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ADAPTIVE PERFORMANCE ASSESSMENT AND EVIDENCE-BASED SCALING OF PUBLIC ADMINISTRATION FOR THE COMPREHENSIVE PSYCHOSOCIAL RECOVERY OF SERVICE MEMBERS AND VETERANS IN UKRAINE

Abstract

The article provides a theoretical and methodological justification for an adaptive performance-assessment model for public administration of the comprehensive psychosocial recovery of service members and veterans in Ukraine. The problem is considered as a public-governance task that extends beyond the delivery of individual medical, psychological or social services and requires the management of a continuous interagency pathway from needs assessment to functional, social and professional reintegration. The aim of the study is to define the architecture, performance domains, indicator rules, feedback procedures and evidence gates that can transform monitoring from a reporting function into an instrument for adaptive decision-making. The study applies systems, institutional and process approaches; normative and comparative analysis; theory-of-change logic; results-based management; indicator design; and structural-functional modelling. The proposed model distinguishes strategic, regional and operational levels of governance and links them through a common results chain: resources – processes – outputs – short-term outcomes – medium-term outcomes – long-term public value. Eight performance domains are defined:

accessibility and timeliness; continuity of the individual pathway; service quality and rights protection; psychosocial and functional outcomes; family and social reintegration; professional and economic reintegration; governance capacity and data quality; equity and resilience. For operationalisation, each indicator is assigned an indicator passport containing its definition, formula, source, periodicity, disaggregation rules, responsible data owner, target range and predetermined management response. A normalised domain score is proposed for analytical comparison, while critical rights, safety or data-protection events operate as non-compensatory red flags and cannot be concealed by a high aggregate score. The model includes an adaptive loop linking data verification, problem detection, causal analysis, correction of objectives and mechanisms, implementation and repeated measurement. Evidence-based scaling is organised through five decision gates: readiness for piloting, early pilot, full pilot cycle, interregional replication and national institutionalisation. The scientific contribution lies in integrating person-centred outcome measurement, public-administration capacity, data governance and evidence-based scaling within a single adaptive architecture. The practical significance is the possibility of using the model for interagency programme management, regional comparison, evidence-informed budgeting, digital pathway design and the gradual institutionalisation of an integrated system of psychosocial recovery in Ukraine.

Keywords: public administration, comprehensive psychosocial recovery, service members, veterans, veteran policy, performance assessment, adaptive management, reintegration, monitoring and evaluation, evidence-based scaling, data governance.

Problem statement. Russia's full-scale war against Ukraine has turned the recovery of service members and veterans into a long-term governance challenge involving health care, mental health, rehabilitation, social protection, employment,

education, local development, digital services and the protection of fundamental rights. From the perspective of the individual, these sectors do not constitute separate policy silos. They form a single life pathway in which delays, duplicated assessments, incompatible procedures or a loss of responsibility at an institutional boundary can negate the results achieved at an earlier stage. Accordingly, the object of public administration should be not a set of isolated services but the continuity and effectiveness of the pathway by which a person moves from prevention and early support during service to sustainable participation in civilian life [1–8].

Ukraine has already created important elements of this system. The Strategy of Veteran Policy until 2030 establishes a person-centred orientation of public policy, while the national legal framework separately regulates veteran guarantees, health rehabilitation, social services and the mental-health system [1–5]. The Cabinet of Ministers has also formalised the work of veteran support specialists and the provision of psychological assistance to veterans and family members [6; 7]. These measures create an institutional basis for comprehensive recovery. At the same time, the existence of sectoral rights and services does not automatically produce a coordinated route, comparable performance data or a feedback mechanism that obliges public authorities to correct ineffective procedures.

The central methodological difficulty is the difference between administrative activity and public outcome. The number of consultations, programmes, providers, referrals or budgetary transactions describes what the system does, but not necessarily what changes for the person. A service can be formally delivered while remaining late, geographically inaccessible, poorly coordinated or unrelated to an individual's recovery goals. Conversely, a programme with relatively modest output volumes may produce high public value if it restores functioning, prevents repeated crisis interventions, supports family stability and enables sustainable employment. Therefore, the assessment system

must distinguish inputs, processes, outputs, outcomes and impact rather than treating them as interchangeable performance measures.

A second difficulty is the multilevel nature of accountability. Strategic authorities establish guarantees, standards and funding rules; regional authorities configure networks and coordinate programmes; operational providers assess needs and deliver interventions. A failure observed at the individual level may be caused by an operational mistake, insufficient regional capacity, a national regulatory gap or a combination of these factors. Performance assessment must therefore connect levels of governance rather than simply aggregate local reports upward.

A third difficulty concerns information. Comprehensive psychosocial recovery requires enough data to ensure continuity of the pathway and evidence-based management, yet information concerning mental health, disability, family circumstances and combat experience is particularly sensitive. The more fragmented the system is, the greater the pressure to create a centralised data repository; however, such a solution may create privacy, cyber-security and discrimination risks. The performance architecture must therefore be compatible with data minimisation, role-based access, federated exchange, audit logging and the use of de-identified or aggregated information whenever individual-level data are not necessary.

The research problem lies in developing a model that simultaneously measures outcomes for people, diagnoses institutional causes, protects rights, supports adaptive management and provides a rational basis for deciding whether a pilot instrument should be corrected, replicated or institutionalised nationwide.

Analysis of recent research and publications. International evaluation practice provides a useful methodological starting point but does not by itself solve the specific problem of veteran recovery. The OECD evaluation framework identifies relevance, coherence, effectiveness, efficiency, impact and sustainability

as complementary lenses for judging public interventions [9]. These criteria are valuable because they force decision-makers to separate the question of whether an intervention addresses the right problem from the questions of whether it achieves results, uses resources rationally and generates lasting effects. For the Ukrainian wartime and post-war context, however, equity, continuity of critical functions and resilience to shocks must be added explicitly, since average improvements can conceal exclusion of rural residents, women veterans, persons with disabilities, internally displaced persons or people with limited digital access.

The World Health Organization's International Classification of Functioning, Disability and Health (ICF) is important for defining outcomes beyond diagnoses [8]. It treats functioning as the interaction between health conditions, activity, participation and environmental factors. This logic is particularly relevant to public administration because the same health condition can produce very different social consequences depending on transport accessibility, housing, family support, workplace adaptation, availability of services and administrative barriers. Accordingly, performance indicators should include changes in participation and functioning as well as the formal completion of treatment or rehabilitation episodes.

Research on military-to-civilian transition confirms the need to treat reintegration as a multidimensional process. Romaniuk, Fisher, Kidd and Batterham developed the Military-Civilian Adjustment and Reintegration Measure (M-CARM) to assess psychological adjustment and cultural reintegration after separation from military service [12]. This supports the use of person-reported outcomes alongside administrative indicators. Hitch, Toner and Armour show that help-seeking by veterans is affected not only by symptoms but also by attitudes, previous experience and barriers in service access [13]. This is significant for governance because low service utilisation cannot automatically be interpreted as

low need; it may indicate stigma, distrust, information barriers or inconvenient service design.

Employment is another area where activity indicators are insufficient. The systematic review by Van Til and co-authors demonstrates that work reintegration of veterans with mental disorders depends on a combination of individual, workplace and system factors [14]. For public administration, the relevant outcome is therefore not merely the number of people who complete training or receive a referral to an employer but sustainable, suitable employment, continuity of work and compatibility between the job, functional capacity and the veteran's goals.

UNDP analyses of veterans' reintegration in Ukraine emphasise the complexity of the transition to civilian life and the need for coordinated professional, social and economic support [10; 11]. These publications are particularly important because they frame veterans not only as recipients of assistance but also as actors in recovery, community development and reconstruction. The governance system should therefore measure participation, agency and opportunities for self-realisation rather than rely exclusively on deficit-based indicators.

The disability-inclusion framework of the World Bank adds a rights and accountability perspective [15]. Its practical relevance lies in the requirement to examine whether public systems are accessible to persons with disabilities and whether participation, monitoring and accountability mechanisms are inclusive. In the field of veteran recovery this means that performance cannot be considered satisfactory if aggregate targets are achieved while specific groups systematically face longer waiting times, inaccessible infrastructure, digital exclusion or lower completion of individual pathways.

The author's previous studies have addressed the public-administration dimensions of psychological support, social rehabilitation and the monitoring of

service members' psycho-emotional state [16–18]. These works confirm the need to connect early detection, social adaptation and rehabilitation with institutional mechanisms rather than treating them solely as clinical or individual matters. Nevertheless, a gap remains between the assessment of separate components and a unified architecture that links indicators to management decisions and evidence-based scaling. The present study addresses this gap.

Purpose of the article. The aim of the article is to substantiate an adaptive model for assessing the performance of public administration of comprehensive psychosocial recovery of service members and veterans in Ukraine and to define the rules by which monitoring evidence should lead to management correction and evidence-based scaling. To achieve this aim, the study: clarifies the object and levels of assessment; constructs a results chain and domain structure; proposes indicator passports and a normalisation rule for analytical comparison; defines critical non-compensatory red flags; develops an adaptive feedback cycle; and substantiates evidence gates for the transition from pilot implementation to national institutionalisation.

Research methods. The methodological basis combines systems, institutional and process approaches with person-centred, risk-oriented and evidence-based public administration. Normative-legal analysis is used to determine the existing guarantees, institutional roles and procedural requirements in Ukraine [1–7]. Comparative and documentary analysis is applied to international evaluation frameworks, reintegration practice and functional-outcome approaches [8–15]. Theory-of-change logic is used to separate inputs, activities, outputs, outcomes and long-term public value. Structural-functional modelling is used to connect governance levels, data flows and management responses. Indicator design is based on the principle of minimum sufficiency: an indicator is retained only if its definition is verifiable and if a specific management decision can be associated with its result. The article is methodological; it does not report a new patient-level

clinical study and does not interpret the proposed analytical thresholds as clinical cut-off values.

Presentation of the main material of the study. The starting point of the proposed model is a change in the unit of public-administration analysis. Traditional sectoral reporting treats the provider, institution or programme as the principal unit. An integrated recovery system should instead use the managed individual pathway as the primary analytical unit and institutions as the organisational environment that enables or obstructs this pathway. This does not mean merging professional records into a single dossier. It means that the state must be able to establish whether a person who entered the system was assessed, received an individual plan, was transferred between providers without losing continuity, obtained the required interventions and reached an agreed result or was appropriately re-assessed.

The pathway can be represented as a recurrent sequence: need – comprehensive assessment – individual plan – administrative and professional decisions – services – result – re-assessment and adjustment. Each element generates different types of evidence. Need and assessment data describe the starting situation; the individual plan records agreed objectives; service events show implementation; outcome measures show whether functioning, participation or economic independence changed; and feedback explains whether the process was acceptable and trustworthy. The management value of the model emerges when these data are linked to decisions about standards, network capacity, funding, staffing and digital design.

The architecture is organised at three levels. At the strategic level, the Cabinet of Ministers and central executive authorities define policy objectives, minimum guarantees, common definitions, budgetary rules, data standards and accountability requirements.

Table 1

Performance domains for public administration of comprehensive psychosocial recovery

Domain	***Core meaning***	***Examples of indicators***	***Primary management use***
Accessibility and timeliness	Ability to enter the pathway and receive support without avoidable delay	time from first contact to assessment; time from assessment to first service; territorial coverage; availability of remote and barrier-free formats	network planning, mobile services, staffing and referral-time standards
Continuity and coordination	Absence of unjustified breaks between military and civilian systems, providers and stages	share of cases with an assigned coordinator; confirmed handover rate; closed-loop referral rate	interagency procedures, case-transfer rules and coordinator responsibility
Quality and rights protection	Compliance with professional standards, dignity, informed participation, confidentiality and appeal rights	complaints and substantiated rights violations; informed participation in the plan; adverse events; confidentiality incidents; satisfaction and trust	quality assurance, supervision, regulatory correction and rights safeguards
Psychosocial and functional outcomes	Measured change in mental well-being, everyday functioning and capacity for independent life	change in validated functioning or well-being measures; reduction in crisis episodes; achievement of individual functional goals	clinical-service integration, intensity of support and re-assessment
Family and social reintegration	Restoration of family roles, social networks and participation in community life	family-support needs addressed; social participation; isolation indicators	family services, community programmes and social-support design
Professional and economic reintegration	Progress towards suitable, sustainable employment, education or entrepreneurship	training completion; employment matched to capacity; employment retention; income stability	employment policy, outcome-based contracting and employer incentives
Governance capacity and data quality	Institutional ability to coordinate, finance, staff, digitise and learn from the system	staffing adequacy; provider-network capacity; data completeness; interoperability; budget execution linked to outcomes	budgeting, workforce planning, digital governance and accountability
Equity and resilience	Fair access and capacity to preserve critical functions under shocks	disaggregated outcome gaps; service continuity during displacement or infrastructure failure	targeted equalisation investments

At the regional level, military administrations and other territorial bodies analyse needs, configure provider networks, coordinate interagency programmes, identify territorial inequalities and reallocate resources within their competence. At the operational level, military units, health-care institutions, rehabilitation providers, social-service organisations, employment services, educational institutions, veteran support specialists and community partners implement the pathway and generate primary data. Information must move upward for analysis, while corrected standards, resources and procedures move downward as a management response.

A performance system that only transfers information upward remains a reporting mechanism. An adaptive system requires a reverse connection: if data reveal a bottleneck, the responsible level must identify the cause, adopt a corrective decision and verify whether the next measurement improves the result. Therefore, the architecture is not a hierarchy of reports but a closed management loop.

The eight domains are analytically distinct but causally connected. Low employment retention, for example, can result from a mismatch between training and labour-market demand, insufficient workplace adaptation, unresolved health limitations, transport barriers or a break in case management. For this reason, the domain profile is more informative than a single aggregate indicator. It enables decision-makers to see where the pathway fails and prevents a strong result in one area from automatically compensating for a critical weakness in another.

The second principle is the separation of indicators by the level of the results chain. Input indicators describe available money, staff, infrastructure and digital systems. Process indicators describe waiting times, assessments, referrals and case transfer. Output indicators describe delivered services and completed activities. Outcome indicators capture changes in functioning, participation, employment or well-being. Impact indicators address longer-term public value, including

sustainable reintegration, reduced long-term dependence, community resilience and confidence in institutions. Reporting should contain all levels, but public-administration performance should be judged primarily by outcomes and the system's ability to explain how inputs and processes contribute to them.

The third principle is minimum sufficiency. Every indicator creates administrative cost, influences professional behaviour and may produce unintended incentives. If an indicator does not affect any decision, does not fulfil a legal accountability requirement and does not provide unique diagnostic information, it should be removed or redesigned. Excessive reporting can weaken the very services being monitored by shifting scarce professional time from interaction with people to data entry.

Each indicator should therefore have a formal passport. The passport makes the indicator reproducible and prevents different institutions from calculating the same label in different ways. It also obliges the designer to specify what should happen if the indicator leaves its acceptable range. This connection between measurement and a predetermined management response is essential for adaptive governance.

For cross-regional or longitudinal analysis, indicators expressed in different units require a common analytical scale. The article proposes a normalised progress score. For an indicator where a higher value is desirable, the score can be calculated as $z_{it} = (x_{it} - b_i) / (T_i - b_i)$, bounded to the interval [0; 1], where x_{it} is the observed value, b_i is the baseline and T_i is the target. For an indicator where a lower value is desirable, the direction is reversed: $z_{it} = (b_i - x_{it}) / (b_i - T_i)$. The purpose of normalisation is not to create a clinical score but to make administrative indicators comparable for management analysis.

A domain score can then be calculated as $Dd,t = \Sigma(w_i\, z_{it}\, q_{it}) / \Sigma(w_i\, q_{it})$, where w_i is the agreed weight of the indicator and q_{it} is a data-quality eligibility variable equal to 1 when the value meets minimum verification requirements and 0 when it

does not. If data are missing or unreliable, the system should show the gap rather than replacing it with an assumed favourable value. Weights should be established through expert and stakeholder review and then tested during the pilot phase; equal weights are preferable to arbitrary pseudo-precision when there is no evidence for a different distribution.

The model intentionally avoids treating a single composite score as the primary result. The vector Gt = (D1,t, D2,t, …, D8,t) is the main governance profile. An optional summary score St = Σ(αd Dd,t) may be used for communication or trend analysis, provided that the weights αd sum to one and that no critical red flag is present. This safeguard is necessary because a high employment score cannot compensate for a severe rights violation, a major data breach or an unsafe interruption of critical mental-health support.

Critical events therefore operate outside the compensatory scoring logic. A confirmed serious rights violation, systemic discrimination, a major confidentiality breach, an unmitigated risk to life or safety, or the failure of a critical continuity function automatically triggers an escalation procedure regardless of the aggregate score. This reflects the principle that some public values are threshold conditions rather than variables that can be traded against better performance elsewhere.

$z_{it} = (x_{it} - b_i) / (T_i - b_i)$, *for indicators where higher values are preferable;*

$z_{it} = (b_i - x_{it}) / (b_i - T_i)$, *for indicators where lower values are preferable;*

$D(d,t) = \Sigma(w_i \cdot z_{it} \cdot q_{it}) / \Sigma(w_i \cdot q_{it})$; $G_t = (D_{1t}, D_{2t}, \ldots, D_{8t})$.

The proposed analytical thresholds are governance signals rather than universal normative standards. During piloting, each domain should be calibrated against baseline capacity, legal requirements, service risk and achievable targets. Nevertheless, a common traffic-light interpretation can support early implementation and make management responses predictable.

The analytical layer becomes a governance mechanism only when it is embedded in an adaptive feedback cycle. The cycle begins with the collection of

data from legally authorised sources and the verification of completeness, timeliness and plausibility. The second stage converts verified data into a domain profile and identifies deviations from targets, inequalities between groups and critical red flags. The third stage is causal analysis. A problem is not corrected by automatically increasing expenditure: the cause may be insufficient capacity, an inappropriate eligibility rule, a weak referral protocol, low awareness, digital exclusion, lack of trust or a poorly designed performance incentive.

The fourth stage is the management response. Depending on the identified cause, the responsible authority may revise a regulation, redistribute funding, expand a provider network, change a staffing model, modify an information exchange, improve communication, introduce an alternative access channel or adjust the individual pathway standard. Every response must have an owner, deadline, resource source and expected measurable effect. The fifth stage is implementation and the sixth is re-measurement. If the indicator does not improve after a reasonable period, the theory of change and causal assumption must be reconsidered rather than repeatedly applying the same intervention.

This cycle makes monitoring an internal function of public administration. Evaluation is not an external event performed after a programme has ended; it is a periodic deeper analysis that tests whether the observed change can plausibly be attributed to the intervention, whether the effect is equitable and whether it is sustainable. Operational monitoring and periodic independent evaluation therefore complement one another.

A distinctive feature of the model is the separation between improving an existing programme and deciding whether to scale it. Scaling is an irreversible or costly governance decision because it creates staffing obligations, information systems, budget expectations and legal dependencies. A politically attractive pilot should therefore not be replicated nationally solely because it produced positive testimonials or high activity volumes. The evidence package must show that the

intervention is feasible, safe, acceptable, effective, equitable, financially manageable and reproducible in different territorial contexts.

The proposed evidence-gate approach organises scaling as a sequence of decisions. Each gate asks whether a minimum package of evidence exists and whether critical conditions are satisfied. Failure to pass a gate does not automatically mean abandoning the intervention. It may require redesign, a longer pilot, additional safeguards or a narrower target group. This reduces the risk of both premature national roll-out and endless piloting without institutional decisions.

The first gate concerns readiness. Before a pilot starts, the theory of change, process map, baseline, risk register, legal basis, minimum service package, data-protection arrangements and staff preparation must be in place. The second gate concerns early feasibility and safety. The third gate evaluates a complete pilot cycle and requires outcome data, disaggregation, cost information and independent verification. The fourth gate tests reproducibility in different types of territories. The fifth gate determines whether the intervention is ready for national institutionalisation through law, budget and permanent governance arrangements.

Data governance is an integral part of performance management rather than a separate technical issue. The integrated pathway should not be implemented as a super-register containing all clinical, psychological, social and employment information. A federated architecture is more consistent with the principle of data minimisation: sectoral data remain with their lawful controllers, while the pathway layer exchanges only verified facts and events necessary for coordination. For example, a coordinator may need to know that a rehabilitation episode has been completed and that a follow-up appointment is due without receiving detailed clinical notes that are irrelevant to the coordination task.

Three information layers are therefore advisable. The first is the individual coordination layer containing the minimum data necessary for identification,

consent or other lawful basis, plan status, referrals, deadlines, responsible actors and key pathway events. The second is the professional layer retained in specialised systems under sector-specific access rules. The third is the analytical layer containing de-identified or aggregated indicators for programme management and evaluation. The separation of these layers reduces the risk that performance analytics becomes a justification for unnecessary access to sensitive personal information.

Role- and context-based access, audit logging, incident detection, privacy impact assessment and cyber-resilience must be included in the indicator system itself. A digital platform cannot be considered successful simply because it increases the volume of exchanged data. Its performance should be assessed through continuity of service, reduction of duplicate submissions, timeliness of handovers, user accessibility, data quality, number and severity of incidents, and the ability to restore critical functions after disruption.

Public accountability requires publication of national and regional results in aggregated form. Reports should contain not only values of indicators but also a management response: what problem was detected, what explanation was accepted, what decision was taken, who is responsible and when the effect will be re-measured. Without this response, transparency can become descriptive rather than corrective. Individual case histories should not substitute for system-level evidence and should not be publicly disclosed without a free and specific legal basis or consent.

For practical implementation in Ukraine, the model can be introduced without creating a new central executive body. The central level should approve an interagency methodology and a minimum set of indicator passports, define the national results chain, establish data-governance requirements and organise an annual independent evaluation. A programme office or other designated coordination function can maintain the methodology, support regions and prepare

quarterly interagency reviews. Existing ministries retain their legal competences, while the shared methodology ensures that sectoral decisions are assessed against the same person-centred outcomes.

At the regional level, the model should be used to compare the availability and completion of pathways, not to construct simplistic league tables. Regional profiles must be interpreted together with population structure, security conditions, rurality, infrastructure damage, workforce availability and displacement patterns. The purpose of comparison is to identify capacity gaps and appropriate adaptation, not to punish regions operating under objectively more difficult conditions.

At the operational level, data collection should be integrated into normal professional workflows as far as possible. Repeated manual entry of information that already exists in a lawful information system should be avoided. Short user-reported measures can be collected at agreed milestones, but the frequency should be proportionate and sensitive to the burden on people in recovery. The principle is to collect the least amount of data necessary to make a better decision.

A quarterly adaptive review is appropriate for interagency programme management. It should examine the domain profile, inequalities, red flags, unresolved corrective actions and budget implications. A deeper annual evaluation should analyse causality, sustainability and the performance of the theory of change. Major incidents or rights violations should trigger immediate review rather than wait for the routine cycle.

The financial dimension is especially important. Evidence from the model can support a transition from financing isolated activities to financing capacity and confirmed outcomes. However, payment for outcomes should not create incentives to avoid complex cases. A mixed mechanism is preferable: base financing for network readiness and critical capacity, payment for standardised services, additional support for complex or long pathways, and carefully designed incentives for verified completion or sustainable employment. Risk adjustment

and independent verification are necessary if performance-based payment is introduced.

The same logic applies to professional reintegration. The state should assess not only how many veterans completed training or obtained an initial job but whether employment was suitable, retained and consistent with functional capacity and the individual's goals. Where employment is not an appropriate immediate outcome, the pathway should recognise other legitimate recovery objectives, including continued rehabilitation, education, family stabilisation or supported participation. This prevents the performance system from imposing a single normative life trajectory on all veterans.

Participation by veterans and family members is required at two levels. At the individual level, recovery goals and the plan should be developed with informed participation. At the system level, veteran representatives should participate in the review of indicators, interpretation of user feedback, pilot evaluation and the design of corrective actions. This improves both relevance and legitimacy and reduces the risk that administratively convenient indicators become disconnected from actual experience.

Discussion. The proposed model has several methodological advantages. First, it shifts the centre of gravity from institutional activity to the completed or appropriately continued individual pathway. This is essential in an intersectoral field where no single institution can produce the final result alone. Second, it combines outcome measurement with governance-capacity indicators, enabling decision-makers to distinguish symptoms from institutional causes. Third, it integrates evidence use into the management cycle and therefore treats evaluation as a mechanism of public administration rather than as an external audit exercise.

Fourth, the model uses a profile rather than relying on a single synthetic ranking. Composite indices are attractive because they simplify communication, but in psychosocial recovery they can hide unacceptable trade-offs. A region could

achieve a high average score through strong employment and access indicators while still having serious confidentiality violations or systematically poor results for persons with disabilities. The non-compensatory red-flag rule and mandatory disaggregation reduce this risk.

Fifth, evidence gates make the model suitable not only for monitoring established programmes but also for reform implementation. In wartime and early recovery, governments often need to introduce new mechanisms rapidly. The gate approach allows speed without abandoning evidence: an intervention may start as a controlled pilot, but each subsequent expansion requires a stronger evidence package. This creates a disciplined pathway from innovation to institutionalisation.

At the same time, the model has limitations. The proposed domains and thresholds require empirical calibration in Ukrainian pilot regions. The availability and quality of longitudinal outcome data may be uneven, particularly across systems that were developed for different administrative purposes. Attribution will remain difficult because recovery outcomes are influenced by security conditions, family resources, local labour markets and individual preferences as well as public programmes. The model should therefore be used for contribution analysis and adaptive decision-making rather than as a claim that all observed changes are caused by a single policy.

Another limitation concerns measurement burden and ethics. Repeated assessment can itself become a barrier to service access, and sensitive self-reported outcomes should not be transformed into punitive performance targets for professionals or regions. The methodology should distinguish information required for individual care from information required for public management and should avoid using clinical instruments outside their validated purpose.

Further research should empirically test the model in different territorial contexts, determine the reliability and sensitivity of proposed indicators, analyse

the administrative cost of data collection, and compare different weighting and threshold approaches. It is also necessary to study how the domain profile can be integrated into programme budgeting and how outcome-based financing can be designed without adverse selection against people with complex needs.

Conclusions. The study substantiates an adaptive model for assessing the performance of public administration of comprehensive psychosocial recovery of service members and veterans in Ukraine. The model interprets recovery as a managed interagency pathway rather than a mechanical set of sectoral services and therefore makes pathway continuity, timeliness, functional change, social participation and sustainable professional reintegration central objects of assessment.

The performance architecture combines strategic, regional and operational levels and organises information through eight domains: accessibility and timeliness; continuity and coordination; quality and rights protection; psychosocial and functional outcomes; family and social reintegration; professional and economic reintegration; governance capacity and data quality; equity and resilience. This structure links individual outcomes to institutional causes and enables evidence to be translated into specific regulatory, organisational, financial, workforce, digital or communication decisions.

Indicator passports are proposed as the basic technical instrument of standardisation. Each indicator must have a clear definition, formula, data source, frequency, disaggregation rules, data-quality requirements, responsible owner, target range and predetermined management response. Normalised domain scores can support comparison and trend analysis, but the principal analytical product is the multidimensional governance profile. Serious rights, safety, discrimination or data-protection events are treated as non-compensatory red flags.

The adaptive cycle consists of data collection, verification, performance profiling, problem detection, causal analysis, management correction,

implementation and re-measurement. This closes the gap between reporting and governance. Monitoring shows what is happening; periodic evaluation explains why and whether the intervention is producing equitable and sustainable results.

Evidence-based scaling is organised through five gates: readiness for piloting, early pilot, full pilot cycle, interregional replication and national institutionalisation. This allows public authorities to expand effective mechanisms while correcting or discontinuing those that do not demonstrate feasibility, safety, effectiveness, equity, reproducibility and budgetary sustainability.

The practical value of the model lies in its compatibility with Ukraine's existing institutional system. It does not require the creation of a new authority; it requires a common interagency methodology, a minimum set of data and indicators, a disciplined feedback procedure and the integration of evaluation results into strategic and budgetary decisions. In this form, performance assessment becomes a mechanism for continuous learning of the public-administration system and for protecting the substantive result of veteran policy: a person's sustainable functioning, autonomy, participation and dignity.

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