGOs in Romania, Slovakia, and Poland. The U-RISE interventions include three face-to-face interventions for individuals (Problem Management Plus; PM+), groups (Self-Help Plus; SH+) and families (Multi-Family Approach; MFA).

5.1. Problem Management Plus

PM + (WHO, 2020b) is a WHO-developed, scalable individual or group intervention (eight to 10 participants per group) aimed at reducing anxiety, depression, PTSD symptoms, and improving daily functioning for people affected by adversity. The intervention encompasses five weekly 90-minute sessions, delivered by peer-helpers under clinical supervision, in which participants focus on different strategies, including stress management, problem solving, behavioural activation, and social support strengthening skills (Dawson et al., 2015). Randomised controlled trials examining PM + showed a reduction in symptoms of depression, anxiety, PTSD, and functional impairments in Pakistan (Rahman et al., 2016) and Kenya (Bryant et al., 2017). This evidence was extended to a trial with Syrian refugees in the Netherlands (de Graaff et al., 2023), even at six and 12-month follow-up (de Graaff et al., 2024; Schäfer et al., 2023). PM + has been culturally adapted for Ukrainians and has since 2015 been implemented in non-occupied Donetsk and Luhansk regions for internally displaced persons and host communities (Goloktionova & Mukerjee, 2021). Ukrainian primary health professionals were trained as PM + trainers and provided an eight-day training in the eastern regions of Ukraine to enable non-professional peer-helpers to deliver PM + during the CHANGE project (Fuhr et al., 2021).

5.2. Self help plus

SH + (WHO, 2021) is a WHO-developed, scalable, evidence-based group intervention (Augustinavicius et al., 2023; Karyotaki et al., 2023; Tol et al., 2020). It aims to reduce distress and build resilience, and can be delivered to groups of up to 30 people. It is delivered by supervised, non-specialist facilitators who complete a short training and use pre-recorded audio, the illustrated guide Doing What Matters in Times of Stress (DWM), and scripted group exercises. Over five sessions lasting two hours each, participants learn strategies derived from Acceptance and Commitment Therapy, like grounding, unhooking, and accepting negative feelings. The intervention has been shown to reduce the risk of developing a mental disorder among refugees displaced to various European countries (Purgato et al., 2021) and Syrian refugees displaced to Turkey (Acarturk et al., 2022). In 2023, with support of the WHO Ukraine office, 90 trainers completed the Self-Help Plus stress management course. The trainers in Ukraine regularly scale the intervention by training facilitators to conduct group stress management sessions within state and civil society organisations in Ukraine (WHO, 2023).

5.3. Multi-Family Approach

MFA is a preventive intervention targeting multiple families sharing experiences of facing adversity (Mooren et al., 2020). It aims to improve parenting skills, attachment, inter- and intra-family support, and prevent generational consequences of stressors. MFA comprises of six sessions, lasting around 2.5 h each. Initial sessions focus on identifying stressors, and distinguishing between those that can and cannot be changed. The focus then shifts from the consequences of these stressors on individual physical and mental health, to interactions within the family. Lastly, the sessions focus on exploring and emphasising resources inside and outside the family. MFA is based on multi-family therapy (Asen & Scholz, 2010), which has been shown to improve family functioning (van Es et al., 2023). While the efficacy of MFA has not yet been empirically evaluated, it was found to be feasible and safe across other populations affected by conflict (Mooren et al., 2018). In 2023, over 40 professionals were trained in MFA.

6. Digital interventions

Digital interventions are being disseminated through partner websites in implementation countries and in Ukraine (e.g. by the Ukrainian mental health programme on the initiative of Olena Zelenska 'How are you?', or Ukrainian Ministry of Health), through leaflets, and word of mouth. Digital interventions are accessible worldwide. Meta-analyses suggest that guided and unguided digital MHPSS interventions are effective overall (Linardon et al., 2019), in low-

and middle-income countries (Fu et al., 2020), and as standalone interventions (Weisel et al., 2019).

6.1. Friend. First Aid Chatbot

The 'Friend' First Aid Chatbot is a digital preventive intervention based on principles of Psychological First Aid (PFA; WHO et al., 2011) that was adapted for Ukrainians dealing with stress due to ongoing hostilities (Frankova et al., 2022). The Chatbot was in development at Bogomolets National Medical University in Kyiv. It was launched in Ukrainian and English upon the full-scale Russian invasion of Ukraine in February 2022, being extended with a Russian language version in September 2022. The Chatbot is particularly suitable for hard-to-reach populations, as it can be accessed through the messenger service Telegram, used commonly in Ukraine. The Chatbot simulates a conversation with a specialist trained in PFA and provides recommendations and exercises for coping with acute stress (WHO et al., 2011). The Chatbot uses various scripts to adapt conversations based on participants' environments, distinguishing between life-threatening or safe environments (Lahutina et al., 2024). Although the Chatbot has not been empirically evaluated in a randomised controlled trial, its content is based on PFA, which offers practical and emotional support to reduce stress and promote coping in the immediate aftermath of a crisis or disaster and has been found to decrease acute distress and PTSD symptoms (Figueroa et al., 2022; WHO et al., 2011) and improved overall functioning following acute traumatic events (McCart et al., 2020). Feasibility study results have additionally shown a medium to large effect of the Chatbot on stress levels (Lahutina et al., 2024).

6.2. Doing what matters in times of stress

The DWM digital smartphone intervention is a self-help stress management guide for coping with adversity, adapted from WHO's illustrated self-help guide from the SH + programme (Mediavilla et al., 2023; WHO, 2020a). DWM is freely available in Ukrainian and Russian via a website (dwmatters.eu). The intervention consists of five modules covering mindfulness-based strategies for managing stress: grounding, unhooking, acting on one's values, being kind, and making room. DWM uses pre-recorded audio exercises to support identifying facilitators and barriers, as well as stress triggers for participants. Guided DWM has been found to be effective at reducing symptoms of depression and anxiety among health workers affected by distress (Mediavilla et al., 2023) and refugees and migrants (Purgato et al in press; Riello et al., 2021). Further, DWM has shown promising results as a standalone app (Fu et al., 2020; Linardon et al., 2019; Weisel et al., 2019).

7. Intervention stratification and selection

U-RISE interventions are provided in a stratified manner (Figure 3). After contacting an NGO, FDPs receive a link to the Chatbot and are assigned to a peer helper. FDPs complete screenings of around 20 min with their peer helper, during which the risk of self-harm, other harm, suicide, and signs of psychosis are assessed. Should any of these risks be present, the individual is immediately referred to specialised mental health services. Subsequently, peer helpers decide which interventions are optimal, depending on the preference and perceived benefit of an individual or group intervention, and whether the individual experiences challenges in parenting. During this process, peer helpers can discuss individual cases in supervision sessions, and refer individuals to specialised care.

8. Quality assessment

To ensure the quality of trainings and care provision, the competency of peer helpers is assessed using the WHO-developed EQUIP materials (Marshall et al., 2010). EQUIP consists of freely available competency assessment tools and e-learning courses to support training institutions and NGOs, to train and supervise their workforce to deliver effective psychological support in humanitarian and development settings. EQUIP encompasses the Enhancing Assessment of Common Therapeutic Factors (ENACT) competency evaluation tool. ENACT assesses the mental health and psychosocial support skills for non-specialist and specialist providers across cultures, contexts and intervention types (Kohrt et al., 2020).

9. Capacity building

Building capacity for face-to-face interventions enables local NGOs in Romania, Slovakia, and Poland to scale-up their MHPSS and train hundreds of professionals and peer-helpers. Although a high turnover of staff and volunteers is expected, there are signals that a substantial proportion of Ukrainian refugees intend to settle in the EU (van Tubergen et al., 2024). Integrating this group into the MHPSS workforce is critical to address the unmet need for mental health support among FDPs from Ukraine.

For PM + and SH+, a training pyramid consisting of trainings of trainers (ToTs) and subsequent trainings of peer-helpers (ToH), provides a structured framework for training a large number of trainers and peer-helpers and maximises the capacity for providing mental health support. Capacity building for PM + and SH + focuses on two sites in Poland, two

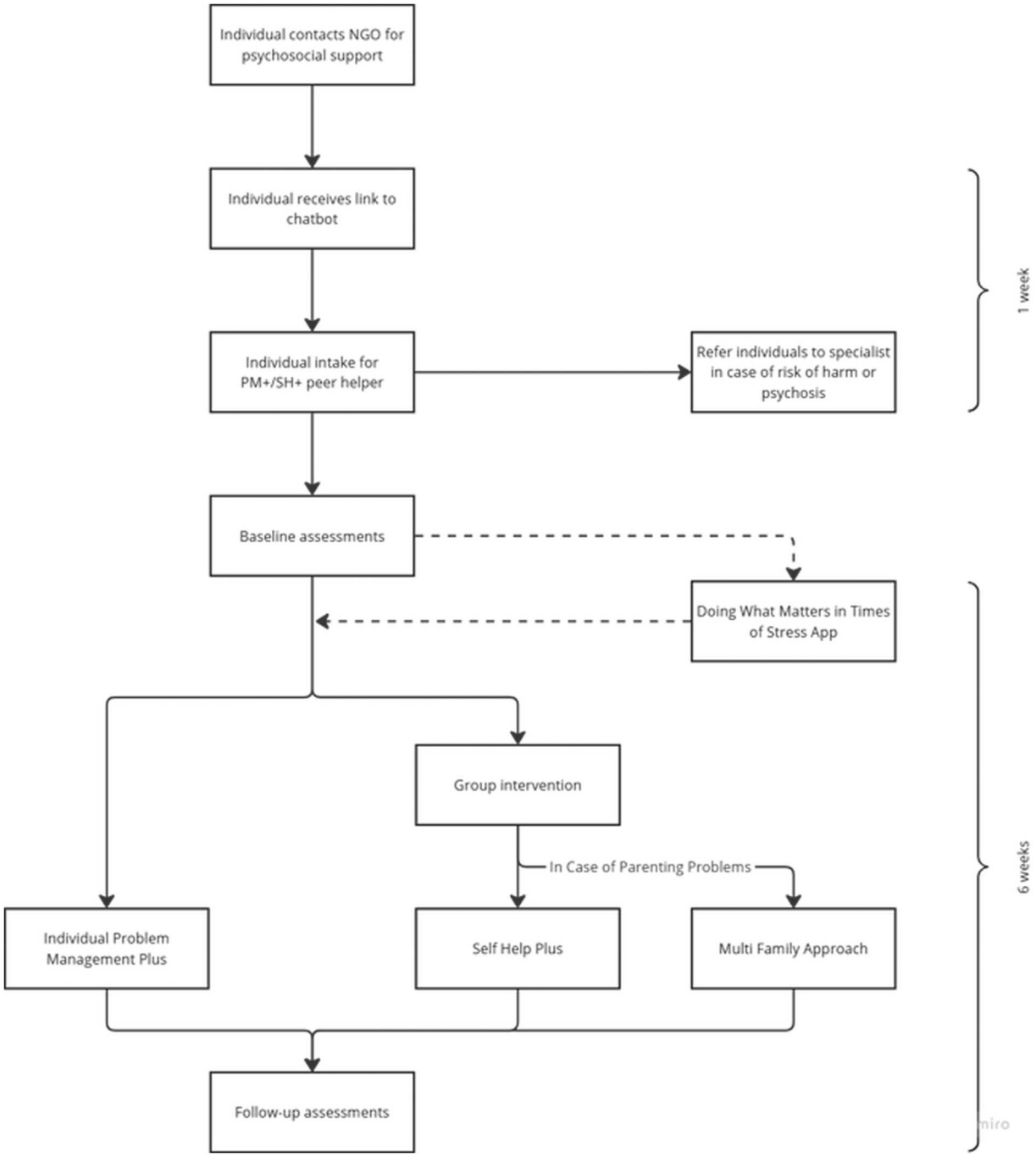

Figure 3. Intake and intervention trajectory of individuals.

in Romania and two in Slovakia. ToTs are provided to trainers, predominantly Ukrainian mental health professionals, employed or recruited by the NGOs. Trainers will train peer-helpers in ToH to deliver the interventions to FDPs seeking mental health support under supervision of a trainer.

In each country (Poland, Romania, and Slovakia) one ToT for PM + and SH + is organised, during which 15 trainers are trained. Afterwards, the aim is that each trainer trains five to seven peer-helpers, resulting in an estimated 100 peer helpers per country. Trainers provide 15–30 h of supervision to peer helpers. Aiming for five individual PM + interventions per helper, an estimated 400 FDPs per country and 1250 FDPs overall receive an intervention. MFA is trained in two locations, Poland and Slovakia, followed by monthly online supervision sessions, during which facilitators are encouraged to set-up and offer family group sessions, and can discuss ongoing proceedings. For the digital interventions (Chatbot and DWM), no helpers need to be trained.

The U-RISE project aims to support the continuous scaling up of MHPSS. Monthly webinars for MHPSS providers are organised, alongside information dissemination through social media and traditional media. These webinars aim to connect Ukrainian mental health practitioners with international experts and facilitate knowledge and skill transfer in psychotrauma management amidst the challenges of the ongoing

conflict. These sessions offer 75 min of interactive communication, engaging experts from high-, middle-, and low-income countries. The online meetings are open for live participants and are available as recordings in English and Ukrainian. Further, training materials and guidance regarding implementation are offered to NGOs to disseminate evidence on the effectiveness of low-intensity interventions for FDPs from Ukraine, as well as guidance regarding implementation.

10. Data collection and evaluation

Qualitative data is collected through semi-structured key informant interviews with Ukrainian MHPSS providers, Ukrainian FDPs, and Ukrainian FDPs who received an intervention. Interviews last between 30 and 60 min each and rely on open-ended questions aimed at establishing the perceived needs of FDPs from Ukraine regarding the future scalability of MHPSS, factors currently impacting their mental health, and feedback for future adaptations. Interviews are recorded and transcribed through videoconferencing or audio recording software. Key themes and topics are identified using hybrid deductive and inductive analysis using ATLAS.ti and NVivo.

Quantitative data on mental health outcomes is collected at pre- and post-intervention among FDPs receiving PM+, SH+, Chatbot, or DWM. Mental health outcomes include depressive symptoms, anxiety symptoms, and health disability, assessed using the Patient Health Questionnaire (PHQ-9; Kroenke et al., 2001), Generalized Anxiety Disorder Scale (GAD-7; Spitzer et al., 2006), PTSD checklist (PCL-5; Blevins et al., 2015), and WHO Disability Assessment Schedule (WHODAS 2.0; WHO, 2010) respectively. Parental warmth and responsiveness are assessed using 14 items from the Parenting Scale (El-Khani et al., 2021). As there is not yet evidence on scalable MHPSS in Ukrainians residing in Europe, we aim to document the overall levels of mental distress in FDPs from Ukraine and any post-intervention changes.

11. Discussion

Europe is currently experiencing its most significant war since World War II, which has forcibly displaced more than 6 million persons from Ukraine into Europe. FDPs from Ukraine are at elevated risk for developing mental health complaints such as depression, anxiety, and PTSD due to exposure to war-related adversities. Many countries receiving high volumes of FDPs have insufficient capacity to adequately support their MHPSS needs, creating an urgent mental health care gap. The present paper describes the U-RISE project protocol, which aims to build a strong network of Ukrainian mental health professionals, to contribute to capacity building for a scalable mental health response and to implement face-to-face and digital interventions. U-RISE promotes the use and dissemination of scalable interventions and addresses the MHPSS service gap in a in real-world setting in a practical and time-efficient manner, thereby providing a framework for the quick implementation of face-to-face and digital interventions across multiple countries. The project evaluates the implementation of interventions in three bordering countries and assesses the needs of various stakeholder groups as well as mental health outcomes of FDPs receiving the interventions. With its complementary approach on capacity building, implementation and research components, including the structured evaluation of the implementation process, U-RISE can serve as an example for future projects focused on scaling up MHPSS in response to humanitarian crises.

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ORCID

Karl J. Weinreich https://orcid.org/0009-0005-7115-3631
Iryna Frankova https://orcid.org/0000-0001-9371-6849
Corrado Barbui https://orcid.org/0000-0003-1073-9282
Vitalii Klymchuk https://orcid.org/0000-0001-7898-5530
Trudy Mooren https://orcid.org/0000-0003-0819-8640
Marianna Purgato https://orcid.org/0000-0002-3783-8195
Marit Sijbrandij https://orcid.org/0000-0001-5430-9810
Anke B. Witteveen https://orcid.org/0000-0002-9636-7522
Els van der Ven http://orcid.org/0000-0001-5103-7186

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